Outpatient Services Contract

Please ask before signing below if you have any questions about psychotherapy or our office policies. Your signature indicates that you have read our Outpatient Services Contract and agree to enter therapy under these conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

I have read and agree to the terms in the outpatient services contract.

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Notice of Privacy One Love Counseling

I have read the notice of privacy section.

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Demographic Information

Client Legal Name:	Date:
Client Preferred Name:	Preferred Pronouns:
Legal Sex: ☐ M ☐ F *While One Love Counseling recognizes a number of genders / sexes, many insurance companies do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.	
DOB:	Email: ☐ Check box if interested in One Love Counseling's updates and information about events and services via email.
Client Address:	
Best number to reach you:	May we leave a message? ☐ Yes ☐ No
Policy Holder Name:	DOB:
Relationship to client:	

Emergency Contact/Guardian Information

Name:	Relationship to client:
Address:	Phone Number:

Additional Information

What are your presenting issues? What (if any) medications are you taking?
How were you referred to One Love Counseling?

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I, _____ hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding _____
(Name of Patient)

The following items must be **checked and initialed** to be included in the use and/or disclosure of other health information:

☐ HIV/AIDS related treatment ☐ Mental health information ☐ Psychotherapy notes

☐ Sexually transmitted diseases ☐ Drug/alcohol diagnosis, treatment/referral

to _____
(receiving Agency/person) (Address)

for the purpose of (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care ☐ Therapist transition

☐ Billing, payment and financial matters and arrangements ☐ Consultation, advise and representation

☐ Housing or other arrangements and services ☐ Other _____

This consent is valid until (calendar date)_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur _____

_____ _____
(Minor recipient, 12-17 yrs. Inclusive) (Signature of adult patient or parent)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

_____	_____
(Patient, parent, guardian)	(Witness)
_____	_____
(Authorized agent - Power of attorney attached)	(Date)

CREDIT CARD ON FILE

Payments are due at the time of service. One Love Counseling requires a credit, debit, or flex spending/HSA card on file in order to schedule sessions. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (in which case, the credit card on file will be charged our full fee on the day of scheduled session). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please check the box and sign below:

☐ Please charge my card for charges in full for sessions at the time of service.

Client Name:		
Cardholder Name:		
Credit Card Number:		
Expiration Date:	Billing Zip Code of Credit Card:	Security Code:
Cardholder's Signature:		Date:

I understand that by signing above, I am authorizing One Love Counseling 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, deductibles, no show or late cancel fees.