afs

augustyn family services

brief intake form

Name and Preferred Name | Preferred Pronouns | Date

Date of Birth | Age | Gender

Address

City, State & Zip

Phone

Email address

Emergency contact | Relationship | Phone

How were you referred to AFS?

Initial here to signal consent to receive emailed invoices.

insurance information

Policy Holder's Name | Policy Holder's DOB | Policy Holder's Relationship to Client

Name of Insurance Company

Policy ID Number | Group Number

presenting concerns

Please describe any Presenting Concerns

risk issues

History of suicidal or homicidal thoughts

History of Domestic Violence

History of Child Abuse

History of Self-harming Behaviors

History of Substance abuse

prior risk issues

Prior suicide attempts

Past self-harm

Past psychiatric hospitalizations

History of abuse

treatment history

Current services

Past services

Current medications

Past medications

Building a therapist-client relationship is dependent upon trust, openness, responsibility and respect. This document contains important information about our professional services. Please feel free to ask your therapist questions about this information at any time.

Confidentiality

It is our goal to provide a safe and supportive environment for our clients as they participate in therapeutic services. We respect your privacy by keeping sessions confidential. Information about you is generally held in confidence by law and our policy is to never release information outside of sessions without your consent. Please be aware that state law and various court rulings require us to make a report to the proper authorities in one or more of the following circumstances:

Suspected abuse, past or present, of a child under the age of 18 years.

Suspected abuse of elders or dependent adults.

Intention of serious and dangerous harm to self or others.

When you waive your confidentiality. (For example, you waive your confidentiality when using your insurance company because your insurance company requires your information for payment or reimbursement of a claim.)

When you voluntarily use your mental or emotional state in legal proceedings.

Following a court order.

Electronic Communication & Social Media

If you choose to communicate with us by electronic means (email, text message, etc), it is important to understand that we cannot guarantee privacy through those means. If you choose to communicate via these methods, please limit the content to general information. Please be aware of privacy risks when using electronic means of communication.

AFS therapists use email and/or texting only to arrange or modify appointments. Please do not use text or email to send private information or information related to the content of your therapy sessions, as these electronic methods of communication are not completely secure or confidential. If you choose to communicate with your mental health provider by email, please be aware that all emails are retained by internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service providers. You should also know that any email correspondence between you and AFS becomes a part of your legal medical record. In addition, AFS therapists do not accept friend or contact requests from current or former clients on any social networking site because it can compromise your confidentiality and privacy.

Scheduling and Fees

Generally sessions are scheduled on a weekly basis, or more frequently if necessary. If you need to reschedule or cancel, it is important to contact your therapist as soon as possible so that we may attempt to find an alternative time to meet. A fee will not be charged for cancellations as long as you notify your therapist at least 24 hours in advance. As the scheduled time is being held for you, a fee of $100 will be charged if a session is cancelled with less than 24 hours notice or if you fail to show for a scheduled appointment. You will be charged the fee as we cannot bill your insurance for a missed appointment. It is understandable that genuine emergencies do occur and an exception will be made in those cases.

Payment

If you are utilizing your insurance benefits, AFS will submit billing to your insurance carrier for you. You will receive a bill each month for your portion of the cost as per your insurance policy. You will be responsible for the amount not covered by your insurance carrier. Payment can be made by cash, check or credit card. If invoice is not paid within 30 days of receipt, you will be asked to pay the bill prior to making any further appointments. AFS does not bill secondary insurances. If you have questions or concerns about your account, please contact our billing manager at jen@augustyn-familyservices.com.

Couples Therapy and Confidentiality

If you are here for couples counseling, our policy is to not hold secrets between the both of you. If one tells a secret between sessions or in an individual session, then we will assume that you are telling it in order to get help disclosing it to your partner.

Substance Use

Sobriety during sessions is mandatory. Should any individual attend therapy in an intoxicated state, the session will be immediately cancelled and payment will be required. This will also constitute a late cancelled appointment and insurance will not be billed.

Out-of-Session Contact

If you need to speak with your therapist outside of your scheduled session time, want them to attend a school meeting for your child, consult with another provider, or any other out of session activities, we bill at $100 per hour in 15 minute increments.

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 or your child's treatment (either at your behest or related to a legal matter you are involved in) please note the following:

We charge a $1500 retainer prior to any preparation or attendance of legal proceedings.

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 the court or attorneys do not pay our fee, 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.

Complaints

If you have a concern or complaint about your treatment or your billing statement, please contact Katie Augustyn at katie@augustynfamilyservices.com or 773-355-8617. We will take any criticism seriously and work to resolve problems with attention and respect.

Emergencies

If you need to reach us between sessions, please call your therapist directly. They will make every effort to return you call as soon as possible.

In the event of a clinical emergency that needs immediate attention, please call 911 or go to your nearest emergency room. After one of those steps has been taken, please leave your therapist a message as soon as possible.

AFS is not a crisis facility, do not contact us by email, fax or phone during an emergency, as we may not get the information quickly. In the event of a clinical emergency, please call 911 or go to your nearest emergency room.

I have read, understand and agree with all of the terms and conditions stated above.

_____

Client's Signature

_____

Date

afs

augustyn family services

credit card authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _____, authorize Augustyn Family Services to charge my credit/debit card for professional services as follows:

Please initial:

_____ Recurring charges in the amount of my monthly invoice.

_____I understand and agree that my card will be charged the full fee should any of the following circumstances arise:

_____Cancellations with less than 24 hour notice

_____ Appointments that are missed without notice

_____Insurance refusal to pay for services

Card Type (circle one): Visa Mastercard Discover American Express

_____

Card Number

_____

Expiration Date

_____

Verification/Security Code

_____

Name, as printed on card Cardholder's email address

_____

Mailing Address

_____

City, State, Zip

_____

Signature

_____

Date

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 Augustyn Family Services (AFS) 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, and the NASW Code of Ethics. 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 my 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 consultants 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, as needed, 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. In addition, 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.

As social workers licensed in this state and as members of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

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. We 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.

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 Augustyn Family Services at 1801 West Warner Avenue, Suite 200, Chicago Illinois, 60613:

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 AFS. 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 all 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 that Augustyn Family Services has violated your privacy rights, you have the right to file a complaint in writing to Katie Augustyn, LCSW, 1801 West Warner Avenue, Suite 200, Chicago Illinois, 60613, 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.

I acknowledge that I have received and reviewed this document:

_____

Client Signature

_____

Date