APPLICATION FOR SERVICES

Date: _____

CLIENT NAME: _____

ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

Client home phone:_____ Cell:_____ Work:_____

Email address: _____

Client Date Of Birth:_____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?
Name: _____ Social Security No.:_____
Address: _____City:_____State: ___Zip:_____
Home Phone:_____Cell:_____Work:_____
Email:_____

WILL YOU BE: Using your insurance: Y N Or paying yourself: Y N
Will you be using your EAP benefits: Y N (if yes please provide)
Name of EAP:_____ Phone for EAP _____

PRIMARY INSURANCE INFORMATION
Name of insurance: _____ Phone:_____
Address of insurance:_____
City:_____ State:_____ Zip:_____
Is there a special number to call for Mental Health Benefits? Phone:_____
Name of Insured: _____ Employer: _____
Social Security No: _____Group No:_____ ID No:_____
Relationship to Client: Self:___ Spouse:___ Parent:___ Stepparent:____ Other: _____
Address of insured: _____City:_____State:_____ Zip:___

SIGN HERE TO VERITY THIS IS THE ONLY INSURANCE COVERAGE FOR THE CLIENT:
Signature:_____ Date: _____

401 E. Prospect Ave, Suite 208; Mount Prospect, IL 60056
Phone: 847-922-5278 Email: patrickmckeelcpc@gmail.com
www.patrickmckeelcpc.com

I/We authorize Patrick McKee, LCPC/P4 Counseling & Wellness Center, LLC to release any information necessary to process this claim:
Signature:_____ Date: _____
I/We authorize the payments of benefits directly to P4 Counseling & Wellness Center, LLC who agrees to accept assignment of benefits. It is understood that the undersigned has the responsibility for payment of services. Assignment of Benefits does not release the undersigned from responsibility for payment.
Signature:_____ Date: _____

Background Information
Please list all members of your household including the client:
Name Age Sex School & Grade or Employer/Occupation

_____
_____
_____
_____

Name of Client's Primary Care Physician: _____
Address: _____ City: _____ State:_____ Zip:_____
Phone: _____

Describe the problems for which you are seeking treatment:_____
_____
Date Symptoms first appeared: _____
Current medications: _____
Previous Mental Health Treatment: Yes___ No ___
Date Previous Treatment Began: _____

CONSENT AND AGREEMENT TO RECEIVE SERVICES

I/We hereby consent to receive treatment at P4 Counseling & Wellness Center, LLC, for myself/ourselves/ our child/children. I/We understand that I/we may choose to terminate treatment at any time. I/We understand that this practice adheres to the Mental Health and Developmental Disabilities Act. Moreover, I/we understand that confidentiality does not apply in instances of suspicion of child abuse, elder abuse, and suicide or homicide risk. Signatures of family members over age 11 Names of those under age 11

_____
_____
_____

FEES

Psychiatric Diagnostic Evaluation (Initial Appt)	**90791**	**60 minutes**	**$180**
Individual Psychotherapy	90834	45 minutes	$140
Individual Psychotherapy	90837	60 minutes	$150
Family Psychotherapy with Client	90847	50 minutes	$160
Family Session without Client	90846	50 minutes	$150
School Meetings/Out of Office Appts		50-60 minutes	$150
Travel Time		15 minutes	$20
Written Reports/Treatment Summaries			$90
Non-Urgent Pages/Phone Consults		15 minutes	$15
Copies of Records			$30+$2/page
Self-Pay		50-60 minutes	$_____
EAP (paid by EAP)		45-50 minutes	____ sessions
Other:			

Payment: Cash, Check or Credit Card accepted. Payment is expected at each session at the time it is held, unless you have insurance coverage that you are using to pay for services.

Billing Insurance: As a courtesy to my clients, I will bill your insurance company for the service you received; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Insurance Information:

Name of Insurance Company_____ Phone#_____

Name of Insured_____ DOB of Insured_____
Relationship to Client_____ Copay_____

ID#_____ Group#_____

Cancellations: If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A $75 fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. Please be aware that these fees are not billable to insurance.

Credit Card Authorizations: Each client is requested to complete the Credit Card Authorizations Form. The purpose of this form is for P4 Counseling & Wellness Center, LLC to have a copy of each client's credit card on file for payment of outstanding account balances that are greater than thirty (30) days past-due. By signature of this form, you are authorization P4 Counseling & Wellness Center, LLC to charge any outstanding account balances greater than (30) days past-due to the credit card on file.

Emergency: If I feel there is an urgent issue that cannot wait for my appointment, I will call my therapist at 847-922-5278. If I am in a life-threatening emergency, I will go to the nearest hospital or call 9-1-1.

Confidentiality: The law protects the relationship between a client and a psychotherapist, and information cannot be disclosed without written permission. The following exceptions apply:

- **Duty to Warn and Protect-**When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
- **Abuse of Children and Vulnerable Adults-**If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- **Minors/Guardianship**-Parents or legal guardians of non-emancipated minor clients have the right to access the clients 'records.
- **Insurance Providers** (when applicable)-Insurance companies and other third-party payers are given information that they request regarding services to clients.

Confidential Communication: I understand that cell-phone, e-mail, texting and the use of voicemail communications are not secure forms of communications and that confidentiality of any cell-phone, e-mail, texting and voicemail information cannot be ensured.

E-mail:_____ Do you give permission to email you? Yes No

Texting:_____ Do you give permission to text you? Yes No

Termination: Your participation in psychotherapy is voluntary and you have the right to withdraw from treatment without adversity at any time. I would recommend that when termination is considered, you discuss this with me, so that we can create a plan for termination to minimize any possible negative effects.

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I understand the statements above and agree to the above terms. I assign the provider to bill my insurance to be reimbursed for services. In order to obtain insurance reimbursement, I authorize the release of any information pertinent to my case to my insurance company. I understand, by signing this document, I am giving consent for treatment and I acknowledge full responsibility for payment of all fees.

Client Signature	**Client Printed Name**	**Date**
Parent/Guardian Signature	**Parent/Guardian Name**	**Date**
Therapist Signature	**Therapist Name**	**Date**

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Peace Purpose

P4

Counseling and Wellness Center, LLC

Positivity Power