Dear New Client,

Welcome to Lakeview Psychology Group. We are pleased to begin our work with you and ask that you review the attached documents to gain an overview of our policies and procedures. Please review this information packet in its entirety prior to your intake session, and keep designated documents for your records.

The following forms must be completed and signed prior to your first session:

• New Client Registration Form

• All-inclusive Consent & Acknowledgment

• Financial Responsibility Agreement

• Child Checklist of Characteristics (if applicable)

Your intake clinician will make a copy of your insurance and credit card upon meeting for your intake session, so please have those available.

Over the next several meetings, we will work together to carefully assess your needs, develop a treatment plan, and establish goals to guide our collaboration.

As the founder of LPG, I invite you to be in touch with me at any time to discuss your questions or concerns about your experience at LPG. You can always feel welcome to reach me directly at (312) 880-9349.

Warmly,

Caitlin E. McGowan, Psy.D.

**NEW CLIENT REGISTRATION FORM *~Child/Adolescent Client***

**PARENT/GUARDIAN CONTACT INFORMATION**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Last) (First) (Middle)*

**Relationship with Client:** □ Mother □ Father □ Step-Parent □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Last) (First) (Middle)*

**Relationship with Client:** □ Mother □ Father □ Step-Parent □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT CONTACT INFORMATION**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Last) (First) (Middle)*

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT SCHOOL INFORMATION**

**School District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Grade: \_\_\_\_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special Education Student (Y/N): \_\_\_\_\_\_ Special Education Eligibility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT IDENTIFYING INFORMATION**

**Biological Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnicity**: □ American Indian/Alaskan Native □ Asian □ African-American □ Hispanic □ White □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Siblings (Names & Ages):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GUARANTOR INFORMATION (Financially Responsible Person)**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Last) (First) (Middle)*

**Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship with Client:** □ Mother □ Father □ Step-Parent □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**Primary Insurance Co.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CREDIT CARD INFORMATION**

**Card Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exp. Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CVV Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**REFERRAL INFORMATION**

**Name/Organization:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*(Street) (Apt #) (City) (State) (Zip)*

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Thank you for choosing Lakeview Psychology Group. We would like to thank whoever referred you to our clinic. We will not include your name in our thank-you note unless you permit us to do so. Please indicate your permission by initialing here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**NEW CLIENT REGISTRATION FORM*~ Adult Client***

**CLIENT CONTACT INFORMATION**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Last) (First) (Middle)*

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we: Call Home** □ Yes□ No **Work** □ Yes □ No **Cell** □ Yes □ No

**In Case of Emergency, Notify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLIENT IDENTIFYING INFORMATION**

**Biological Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnicity**: □ American Indian/Alaskan Native □ Asian □ African-American □ Hispanic □ White □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GUARANTOR INFORMATION (Financially Responsible Person)**

**Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Last) (First) (Middle)*

**Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship with Client:** □ Self □ Spouse/Partner □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION**

**Primary Insurance Co.**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subscriber’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Client:** □ Self □ Spouse/Partner □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CREDIT CARD INFORMATION**

**Card Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exp. Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CVV Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Street) (Apt #) (City) (State) (Zip)*

**REFERRAL INFORMATION**

**Name/Organization:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*(Street) (Apt #) (City) (State) (Zip)*

**Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Thank you for choosing Lakeview Psychology Group. We would like to thank whoever referred you to our clinic. We will not include your name in our thank-you note unless you permit us to do so. Please indicate your permission by initialing here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**CLIENT SERVICES AGREEMENT**

**Our Clinic**: We are a group of Licensed Clinical Psychologists and Doctoral-level paraprofessionals providing psychological, emotional, and behavioral health care services to children, adolescents, adults, and families. Through the treatment process, we will evaluate the ways in which our services can help you better understand yourself to move towards resolving life’s difficulties so you can enjoy a more fulfilling, balanced life. Following your initial intake appointment, we will share our impressions and recommendations with you. We will develop a comprehensive treatment plan over the next several weeks, which we will jointly evaluate routinely and make changes to your care accordingly. Should a higher level of services ever be indicated, we will work to connect you to the most appropriate care through our strong network of area resources.

**Appointments & Cancellations**: Appointments are scheduled weekly, and progress is contingent upon regular attendance. As such, we encourage you to protect your scheduled time. Please call to cancel or reschedule your appointment at least 24 hours in advance or you will be charged for the missed appointment. The exception to cancellation charges include: a) you reschedule your appointment within the week; b) your session falls on a holiday; c) your session is during a therapist’s absence (e.g. illness, vacation); d) your child has significant illness; or 3) you have a significant scheduling conflict and provide 24-hours’ notice. Please note that, by law, your insurance company is not liable for payment of a late cancellation or a missed appointment. In these cases, you are financially responsible for the full session fee. In signing our credit card agreement form, you consent for the account on file to be automatically charged.

**After-hours Emergencies**: Please note that there is not a clinician on-call 24-hours a day and we do not provide crisis services. Should you have an emergency during non-business hours, call 911, proceed to your nearest emergency room, or contact Linden Oaks 24-hour intake line at 630-305-5500. Also, by calling 1-800- 273-TALK (800-273-8255), you will be connected to the nearest certified national crisis call center. Should your treatment needs ever intensify over the course of our work, we will coordinate a crisis care plan together that may involve more intensive services beyond the scope of our outpatient clinical practice.

**Telephone Messages and Callback Requests**: Telephone messages and callback requests are conducted via our confidential voice mail system at (312) 880-9349. Calls will be returned within 24 hours, Monday through Friday. If telephone consultations extend beyond 10 minutes, please understand our two options: 1) we can both continue the call and have the rest of the consultation pro-rated at the hourly fee, or 2) we can schedule an additional in-person session.

**Number of Visits**: The number of sessions needed depends on many factors. Research demonstrates that therapy is most effective when treatment is consistent, people are motivated to change, and an open, trusting relationship with the therapist develops. Our approach aims to provide the short-term relief from life’s current challenges while also addressing underlying contributors to support long-lasting change. Together with your clinician, you can discuss projected length of treatment as you continuously assess achievement of established treatment goals.

**Length of Psychotherapy Sessions**: Psychotherapy sessions can vary in length. The length of your sessions will be discussed with you at the onset of your therapy. If you arrive late, we will have less time in which to work, and progress may be delayed.

**Divorce/Separation Agreement**: Therapy services provided to families in separation or divorce are for the purposes of providing a neutral professional to help families through the challenges of these changes. Our clinical work cannot be used to establish custody agreements, visitation schedules, or other family court matters. To ensure we have a shared understanding of custody arrangements, you are responsible for: 1) providing the most recent copy of your divorce decree, and 2) providing signatures of both parents on the Divorce/Separation Agreement. Please note that our policy requires that the parent transporting the child to sessions provide payment at the time of service.

**Risks of Therapy**: Throughout this process, we will strive to create both short-term awareness and long lasting change. Many people in therapy discover things that feel challenging as we work towards understanding and growth. The success of our work together depends on the quality of the efforts on both our parts and your commitment to the lifestyle choices and changes that may result from therapy. Of note, one risk of participation in couples' therapy is the possibility that you may choose to pursue divorce if therapy services are unable to facilitate reconciliation and renewed commitment to the relationship. We also strongly encourage the ongoing involvement of parents in the work with children and adolescents to facilitate and strengthen treatment gains within the larger family experience.

**Limitations and Potential Risks of Email Communication**: In order to afford the highest protection to your privacy given the inherent risks of online security, the use of email at our office is highly restricted. Any online communication with LPG staff is to be limited to scheduling or administrative concerns. Because we cannot guarantee the writer or recipient of such communications nor the encryption of the information transmitted, we prohibit the communication of any personal information that should be confidentially discussed in-person or over the phone. Turnaround time for email responses to administrative inquiries is no sooner than 72 hours. In the event you require a more timely response, we advise you to contact your clinician by telephone. Do not utilize email to communicate during any crisis situation you may encounter, rather we instruct you to follow our emergency policies. Please know a copy of any email communication received by LPG staff is printed and placed within your confidential record.

**Records:** Although it is our goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and its exceptions are discussed below and in the HIPPA Illinois Notice Form. In the event that law requires the disclosure of your records, you will be responsible for and shall pay any costs involved in producing the records and for the time involved in preparing for and giving testimony. Such payments, at our normal hourly rate, are to be made at the time or prior to the time these services are rendered. Copies of records are charged at a $0.25 per page fee.

**Confidentiality**: Without written consent, all discussions between psychotherapist and client, including minors, are strictly confidential. Possible exceptions to confidentiality include, but are not limited to, the following situations: suspected child abuse (including neglect and emotional abuse); suspected abuse of the elderly or disabled; suspected sexual exploitation/abuse; when the client communicates threat of serious harm to another or is suicidal; when a third-party communicates to the therapist that a client is threatening harm to another; when information is required by law or ordered by the court; or addressing complaints with state board officials. Please see Illinois Notice Form for more information.

*Please retain this Client Services Agreement for your records.*

**ILLINOIS NOTICE FORM**

***Notice of our Policies and Practices***

***To Protect the Privacy of your Health Information***

This notice describes how psychological and medical information about you may be used and disclosed and how you can access this information. Please review this document and feel welcome to contact us at (312) 880-9349with any concerns.

**1) Uses and Disclosures for Treatment, Payment, and Health Care Operations**

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

* “PHI” refers to information in your health record that can identify you.
* “Treatment” is when we provide, coordinate, or manage your health care and other related services, such as consulting with another health care professional.
* “Payment” is when we obtain reimbursement for your health care. Examples are when we disclose your PHI to your insurance company to obtain reimbursement or determine eligibility and coverage.
* “Health Care Operations” are activities related to the performance and operation of my practice, such as quality assessment and improvement activities, business-related audits, administrative services, and case management.
* “Use” applies only to activities within out office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
* “Disclosure” applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.
* “Authorization” is your written permission to disclose confidential mental health information. All authorizations to disclose require a written form. Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a sale of PHI require patient authorization.

**2) Other Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your authorization is obtained prior to the release of information. Uses and disclosures not described in this notice will be made only with authorization from the individual.

In most cases, we will not keep psychotherapy notes, but in the event that we do, we will also need to obtain your authorization before releasing these. Psychotherapy notes are notes made about our conversation during a private, group, joint, or family counseling session, which are kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations at any time, in writing. You may not revoke an authorization to the extent that, (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, as the law provides the insurer the right to contest the claim under the policy.

**3) 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 appropriate authorities.
* **Adult and Domestic Abuse:** If we have reason to believe that an individual (who is 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 PHI regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.
* **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 court-ordered. You must 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 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 from harm.
* **Worker’s Compensation:** We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

**4) Patient Rights and Psychologist’s Duties**

**Patient Rights:**

* **Right to Request Restrictions:** You have the right to request restriction on certain uses and disclosures of PHI. However, we are not required to agree to a restriction you request. Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out of pocket in full for the health care service
* **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 me. 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 the mental health and billing records used to make decisions about you for as long as the PHI is maintained in our records, and to inspect and copy your Psychotherapy Notes. On your request, we will discuss with you the details of the process for requesting access.
* **Right to Amend:** You have the right to request an amendment of your PHI for as long as the PHI is maintained in your record. We may deny your request. Requests for amendment must be made in writing and you must provide a reason for the requested amendment. On your request, we will discuss with you the details of 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, even if you have agreed to receive the Notice electronically.

**Clinician’s and Lakeview Psychology Group, Inc. 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 in effect.
* If we revise out policies and procedures, we will notify you by providing you a revised notice.
* In the event of a breach of unsecured protected health information, affected patients have the right to be notified.

**5) Complaints**

\*If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact Dr. Caitlin McGowan, at (312) 880-9349.

\*You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Dr. Caitlin McGowan, listed above, can provide you with the appropriate address upon request.

**6) Effective Date, Restrictions, and Changes to Privacy Policy**

\*This notice will go into effect on August 1, 2016.

\*We will limit the uses or disclosures that we will make as follows:

(None at this time)

\*We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by providing you with a copy of the changes.

**ALL-INCLUSIVE CONSENT & ACKNOWLEDGMENTS**

***Consent to Treatment***: You voluntarily agree to receive mental health assessment, care, treatment, and services, and authorize Lakeview Psychology Group, Inc. to provide such care, treatment, and services as are considered necessary and advisable. You understand and agree to participate in the planning of your care, treatment, and services, and that you may stop such care, treatment, and services at any time. You understand that LPG upholds a commitment to professional training of doctoral and postdoctoral candidates, and, should your treatment be conducted by a clinician operating under the license and supervision of a Clinical Psychologist, this will be discussed with you prior to the initiation of care.

By signing this consent form, you, the undersigned client or parent/guardian, acknowledge that you understand all the terms and information contained herein. Ample opportunity has been offered to ask questions and seek clarification.

Your signature below grants consent to Lakeview Psychology Group and the clinician coordinating your services to use and disclose your protected health information for the purposes of treatment, payment, and healthcare operations. Your signature also provides consent for direct payment of medical benefits to Lakeview Psychology Group, Inc. We encourage you to read this agreement in full before signing this consent.

***Consent for Contact***: I agree to have my name placed on a mailing list and an email list to receive follow up contact from Lakeview Psychology Group, including, but not limited to, newsletters, educational information, Clinic updates, etc. LPG will not sell or provide mailing list(s) to any third party. I understand that I can revoke this consent at any time. By initialing, I provide my consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please complete the following section only if applicable:*

**Child and Adolescent Consent for Treatment**

I certify that I am the ☐Mother ☐Father ☐Legal Guardian and have legal custody of the above-named patient. I, hereby, give my authorization and consent for the patient to receive outpatient assessment/treatment from Lakeview Psychology Group. I understand it is the policy of LPG that the parent/guardian bringing the patient is responsible for payment at the time services are rendered. I will be responsible for payment of the patient’s treatment regardless of any financial arrangement for the payment of the patient’s medical care, either oral or written, with the patient’s other parent or responsible party. I understand that LPG assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements for the patient’s medical care.

Parent/Guardian Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Acknowledgments**

By signing below, I acknowledge the following:

* I have been offered the Illinois Notice Form outlining privacy regulations relevant to my care.
* I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the behavioral health operations of Lakeview Psychology Group. I authorize LPG to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that LPG may release objective clinical information related to my diagnosis and treatment that may be requested by my insurance company (if applicable) or its designated agent.
* I authorize and request my insurance plan (if applicable) pay directly to LPG the amount due for services rendered to the patient, myself, or others covered by the insurance plan(s) under which I have registered. I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for services rendered. I understand that this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. Unless revoked earlier, this consent will be null and void six months after the final payment has been received on this account. This consent is subject to state and federal confidentiality regulation.
* I agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with my insurance company, I will be responsible only for the co-pay, coinsurance, deductible, and non-covered services as determined by the insurance plan. If I do not inform LPG in a timely manner of any changes to my insurance coverage, I understand that I many need to pay for services in full if payment is denied in part or in full by my insurance carrier. I further understand that I may not be able to schedule appointments if my account becomes delinquent and/or my account is turned over to collections.
* I agree to provide a credit card to have on file in order to process payments. I grant permission for the credit card account listed to be charged per LPGs policies.
* I understand that my patient records are the property of LPG and shall be treated as confidential; that LPG will conduct routine patient audits to insure quality record maintenance; that my records will not be released without my written consent or as provided by the Illinois law. I understand that if I choose to have my records or treatment updates provided to a third party, I must request this in writing using LPGs ‘Authorization for the Release of Information’ form or another acceptable form, with the exception of information I have agreed to release per this Acknowledgment.
* I acknowledge that if I need to cancel or reschedule an appointment, I will provide a minimum of one business day’s notice. Otherwise, I understand that I am subject to the full charge for the missed appointment and am responsible for payment in full.
* I acknowledge that LPG is not a 24-hour crisis care facility and that I am responsible for seeking care at my nearest emergency room or through another provider of choice when my LPG therapist is not available. I certify that all of the information I have provided is true and correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Legal Guardian (If applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LPG Clinician/Witness Date

***Please return both pages of this signed form to your Intake Clinician.***

**FINANCIAL RESPONSIBILITY AGREEMENT**

**Insurance Coverage:** We will communicate an estimate of insurance benefits at the onset of treatment. We strongly encourage you to contact your insurance company to verify your coverage. This estimate of benefits is not a guarantee of coverage, and you are ultimately responsible for any fees not paid by your insurance plan.

**If Private Health Insurance Covers the Treatment:** If private health insurance covers the treatment, LPG will submit both bills directly to the insurance company or plan. Although LPG will bill the company or plan for the full amount of the list charges, the company or plan may have a contract with LPG that provides for LPG to accept, in payment of the bill, amounts that are discounted from the list charges as stated on the bills.

Your insurance coverage may provide that some amount of both of these bills will remain your personal responsibility. If that is the case, the insurance company or plan will notify both LPG and yourself of how much of each bill remains your responsibility. LPG will then bill you for those remaining amounts and you will be responsible for paying them.

Please note that LPG does not know the terms of your insurance coverage and cannot tell you in advance either what the exact amount of either bill will be or what part of either bill will end up being your personal responsibility. If you have questions about the action your insurance company or plan takes on these bills, please contact the company or plan.

If your insurance company or plan denies coverage of either of the bills, or if it does not act within a reasonable period of time on the claim to pay it, LPG will have the right to require you to pay the entire bill. If any part of these bills is your responsibility to pay, you may be eligible for a financial plan to help you with that obligation.

**Assignment of Benefits:** If the treatment is covered by insurance, you authorize and direct the insurance company or plan covering the treatment to directly pay LPG. If the insurance company or plan makes the proper payment in compliance with its obligations of your insurance plan, it will have no further responsibility toward you or toward LPG with respect to the bills.

**Copayments:** You may have a copayment, which is a fixed payment due at the time of service.

**Coinsurance:** You may also have to pay co-insurance, which is a percentage of the session fee unpaid by your insurance company.

**Deductibles:** You are responsible for full payment of fees until your deductible amount is met.

**Billing:** We will bill your primary insurance policy for services rendered. We do not bill secondary insurance.

**Outstanding Balances and Unpaid Claims:** You will receive a monthly bill by mail. **Any outstanding balance due on your account at month’s end, including unpaid co-payments, coinsurance, deductibles, or denied claims, will be charged to the credit card account on file.**

**Cancellations:** Once you are scheduled for a regular therapy appointment, you will be expected to pay for that session each week. LPG charges for all missed scheduled appointments. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Therefore, you will be charged the full fee for a missed appointment, and not only your co-pay amount. By law, you are responsible for the full payment of cancelled session fees.

We recognize that family’s lives are increasingly busy and scheduled. We are available to work with you so that you or your child can still have the benefit of consistent weekly appointments; we will always do what we can to reschedule your appointment during the same week or schedule a phone session. Keep in mind that treatment is most effective when it occurs at the regularly-scheduled time each week. Therefore, whenever possible, it is best to try to protect your scheduled time.

**Authorization to Discuss Medical Information:** It may be necessary for LPG to disclose your medical information (also known as protected health information) to physicians, nurses, and other healthcare professionals in connection with your treatment; to insurance companies and plans in connection with obtaining payment for your treatment; and otherwise as permitted by law. Please understand that, by signing this form, you authorize LPG to release both routine and sensitive medical information, including, for example, information relating to AIDS/HIV, mental health treatment, or drug and alcohol abuse. LPG will make reasonable effort to limit disclosure of protected health information to the minimum necessary to accomplish the intended purpose.

**How This Agreement and Authorization Apply to Future Treatment:** You agree that your financial obligations and authorizations as stated above will apply to all treatment that the patient named in this form receive from the Practice Group and LPG for a period of two years commencing on the day you sign this form. You may revoke this Financial Responsibility Agreement and Related Authorizations at any time. If you do revoke it, the revocation will not affect your obligation to pay for treatment given prior to the revocation. Moreover, the revocation will not affect the validity of the assignment of benefits discussed above. It also will not affect the authority of LPG to discuss medical treatment that occurred prior to the revocation.

**Questions:** If you have any question about this document, we encourage you to consult an LPG Clinician or a person of your own choosing before you sign it. If you are insured, we also encourage you to talk to your insurance company or plan about any questions you have about how your bill will be covered under the terms of your coverage. The number to reach Dr. Caitlin McGowan, is (312) 880-9349.

**Please sign the next page to acknowledge your consent to these policies.**

**Please retain this copy of the agreement for your records.**

**Consent to Financial Responsibility Agreement**

***In signing this form, you agree to LPG Financial Responsibility Policies outlined for you.******You also grant permission for the credit card account on file to be charged per the policies outlined above.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print) Client Name (If different)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Witness Date

***Please return this signed form to your Intake Clinician.***

**CHILD CHECKLIST OF CHARACTERISTICS**

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If you have brought a child in for treatment please mark any and all items that describe your child. Please add any other significant characteristics at the bottom of the form****.*

* Has Imaginary playmates
* Independent
* Interrupts, talks out, yells
* Lacks organization, unprepared
* Lacks respect for authority, insults, dares, provokes, manipulates
* Learning disability
* Legal difficulties/Truancy
* Loitering, drinking, vandalism, stealing, fighting, drug sales
* Likes to be alone, withdraws
* Lying
* Low frustration tolerance, irritability
* Intellectual Disability
* Moody
* Mute/refuses to speak
* Nail biting
* Nervous/anxious
* Nightmares
* Need for high degree of supervision
* Obedient
* Obesity
* Overactive, restless, hyperactive, out-of-seat behaviors, fidgety
* Oppositional, resists, refuses, does not comply, negativism
* Prejudiced, bigoted, insulting, name-calling, intolerant
* Pouts
* Responsible
* Recent Move
* Relationships with siblings or friends are poor: teasing/fights/provoking
* Affectionate
* Argues “talks back” smart-alecky, defiant
* Bullies/intimidates, teases, inflicts pain on others, picks on, provokes
* Cheats
* Cruel to Animals
* Concern for others
* Conflicts with parents over persistent rule breaking, money, chores, homework, grades, and choices in music/clothes/hair/ friends
* Complains
* Cries Easily, feelings are easily hurt
* Procrastinates, wastes time
* Difficulties with parent’s partner/new marriage/new family
* Overly Dependent/ immature
* Death of Family member or friend
* Developmental Delays
* Disrupts family activities
* Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
* Distractible, inattentive, poor concentration, daydreams, slow to respond
* Dropping out of school
* Drug or alcohol use
* Eating-poor manners, refuses, appetite increases or decreases, odd combination, overeats
* Failure in school
* Fearful
* Fighting, hitting, aggressive, hostile, threatens, destructive
* Fire Setting
* Friendly, outgoing, social,
* Somatic, always complains of feeling sick
* Immature, “clowns around,” has only younger friends
* Runs away
* Rocking or repetitive movement
* Speech difficulties
* Sad/unhappy
* Self-harming behaviors: biting/hitting oneself/ head banging/ cutting/scratching
* Sexual behavior- sexual preoccupation, public masturbation, inappropriate sexual behaviors
* Shy, timid
* Stubborn
* Suicide talk/ ideation
* Suicide attempt
* Swearing, foul language, irreverent comments
* Temper tantrums/ meltdowns/ rages
* Thumb sucking/finger sucking/ hair chewing
* Tics- involuntary rapid movements, noises, or word productions
* Teased/ picked on/ bullied
* Truant/ School Refusal
* Underactive, slow moving or slow responding, lethargic
* Uncoordinated, accident prone
* Wetting or soiling the bed or clothes
* OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT TO RELEASE CONFIDENTIAL INFORMATION**

**Client Name: Date of Birth:**

**Address: Telephone Number:**

I hereby authorize and consent **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** to release ***and*** exchange written, oral or electronically transmitted protected health information, indicated below, related to the above named individual with:

**Provider Name/Organization/Individual:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full address of Provider/Organization/Individual\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Including information related to:**

\_\_\_\_Mental Health Care & Treatment \_\_\_\_ Substance Abuse Care & Treatment

\_\_\_\_ Medical Care & Treatment \_\_\_\_ School Records

**For the following purpose(s):**

\_\_\_\_ Legal Purposes \_\_\_\_ Follow-up Care \_\_\_\_ Case Consultation

\_\_\_\_ Insurance Determination \_\_\_\_ Referral \_\_\_\_ Continuity of Care

\_\_\_\_ At Request of the Client \_\_\_\_ Family Therapy

\_\_\_\_Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Valid From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**INFORMATION TO BE DISCLOSED**: \_\_\_ Progress Notes \_\_\_ Laboratory Results

\_\_\_ Treatment Progress \_\_\_ Dates of Treatment \_\_\_ Therapy Attendance

\_\_\_ Psychiatric Diagnosis \_\_\_ Psychosocial History \_\_\_ Consultation

\_\_\_ Discharge Summary \_\_\_ Medical History \_\_\_ Medication Information

\_\_\_ Psychosocial Assessment \_\_\_ Psychological Evaluation

\_\_\_ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

**• The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**

• I have the right of access to inspect and obtain a copy of my protected health information.

• I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to Caitlin McGowan, Psy.D.

• Revocation will not apply to information that has already been released in response to this authorization.

• Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.

• Failure to provide all required information may not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.

• Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of patient Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Parent or Legal Representative Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Signature Date**

\*Patients l2 to l7 years of age must sign in addition to the Parent or Legal/Personal Representative.

\*If signed by a legal representative, indicate the relationship to patient or authority to act for patient.

\*Fees/charges will comply with all laws and regulations applicable to release protected health information.