



1431 Opus Place, Suite 110
Downers Grove, IL 60515
p: 847.477.8244
info@creativeclinicalconsulting.com
www.creativeclinicalconsulting.com

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? _____

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: _____

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

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status: _____

Social Security Number: _____

Employer or School Name: _____

Employer Address, City, State, Zip: _____

Insurance:

Name, birth date and social security number of insured:

Insurance Company: _____ Telephone Number: _____

Group and other insurance ID numbers: _____

PSYCHOTHERAPIST – CLIENT SERVICES AGREEMENT

Welcome to **Creative Clinical Consulting, LLC**. 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 CREATIVE CLINICAL CONSULTING

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 24-hour 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.

Please do not contact us through text messages or emails regarding clinical issues. These are not secure communications, and there is 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. 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 Therapy: \$120.00 (50 minute session)
- Patients with insurance: the negotiated rate with each insurance company These fees are reviewed annually and may be subject to change.

For individuals 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.

USE OF INSURANCE

We are happy to provide you with a detailed receipt to help you seek reimbursement from your insurance company. You may want to call them to ask if your plan has "out-of-network mental health benefits" and get details about your benefits. In addition, you must qualify for a mental health diagnosis in order to have insurance reimburse you for treatment. Insurance generally does not cover relationship/marriage counseling. If this arrangement does not work for you, we are happy to help you find another provider who is on your insurance provider panel.

Insurance is a complex issue. **We ask our Clients to call their insurance company to discover what mental health/chemical dependency coverage is available.** Mental health coverage is usually different than physical health coverage. Please ask your insurance company if you need pre-certification, what your co-pay is given our hourly rate, and how many sessions you are allowed in what period of time. We reserve the right to call your insurance company and verify coverage and benefits. We also ask that you assume the responsibility of tracking the usage of allotted sessions. In this regard you should take the initiative to discuss with your therapist (1) the number of sessions remaining before further approval is needed, and (2) when no further sessions are available under your policy.

Ultimately you are responsible for full payment of fees that your insurance company does not agree to cover. Therefore it is important for you to fully understand your coverage benefits regarding mental health. You will be responsible for discussing with your health insurance company any disputes regarding coverage. If you are disputing a claim for lack of payment with your insurance company, Creative Clinical Consulting, LLC may request that you pay your balance with us and agree to be reimbursed by the insurance company at a later date if the matter is eventually resolved.

OTHER BILLING ISSUES

Creative Clinical Consulting, LLC, 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, and insurance companies do not pay charges for missed appointments.

We ask that you provide a credit card number for us to keep on file to cover balances that are more than 30-days overdue. We will notify you in the event that we bill your card.

Creative Clinical Consulting, LLC, does use a collections agency and may do so if an account is 30-days past due and compliance with a suitable payment plan has not occurred. If it is necessary to take legal action to collect fees, then attorney's fees and costs will be included in the claim. Rather than enter an adversarial situation we encourage you to speak directly to your therapist should financial issues arise which make timely reimbursement impossible.

Acceptable forms of payment include cash, check and major credit cards, and payment is expected at the time of service.

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 or 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.

Please do not contact us through text messages or emails regarding clinical issues. These are not a secure communications, and there is 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. Text messages and emails are only to be used for scheduling, changing or canceling appointments.

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, 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



1431 Opus Place, Suite 110
Downers Grove, IL 60515
p: 847.477.8244
info@creativeclinicalconsulting.com
www.creativeclinicalconsulting.com

PAYMENT CONSENT FORM / CREDIT CARD ON FILE

Client Name _____
Last First Middle

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. I understand that Creative Clinical Consulting, LLC prefers to receive payment in the form of check or cash. I also understand that Creative Clinical Consulting, LLC may charge my credit card for any unpaid or overdue balances. I agree to provide a current, valid 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. For your convenience, in lieu of paying at each session, you may opt to have Creative Clinical Consulting, LLC charge your payments once per month, at the beginning of the month. Please be aware that we will **NOT** notify you of credit card being charged ahead of time, and you will receive a paid statement as a receipt if your credit card is charged. I authorize Creative Clinical Consulting, LLC to charge my credit/debit card for professional services as follows:

Please Initial

_____ This visit only, for the amount of \$_____.

_____ Please charge my card for all balances that accrue each month (30 days). Charges will be made at the beginning of each month.

_____ Recurring charges, _____ weekly, _____ per visit.

_____ **To charge my card for the balance of fees not paid by myself or insurance company (required) within 30 days.**

Type of Card:

_____ Visa _____ MasterCard _____ Discover _____ Medical Flex/Savings

Name as it appears on Card _____

Card Holder's Address _____

Credit Card Number _____ - _____ - _____ - _____ , CVV Number _____

Expiration Date _____ A 3-digit number on the back of credit card

I understand that by signing below, I am authorizing Creative Clinical Consulting, LLC to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, or deductibles. I understand that Creative Clinical Consulting, LLC will provide me a statement as proof of payment.

Card Holder Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Request/Authorization for Release of Information

I _____
Client Name Date of Birth

hereby authorize the Creative Clinical Consulting 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:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Drug/Alcohol History | <input type="checkbox"/> Treatment Summary |
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Mental Status Exam | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Progress | <input type="checkbox"/> Physical Examination | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prognosis | <input type="checkbox"/> Discharge Summary | |

3. Purpose of disclosure:

- | | | |
|--|---|--|
| <input type="checkbox"/> Provision of Mental Health Services | <input type="checkbox"/> Billing Purposes | <input type="checkbox"/> Aftercare Planning |
| <input type="checkbox"/> Continuity of Treatment | <input type="checkbox"/> Family Involvement | <input type="checkbox"/> 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 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

CREATIVE CLINICAL CONSULTING, L.L.C.
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. 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 Mind Body Connections, L.L.C. 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. 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.** 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 and Administrative.** At Creative Clinical Consulting 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. 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. **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.**

- 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. **Patient Rights and Therapist Duties**

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 it 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 Mind Body Connections, L.L.C. 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 is comprised of multiple independent practitioners. That said, Creative Clinical Consulting, LLC is not responsible for the actions of the other professionals at Creative Clinical Consulting, LLC. 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 with 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., you may send your written complaint to Creative Clinical Consulting, L.L.C. 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 April 14, 2003. 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.

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



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 completed and signed the **Payment Consent Form/Credit Card on File**.
- _____ 4) I have completed and signed the **Authorization for Release of Information Form**.
- _____ 5) I have received a copy of **Creative Clinical Consulting Notice of Privacy Practices**.
- _____ 6) I have provided my **insurance card** to be photocopied.
- _____ 7) I have provided my **credit card number** for coverage of service fees and/or overdue balances.
- _____ 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.

Your signature below indicates that you have received the Psychotherapist-Client Services Agreement and the Notice of Privacy Practices and that you agree to abide by its terms. These documents represent an agreement between you and your therapist. You may revoke this agreement in writing at any time. However, revoking either of these two agreements will result in termination of professional services provided to you by your therapist. 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 _____

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