Correspondence Address

684 Barrington Rd, Suite 112, Streamwood Il 60107
www.Ardentcenter.com

(888) 870-1775 (Main)
(847) 349-1619(Fax)

Dear New Client:

Welcome, and thank you for choosing us to help you on your healing journey.

Your work is just beginning. Filling out the enclosed forms before coming to your first appointment allows your therapist to use your time wisely. Please either bring all the forms with you to your first session, so that we may enter you information into our system.

1. **Billing Insurance Registration**: We need this information from you for billing and audits. Please bring your insurance card in with you so we can make a copy for our records.
2. **Therapy Service Agreement**: Two copies. One is yours to keep. Please read through this carefully. If you have any questions, please feel free to ask your therapist, they can help you understand the contents of the agreement.
3. Copies of our HIPPA Privacy notice is available upon request from our HIPPA privacy officer. Please contact our office to request.

We are in-network providers for most major insurance companies. As a courtesy to you, we work directly with your insurance and will make every effort possible to bill your insurance company.

In compliance with health insurance contracts, Ardent Counseling Center requires that all copayments are collected for payment at the time of service and that all coinsurance and deductible amounts are collected immediately following insurance claim processing. Please make sure that you are prepared to make payment for your copayment via (check/money order or credit card via a reoccurring authorization form attached) We do not have the ability to waive copayments, deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company.

Please be on time for your appointment. This is ***your*** time.

Sincerely,

REGISTRATION FORM

Instructions: Please fill out this form and make a copy of the front and back of your insurance card and attach it.
Please complete a copy of this form for each family member being seen.

CLIENT INFORMATION - DETAILS OF THE PERSON BEING SEEN

Client's last name:	First:	Middle:	Mr.____ Mrs.____ Miss____ Ms.____	Marital Status: Single____ Married____ Divorced____ Separated____ Widowed____

Is this your legal name? Yes____ No____	If not, what is your legal name?	(Former name):	Birthdate:	Age:	Gender: M____ F____ Other:________

Street address:	Social Security no.:	Home phone no.: Cell phone no.:
P.O. box:	City:	State:	ZIP Code:
Email Address:	Employer:	Employer phone number

INSURANCE INFORMATION - DETAILS OF THE PERSON RESPONSIBLE FOR THE BILL = THE INSURED

(Please give your insurance card to your Therapist.)

Person responsible for bill:	**Birthdate:**	Address: street/city/state/zip (of person responsible for bill):	Home phone no.:
Occupation:	Employer:	Employer Address: street/city/state/zip:	Employer phone no.:
Primary Insured's name:	**Primary Insured's S.S. no.:**	**Primary Birthdate:** **Group no.:**	**Subscriber ID:**

Primary's Address: street/city/state/zip	**Co-payment / Deductible :**	**EAP Auth:**
Insurance Company Name	Billing Address:	
Billing Address Cont.	Insurance phone no.:	

Client's relationship to Insured:	Self	Spouse	Child	Other

IN CASE OF EMERGENCY

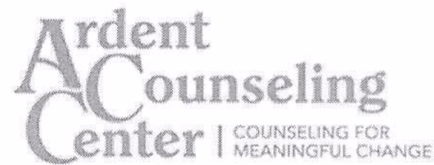
Name of local friend or relative (not living at the same address):	Relationship to Client:	Home phone no.:	Work phone no.:

I permit Ardent Counseling Center and billing staff to send the required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that I will be responsible for any unpaid balance such as co-pays, deductibles, and non-covered services. **I understand that appointments missed or canceled less than 24 hours before the appointment will be billed at $60.00.** I understand that neither my insurance nor EAP covers the cost of missed sessions. I know that my Therapist may not schedule further sessions until all unpaid balances, such as co-pays due, are paid in full.

In consideration of services to be provided to me or my dependent, I hereby assign, transfer, and set over to Ardent Counseling Center all of rights, title and interest To reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to the Ardent Counseling Center for charges not covered by this assignment.

______________________________ ______________________

Client/Guardian Signature DATE



CLIENT COUNSELING, THERAPY MEDICATION MANAGEMENT SERVICE AGREEMENT

Corporate Office

684 Barrington Rd, Ste 112

Streamwood, Illinois 60107

Please read. Keep one copy for your records.

Ardent Counseling Center is a business facility where many mental health professionals practice. Your contract for services is with Ardent Counseling Center and all therapists who practice at Ardent Counseling Center. Your therapy will be handled by your therapist or medication management provider, although your treatment may be discussed with other providers at Ardent Counseling Center. If, for any reason, youwish to change to a different therapist practicing at Ardent Counseling Center, don't hesitate to get in touch with Ardent Counseling Center with this request.

Rights and Risks: Please feel free to ask questions about any aspect of the counseling process. · If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report. ·You need to be willing to discuss what troubles you and be open to change. · As a result of counseling, you may remember unpleasant events, arouse intense emotions, and/ or alter close relationships.

Confidentiality: Confidential Information shared will be held in confidence in compliance with applicable state and federal law. "Confidential Information" includes recordings or transcripts of therapy sessions, therapist notes, medical reports, or therapy progress reports. · Information will not be released without your written consent, except for professional consultation if needed or if the disclosure is required by law. Your provider may be required by law to disclose information pertaining to suspected child abuse; inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others. · Should your therapy be involved or subject to court proceedings or litigation, your counseling records may be subject to subpoena. · It is understood that information regarding treatment and diagnosis may be provided to an insurance company. · You may want to discuss further limits or exceptions of confidentiality. · Information regarding your counseling, therapy, and/or medication management will be used internally by Ardent Counseling Center for coordination of supervision, and will not be released to any third party without your express written release.

Client Agrees to: ☐ Allow **the Therapist to be assisted by a co-therapist if either or both deems it appropriate.**

Note on Privacy: I understand that the counseling sessions in which I participate with a co-therapist are for the purpose of improving my care. I understand that confidential information will be shared between my therapists and any co-therapists involved and I hereby authorize such disclosure.

Appointments: All office visits are by appointment with your Therapist directly. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 60 minutes. · Late cancellation (less than 24 hours before) and/or no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get the voice mail or our answering service. If your appointment is canceled or missed, contact thereception staff for a new appointment time. Insurance companies will not pay for no-show charges or latecancellation charges.

Fees:

The client portion (co-pay or full amount) of fees is expected at the time of service. · Your health insurance may help you recover some of your counseling costs. Please verify with your insurance company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires pre-authorization to receive services, this is your responsibility and needs to be handled before your first visit.

Uninsured clients are expected to pay their fees as services are rendered. If required, Ardent will fill out and submit forms to your insurance company. Otherwise, Ardent Counseling Center will provide you with whatever forms and assistance available to help you receive the benefits to which you are entitled. This office will not accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. **Clients are responsible for payment (and insurance claims) on their accounts.**

Failure to pay your part may jeopardize your benefits. Co-pays are not negotiable. Clients paying on a cash basis and not billing any insurance company are expected to pay in full at the time of service unless a payment plan has been previously arranged. Except in the case of minors or when other arrangements are made, the person receiving the counseling service or medication management is financially liable. Accounts become delinquent after thirty (30) days. Delinquent accounts may be turned over forcollection. Clients agree that they will be responsible for any collection/legal fees associated with collection efforts.

If, for any reason, my insurance company does not make complete payment to Ardent Counseling Center within **30** days of my office visit. I understand that I may be sent a bill explaining my amount due. If I failto submit payment to The Ardent Counseling Center within the following 10 calendar days. **I hereby authorize you to debitmy credit card (on-file) for the total amount due.**

If the Insurance Company denies payment or applies the visit charge to my deductible, I understand that I am responsible for the amount billed by The Ardent Counseling Center. As we are a fee for service Counseling Center the balance of your bill is due in full immediately, **I hereby authorize Ardent to debit my credit card for the total amount due.**

I understand that should my credit card on file not be approved. I am still fully responsible for payment. I know that if my account is not paid in full within 30 days, my account may be turned over for collections and I will be responsible for all costs of collection and monies owed, including court costs, collection and attorney fees.

If I cancel an appointment within 24-hours of my appointment start time, or fail to attend a scheduled appointment, I hereby authorize Ardent Counseling Center to charge to my credit card the cancellation or missed appointment fee in the amount of $60. I authorize my credit card to be charged for patient balances pursuant to the above signed agreement.

Returned Checks: If a check that I have written to The Ardent Counseling Center is returned, I hereby authorize you to debit my credit card for the total amount due plus an administrative fee of $40.00. After that, any account balances must be paid by credit card, cash, or money order.

Cost NOT covered by Insurance: Completion of forms are not billable to your insurance and you will be billed at $30 per 15 minutes, i.e., workman compensation, disability, FMLA forms {not inclusive listing}. This will not be processed by insurance (if the insurance company does not cover phone sessions) and will be owed from the client to Ardent Counseling Center.

Financial Status Changes: I will discuss any change in my financial situation with my provider or office staff.

Insurance Communication: I hereby authorize Ardent Counseling Center and my Therapist to release any information acquired in the course of my therapy to my insurance company. If client is a minor, by signing this agreement, I certify that I am the parent or guardian of the minor child and authorize this release). I understand my insurance coverage is a relationship between my insurance company and me, and I agree to accept financial responsibility for payment of charges incurred. I know that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by or on account of the client named below and hereby assign Ardent Counseling Center and all Insurance benefits due to me to the full extent of my financial obligation to Ardent Counseling Center. I have read and/or received a copy of Ardent Counseling Center Privacy Policy. If conjoint (couple or family) all adults need to sign this contract because of confidentiality and our rights, even though one person is the identified client.

ELECTRONIC COMMUNICATION POLICY: Ardent Counseling Center and your Therapist or medication management provider take confidentiality and privacy issues and healthy boundaries relating to the therapeutic relationship very seriously. To protect the right of client and Therapist for Privacy, to safeguard the confidentiality of information shared between them, and to avoid confusion and maintain clear boundaries between client and Therapist, (Therapist's name) has chosen to follow these principles concerning the use of social media:

- Your Therapist or medication management provider does not engage with clients in any way on social networking sites. For example, friend requests on Facebook will be denied and any communication on social platforms such as Messenger will be ignored.
- If your therapist or medication management provider has an active Facebook page as part of a professional practice, which aims to share updates and blog posts. Clients are welcome to view and share the posts but they will not be able to become fans of that page.
- If your therapist or medication management provider has an active Twitter account used to publish clinical news. Clients are not expected to follow this account. While clients have the right to follow any twitter account they wish, they should consider safer options (such as using an RSS feed or a locked Twitter list). Our Providers do not follow past or current clients on Twitter.
- The preferred method to contact your Therapist or medication management provider between sessions is the phone. This is especially true when a client wishes to discuss therapeutic related issues.
- For brief pragmatic communications, such as rescheduling a session, clients may also use email. To protect your information, please avoid using email to communicate matters related to the sessions. Computers and unencrypted email, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and therefore can compromise the privacy and confidentiality of the information used in such communications. Servers and telecommunication companies often have direct and unlimited access to all the information contained in the emails, texts, and e-faxes that use their services. Should you communicate with your Therapist or medication management provider using unencrypted email, texts or e-fax or via phone messages, you assume the responsibility of the risk that your information and identity may be intercepted. Please do not use texts, email, voice mail, or faxes for emergencies as they will not be accessed in a timely manner.
- Your therapist or medication management provider will not be able to see materials clients post on social media but if they wish to bring something relevant to the treatment or otherwise to the session, they are welcome to do so.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of Ardent Counseling Center require that we keep treatment records for at least 7 years unless legally required to maintain for a longer period. Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. If you have concerns regarding the treatment records, please discuss them with your Therapist or medication management provider. As a client, you have the right to review/ receive a summary of your records at any time, except in limited legal or emergency circumstances or when the therapist or medication management provider assesses that releasing such information might be harmful in any way. In such a case, your therapist or medication management provider will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, your therapist or medication management provider will release information to any agency/person you specify unless therapist or medication management provider assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in couple and family therapy cases, the therapist or medication management provider will release records only with signed authorizations from the patient of record (as identified by your provider in the initial diagnostic session.

AUDIO OR VIDEO RECORDING: Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by Therapist or medication management provider.

TERMINATION: As set forth above, after the first couple of meetings, your therapist or medication management provider will assess if he/she can be an effective provider for you. If appropriate, the provider will give you a referral that you can contact in such a case. If at any point during psychotherapy, your therapist or medication management provider either assesses that he/she is not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive. If you are available and/or it is possible and appropriate to do, he/she will discuss with you the termination of treatment and conduct pre-termination counseling.

In such a case, if appropriate and/or necessary, the provider would give you a couple of referrals that may help you. If you request it and authorize it in writing, Your therapist/ medication management provider will talk to the psychotherapist of your choice to help with the transition. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, your therapist / medication management provider may provide you with names of other qualified professionals whose services you might prefer.

Telehealth: I consent to engage in telemedicine (e.g., Video or telephone-basedtherapy) with licensed clinical professionals at the Ardent Counseling Center as a mode of my psychotherapy or medication management treatment. I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health carepractitioners.

I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; unauthorized persons could access the electronic storage of my medical information; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telehealth-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist/medication management provider believes I would be better served by another form of psychotherapeutic service (e.g., face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy/medication management. Despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even worsen.

INFORMED CONSENT FOR IN-PERSON SERVICES DURING PUBLIC HEALTH CRISIS: I understand that by seeking in-person therapy/ medication management, I am assuming the risk of exposure to any public health risk. I agree to take appropriate precautions which will help keep all that come to the offices of The Ardent Counseling Center safer from exposure, sickness and possible death.

I acknowledge I have received, read and understand The Ardent Counseling Center, CLIENT COUNSELING, THERAPY MEDICATION MANAGEMENT SERVICE AGREEMENT as well as the Ardent Counseling Centers HIPAA Privacypolicy.

By signing below, I agree to the terms of the agreement:

Client's Name(print) ____

Signature____________________________________Date ______________

Please Initial One

Recurring Authorization:	
Update Information:	
Cancel Authorization:	

Credit Card On File - Authorization Form

Name of Person authorizing payment:		
Name of business (if Applicable and hereafter "Accountholder")		
Address:		
City	State:	Zip:

Credit Card Information

Card Type: ☐ MasterCard ☐VISA ☐ Discover ☐ AMEX

☐Other ___________________________

Cardholder Name (as shown on card): ___________________________

Card Number: ___________________________ CVV ___________

Expiration Date(mm/yy): ___________________________

Cardholder ZIP Code (from credit card billing address): ___________________________

By completing and executing this **reoccurring authorization form**, the cardholder acknowledges and agrees that The Ardent Counseling Center (hereafter "Company) is authorized as of the authorization date set forth below and subject to the terms and conditions set forth below, to charge the credit card, debit card, chard card, electronic check draft (ACH) or other payment card (each referred to herein as "Credit Card" or Check), specified above for the amounts billed to the accountholder or the card holder specified above for service rendered.

Company will send the accountholder or cardholder an invoice for service rendered. Company will charge the above credit card or ACH for the amount specified in the invoice on or around the date of the invoice. The account holder/credit card holder should ensure such charge will not cause the credit card account or ACH draft to exceed any established credit /bank limits or available balances as on the date of charge/draft. There will be a $35.00 penalty for any rejected charge pursuant to this authorization. Cardholder acknowledges that they will continue to be liable for any such rejected or any unpaid charges including all penalties and legal fees. Cardholder further authorizes Company to initiate a chard or credit as necessary to correct any prior overpayment or underpayment of any invoice or any other charge or credit effected under this or prior authorization(s) Company and cardholder further acknowledge that if this payment authorization is for a recurring charge/ draft, then Company will inform cardholder of any variances in the recurring amount. Each charge will appear as a payment on the next invoice sent to accountholder/cardholder after the charge date. All charges and ACH debits will appear as **Mental Health Billing**.

To Update/Cancel the above credit card information, please execute this form and check "Update information" or "Cancel authorization and fax back to number provided below. This authorization shall remain in effect until Ardent Counseling Center, receives a new form requesting an update or cancellation, and the Ardent Counseling Center LLC has had sufficient time to clear any arrears and act on the authorization. Cardholder will continue to be liable for any invoices due and pending as of such termination. Cardholder is responsible for informing Company of and any changes in the above information.

If you have any question on billing or credit card/ACH charges please contact our correspondence address, Ardent Counseling Center, 684 Barrington Rd, Suite 112 Streamwood, Illinois 60107

Signature of Cardholder/Accountholder:
Authorization Date:

Ardent Counseling Center | COUNSELING FOR MEANINGFUL CHANGE

HIPAA Privacy Policy

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment. Payment. and Health Care Operations

We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposeswith your written authorization. To help clarify these terms, here are some definitions:

"**PHI**" refers to information in your health record that could identify you.

"Treatment, Payment, and Health Care Operations"

– Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. Treatment includes consultation with another health care provider, such as your family physician or another therapist or psychiatrist.

– Payment is whenwe obtain reimbursement for health care services rendered. Payment includes disclosure of your PHI to your health insurer to obtain reimbursement for services or to determine eligibility or coverage.

– Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessmentandimprovement activities, business-related matters such asaudits andadministrative services, andcasemanagementandcarecoordination.

"**Use**" applies only to activities within our practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"**Disclosure**" applies to activities outside of our practice group such as releasing, transferring, or providing access to information about you to other parties.

"**Authorization**" is your written permission to discloseconfidential mental healthinformation. All authorizations to disclose must be on a specific legally-required form.

II. Other Uses and Disclosures Requiring Authorization:

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations with your authorization. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes that some providers choose to make about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your record. These notes include recordings and transcripts of any therapy sessions. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have taken some action in reliance on that authorization; or (2) if the authorization wasobtained as a condition of obtaining insurance coverage, as applicable state and federal law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse – If we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or a neglected child, we must report this belief to the appropriateauthorities.

Adult and Domestic Abuse – If we have reason to believe that an individual protected by state law has been abused, neglected, or financially exploited, we must report this belief to the appropriate authorities.

Health Oversight Activities – we may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

Worker's Compensation – we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is pursuant to court order. You will be informed in advance if this is the case.

Serious Threat to Health or Safety – If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you fromharm.

IV. Client's Rights and Behavioral Health Provider's Duties

Client's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, we will discuss with you the details of the access process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. Upon request, we will discuss with you the amendment process.

Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of this notice from us upon request.

Behavior Health Provider's Duties:

We are required by law to maintain the Privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently ineffect.

If we revise our policies and procedures, we will notify you in person or by mail.

V. Questions andComplaints

If you have questions about this notice, disagree with a decision that your Therapist makes about access to your records, or have concerns about your privacy rights, you may contact your Therapist or Ardent Counseling Center staff. If you believe that your privacy rights have been violated and wish to file a complaint against Ardent Counseling Center, you may send your

written complaint to the Secretary of the U.S. Department of Health and Human Services. Ardent Counseling Center can provide you with the appropriate address upon request. You have specific rights regarding the Privacy and use of your PHI under federal law. Ardent Counseling Center will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy.

This notice will go into effect on July 1, 2010. Ardent Counseling Center reserves the right to change the terms of this notice and to make the new, notice provisions effective for all PHI that Ardent Counseling Center maintains. Ardent Counseling Center will provide you with a revised notice in person or by mail.

Ardent Counseling Center Corporate Office
684 Barrington Rd
Suite 112
Streamwood, Il 60107
Voice: 888-870-1775
Fax: 847-349-1619

Ardent Counseling Center
684 Barrington Rd, Suite 112
Streamwood, Il 60107
Phone: (888)870-1775

For internal use only:

Check one:
___ Enter in chart only
___ Send Records
___ Obtain Records

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Client Name:		Date of Birth:	

I hereby authorize the Ardent Counseling Center (ACC) to release and/or obtain the information concerning the above named client with:

Name of Person or Agency:			
Complete Mailing Address:		Phone Number:	

The information being released and/or requested will be used for the following purpose(s):

☐ Ongoing evaluation and treatment	☐ Referral	Litigation
☐ Coordination of services and supports	Academic planning and placement	Insurance
☐ Coordination of medical treatment	☐ Personal file	Other: ____

INFORMATION TO BE RELEASED	**INFORMATION TO BE OBTAINED** *For dates of service from: to:*
☐ Evaluation/Assessment	☐ Social & Family History
☐ Social History	☐ Health & Treatment History
☐ Diagnosis	☐ Evaluation Results
☐ Treatment or Service Plan	☐ Records of Contact
☐ Progress/Prognosis	☐ Discharge Summary
☐ Copy of Record	☐ Medication List
☐ Medication List	☐ Prognoses/ Treatment
☐ Discharge Summary	☐ Legal Status/Legal History
☐ Laboratory results (specify type& date:______)	☐ Grades, Test Scores, Conduct, Attendance
☐ Billing Information	☐ Educational/Vocational Plans
☐ Other: _____	☐ Other: _____

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify date of expiration): ______

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the ACC. I understand that the person or agency receiving this information, in accordance with state regulations, will be notified not to disclose this information without further written consent. However, I understand that Ardent Counseling Center cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information.
However, if the disclosure consists of treatment information about a client in a federally assisted alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosures of such information unless further disclosures are expressly permitted by written consent of the client or as otherwise permitted under federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2). I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information or ask questions by contacting the ACC at the above address. I understand that ACC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of research related treatment or creating information for disclosure to a third party, refusal to sign may result in denial of those services.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW	**Type of Information**	**Authorizing**
I authorize the release of the information at the right, which requires specific consent:	Substance Abuse	☐ Yes ☐ No
Signature of Client/Legal Representative	Mental Health	☐ Yes ☐ No
Signature of Minor, if required:	HIV-related info	☐ Yes ☐ No

Signature of Client/Legal Representative ______________________ **Date:** __________

Relationship, if NOT the client: ______________________

Witness Signature ______________________ **Date:** __________

To the recipient of mental health information: Disclosure of mental health information may only be made pursuant to the written authorization of the individual or their legal representative, or as otherwise provided in 410 ILCS 50. The unauthorized release of mental health information is unlawful, and civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

Copy given to client Initials: _________

THE **ARDENT** COUNSELING CENTER
counseling for individuals of all ages

Employee Assistance Program (EAP) Registration Form

Client Name (First & Last): ____

EAP Company Name: ____

Phone number of EAP: ____

Billing address of EAP: ____

EAP Authorization Number: ________________

Number of Visits Authorized: ________________

Authorization Period: ________________ to ________________

Ardent Counseling Center | COUNSELING FOR MEANINGFUL CHANGE

Child Biopsychsocial History Form

Please provide the following information about your child:

Childs Full Name: ______________________________

Nick Name: ______________________________

Birth Date: _______________ Today's Date _______________

Behavioral Excesses:

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:

What does your child do that you like? What does he /she do that other people like?

Others Concerns:

Do you have any other concerns about your child or your family that you have not mentioned yet.

Child's Name: ____________________

Nickname: ____________________ **Birthdate:** ________

Treatment Goals:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Please provide the following information about your child:

Family History:

The name of the child's biological parents:

Mother: ____________ Father: ____________

Who has legal guardianship of your child? ____________

Who does your child currently live with? ____________

Names	Ages	Relationship to child	Grade/Job

Who are your child's significate others NOT living with your child?

Names	Ages	Relationship to child	Grade/Job

Please describe any past counseling that either your child or any family member has had

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ If yes, Please describe:

Child's Name: ______________________________

Nickname: ______________________________ **Birthdate:** ________

Education History:

What school does your child attend? ______________________________
Address: ______________________________
Phone: ______________ Teachers Name: ______________________
Current Grade: ____________.

What does your child's teacher say about him/her?

____
____
____

Other schools attended (including Pre-school)

____
____

Has your child ever repeated a grade? _____ If so which one(s) __________

Has your child ever recieved special education services?

____
____
____
____
____

Has your child experienced any of the following problems at School?
(Place check to the left of all that apply)

- [ ] fighting
- [ ] suspension
- [ ] gang influence
- [ ] lack of friends
- [ ] learning disabilities
- [ ] incomplete homework
- [ ] drug/alcohol
- [ ] poor attendance
- [ ] behavior problems
- [ ] detention
- [ ] poor grades

Medical History:

What is the name of your child's medical doctor? ____________________
Address: ______________________ Phone: ______________

Date of your child's last medical examination: ____________________
Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? _____ If so, please list which ones:

____
____
____
____

Did the child's mother have any problems during the pregnancy or at delivery? _____ If so, Please describe them:

____
____
____
____
____

Child's Name: ______________________________

Nickname: ______________________ **Birthdate:** ________

Has your child experienced any of the following medical problems?
(Place Check to the left of all that apply)

- [ ] A serious accident
- [ ] A head injury
- [ ] Eye/ear problems
- [ ] Allergies
- [ ] Other ______________________________
- [ ] Hospitalization
- [ ] High fever
- [ ] Meningitis
- [ ] Loss of consciousness
- [ ] Surgery
- [ ] Asthma
- [ ] Convulsions/seizures
- [ ] Hearing problems

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? ____ If so please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? ____ Has he/she ever purposely hurt himself or another? ___
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? ____ If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

Clear Form | Print | Save

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Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? ______________________________

Client Name: ______________________________ Date:____________

Therapist Name:______________________________

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Patient Health Questionnaire (PHQ-9)

Patient Name: ______________________ **Date:** ____________
Therapist Name: ______________________

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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PATIENT COMMUNICATION CONSENT FORM

Most patients have family members and friends who occasionally become involved in their care. For example, your spouse calls to confirm your appointment time, **OR** your adult child calls with questions about your medication; **OR** a friend calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

I authorize The Ardent Counseling Center staff to contact me using the following methods regarding my personal health information, financial responsibilities and evaluation and treatment.

Check to Confirm Approval of Method	Method	Number/Address	Leave Messages
____	Home Phone		Yes No
____	Cell Phone		Yes No
____	Work Phone		Yes No
____	Alternate Phone		Yes No
____	Email		Yes No

I give the staff of The Ardent Counseling Center my permission to speak with the following individuals regarding my care. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number
____________	____________	____________
____________	____________	____________
____________	____________	____________

EMERGENCY CONTACT ONLY:

Name:____________________ Phone: ____________________

I understand that I have the right to revoke this authorization **in writing** at any time. I request that my confidential information be handled in the following manner and authorize the staff of The Ardent Counseling Center to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

____________________ ____________

Patient Name Printed Date

____________________ ____________

Patient/Authorized Signature Relationship to Patient

Life Goals Worksheet

Name: ____________________

My top goals in each of the following seven areas are:

Health/Fitness/Appearance:

1) ____________________
2) ____________________
3) ____________________

Financial/Income/Investments/Net Worth:

1) ____________________
2) ____________________
3) ____________________

Business/Professional/Career/Job:

1) ____________________
2) ____________________
3) ____________________

Relationships/Family/Friends:

1) ____________________
2) ____________________
3) ____________________

Fun Time/Recreation/Hobbies/Travel:

1) ____________________
2) ____________________
3) ____________________

Personal/Learning/Projects/Purchases:

1) ____________________
2) ____________________
3) ____________________

Contribution/Service/Community/Spiritual:

1) ____________________
2) ____________________
3) ____________________

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