# Patient information Sheets

Patient Name | Date of Birth | Gender | Marital Status

Home Address (Street, City, State and Zip Code)

Cell Phone Number | Work Phone Number | Home Phone Number

Employer/Student Status | Email Address

Medication taken by Patient:

Patient Primary Care Physician: ( )

Patient Psychiatrist: ( )

Emergency Contact: ( )

Referred By:

## Spouse or Parent Information:

Name | Date of Birth | Relation to Patient

Address (Or Write Same as Above) ( ) Home Phone Number

## Insurance/Guarantor Information:

Primary Insured's Name | Date of Birth | Relation to Patient

Guarantor Address (Or Write Same as Patient) ( ) Guarantor Cell/Home Number

Primary Insured's Employer:

Name of Insurance Company: Phone Number: ( )

ID Number: Group Number:

***Authorization*:** I authorize Sharon A. Saad, PsyD, LCPC or Psychological Associates, LLC to release any information obtained during examination or treatment which is necessary to expedite and support any insurance claims on the above patients account. This authorization gives Counseling Associates or Psychological Associates consent to bill the insurance policy provided. **I understand that I am responsible for all charges, regardless of insurance coverage. Please Note: We are not Medicare/Medicaid providers. I authorize the payment of benefits to Sharon A. Saad, PsyD LCPC or Psychological Associates, LLC.**

**Signature:** **Date:**

# COUNSELING ASSOCIATES, LLC.

**COUNSELING ASSOCIATES:**
**Sharon A. Saad, Psy.D, LCPC**
**Heather A. Dropski, LCPC**

**9651 W. 153rd St.**
**Suite # 54**
**ORLAND PARK, IL 60462**
**PHONE: 708 460-4840**
**FAX: 708 460-4842**

Dear Client,

We would like to welcome you to Counseling Associates. Our mission is to provide psychological services via individual, family and group sessions. Our goal is to help you develop healthier coping, stress management, anger management, parenting skills and problem-solving skills.

The following information is provided to inform you of our office policies and procedures:

1. All appointments should be scheduled by calling the office number (708)460-4840
2. **We require 48 hours notice for all cancelled appointments. If less than 24-48 hours notice is given, you will be charged a $60 late cancellation fee.** *This is the clients responsibility, insurance will not cover this.
3. **There will be a $30 fee charged every 15 minutes for urgent and crisis calls.**
   *This is the clients responsibility, insurance will not cover crisis phone calls.
4. There may be a fee charged for correspondences and coordination of services with other health care professionals, services, etc. (Cost is $20 per letter)
5. Clients are responsible for obtaining prior authorization from their insurance(s) company for the initial evaluation, unless contacting the billing department otherwise.
6. All therapists and Healthcare providers are mandated reporters. This means that we are required by law to report all incidents of physical, emotional, verbal or sexual abuse the appropriate agencies.
7. If a client is suicidal or homicidal, they may be transported to the closest emergency room for a psychiatric evaluation.
8. If court mandated or custody evaluation, the typical limits of confidentiality do not apply. Clinical data will be shared with the court, attorneys, etc. **All court fees, therapist fees and balances should be paid immediately.**
9. **All Co-Pays and/or Deductibles are due at the time of service.** *Any minors must have co-pay paid by accompanying adult. Counseling Associates is not a party of any divorce/parenting decrees.*

Our policies and procedures ensure that your protected information remains confidential. If at any time during your treatment you feel your needs are not being met, please contact the Clinical Director. We strive to provide excellent care. Thank you for choosing us and we look forward to caring for you and your family.

Sharon A. Saad, Psy.D, LCPC & The Staff of Counseling Associates, LLC, Psychological Associates

---

I have received, read and understand your office policies, procedures and privacy notice.

**Patient Signature:**_____ **Date:**_____

# Counseling Associates (HIPPA)

**Counseling Associates**

**Sharon A. Saad, Psy.D, L.C.P.C**

**Heather Anne Dropski, LCPC**

**9651 W. 153rd St. Suite #54**

**Orland Park, IL 60462**

**(P) 708-460-4840**

**(F) 708-460-4842**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY TO UNDERSTAND YOUR PRIVACY RIGHTS.**

**The Health Insurance Portability & Accountability Act of 1966 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significantly new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.**

**As required by HIPPA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.**

**We may use and disclose your medical records only for each of the following purpose: treatment, payment and health care operations.**

- **TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be radiology services.**
- **PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collecting activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.**
- **HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.**

**-We may also create and distribute de-identified health information by removing all references to individually identifiable information.**

**-We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.**

**-Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.**

**You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our office:**

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any person identified by you. We are, however, not required to agree to a requested restriction if we do not agree to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to inspect and copy your protected health information.**
- **The right to amend your protected health information.**
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

**-We are requested by law to maintain the privacy of your protected health information and to provide you with notices of our legal duties and privacy practices with respect to protected health information.**

**-You have recourse if you feel that your privacy protection has been violated. You have the fight to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.**

**For more information about HIPPA or to file a complaint:**

**The U.S Department of Health and Human Services Office of Civil Rights**

**200 Independence Avenue, S.W Washington, D.C. 20201**

**(202) 619-0257 Toll Free: 877-696-6775**

# Counseling Associates, LLC

**Counseling Associates**

**Sharon A. Saad, Psy.D., LCPC**

**Heather A. Dropski, LCPC**

**9651 W. 153rd St. Suite # 54**

**Orland Park, IL 60462**

**(P) 708-460-4840**

**(F) 708-460-4842**

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**I understand that, under the Health Insurance Portability and Accountability Act of 196 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from third party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

**I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.**

**I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.**

**Authorization to discuss healthcare and/or billing information with another party:**

**Authorized Party Name:_____ Phone Number: _____**

**Relation to Patient:_____**

**Patient Signature: _____ Date: _____**

**Parent/ Guardian Signature: _____ Date: _____**

# Counseling Associates, LLC

**Counseling Associates**

**Sharon A. Saad, Psy.D, L.C.P.C**

**Heather A. Dropski, LCPC**

**9651 W. 153rd St. Suite #54**

**Orland Park, IL 60462**

**(P) 708-460-4840**

**(F) 708-460-4842**

## Request for Confidential Information

I, _____herby request Counseling Associates, LLC to keep communications regarding my protected health information confidential.

To accomplish this request please adhere to the following requests:

**Phone:** You can contact me by phone at_____ Cell_____ Home_____

Leave message on answering machine: _____ Yes _____ No

Leave message with any other person: _____ Yes _____ No

**E-Mail:** You can contact me at the following email address: _____

**Texting:** You can contact me by text regarding appointments/scheduling _____Yes _____No

---

**Appointment Reminders:** Please select the method of choice for appointment reminders: (Select all that apply)

Voicemail: _____ Text:_____ Email: _____

**Physician:** Counseling associates has authorization to contact my physician to coordinate care: _____ Yes _____ No

Doctors Name: _____

Doctors Phone Number: _____

Doctors Address: _____

**School:** Counseling Associates has authorization to contact the named school to coordinate care: _____ Yes _____No

Name of School: _____

Contact person / title: _____

School phone number: _____

**Patient Signature: _____ Date: _____**

**Parent Signature: _____ Date: _____**

**This signed authorization for coordination of care and confidentiality agreement expires one year from today on:**

**_____/_____/_____**

# COUNSELING ASSOCIATES, LLC.

**COUNSELING ASSOCIATES:**
**Sharon A. Saad, Psy.D., LCPC**
**Heather A. Dropski, LCPC**

**9651 W. 153rd St. Suite 54**
**ORLAND PARK, IL 60462**
**OFFICE: 708 460-4840**
**FAX: 708 460-4842**

## RELEASE OF INFORMATION FORM

**I,_____, D.O.B_____residing at _____**
**(Name)** **(Street Address)**

**_____ _____ _____ (_____)_____**
**(City)** **(State)** **(Zip)** **(Phone)**

Authorize *Counseling Associates, LLC* to release the following information concerning psychological services provided from the Dates of _____through _____

**The Following information may be released to/from: _____**
(Name)

_____ _____ _____ _____
(Street) (City) (State) (Zip)

_____ _____
(Telephone Number) (Fax Number)

**( ) Diagnostic Evaluation Results** **( ) Verbal Information** **( ) Progress Report**
**( ) Clinical Records** **( ) Letter** **( ) Other: _____**

**The Purpose for this request being made is for:**

**( ) Discharge Planning ( ) Educational Planning** **( ) Treatment Planning**

**( ) Medication Planning** **( ) Coordination of Care** **( ) Other: _____**

I understand that I have the right to revoke this authority, in writing, at any time. I understand that failure to sign this authorization will result in the above indicated purpose not being achieved. The information disclosed will not be used for any purpose other than that indicated above, nor will it be further disclosed or distributed by any receiving party without our or your written consent.

**Today's Date:**_____

**This Authorization Expires on the Date of** (Maximum One Year)**:**_____

**Parent/Guardian Signature:** _____

**Signature of Client (Age 12 and Over):** _____