

# Myers Counseling Group Intake Form

Date: \_\_\_\_\_

CLIENT INFORMATION	Name		Social Security Number	
	Street Address		Home Telephone Number	
			Cell Phone Number	
	City	State	Zip	Email Address
	Birthdate ____/____/____		Age	Can we email if needed? Y                      N
	(Please Circle One) Single    Married    Divorced    Widowed		(Please Circle) Male                      Female	
	Client Employment/School		Occupation	
	Business Address		Business Telephone	
In case of emergency who should we notify?		Relationship to Client		
PRIMARY INSURANCE	Person responsible for Account		Relationship to Client	
	Birthdate for Policy Holder		Social Security Number (Policy Holder)	
	Address (if different from client)		Telephone Number	
	City	State	Zip	Person responsible employed by:
	Occupation		Business Address and telephone	
	Insurance Company		Policy number	
	Group number:		Certification or Authorization number	
	Insurance Telephone Number		Number of sessions authorized	

### (For Office Use Only)

Referral Source:	Diagnosis  -----	Therapist Initial	Crystal Lake EAP Therp Insurance	Gurnee EAP Billing Mgr. Self-Pay
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**M**yers  
**C**ounseling  
**G**roup, Ltd.

501 N. Riverside · Suite 208 · Gurnee, IL 60031  
(847) 263-1269 Fax: (847)263-1310

## Permission for Services

I/we \_\_\_\_\_ grant permission for  
Myers Counseling Group to provide services to \_\_\_\_\_  
for Mental Health Counseling. I/we understand that all information shall be treated as  
confidential in accordance with state laws.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if client is under the age of 18 years).

\_\_\_\_\_  
Date

**Myers**  
**Counseling**  
**Group, Ltd.**

**Client Consent/Waiver For Primary Care Physician Notification of Service Provision**

Pursuant to Illinois Law (PL 86-1434) you are hereby notified that it is desirable that you confer with your primary care physician, if you have one, about seeking and receiving mental health services. Unless you waive such notification, I am required to notify your primary care physician that you are seeking or receiving mental health services.

Please indicate your desire by checking the appropriate box.

- ( ) I do not have a primary care physician and don 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.
- ( ) I **WAIVE NOTIFICATION** of my primary care physician that I am seeking or receiving mental health services, and I direct you **NOT** to notify him or her.
- ( ) I **AGREE TO YOUR NOTIFYING** my primary care physician, that I am seeking or receiving mental health services.

My primary care physician is:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone number: \_\_\_\_\_

Please act in accordance with these, my instructions:

Client name: \_\_\_\_\_ Date: \_\_\_\_\_

Client signature: \_\_\_\_\_

Parent\Guardian signature: \_\_\_\_\_  
(required if minor)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## Myers Counseling Group E- mail Permission Notice

I, \_\_\_\_\_ grant permission to Myers Counseling Group  
(Name)

to include my name on their e-mail distribution list. I understand my e-mail address will only be used for follow up surveys, newsletters, and notices regarding Myers Counseling Group services. It will not be distributed to any third parties. I also am aware that I could unsubscribe at any time.

Name of Client: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

E- Mail address: \_\_\_\_\_

Additional e-mail address: \_\_\_\_\_

*Myers Counseling Group*

**CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT,  
PAYMENT, AND HEALTH CARE OPERATIONS (TPO)**

Patient Name \_\_\_\_\_

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as “health care operations.”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

# Myers Counseling Group Financial Agreement

## **Insurance:**

It is up to you to check your insurance plan and the limits of your coverage. For initial sessions, you will be required to obtain approval/authorization/certification. If you do not obtain this prior to the first session, you will be responsible for full payment. Myers Counseling Group will get approval for subsequent sessions. Myers Counseling Group is willing to assist you by filing insurance claims. We do not bill secondary insurance, however, we will be glad to assist you so that you may be reimbursed. If your insurance company does not pay your bill in full within 30 days, we ask you to contact your insurance company to help speed up payment. Your insurance policy is between you and your insurance company. We may not be party to that relationship. Our primary relationship is with you, not your insurance company. All charges are your responsibility whether your insurance company pays or not. You will also need to notify us of any changes in your insurance plan. If you do not notify us, and your new policy does not cover services, you will be billed for the full payment.

## **Payment Policy:**

You are expected to pay for all fees/co-payments at the end of each appointment, unless special arrangements have been made. Payment for services is due at the time services are rendered. Myers Counseling Group accepts cash, checks, Visa, MasterCard, and Discover. There is a \$25.00 fee for returned checks. We understand that things do happen and financial problems may affect timely payment of your bill. We will do everything we can to help you. All we ask if that you contact us as soon as possible to make arrangements.

## **Divorce Situation:**

Myers Counseling Group looks to the adult who has brought the child in for the appointment to be responsible for payment of services which are rendered to the child. We also expect the parents to be able to work out payment arrangements with each other and not involve our office in any disputes which may arise.

## **Cancellation policy:**

Unless appointments are cancelled at least 24 hours in advance of their scheduled time, there will be a charge for all missed appointments at the rate if a normal office visit. Insurance will not reimburse for missed sessions.

## **Collection Costs and Procedures:**

If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including, but not limited to, reasonable attorney fees, court costs and collection agency fees. By signing this policy, you acknowledge that Myers Counseling Group reserves the right to release any patient information and any medical records to our collection agency deemed necessary to assist their staff and attorneys in the collection of this debt.

## **Assignment and release:**

I hereby authorize payment to be made directly to Myers Counseling Group and fully understand that I am the responsible party for all charges incurred by me or my dependents at Myers Counseling Group. I also authorize the release of any and all information required to collect or process my claims. If legal action becomes necessary, I agree to pay all reasonable fees.

By signing below, you do affirm that you read and understood our Financial Policy and that you agree to it's contents.

Name of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of patient or responsible party: \_\_\_\_\_