

Radzom Counseling LLC Client Information

Primary Client

NAME	DOB	SSN
ADDRESS	PHONE 1	<i>Home / Mobile / Work / Other</i>
CITY / STATE	<i>do not leave message message with name and phone number only detailed message</i>	
ZIP	PHONE 2	<i>Home / Mobile / Work / Other</i>
EMAIL	<i>do not leave message message with name and phone number only detailed message</i>	
<i>okay to send email do not send email</i>	SCHOOL NAME	EMPLOYER
EMERGENCY CONTACT	GRADE LEVEL	OCCUPATION
EMERGENCY PHONE	PHYSICIAN NAME	PHYSICIAN PHONE
WOULD YOU LIKE THE E-NEWSLETTER SENT TO YOU?		<i>Yes / No Thanks</i>

Parent / Guardian 1 (Complete only if "Primary Client" is younger than 18)

NAME	DOB	RELATION TO CLIENT
ADDRESS	PHONE 1	<i>Home / Mobile / Work / Other</i>
CITY / STATE	<i>do not leave message message with name and phone number only detailed message</i>	
ZIP	PHONE 2	<i>Home / Mobile / Work / Other</i>
EMAIL	<i>do not leave message message with name and phone number only detailed message</i>	
<i>okay to send email do not send email</i>	WOULD YOU LIKE THE E-NEWSLETTER SENT TO YOU?	
		<i>Yes / No Thanks</i>

Parent / Guardian 2 (Complete only if "Primary Client" is younger than 18)

NAME	DOB	RELATION TO CLIENT
ADDRESS	PHONE 1	<i>Home / Mobile / Work / Other</i>
CITY / STATE	<i>do not leave message message with name and phone number only detailed message</i>	
ZIP	PHONE 2	<i>Home / Mobile / Work / Other</i>
EMAIL	<i>do not leave message message with name and phone number only detailed message</i>	
<i>okay to send email do not send email</i>	WOULD YOU LIKE THE E-NEWSLETTER SENT TO YOU?	
		<i>Yes / No Thanks</i>

How Did You Learn About Us?

<i>Physician</i>	<i>Psychiatrist</i>	<i>Another Counselor</i>	<i>School</i>	<i>Friend / Family</i>	<i>Insurance / EAP</i>
<i>Attorney</i>	<i>Other Professional</i>	<i>Employer</i>	<i>Web Search</i>	<i>Psychology Today</i>	<i>Therapist Directory</i>
Other: _____					

Radzom Counseling LLC

40B Edwardsville Prof Park
Edwardsville, Illinois 62025

(618) 795-2697
www.RadzomCounseling.com

Consent to Treatment

I consent to treatment with Radzom Counseling LLC and the providers that work with and for the practice. I understand that therapy is completely voluntary and that the therapy may be discontinued at any time by either party. If therapy is discontinued by either party, I (or my guarantor, if someone else is financially responsible for payment) am still financially responsible for the services that I have already received. I understand that my provider may stop treatment if payment for the services I receive is not made. I understand that my health record will be maintained by my provider, is the property of Radzom Counseling LLC, and may be accessible to me upon review of written request.

I understand that therapy has potential risks and benefits. I understand that no promises have been made to me as to what the result or success of my treatment will be. I have had all my questions about therapy with my provider fully answered.

My signature below indicates that I fully understand and agree with all above statements.

Client Signature

Client Name (Printed)

Date

Guardian Signature, *if applicable*

Guardian Name, *if applicable* (Printed)

Date

****Please complete one form for each adult client. A legal guardian must sign in the designated location for minors under the age of 18. Minors twelve or older and eighteen or younger must also assent to treatment on the "client" portion of form.****

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Office Policies

Confidentiality and Privacy

Aside from the following exceptions and others that may be required by law, everything discussed in therapy and in your record is confidential. Your provider is a mandated reporter and is required to report suspected child or elder abuse. If you are in imminent risk of harming yourself or someone else, confidentiality may be breached to take steps to protect you or that person. If you have authorized the practice to bill a third-party payer for your services, the practice will be required to provide confidential information about the nature of your services to access your benefits. Except in some cases, information about treatment with minors aged twelve through seventeen *involving* substance abuse cannot be provided to parents or guardians without consent of the minor. Likewise, only limited information about any treatment with minors aged twelve through seventeen may be provided to parents or guardians without consent of the minor except in certain situations.

Contact in Emergencies

Your provider does not guarantee immediate availability by telephone. You may always call the general practice at 618-795-2697 and leave a message. The voice mail is monitored frequently. Alternatively, you may send an email to your provider or info@RadzomCounseling.com. Every effort is made to respond to clients within twenty-four hours. If you need immediate help or are in imminent danger, call 911.

Cancellation Policy

It is required that appointments be canceled or rescheduled twenty-four or more hours before a scheduled appointment. Clients canceling or rescheduling sessions less than twenty-four hours prior to the session will be charged a fee of \$35.00.

Fees, Payment, and Billing

Unless other arrangements are made, each session extends for fifty minutes and is \$110. Payment is required at the time of each session. Payments may be made by check, cash, or credit card. Credit card payments are accepted as a convenience and must be made prior to a session. Clients will be charged \$30.00 for each returned check. Upon request, provider will supply a detailed receipt that client can submit to insurance company for possible reimbursement.

Assignment of Benefits and Release of Information

By signing below, I hereby assign, transfer, and set over to Radzom Counseling LLC and the providers working with Radzom Counseling LLC, all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and/or Employee Assistance Program (EAP). I authorize the release of any medical information needed to determine benefits, including: psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my insurance/EAP company or of any balance due after payments by my insurance company. I also authorize payment of medical and EAP benefits directly to Radzom Counseling LLC in circumstances when the practice is billing the insurance or EAP company directly. I am financially responsible for any services that are provided and are not reimbursed by the insurance or EAP plan.

Please initial the statements below to indicate your acceptance. Then sign and date the form.

____ I understand, acknowledge, and accept the policies above.

____ I am financially responsible for all services rendered (including any fees or charges that may not be covered by my insurance or EAP).

____ I acknowledge that I received, read, and understand the Notice of Privacy Practices.

____ I assign, transfer, and set over to Radzom Counseling LLC, all my rights, title, and interest to my medical reimbursement benefits under my insurance policy and/or Employee Assistance Program (EAP) as described above.

Client/Guardian Signature

Client/Guardian Name (Printed)

Date

Cancellation of Appointments

Please keep in mind that your appointment time is reserved for you and only you. If you will not be able to attend your appointment, please call and cancel your appointment no less than twenty-four hours prior to your appointment.

A client who cancels an appointment with less than twenty-four hours prior to an appointment or who does not attend a scheduled appointment will be charged \$35.00 for that appointment. Please note that EAP and insurance plans will not pay for this fee.

My signature below indicates that I understand, acknowledge, and accept the policies above.

Client/Guardian Signature

Client/Guardian Name (Printed)

Date

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Recurring Credit Card Payment Authorization Form

For your convenience, you may complete this form to have incurred fees charged directly to your credit card.

How Recurring Payments Work:

You authorize regularly scheduled charges to your Visa or MasterCard. You will be charged after the service is provided or the fee is assessed. A receipt will be emailed to you, if an email address is provided, and the charge will appear on your credit card statement.

Please complete the information below:

I _____ authorize Radzom Counseling LLC to charge my credit card
(full name)

indicated below for payment of incurred counseling fees associated with _____.
(client name)

Billing Address _____

Phone# _____

City, State, Zip _____

Email _____

Account Type: Visa MasterCard

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of card) _____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.