PATIENT INFORMATION

Patient Name:_____ Suffix:_____ SS#:___XXX-XXX-_____

Address: _____ City:_____ State: _____ Zip: _____

Primary Phone Number: _____ Alternate Phone: _____

Email: _____ Acceptable Contact: Email* ☐ Texting* ☐ Cell/Voicemail ☐ Mail ☐

**Please note MN Therapies cannot guarantee confidentiality within texts or electronic communication. By selecting this method, you acknowledge this risk and consent to its use.*

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Sexual Orientation/Identity: _____ Race/Ethnic Identity: _____

Education (Degree/Years Completed): _____ Employment: _____

Primary Language: _____ Is English your second language? YES / NO

Living Arrangements (Who lives with you?): _____

_____

Household Income: _____ Patient Income: _____ Household Size (Including Patient):_____

Emergency Contact Person: _____ Number: _____

Do you have any special needs? Describe: _____

Referral Information:

How did you hear about us? If you were referred from another provider, please include his or her name, phone number and reason for the referral. _____

_____

_____ _____

Patient Signature Date

_____ _____

Clinician Signature Date

MN THERAPIES
3166 N. Lincoln Ave. Suite 217 - Chicago, IL 60657
Phone -773.270.2246
E-mail - mnovaklcsw@gmail.com
www.mntherapies.com

NOTICE OF PRACTICE POLICIES

Welcome to MN Therapies. We look forward to working with you and helping you reach your goals. In order to facilitate good client-therapist relations, there are a few policies you should know. Please feel free to ask any questions regarding these policies.

FIRST VISIT

There is a lot to get done on your first visit, so to help move things along, you will be asked to either complete the paperwork and fax it to the practice ahead of time, or to arrive early for your appointment in order to allow sufficient time to complete it. It typically takes about 15 minutes to complete the paperwork. Your first visit to this practice will be for assessment purposes, in order to determine the type and course of treatment. A brief treatment plan will be discussed with you near the end of the first appointment and any additional questions you may have will be answered.

INSURANCE

This practice is currently a contracted provider for Blue Cross Blue Shield PPO, and Medicare. This means that you will receive "in-network benefits" if you are covered by one of these insurance policies. Please bring your insurance card to your first visit, and also any time your policy changes or you are issued a new card. Most insurance plans require a "co-pay" or "co-insurance" paid by the patient for each service. Some will also have a deductible or amount a client must spend before receiving benefits. It is always best to verify this amount before your visit so you have an idea of your out-of-pocket costs. You can do this by calling the number listed on your insurance card and asking them about your coverage for mental health services.

After your first session, your claim will be submitted and benefits will be verified. All payments will be **due at each session**. Please bring a check or cash to each appointment to cover this cost. Alternatively, you can request that your credit card, debit card, or Health Savings Account card be charged after each session.

If you have any other type of health insurance, you will likely need to do a few things to be reimbursed. While we are willing to assist you in the process of being reimbursed for services, **payment will be due at the time of service**. You will need to bring a check or cash to each session to cover the service. Alternatively, if you prefer, or forget your payment, we can charge your credit card, debit card, or Health Savings Account card. In order to facilitate being reimbursed by your insurance company, we suggest you do the following:

1) Please contact your insurance company and verify that out-of-network mental health services will be covered under your plan and inquire about the exact dollar amount they will cover, as well as what your portion will be. Often they will give you a percentage that is capped at a certain dollar amount, so it is best to know the maximum amount they will pay.
2) Ask if there are any limitations to number of visits or sessions lengths (i.e. 45 minutes or 53+ minutes) that they will cover.
3) Ask about whether or not "pre-certification" will be required for continued treatment, and, if applicable, when it will be required. We will call the insurance company to obtain pre-certification, if needed, but it is ultimately **your responsibility to secure reimbursement**.

PARKING

We do not have reserved parking at our practice. However, most people do not have much difficulty finding street parking. There are metered parking spots along Lincoln Avenue, or you can usually find free parking on side streets. Alternatively, we are a 15-minute walk from the Paulina Brown-line CTA stop and the Belmont Red/Purple/Brown-line stops. Additionally, there are several CTA bus stops near our practice. If you need further assistance or have questions regarding public transportation or parking, please let us know.

APPOINTMENTS AND CANCELLATIONS

If you need to cancel or reschedule an appointment, please contact your therapist by phone or email with ***at least 24 hours notice*** for daytime appointments (before 5 pm) and ***48 hours notice*** for evening appointments (5pm and later) or weekend appointments. Evening and weekend appointments are in high demand. We will never double-book your appointment, and we ask that you only make evening or weekend appointments if you can consistently attend. We reserve the right to ask you to change your appointment time to a daytime appointment if you miss too many evening appointments, with or without notice. Please note, ***if you do not give adequate notice, within the parameters stated above, you will be charged the full fee for that appointment.*** It is important to note that insurance companies do not reimburse for missed appointments.

FEES AND PAYMENT

All payments are due at the time of service. Cash, check, credit/debit cards, and money orders are all acceptable forms of payment. We will submit claims for you for in-network insurance companies, but if your claims are denied, payment will ultimately be your responsibility. In limited cases, we do offer reduced-fee services to students or patients with lower incomes. If you believe you qualify for this service, please inquire further with Melissa A. Novak, LCSW.

EMERGENCIES

This practice is not properly equipped to handle psychiatric emergencies. **If you are in a crisis or feel that you are in danger of hurting yourself or others, please call 911 or go to your nearest emergency department.** If you are not in a crisis situation, but would like to speak to your therapist between sessions, please contact them by phone or email. It is our practice policy to return calls and emails within 24 hours on weekdays. We may not return calls on weekends, but will return your call as soon as possible on the next business day.

CONFIDENTIALITY AND PRIVACY PRACTICES

This section will cover general confidential guidelines to which this practice adheres. While this written summary of exceptions to confidentiality is intended to be helpful in informing you about confidentiality and its limitations, it is not exhaustive. Please see the Notice of Privacy Practices for more information on professional records and your rights pertaining to your protected health information (PHI) and HIPAA (Health Insurance Portability and Accountability Act of 1996) guidelines.

Your health information is considered confidential and will not be released to anyone outside of this practice without your written consent as stated by HIPAA (Health Insurance Portability and Accountability Act of 1996). There are other situations that require only written advanced consent. Your signature on this Notice provides consent for those activities, as follows:

1. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Notice.
2. Disclosure among employees within this practice for consultation, treatment, payment, and other health care operations.
3. Occasionally, it is helpful to consult with other health and mental health professionals **outside this practice** about a case. The same confidentiality laws and guidelines as in this practice also bind these professionals. During such consultations, we make every effort to avoid revealing the identity of a client. Such consultations may not always be reported to you, unless it is important to your therapeutic growth.
4. **E-MAILS, CELL PHONES, COMPUTERS AND FAXES:** It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on our laptops are encrypted, e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. To help ensure your confidentiality, all files are password protected and encrypted. Further our computers are password protected. Also, be aware that phone messages are transcribed and sent to your therapist via unencrypted e-mails. Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

There are some situations in which your therapist is permitted or required to disclose information without your consent or authorization:

1. If you are a threat to yourself, your therapist may be obligated to seek hospitalization for you, or to contact your support network to help provide protection.
2. If you are a threat to others, I may be obligated to alert the authorities or that individual.
3. If there is any suspicion of abuse or neglect of children, elders or people with disabilities.
4. If it is required by a court of law.
5. If you file a complaint against your therapist or MN Therapies, your information may be used as part of the defense.

As always, MN Therapies strives to maintain confidentiality and minimize disclosures to only necessary information. While we hope to be comprehensive and clear regarding confidentiality and its limitations, we understand that the laws can be quite complex. Please let us know if you have any questions or concerns. In situations where specific advice is required, formal legal advice may be needed.

Client's Initials_____ Therapist's Initials_____

SOCIAL MEDIA AND PERSONAL ONLINE ACCOUNTS

This practice adheres to the professional ethics as set forth by the National Association of Social Workers which precludes us from engaging in personal communications and networking with past and current—as well as potential future— clients. These boundaries are not meant to be punitive but serve as a means of protecting your confidentiality and respecting the sensitive nature of our work together. You are invited to access the various resources and links provided to you through our professional outlets, but please note that we do not respond to "friend requests" and the like on any social networking sites outside of our professional work. Additionally, to respect our client's privacy we do not search our clients online and if we do see someone's account we do not explore it further. We ask that our client's follow the same protocol with our personal online accounts. Please do not search for us on social media sites and if you encounter one of our accounts, please ignore it.

CLIENT'S RESPONSIBILITIES

1. Actively participate and cooperate in the therapeutic process.
2. Ask questions and provide feedback if there is confusion or something is not working.
3. Complete any readings, assignments or "homework" you agree upon.
4. Arriving and leaving on time for all scheduled appointments.
5. Give 24 hour notice if you are unable to keep an appointment (48 hours for evening appointments).
6. Refrain from coming to sessions under the influence of any alcohol or other consciousness altering drug.
7. Pay as agreed upon for services rendered.

THERAPISTS RESPONSIBILITIES

1. To treat you with respect at all times and to maintain your confidentiality as outlined above and according to all signed agreements, including any Release of Information.
2. To practice within my level of competence, licensure guidelines and ethical guidelines outlined in state and federal laws and as stated by the National Association of Social Workers, as well as the American Association for Sexuality Educators, Counselors and Therapists.
3. To have a set time reserved for you, in which you are the primary focus and the therapist is free from all reasonable distraction.
4. To continue to actively grow as a therapist and stay current in my approach, whether through consultation with other therapists or relevant research on the treatment of mental health disorders.

We are happy to answer any question that you may have regarding these policies. We can be reached via the contact information on top of this form. Please keep a copy of this form for your records.

I certify that I have read and understand the policies, rules and guidelines described above.

_____ _____

Signature of Client or Guardian Date

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RIGHTS OF CLIENTS

Your Rights:

Participation in any program or service at this practice does not remove or in any way diminish your rights and privileges as an individual. Chapter Two of the Mental Health and Developmental Disabilities Code (*405 ILCS 5/2-100 et seq.*) and the Mental Health and Developmental Disabilities Confidentiality Act (*740 ILCS 110/1 et seq.*) describe specific rights of consumers of mental health services. Copies of these documents may be obtained by writing to the Illinois Department of Mental Health and Developmental Disabilities, 402 Stratton Office Building, Springfield, IL 62706. There may be a nominal charge.

1. You have the right to impartial access to treatment regardless of race, religion, sex, ethnicity, age, or handicap.
2. You are entitled to adequate and humane care and services in the least restrictive environment in accordance with an individual treatment plan that you participate in developing, reviewing, and revising.
3. Any unusual, hazardous, or experimental services require your written and informed consent.
4. Except in emergencies, no services will be provided to you without your informed consent.
5. All clients shall be free from abuse and/or neglect by this practice or any therapist within this practice.
6. You have the right to request the opinion of a consultant, at your expense, to review your individual treatment plan.
7. You have the right to inspect and copy your record if you are age twelve and older.
8. You have the right to refuse services. You (or your guardian on your behalf) have the right to refuse services at any time. If you refuse, you will not be given such services except when necessary to prevent you from causing serious harm to yourself or others. You will also be informed of alternate services available and the risks of such alternatives as well as the possible consequences to you of refusal of such services.
9. You have the right to expect that all measures will be taken to ensure the confidentiality mandated by the Mental Health and Developmental Disabilities Confidentiality Act. In limited circumstances, information about your treatment may be released without your permission, such as during emergencies. These circumstances are defined in the Mental Health and Developmental Disabilities Confidentiality Act, which can be obtained as noted above.
10. Clients have the right to expect that all measures will be taken to ensure the confidentiality mandated by the federal alcohol and drug abuse confidentiality regulations (*Federal Regulations 42 CFR pt. 2 passed in July, 1987*) as well as any applicable state laws.
11. Clients have a right to expect that information about their AIDS/HIV status will be kept confidential, as mandated by state regulations. Clients cannot be required to disclose this information as a condition of treatment.

12. You have a right to legal counsel and other due process.
13. If your rights are restricted, the facility must notify:
    a. Your parent or guardian if you are under age eighteen,
    b. You and the person of your choice,
    c. The Guardians and Mental Health Advocacy Commission if you say you want the commission to be contacted. The Commission's address and telephone number are:

        160 North LaSalle, Suite S-500
        Chicago, IL 60601
        (312) 793-5900

    d. Equip for Equality if you say you want this organization to be contacted. Equip for Equality's Address and telephone number are:

        11 E. Adams, Suite 1200
        Chicago, IL 60603
        (312) 341-0022 or (800) 537-2632

14. You may not be denied services, or have services suspended, terminated, or reduced in any way for exercising any of your rights as an individual.

I have read and understand these rights.

_____ _____
Signature of Client or Guardian Date

_____Client refuses to sign Rights of Clients

_____ _____
Signature of Therapist/Clinician Date

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Notification to Patient of Desirability of Conferring with Primary Care Physician

Pursuant to Illinois law, you are hereby informed that it is desirable that you confer with your primary care physician, if you have one. If you have a primary physician, I am required to notify him or her that you are seeking or receiving mental health treatment unless you waive such notification.

Please indicate your wishes:

_____ I AGREE to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing the Authorization to Release Information permitting you to communicate with my said physician.

_____ I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services, and I direct you NOT to so notify him or her.

_____ I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

My primary physician is _____

Address: _____

Phone number: _____

Signature_____ Date _____

Please Print Name_____

Notification to Primary Physician of Patient Receiving Mental Health Services

Pursuant to Illinois law requiring that Licensed Clinical Social Workers inform their patients' primary care physicians that a patient is seeking or receiving mental health services, you are hereby notified that

Client _____ DOB _____

is seeking or receiving such services from me. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your record. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.

Melissa A. Novak, LCSW

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CREDIT CARD AUTHORIZATION FORM

NAME ON CARD:_____

BILLING ADDRESS:_____

_____

_____

Circle one: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

ACCOUNT #: _____

EXPIRATION DATE: _____ CVC # (ON BACK OF CARD): _____

OFFICE POLICY: A credit card will be kept on file for all clients. By signing this form, I understand that payment is due at the time of service and I may choose to use other forms of payment such as cash, check or an HSA account.

OPTIONAL: I hereby grant permission to charge my credit card after every ____ session(s) or if my balance reaches $_____ without further authorization.

☐

AUTHORIZED SIGNATURE:_____

Thank you for choosing MN Therapies.

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HIPAA Waiver and Legal Agreement

I, _____, understand that in the event that I or my attorney requests information (including any and all client notes or releases) pertaining to my sessions with the clinicians of MN Therapies, I will be required to agree to open communication between my clinician* and my attorney(s). Furthermore, I understand that in the event that my MN Therapies clinician* is deposed by an attorney on my behalf for any and all legal matters or proceedings, I will be responsible for any and all fees related to such a deposition (including the fees for an attorney for my clinician*, my clinician's* hourly rate of $250 per hour for any time spent either in traveling to or from a deposition or participating in the deposition itself, and any fees for time spent copying and sending records for the deposition). I understand that I will be charged a standard fee of $25 for materials for each request of records. I release my clinician* from any unwanted or unforeseen consequences of releasing such information.

In the event that my records are subpoenaed against my wishes, I understand that my clinician* will advocate for me and request that my record and the content of my sessions with my clinician* be considered privileged information.

*MN Therapies Clinicians (*please initial your clinician's name*).

_____ Marissa Bohrer, MSW

_____Stacey L. Skowronski, LCSW, CST

_____ Katie Jensen, LCSW

_____ Melissa A. Novak, LCSW, CST

_____ _____
Client's Signature Date

_____
Client's Name (Printed)

_____ _____
Clinician's Signature Date

7. Standard Intake Questionnaire

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Libido Changes
- ☐ Loss of Interest
- ☐ Panic Attacks
- ☐ Racing Thoughts
- ☐ Risky Activity
- ☐ Sleep Changes
- ☐ Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grown up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

What is your sexual orientation?:

Race/Ethnic Identity:

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuanna
- ☐ Hallucinogens (LSD)
- ☐ Heroin
- ☐ Methamphetamines
- ☐ Cocaine
- ☐ Stimulants (Pills)
- ☐ Ecstasy
- ☐ Methadone
- ☐ Tranquilizers
- ☐ Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

How did you hear about us?:

Anything else you want the doctor to know?: