New Client Information:

Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

E-mail Address:_____

Birthdate:_____ Social Security #:_____

Marital Status:_____ Referred by:_____

Medical Information

Reason for seeking help:_____

_____ Date when the problem first began:_____

Are you now under a doctor's care?_____ If yes, name of doctor_____

Reason for doctor's care_____

Are you taking any medication?_____ If yes, what kind?_____

Reason for medication_____ Last medical examination_____

Have you ever been hospitalized for a physical illness?____ Describe_____

Have you ever been hospitalized for a mental illness?____ Describe_____

Family Information:

Client currently lives with: __Family __Roommate __Alone. If married, length of current marriage:_____

Spouse:_____ Father:_____

Children:_____ Mother:_____

_____ Siblings:_____

_____ _____

North Shore Family Wellness, LLC
Individual, Couples and Family Therapy
847.231.3729 • 5225 Old Orchard Road • Suite 34 • Skokie, Il 60077

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Statement of Understanding
I hereby agree that I am seeking mental health services and agree to be treated by a North Shore Family Wellness therapist. I am aware of the policies contained below and agree voluntarily to participate in the treatment process.

Confidentiality
All information discussed in your sessions is considered totally confidential and will **not** be released to anyone without your expressed written permission. (A formal Release of Information Form provided by my office or by another professional's office is often used, but any signed letter clearly stating your request for records to be released will suffice.) The laws of the State of Illinois require that, in certain situations, your therapist has a "duty to warn." These situations include: child abuse, elder abuse, expressed intent to commit a serious crime, expressed intent to take someone's life or to do bodily injury, including to oneself. I understand this policy and agree to its conditions.

Waiver of Responsibility
Initiating and undergoing therapy is not a guarantee of results. Many factors contribute to treatment outcome. It is the responsibility of the therapist to provide treatment recommendations consistent with established guidelines and to do so in a manner consistent with the Code of Ethics and laws of the state of Illinois. Aside from those ethical and legal obligations, I hereby release North Shore Family Wellness and its therapists of all responsibility for any actions I might take inside or outside therapy.

Appointment and Cancellation Policy
Every effort will be made to reserve a regularly scheduled appointment time for you. You will be notified well in advance of any cancellations. Should an illness or emergency occur, your therapist will make every effort to notify you and reschedule at the next convenient time.
If you need to cancel or reschedule an appointment, a minimum of 24 hours is required or charges for services will be incurred.

Messages and Emergencies
Voicemail is available at all times during the day or night. Messages will be checked, periodically, between the hours of 9 AM and 8 PM, daily. Calls will be returned within 24 hours. All needs that require more than a 15 minute call should be handled in session or they may be subject to a charge of $75 per 30 minutes. If you are in crisis, or there is an emergency, you should call 911 or proceed to the nearest hospital emergency room and ask for help.

Payment
Payment is expected at the time of treatment. Checks or cash are accepted.

_____ _____
Client's Signature date

_____
Client's name printed clearly

_____
Therapist signature

Credit card to be kept on file

_____

Credit card number

_____

Expiration date

_____

CVV code

_____

Name as it appears on the card

☐ Please automatically charge my monthly balance to my credit card and send me a receipt.

I understand that I am giving a credit card to be kept on file. Unless I have requested automatic payment of my balance, it will be charged only in the event of a cancellation in less than 24 hours, missed appointment without a call or an outstanding balance that is more than 90 days old. I also understand that there will be an attempt to contact me before I am charged for any of these circumstances.

_____ _____

Client signature Date

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NS | FW

Concierge services

Consistent Contact

Consistent Contact is a service for clients or the parent of an adolescent who believe that they may need more support than a single session provides but are unable to come in for a second session or do not need a full session. Consistent Contact consists of a 30 minute phone call once per week. The fee for this is $300 per month.

Intensive Contact

Intensive Contact is a service for clients or the parent of an adolescent who believe that they may need more time than a single session provides but are unable to come in for a second session. Intensive Contact consists of a 60 minute phone call, once per week. The fee for this service is $540 per month.

I would like to sign up for:

☐ Consistant Contact ☐ Intensive Contact

_____ _____

Client signature Date

** All concierge services are retainer services. As such they are not prorated when they are not used. There is also no up-charge for a four week month versus a five week month.*

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