Fitzgerald Counseling

15 Spinning Wheel Rd., Suite 422, Hinsdale, IL 60521 – 401 S. LaSalle St., Suite 1600-P, Chicago, IL 60605 Phone (708) 337-6936; Fax (314) 675-6788

APPLICATION FOR SERVICES – Page 1 of 2

CLIENT INFORMATION:

Primary Client Name: ____ ___________________________
Last First MI Social Security No. (See note*)

Gender: __M __F __Other Date of Birth: _____/_____/_________Marital Status: __S __M __D __Sep __W

Address: ____

City: ______________________ ST:_____Zip:__________ E-Mail Address: __________________________________

Primary Phone: _______________________________ This is: __Mobile __Hm __Wk __VM OK __Text msgs OK

Secondary Phone: ____________________________ This is: __Mobile __Hm __Wk __VM OK __Text msgs OK

Correspondence Preferences (Check all that apply):__ Voice __Paper __Text __E-mail (appt/non-sensitive)

Second Client Name: ____ ___________________________
Last First MI Social Security No. (See note*)

Gender: __M __F __Other Date of Birth: _____/_____/_________Marital Status: __S __M __D __Sep __W

Relationship to primary Client: ________________________________

FINANCIAL ARRANGEMENTS: WILL YOU BE: ____USING INSURANCE ____PAYING YOURSELF, or

___USING AN EMPLOYEE ASSISTANCE PROGRAM WHICH COVERS COST OF SESSIONS

☞ **IF USING INSURANCE OR EAP, PLEASE FILL IN THE INFORMATION BELOW**:

Name of Insurance Carrier / EAP: _______________________________________ Phone: _________________________

Name of Insured: ______________________________ Insured Employer: __________________________________

Member ID Number: ____ Plan Name: ______________________

Relationship to Client: ___Self ___Spouse ___Parent ___Step-Parent

Date of Birth: ___________________ Social Security *: ___________________ Group Number: __________________

Address: ___ Same as Client or: _________________________________ City: ____________ST ___ Zip:_____

WHO IS FINANCIALLY RESPONSIBLE FOR THESE SERVICES?

__ Same as Client __Parent/Guardian __Other: ____________________________

Name: ____ Address same as client?__Yes __No

Address: ____ City : _____________________ ST: ___ Zip______

Hm Phone: ________________________ Wk Phone:____________________ Social Sec* _____________________

** SSN may be required for certain work-related referrals and may be needed to process insurance claims. The Practice will treat this information as securely as any other protected health information. Otherwise, you may decline this. SSN is not required for EAP sessions.*

Office Use Only ICD-10 (1) _____________________
Date of First Appt: _________________ CPT: __________ ICD-10 (2) _____________________Fee: __________
Co-pay/Co-Ins: _______________ Deductible: ________________ Sessions Authd: ____ Sessions/Yr: ____
Auth # _________________________ Spoke with: _____________________________ Ph: ___________________
___ Copy of Insurance Card Made. Note: ____

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Application for Services – Page Two – Informed Client Consents and Releases

Release of Claims and Benefits Information (To be signed by Client[s])

I/We authorize Paul J. Fitzgerald, Psy.D., LCPC to release my health care information as necessary to process claims and payment. Generally this includes diagnoses, dates of service, and procedure codes; but it may include more detailed clinical information, treatment goals, and progress toward goals if requested by the payer for utilization review to determine medical necessity. I understand that the therapist cannot control what insurance companies do with this data. This release is valid until or unless revoked by me.

☞ Signed: ____

Date: ______________________________

Assignment of Benefits (To be signed by Insured or Authorized Representative)

I/We authorize the payment of benefits directly to Paul J. Fitzgerald, Psy.D., LCPC, who accepts assignment. It is understood that the undersigned has the responsibility for payment of services. Assignment of Benefits does not release the undersigned from responsibility of payment.

☞ Signed: ____

Date: ______________________________

INFORMED CONSENT AND AGREEMENT FOR BEHAVIORAL HEALTH SERVICES

Appointments: I understand that each appointment, whether in the office or electronic, represents a specific amount of time reserved for me. If a problem arises and I am unable to keep this time, 24-hour notice of cancellation will be required. I understand that I will be charged for late cancellations or failed appointments unless there is a clear emergency. *Because insurance does not typically reimburse for missed appointments, I understand that charges for late cancellations or failed appointments will be entirely my responsibility*. Repeated missed appointments will result in inability to offer preferred times for future appointments.
Confidentiality and privacy: I understand that information discussed and written during our sessions will be treated as confidential and private in accordance with state and Federal laws and regulations, including the Illinois Mental Health and developmental Disabilities Confidentiality Act, and the Federal HIPAA and HITECH Acts. I understand that the provider has a “Notice of Privacy Practices” which I may view and sign. I understand that confidentiality may be broken when it is deemed necessary to report child abuse or neglect under Illinois law, or when a legal obligation exists to report safety concerns to protect others or me, or when ordered by a court. I understand that couple or family sessions, and treatment of a child or adolescent, may invoke more restrictive policies, to help protect individual privacy in a family therapy setting. I agree to additional limitations on disclosure of family information when contraindicated.
Insurance and Payments: I understand that all professional services rendered, except for Employee Assistance services, are charged directly to me, and that I am are responsible for payment of the fees. (All fees are due at the time that services are rendered unless other specific arrangements have been made with the therapist. The therapist will credit or refund any overpayment. Payments may be made in cash, by credit card, or by personal check.
Consent: I/We hereby consent to health care treatment with Paul J. Fitzgerald, Psy.D., LCPC for myself/ourselves and/or our children. I/We understand that we may choose to terminate treatment at any time, and that no guarantee of results can be given. We understand that our communications are protected by relevant state and federal laws and by the therapist’s ethical codes. I/We agree to work with the therapist to set treatment goals and review progress.

☞ Signature: ____ Date: ______________________________
Relationship to Client: ___Self ___ Parent/Guardian (if client is under 18)

Second Signature, if applicable: ____ Date: __________________________
Relationship to Client: ___Second client ___ Parent/Guardian (if client is under 18)

Witness: ____ Date: _______________________________