CENTER FOR
CREATIVE ARTS THERAPY
Healing through the Arts

4336 Saratoga Ave., 2nd Floor
Downers Grove, IL 60515
p: 847-477-8244
info@c4creativeartstherapy.com
www.c4creativeartstherapy.com
(rev. 03/08/19)

NEW CLIENT INTAKE FORM

Client Information:

Full Name:_____ Date:_____

Address:_____ Date of Birth:_____

City/State/Zip:_____

Home Phone:_____ Cell phone:_____

Work Phone:_____ Email Address:_____

Which phone number would you prefer to receive voice mail messages on? ☐ Home ☐ Cell ☐ Work

Social Security Number:_____ Marital Status:_____

Employer or School Name:_____

Employer Address, City, State, Zip:_____

Employed: ☐ Full time ☐ Part time Student: ☐ Full time ☐ Part time

Occupation: _____ Education: _____

Emergency Contact: (for safety of client ONLY; does not include disclosure of service information)

Name: _____ Relationship to Client: _____

Phone Number: _____ Email Address: _____

Party Responsible for Payment: (if different from above please fill out entirely)

Name:_____ Date of Birth:_____

Address:_____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Social Security Number:_____

Employer or School Name:_____

Employer Address, City, State, Zip:_____

Is the party responsible for payment also the contact person for all billing inquiries? ☐ **Yes** ☐ **No**

If "no", who may we contact for billing inquiries? Name_____

Phone Number_____ Email_____

Medical Information:

Pertinent Health Information:_____

Physician Name and Phone Number:_____

Current Medications and Dosage:_____

By signing below, I verify that the information provided on this form is correct and accurate to the best of my ability. If information provided by parent and/or legal guardian of client, please sign below, verifying that the information provided on this form is correct and accurate to the best of your ability.

_____ _____

Signature of Client (12 years and older) Date

_____ _____

Signature of Parent/Guardian (children up to 18 years) Date

_____ _____

Signature of Parent/Guardian (children up to 18 years) Date

_____ _____

Signature of Therapist Date

_____ _____

Signature of Clinical Supervisor Date

PSYCHOTHERAPIST – CLIENT SERVICES AGREEMENT

Welcome to **Creative Clinical Consulting, LLC/Center for Creative Arts Therapy**. We are glad you have chosen us as your place for personal growth and recovery. This document contains important information about our professional services and business practices. **Please read it carefully** and feel free to discuss any questions you have with your therapist.

PHILOSOPHY OF CARE AT CENTER FOR CREATIVE ARTS THERAPY

We believe that treatment of the whole person is necessary for growth and development. This means that psychological, physical, spiritual, relational and fiscal issues may be addressed in therapy. Therapy may occur in a talk-therapy style and/or may include experiential components. Furthermore, therapy is most effective when the client is active in the therapeutic process. This means you will be expected to work on things discussed in therapy both during session and at home.

Psychotherapy has both benefits and risks. Risks sometimes include painful feelings such as sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy also often involves discussing unpleasant aspects of anxiety and distress as well as better relationships, greater self-esteem and resolution of specific problems. Unfortunately there are no guarantees of therapy outcomes.

Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness in order to change thoughts, emotional reactions and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication and stability in relationships, and lessening of distress. Some potential risks include increased uncomfortable emotions as you self-explore, and changes in dynamics or communication with significant people in your life. Sometimes couples that come for therapy choose to end their relationships. Although there are many benefits to therapy, there is no guarantee of positive or intended results.

If during your work together with your therapist, noncompliance with treatment recommendations becomes an issue, we will make effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. We encourage you to discuss any concerns you have about our work together directly so that we can address it in a timely manner. Other factors that may result in termination of therapy include, but are not limited to, violence or threats toward us, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

THE FIRST FEW SESSIONS

In the first few sessions your therapist will want to evaluate your treatment needs and learn more about you. During this time you and your therapist will work together to create treatment goals and an initial plan for treatment. Most importantly, this is your time to evaluate your comfort level and confidence in your choice of therapist. Your therapist will also be evaluating if they are a good choice of therapist for you and your specific needs and goals at this time. If for some reason you do not feel as though you are with the right therapist for you, please tell your therapist, as we would like to assist you in finding the right match.

CONTACTING THERAPISTS AND EMERGENCIES

If needed, you can leave your therapist a message on our answering service at 847-477-8244. When you leave a message, include your telephone number even if you think we already have it, and best times to reach you. Therapists check their voice mail each business day unless they are unavailable for an extended

period of time. If we are unavailable for an extended time, such as on vacation, we will inform you of the contact information for the therapist on-call during our absence, and their contact information will be included in your therapist's outgoing voicemail message. Therapists will make every effort to return calls within 48 hours. It is best to leave some times when you are available to be reached. If you need to reach your therapist more urgently you can call Azizi Marshall on her direct line at 847-477-8244, extension 700.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications, and there is a possibility that we will not get the message in a timely manner, or that communication will be interpreted in an unclear manner. If you need to contact your therapist between sessions, please call 847-477-8244 and their direct extension or the main extension 6. Text messages and emails are only to be used for scheduling, changing or canceling appointments.

If you are in an emergency situation and cannot wait for us to return your call, contact your psychiatrist, go to the nearest emergency room or call 911. Do not contact us by email or fax in an emergency, as we may not get the information quickly.

PROFESSIONAL RECORDS

The laws and standards of the mental health profession require therapists to keep Protected Health Information (PHI) about you in your clinical record. It is important to understand that pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and updated in 2013, your therapist may keep PHI about you in two sets of professional records. One set is your clinical chart, which may be accessed by third parties (such as insurance companies) with your written authorization. Some therapists keep a second record, referred to as Psychotherapy Notes. These notes are only for use by your therapist and may include contents of therapeutic conversations, analysis of those conversations and how they impact treatment. These notes are kept separate from your clinical record and cannot be released to insurance companies without your authorization. Insurance companies cannot penalize you if you refuse to authorize disclosure of psychotherapy notes. You may examine and/or receive a copy of your clinical and psychotherapy notes if you request this in writing. Because these records can be misinterpreted it is recommended that you review them in the presence of your therapist or have them forwarded and reviewed with another mental health provider. Your therapist may charge a copying fee if you request of copy of these records.

RECORDS OF MINORS

Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and the therapist finds no compelling reason to deny the access. Parents can request information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Since parental involvement is usually crucial to successful treatment, it is recommended that Clients between 12 and 18 years of age and their parents enter into an agreement that allows parents access to treatment information.

For children under the age of 18, all paperwork should be co-signed by both parents. Signature of both parents is required in all cases of separation and all divorce situations involving any type of joint custody. Although not required by law, it is preferred to have both parents agree to treatment even in cases of sole custody with no stipulation regarding medical treatment.

COST

Therapy is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits so you understand your coverage prior to your

appointment. Some insurance companies require a precertification before the first appointment or they will not cover the cost of services.

Our current fees are as follows:

- Initial Intake Appointment: $150.00 (60 minute session)
- Subsequent Individual Therapy: $135.00 (50 minute session)
- Subsequent Couples/Family Therapy: $175.00 (60 minute session)

Creative Clinical Consulting LLC/Center for Creative Arts Therapy, has a 24 hour cancellation policy for all sessions including group therapy. Cancellations or missed appointments without 24 hours notice will be subject to full fee charge (up to $150.00), and insurance companies do not pay charges for missed appointments.

Clients with insurance: the negotiated rate with each insurance company. These fees are reviewed annually and may be subject to change.

For clients struggling to afford co-payments or cost of sessions please speak with your therapist about your situation since it is likely that we could work out an alternative financial arrangement. It is also important to know that fees may be charged for lengthy telephone conversations and time spent providing other services on your behalf. This may include extensive report writing, preparation and photocopying records or treatment summaries, consulting with other professionals with your consent, and attendance at staffing. If you become involved in legal proceedings that require your therapist's participation you will be expected to pay for all of their professional time including preparation and transportation costs, even if they are called to testify by another party. Please discuss this with your therapist so that you clearly understand what services you will be charged for. In addition, therapists reserve the right to limit phone calls or other uses of their time to what they consider clinically appropriate. They will discuss these limits with you should they become an issue.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current of former clients on any social networking sites including; Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly.

COURT RELATED SERVICES

We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.

If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

- We charge $200/hour to prepare for and/or attend any legal proceeding and for all court related services.
- Charges for court related services are not covered by insurance.
- Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.
- If our fee is not paid by the court or attorneys, you will be charged for the time we spend responding to legal matters
- You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

CONFIDENTIALITY

Illinois law protects the privacy of all communications between a Client and a mental health provider. In most situations, if you are 18 years of age or older, your therapist can only release information about your treatment to others if you sign a written authorization form and meet certain legal requirements imposed by HIPAA and/or Illinois law. However, there are several situations in which no authorization is required. Please see Creative Clinical Consulting, LLC/Center for Creative Arts Therapy, Notice of Privacy Practices for further explanation and clarification.

Therapists are mandated reporters and as such we have the legal obligation of notifying appropriate authorities in the following situations. Please note that these situations are handled with the utmost care to protect those at risk for harm and with respect to the Client's confidentiality.

- If your therapist believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself.
- If you have made a specific threat of violence against another or if your therapist believes you present a clear, imminent risk of serious physical harm to another.
- If your therapist has reasonable cause to believe that a child under 18 known to your therapist in her professional capacity may be abused or neglected by a parent, caretaker, or other person responsible for the child's welfare.
- If your therapist has reason to believe that an adult over 59 years old, or under 60 years old and who is disabled, has been abused, neglected, or financially exploited in the preceding 12 months.
- In accordance with Illinois Firearm Concealed Carry Act of 2013 if you are determined to be a clear and present danger to yourself or others, developmentally disabled or intellectually disabled your therapist may be responsible for reporting your mental health information to the Illinois Department of Human Services.

STATEMENT OF INDEPENDENCE

Creative Clinical Consulting, LLC/Center for Creative Arts Therapy is comprised of multiple independent practitioners. That said, Creative Clinical Consulting, LLC/Center for Creative Arts Therapy is not responsible for the actions of the other professionals at Creative Clinical Consulting, LLC/Center for Creative Arts Therapy. Although independent from other practitioners, we sometimes consult with them regarding our Clients' situations. By signing below you grant your therapist permission to consult with the other practitioners at Creative Clinical Consulting.

TERMINATION

Deciding when therapy is complete is meant to be a mutual decision, and we will discuss how to

know when therapy is nearing completion. Sometimes people begin to schedule less frequently to gradually end therapy. Others feel ready to end therapy without a phasing out period of time.

QUESTIONS

If during the course of your therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.

A FINAL WORD

The counseling relationship is a very personal and individualized partnership. We want to know what you find helpful and what, if anything, may be getting in the way. We want you to feel free to share with me what I can do to help.

Please ask before signing below if you have any questions about psychotherapy or Creative Clinical Consulting/Center for Creative Arts Therapy's policies. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

_____ _____

Signature of Client (12 years and older) Date

_____ _____

Signature of Parent/Guardian (children up to 18 years) Date

_____ _____

Signature of Parent/Guardian (children up to 18 years) Date

_____ _____

Signature of Therapist Date

_____ _____

Signature of Clinical Supervisor Date

AUTHORIZATION FOR RELEASE OF INFORMATION
Request/Authorization for Release of Information

I _____ _____

Client Name Date of Birth

hereby authorize the Creative Clinical Consulting, LLC/Center for Creative Arts Therapy to release information contained in my client records to the following individual(s) and/or organizations(s), and only under the conditions below:

1. Name of person(s), organizations(s), address to whom disclosure is to be made:

_____

_____

_____

Approximate dates of service at site from which information is requested: _____

2. Information to be disclosed:

❑ Diagnosis ❑ Drug/Alcohol History ❑ Treatment Summary
❑ Attendance ❑ Mental Status Exam ❑ Entire Record
❑ Progress ❑ Physical Examination ❑ Other _____
❑ Prognosis ❑ Discharge Summary

3. Purpose of disclosure:

❑ Provision of Mental Health Services ❑ Billing Purposes ❑ Aftercare Planning
❑ Continuity of Treatment ❑ Family Involvement ❑ P.O./Attorney/Judge/Court

4. This release will expire on_____.

I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the contact person at Creative Clinical Consulting, LLC/Center for Creative Arts Therapy except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. If I refuse to release information, it may negatively impact my quality of care in that providers will not be able to coordinate care between each other which may limit my recovery. RE-DISCLOSURE: Notice is here-by given to the patient or legal representative signing this Authorization and the recipient named above that the health information disclosed under this Authorization may not be re-disclosed by the recipient to others without the written consent of this client. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding diagnosis or treatment for Mental illness, HIV or drug/alcohol abuse.

_____ _____
Client (12 years or older) Signature Date

_____ _____
Parent/Guardian (children up to 18 years) Signature Date

_____ _____
Parent/Guardian (children up to 18 years) Signature Date

_____ _____
Therapist Signature Date

_____ _____
Clinical Supervisor Signature Date

CENTER FOR
CREATIVE ARTS THERAPY
Healing through the Arts

INSURANCE POLICY AGREEMENT

(revised 03/21/18)

In consideration of receiving counseling services from Creative Clinical Consulting, LLC DBA Center for Creative Arts Therapy, I agree to the following terms and conditions:

- I authorize the release of information to all my insurance companies for billing purposes.
- I understand that **I am fully responsible for my bill**.
- I understand that any co-payment, deductible, coinsurance, or services not covered by my insurance company are my financial responsibility.
- **I understand that all co-pays, deductible, and/or coinsurance financial responsibilities are due at the time of service. If any credit is due to you post insurance remittance, the credit will be applied to your account OR refunded if services have been discontinued.**
- **If after 2 sessions I have not paid my co-pay/deductible/coinsurance, I understand services will be suspended until payment is received.**
- If insurance requests pre-authorization or referrals for services, I understand that I am responsible for calling my insurance company directly and completing necessary authorization requirements.
- I authorize Creative Clinical Consulting, LLC to act as my agent in helping me to obtain payment from my insurance company and agree a copy of this form can be used in place of the original.
- I authorize payment direct to Creative Clinical Consulting, LLC from my insurance.
- If an outside agency is not paying for services and reports are requested, Creative Clinical Consulting, LLC can bill as follows:
    - Narrative Progress Report (done every 3-6 months or as requested by court) at $200 per report
    - Closing Summary at $200 per report
    - Risk assessment/Reassessment at $250

  ***No reports will be released without payment or an outstanding balance on your account.**
- I recognize and understand that if a written evaluation is not requested and completed at time of original referral but an evaluation is requested or needed in the future, my child will need to be re-evaluated.
- In the event that it becomes necessary for Creative Clinical Consulting, LLC to hire an attorney to collect the amount due under this payment agreement, Creative Clinical Consulting, LLC shall be entitled to recover all costs and expenses associated with collection activities and litigation including Creative Clinical Consulting, LLC attorney's fees.
- **In the event of collections or legal proceedings, I consent to a credit check and agree to be responsible for legal fees and court costs.**

Insurance Information:

Client's Name: _____

Client's Date of Birth: _____

Insurance Policy Holder's Information (if different from above):

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____

Insurance Company:_____ Telephone Number:_____

ID Number:_____ Group Number:_____

By signing below, I agree to all above statements in this contract. My signature below also confirms my choice to utilize insurance for payment of services. I understand that I may elect to revoke this agreement at anytime, in writing. I also agree to responsibly utilize my insurance benefits per Creative Clinical Consulting LLC's insurance policy and payment agreement.

_____ _____

CLIENT'S SIGNATURE (if 18 years of age or older) **DATE**

_____ _____

PARENT/GUARDIAN'S SIGNATURE **DATE**

_____ _____

CREATIVE CLINICAL CONSULTING, LLC STAFF MEMBER'S SIGNATURE **DATE**

CENTER FOR CREATIVE ARTS THERAPY
Healing through the Arts

4336 Saratoga Ave, 2nd Floor
Downers Grove, IL 60515
Ph: 847.477.8244
info@c4creativeartstherapy.com
www.c4creativeartstherapy.com

PAYMENT CONSENT FORM / CREDIT CARD ON FILE

Client Name _____
Last First MI

Payments are due at the time of service. I agree to be responsible for full payment of my bill due to Creative Clinical Consulting, LLC DBA Center for Creatve Arts Therapy. I understand that Creative Clinical Consulting, LLC/Center for Creative Arts Therapy prefers to receive payment in the form of check or cash. **I also understand that Creative Clinical Consulting, LLC/Center for Creative Arts Therapy may charge my credit card for any unpaid and/or overdue balances past 30 days.**

I agree to provide a current, valid, personal credit card for this purpose. I understand that charges may appear on my credit card statement as Professional Charges, Square, or Creative Clinical Consulting, LLC/Center for Creative Arts Therapy. I understand that I can elect to utilize other forms of payment, including an HSA/FSA, for co-pays/deductible amounts/coinsurance. I authorize Creative Clinical Consulting, LLC/Center for Creative Arts Therapy to charge my credit/debit card for professional services as follows:

I prefer to pay accrued fees including but not limited to co-pay/deductible/coinsurance by:

☐ HSA/Flexible Spending (*please fill out pg 2 in addition) ☐ Cash ☐ Credit Card ☐ Personal Check ☐ Money Order

***Please note that per center policy, payment is due at time of service. If alternative payment frequency is needed please contact Billing Specialist, Kristen Sipek, at ksipek@c4creativeartstherapy.com or 847.477.8244 extension 2 to make other arrangements.**

Preferred Credit Card for Payments

Type of Card:

☐ HSA/Flexible Spending ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Name as it appears on Card _____

Billing Address: Street _____

City/State _____ Zip Code _____

Credit Card Number _____-_____-_____-_____, CVV Number _____
A 3-digit number on the back of credit card

Expiration Date _____

Additional Notes:

_____

_____

_____

Credit Card on File for Balances Due Past 30 days (REQUIRED)

Type of Card: (required per center policy regardless of preferred method of payment. Leave blank if same as above payment card)

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Name as it appears on Card: _____

Billing Address: Street _____

City/State_____ Zip Code _____

Credit Card Number_____-_____-_____-_____, CVV Number _____
A 3-digit number on the back of credit card

Expiration Date: _____

I understand that by signing below, I am authorizing Creative Clinical Consulting, LLC/Center for Creative Arts Therapy to charge my personal credit card for any outstanding balances due past 30 days . These balances may include co-pays, co-insurance amounts, out of pocket fees, or deductibles. Out of pocket fees may include but is not limited to, fees accrued for late cancellation of sessions or not showing to scheduled sessions without notification of need to cancel. I understand that Creative Clinical Consulting, LLC/Center for Creative Arts Therapy will provide me a statement as proof of payment. By signing below I agree to all payment terms and attest that I understand all information on this form.

_____ _____

Party Responsible for Payment (Signature): Date:

CENTER FOR
CREATIVE ARTS THERAPY
Healing through the Arts

SIGNATURE PAGE

Please initial the following statements to indicate that you agree. If an item is not applicable please write N/A.

_____ 1) I have completed and signed the **New Client Intake Form**.

_____ 2) I have read and signed the **Psychotherapist-Client Services Agreement**.

_____ 3) I have read, completed, and signed the **Insurance Policy Agreement.**

_____ 4) I have completed and signed the **Payment Consent Form/Credit Card on File**.

_____ 5) I have completed and signed the **Authorization to Release Information Form.**

_____ 6) I have received a copy of **Creative Clinical Consulting/Center for Creative Arts Therapy Notice of Privacy Practices** for my personal records.

_____ 7) I understand the 24 hour cancellation policy. I understand I am financially responsible for any late cancellation fees as this is not covered by my insurance.

_____ 8) I agree to hold confidential the identities and personal information of any other clients that I may see or interact with at Creative Clinical Consulting/Center for Creative Arts Therapy.

Your signature below indicates that you have received the 1) New Client Intake Form, 2) Psychotherapist-Client Services Agreement, 3) Insurance Policy Agreement, 4) Payment Consent Form/Credit Card on File, 5) Authorization to Release Information Form and the 6) Notice of Privacy Practices, and that you agree to abide by its terms. These documents represent an agreement between you, your therapist and Creative Clinical Consulting LLC DBA Center for Creative Arts Therapy. You may revoke this agreement in writing at any time. However, revoking any of these agreements will result in termination of professional services provided to you by your therapist and Creative Clinical Consulting LLC. Your signature below also indicates that you have initialed all the above statements which were applicable.

Client_____ Date_____

Parent/Guardian* _____ Date_____

Parent/Guardian*_____ Date_____

Witness_____ Date_____

_____ Date_____

Clinical Supervisor

*Parent signature is required for clients under age 18. Signature of both parents is usually required.

CREATIVE CLINICAL CONSULTING, L.L.C./Center for Creative Arts Therapy
NOTICE OF PRIVACY PRACTICES
Version IV: 10/2014

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. **Uses and Disclosures of Protected Healthcare Information**
    a. **Creative Clinical Consulting, L.L.C./Center for Creative Arts Therapy may use or disclose your Protected Health Information (PHI) for treatment, payment and healthcare operation purposes with you written authorization.**
        i. To help clarify these terms, here are some definitions:
            1. "PHI" refers to information in your health record that could identify you.
            2. "Treatment" is when your therapist provides, coordinates or manages your healthcare.
            3. "Payment" is when Creative Clinical Consulting, L.L.C./Center for Creative Arts Therapy obtains reimbursement for services.
            4. "Healthcare Operations" are activities that relate to the performance and operation of our practice.
    b. **Creative Clinical Consulting, L.L.C./Center for Creative Arts Therapy may use or disclose PHI for purposes outside of treatment, payment or healthcare operations, if we obtain your authorization prior to release of information.**
        i. You may revoke all such authorizations of PHI at any time provided each revocation is in writing. You may not revoke an authorization to the extent that:
            1. Your therapist has acted on that authorization or
            2. If the authorization was obtained as a condition of obtaining insurance coverage. The law provides the insurer the right to contest the claim under the policy.
2. **Uses and Disclosures of PHI Without Your Authorization**
    a. **Therapists may use or disclose PHI without your consent or authorization in the following circumstances:**
        i. **Consultation with other health and mental health professionals outside Creative Clinical Consulting/Center for Creative Arts Therapy.** During such consultations your therapist cannot reveal any information that identifies you without your written consent. All other professionals are also legally bound to keep the information confidential. In most cases your therapist will not tell you about these consultations unless it is beneficial to your work together. All consultations will be noted in your clinical record.
        ii. **Teaching and supervision.** At times you therapist may refer to clinical cases for teaching or supervision purposes. In these situations your therapist will not reveal any information that could identify you. In most cases your therapist will not discuss these occurrences with you unless it is beneficial to your treatment.
        iii. **Within Creative Clinical Consulting/Center for Creative Arts Therapy and Administrative.** At Creative Clinical Consulting L.L.C./Center for Creative Arts Therapy independent practitioners consult with each other regularly as a means of providing the highest quality of care to their clients. Creative Clinical Consulting, L.L.C./Center for Creative Arts Therapy also employs administrative staff. Your therapist may need to share protected information with these individuals for both clinical and administrative purposes such as scheduling, billing and quality assurance.

All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the oversight of a professional staff member.

iv. **If you are involved in a court proceeding.** Your therapist cannot disclose any protected information to the courts without a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order your therapist to disclose information. In some cases, including but not limited to child custody proceedings and situations in which your emotional condition is an issue, a judge may require your therapist to testify in court. If it is your decision to open your protected information to the courts, please be advised that not only your clinical chart (PHI) may be opened but the Psychotherapy Notes that your therapist might keep in a separate file may be brought into the court, even if that is not what you wish. Unfortunately, once you offer your record for the court, you may not choose what is disclosed. It is advisable that you review records with your therapist and your attorney before making such a decision.

v. **Government.** If a government agency is requesting information for health oversight activities, your therapist may be required to provide it for them.

vi. **Malpractice Suits.** If you file a lawsuit against your therapist, they may disclose all of your record (including PHI and Psychotherapy Notes) regarding you to defend themselves.

vii. **Workman's Compensation.** If you file a worker's compensation claim and your therapist is rendering treatment or services in accordance with the provisions of Illinois Worker's Compensation law, your therapist must, upon appropriate request, provide a copy of your record to your employer or their designee.

3. **<u>Therapists are mandated reporters and as such have the legal obligation of notifying appropriate authorities in the following situations. Please note that these situations are handled with the utmost care to protect those at risk for harm and with respect to the clients broken confidentiality.</u>**

   a. **If your therapist believes you present a clear, imminent risk of serious physical or mental injury or death to yourself,** they are required to take protective actions that can include notifying the police, seeking hospitalization or releasing relevant information to friends or family in order to keep you safe.

   b. **If your therapist has reasonable cause to believe that a child under 18 known to them in their professional capacity may be abused or neglected by a parent, caretaker or other person responsible for the child's welfare,** the law requires that they file a report with the local office of the Department of Children and Family Services. Once a report is filed your therapist may be required to provide additional information.

   c. **If your therapist has reason to believe that an adult over 59 years old, or under 60 years old and disabled, has been abused, neglected or financially exploited in the preceding 12 months,** the law requires them to file a report with the agency designed to receive such reports by the Department of Aging. Once such a report is filed your therapist may be required to provide additional information.

   d. In accordance with **Illinois Firearm Concealed Carry Act of 2013** if you are determined to be a clear and present danger to yourself or others, developmentally disabled or intellectually disabled your therapist may be responsible for reporting your mental health information to the **Illinois Department of Human Services.**

4. **<u>Patient Rights and Therapist Duties</u>**

   a. **Patient Rights**

      i. **Right to Request Restrictions –** You have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction you request.

ii. **Right to Receive Confidential Communication 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 request all written communication be sent to an address other than your home address.

iii. **Right to Inspect and Copy –** You have the right to inspect and obtain a copy or PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained. On your request, your therapist will discuss with you the details of the request for access process.

iv. **Right to Amend –** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request may be denied. On your request your therapist will discuss with you the details of the amendment process.

v. **Right to an Accounting –** You generally have the right to receive an accounting of disclosures of PHI. On your request your therapist will discuss with you the details of the accounting process and when if applies.

vi. **Right to a Paper Copy of Notice of Privacy Practices –** You have the right to obtain a paper copy of this notice from Creative Clinical Consulting, L.L.C./Center for Creative Arts Therapy upon request.

b. **Therapist Duties**

i. Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.

5. **Statement of Independence**

a. Creative Clinical Consulting, LLC/Center for Creative Arts Therapy is comprised of multiple independent practitioners. That said, Creative Clinical Consulting, LLC/Center for Creative Arts Therapy is not responsible for the actions of the other professionals at Creative Clinical Consulting, LLC/Center for Creative Arts Therapy. Although independent from other practitioners, we sometimes consult with them regarding our Clients' situations. By signing below you grant your therapist permission to consult with the other practitioners at Creative Clinical Consulting

6. **Questions and Complaints**

a. If you have questions about this notice, disagreement wish a decision made about access to your records or other concerns about your privacy rights, please talk to your therapist.

b. If you believe that your privacy rights have been violated and wish to file a complaint with Creative Clinical Consulting, L.L.C./ Center for Creative Arts Therapy, you may send your written complaint to Creative Clinical Consulting, L.L.C./ Center for Creative Arts Therapy and to the Secretary of the U.S. Department of Health and Human Services.

7. **Effective Date, Restrictions and Changes to Privacy Policy**

a. The terms of this notice are unchanged since our first version, and thus have been in effect since December 31, 2014. We reserve the right to change the privacy policies and practices described in this notice, and make those changes effective for all protected information that we maintain. You will be notified if such changes occur. We will post a new notice in the waiting area, post the revised notice on our website, and have paper copies available. If substantial changes are made to this agreement and you are no longer in treatment with us, you will receive notification via mail within 60 days of the revision. If we fail to attempt to contact you then we are required to abide by the terms currently in effect.