Wildflower
Center for Emotional Health

NEW CLIENT REGISTRATION

Today's date: _____

Name _____

Address _____ City _____ State ____ Zip _____

Gender _____ Sexual Orientation/Identity: _____ Race/Ethnic Identity: _____

Birth date _____

Marital Status (circle one) Single Married Partnered Widowed Separated Divorced

Employer _____

Occupation _____

Education (degree/years completed) _____

Primary Language _____ Is English your second language? yes / no

Cell Phone _____ OK to leave msg? yes/no Other Phone _____ OK to leave msg? yes/no

E-mail address _____

Do you have any special needs? _____

Do you have a Firearm Owners Identification (FOID) Card? yes / no

Do you own and/or possess a firearm? yes / no

If so, do you have a license to carry a concealed firearm? yes / no

How were you referred? _____ May we thank them? yes/no

Reason for referral _____

In case of emergency, who should be notified? _____

Relationship to client _____ Phone _____

PRIMARY INSURANCE

Insurance Company:

Insured ID#:

Group #:

Subscriber Name (if different):

Subscriber ID# (if different):

Subscriber DOB (if different):

Subscriber Address (if different):

SECONDARY INSURANCE (if any)

Insurance Company:

Insured ID#:

Group #:

Subscriber Name (if different):

Subscriber ID# (if different):

Subscriber DOB (if different):

Subscriber Address (if different):

PROBLEM INVENTORY

Please complete the questionnaire below to help us understand what has been troubling you. Place a check next to the problem only if you have experienced it **within the past two weeks.**

- ☐ Relationship problems
- ☐ Physical abuse
- ☐ Problems on the job
- ☐ Losing someone or something close to me (person, job, pet, moving, etc.)
- ☐ Problems with my children
- ☐ Sexual abuse
- ☐ Current problems from past sexual abuse
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Feeling guilty about past misdeeds
- ☐ Feeling that I am no good
- ☐ Feeling the need to get more sleep
- ☐ Losing pleasure in my daily activities
- ☐ Often feeling restless or irritable
- ☐ Thinking about dying or killing myself
- ☐ Trouble keeping my mind on a task
- ☐ Feeling sad or "down in the dumps"
- ☐ Preoccupied with sexual thoughts/urges
- ☐ Needing less sleep than usual
- ☐ Spending sprees
- ☐ Trouble making myself slow down or talk less
- ☐ Fear of crowds or public places
- ☐ Specific fear of a thing or place
- ☐ Attacks of fearfulness where I feel I need to run
- ☐ Heart palpitations
- ☐ Chest pains or discomfort
- ☐ Feeling dizzy or unsteady
- ☐ Feeling things that aren't there
- ☐ Tingling in hands or feet
- ☐ Hot or cold flashes
- ☐ Trouble breathing
- ☐ Feeling trembly or shaking
- ☐ Fears of dying or going crazy
- ☐ Feeling the urge to avoid certain places or objects
- ☐ Feeling troubled by repetitive thoughts
- ☐ Feeling anxious and nervous
- ☐ Worrying about things over and over
- ☐ Checking, hand washing, hair pulling
- ☐ People following me, out to hurt me, or talking about me
- ☐ People reading my thoughts
- ☐ Hearing voices
- ☐ Thoughts being put into my head, controlling me, making me do things
- ☐ Special messages to me from TV or radio
- ☐ Feeling emotionally "numb"
- ☐ Recurring nightmares
- ☐ Frequently feeling startled
- ☐ Being troubled by painful memories
- ☐ Parts of my body not functioning well
- ☐ Feeling aches and pains all over my body
- ☐ Often feeling sickly
- ☐ Fear of having or getting a disease
- ☐ Problems with my memory
- ☐ Not knowing where or who I am
- ☐ Getting lost or confused
- ☐ Having trouble remembering my past
- ☐ Finding things I don't remember having
- ☐ Feeling that I've lost time
- ☐ Urges to do something harmful to myself or others
- ☐ Urges to set fires
- ☐ Difficulty controlling my temper
- ☐ Feeling anger or resentment
- ☐ Taking laxatives to control my weight
- ☐ Vomiting to control my calorie intake
- ☐ Exercising frequently and vigorously
- ☐ Restricting in order to control my weight
- ☐ Feeling helpless about my eating habits
- ☐ Extreme changes in my weight
- ☐ Any other problem not mentioned above:

_____

_____

_____

Wildflower
Center for Emotional Health

INFORMED CONSENT, POLICIES AND GUIDELINES

Welcome to Wildflower Center for Emotional Health! Please take a moment to acquaint yourself with our policies and procedures. We are happy to address any questions, comments or concerns you may have about the information contained below.

Initial Session. In your first session, you will have an opportunity to talk with your therapist about your difficulties, strengths and goals. Your therapist will want to learn about you and will inquire about details of your personal history. Together you will discuss the treatment process and create a plan to achieve your goals.

Confidentiality. Wildflower Center for Emotional Health LLC holds as confidential all information it has received concerning you. **Confidentiality is both a legal and ethical obligation that we approach very seriously.** However, please note that Illinois and federal law require release of confidential material in limited situations, such as in cases of suspected child or elder abuse or neglect, imminent risk of harm to yourself or others, or when the court demands records. Also, State of Illinois requires us to report to the State if you are a danger to yourself or someone else and you are a firearm owner (Public Act 095-0564). Please read our Notice of Privacy Practices which describes these limits in greater depth.

Financial Responsibility. Unless mutually agreeable alternative arrangements have been made, full payment is expected at the time that services are rendered. All balances not paid or covered by your insurance company, if any, shall be your sole responsibility. Wildflower Center for Emotional Health LLC reserves the right to periodically adjust fees. You will be notified of any fee adjustment in advance. If finances are of concern, please discuss this prior to beginning therapy and Wildflower Center for Emotional Health LLC can look into payment options and provide referrals. If you submit a check which is returned for any reason, you may be assessed a service charge of $25.

Insurance Coverage. Insurance coverage for services provided by Wildflower Center for Emotional Health LLC is a contract between you and your insurance company. **Prior to your visit, please verify that we accept your insurance plan and acquaint yourself with details of your coverage.** If you are covered by one of our accepted plans, you must provide a valid insurance card, and we will bill your insurance for the services provided. You are responsible for all charges for services that you receive (such as copays or charges applied to your deductible or coinsurance). If you plan to use out of network benefits to receive services, contact your insurance to verify terms. When using out of network benefits, you will be expected to pay in full at the time of service and we will provide you with a statement to submit to your insurance carrier for reimbursement. Wildflower Center for Emotional Health LLC is not responsible for negotiating any settlements between you and your insurance company.

Credit Card Policy. We require credit card information on file in our secure medical record at the time of the initial appointment. Please provide it below. By signing below, you acknowledge that if you are in receipt of our services, Wildflower Center for Emotional Health is authorized to bill the credit card for any outstanding charges not paid in full within 30 days from the date on which you receive notification of the charges. Exception: No show and late cancellation fees will be charged no later than the end of the week during which your scheduled appointment was to occur. You will receive a courtesy message to let you know that we will charge the credit card listed on record. If your credit card information changes, it is your responsibility to update this information.

Cancellations and Missed Appointments. When you schedule an appointment, we reserve a time just for you. We commit to never double-book your appointment time. **We require a 24 hour notice of cancellation for all appointments. If you fail to give a 24 hour notice or miss a scheduled appointment ("no show"), you will be responsible for full fees for that appointment. Your credit card on file will be charged no later than the end of the week during which the appointment was to occur.**
Please call or email your therapist directly to cancel or reschedule all appointments. Messages will be returned within 24 hours unless otherwise stated on the outgoing voicemail message. Email is only to be utilized for scheduling purposes unless an alternative agreement has been made between you and your therapist.

Emergencies. We are an outpatient facility, which means we are not able to handle psychiatric emergencies. **If you are experiencing an acute crisis, please call 911 or go to your nearest emergency room.** If you are not experiencing a psychiatric emergency but wish to see your therapist sooner than your next scheduled appointment, please contact him/her directly and they will gladly accommodate you if able.

By signing below, I acknowledge that I have read, understand and agree to the terms as outlined in the "Informed Consent, Policies and Guidelines" document. I consent to participate in mental health services at Wildflower Center for Emotional Health LLC. Moreover, I agree to hold free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Client Signature	Client's Printed Name	Date
Wildflower Staff Signature	Wildflower Staff Printed Name	Date

Credit card authorization

(used only for charges 30 days overdue AND for no show/late cancellation fees)

Name on card	
Type of card	**Note: we do not accept American Express**
Card number	
3-digit code	
Expiration date	
Billing zip code	

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CLIENT RIGHTS

You have the right to expect quality service from therapists at Wildflower Center for Emotional Health LLC. You have the right to non-discriminatory treatment without prejudice to sex, age, race, religion, creed, color, national origin, disability, ethnicity, marital status or sexual orientation.

You have the right to have all communication and records pertaining to your care treated confidential as governed by the Illinois Mental Health and Developmental Disabilities Confidentiality Act and the Health Insurance Privacy and Accountability Act (HIPAA). Your information will not be released without your consent. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which your therapist is court-ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices."

You have the right to be an active participant in your treatment planning. You have the right to be involved in the planning for termination of services or transfer of care.

You have the right to receive accurate, clear information in order to make informed health care decisions about your treatment. You have the right to have your questions answered regarding your treatment at any time.

You have the right to ask for an outside consultation, evaluation and/or treatment. You are liable for the costs incurred by any of these services.

You have the right for your communication attempts to be responded to in a timely manner. Please note that any protected health information that may be contained in an email, text message or voicemail may be at risk of being intercepted by or disclosed to third parties.

You have the right to consent to, refuse or withdraw from treatment. You can receive treatment without consent if your immediate safety is jeopardized.

You have the right to voice grievances and make recommendations with regard to your treatment. You shall not be denied, suspended or terminated from services for exercising any of your rights. Wildflower Center for Emotional Health LLC will not retaliate against you for filing a complaint. You are requested to make your grievance in writing and send it to Wildflower Center for Emotional Health LLC. If the matter is not resolved in a timely manner, you may contact the Illinois Department of Financial and Professional Regulation.

If you would like to learn more about your rights as a client receiving mental health services, please consult Chapter Two of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-100 et seq.) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1, et seq.). Copies of both can be obtained by writing to the Illinois Department of Mental Health and Developmental Disabilities, 402 Stratton Office Building, Springfield, IL 62706.

Wildflower
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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protecting your confidentiality is very important to us. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting Privacy Officer Aga Grabowski at Wildflower Center for Emotional Health, 820 N. Orleans St Suite 206, Chicago, IL 60610.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Client Signature	Client's Printed Name	Date
Wildflower Staff Signature	Wildflower Staff Printed Name	Date

Wildflower
Center for Emotional Health

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. **For Payment**. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection. **For Health Care Operations**. We may use or disclose your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. **Required by Law**. Under the law, we must disclose your PHI to you upon your request. We must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect. **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process. **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA. **Medical Emergencies.** We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency. **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm. **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and

organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises. **Specialized Government Functions**. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm. **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority. **Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. **Research**. PHI may only be disclosed after a special approval process or with your authorization. **Fundraising.** We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive. **Verbal Permission.** We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer Aga Grabowski at Wildflower Center for Emotional Health, 820 N. Orleans St Suite 206, Chicago, IL 60610.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Aga Grabowski at Wildflower Center for Emotional Health, 820 N. Orleans St Suite 206, Chicago, IL 60610 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is February 2015.

Wildflower
Center for Emotional Health

NOTIFICATION TO PATIENT OF DESIRABILITY OF CONFERRING WITH PRIMARY CARE PHYSICIAN

Unless you waive this notification, Illinois law requires your therapist to notify your Primary Care Physician, if you have one, that you are seeking or receiving mental health services. We believe that it is desirable for us to confer and work together with your primary care physician on your care. Please indicate your wishes by checking the appropriate box below and providing the requested information:

☐ I agree for you to notify my Primary Care Physician that I am seeking or receiving mental health services. In addition to this form, I am signing the attached Authorization to Release Information permitting Wildflower Center for Emotional Health to communicate with my physician.

☐ I waive notification to my Primary Care Physician that I am seeking or receiving mental health services, and I direct you not to notify him/her.

☐ I do not have a Primary Care Physician and do not wish to confer with one. I therefore waive notification to my Primary Care Physician that I am seeking or receiving mental health services.

Name of Primary Care Physician _____

Physician Address _____ City_____ State_____ Zip_____

_____	_____	_____
Client Signature	Client's Printed Name	Date

_____	_____	_____
Wildflower Staff Signature	Wildflower Staff Printed Name	Date

Wildflower
Center for Emotional Health

AUTHORIZATION FOR OBTAINING AND RELEASING CONFIDENTIAL INFORMATION

I, _____, whose date of birth is __/__/__, authorize Wildflower Center for Emotional Health LLC to disclose to and/or obtain from:

_____ at _____ the following information:
[Name of Person or Organization] [Address and Phone Number]

Description of Information to be Disclosed/Obtained

__ Assessment
__ Diagnosis
__ Psychosocial Evaluation
__ Psychological Evaluation
__ Psychiatric Evaluation
__ Treatment Plan or Summary
__ Current Treatment Update
__ Medication Management Information
__ Presence/Participation in Treatment
__ Nursing/Medical Information
__ Educational Information
__ Discharge/Transfer Summary
__ Continuing Care Plan
__ Progress in Treatment
__ Demographic Information
__ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
__ Other _____
__ Other _____

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than as specified above, please specify: _____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Aga Grabowski or Christina Johnson at Wildflower Center for Emotional Health. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration: Unless sooner revoked, this authorization expires on the following date:_____ or as otherwise indicated: _____

Conditions: I further understand that Wildflower Center of Emotional Health LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

If requested, I will be given a copy of this authorization for my records. ☐ I decline to sign this authorization

_____	_____	_____
Client Signature	Client's Printed Name	Date
_____	_____	_____
Wildflower Staff Signature	Wildflower Staff Printed Name	Date