

CHICAGO CENTER FOR WELL-BEING, INC

230 E Ohio Street, #705 Chicago, IL 60611 tel: +1 312 539 3345

Authorization for release of information for billing purposes

I hereby authorize the release of any information necessary for third-party claim submission and/or payment for services. I authorize payment of third-party benefits to Milates Center for Well-being, Inc. dba Chicago Center for Well-being, Inc for services described herein. I understand that I am responsible to pay for all sessions, including No Show appointments. A No Show appointment is a cancellation with less than 24 hours notice. I understand that there will be a **\$130.00** cancellation fee **if cancellation is made less than 24 hours in advance.** _____ (initial)

Please fill-in the following:

Gender: _____ Ethnic Identity: _____

Relationship Status: (circle one) single married living w/partner divorced widowed

previous marriages _____ # of children _____ age of children _____

Highest level of education completed: _____

Current occupation: _____

Current annual income: _____

In the space below, please briefly describe your reason(s) for seeking services:

Have you ever had previous counseling or psychotherapy? ___ Yes ___ No

If "yes," by whom and when? _____

Are you currently taking any psychotropic medication (e.g. antidepressants/anti-anxiety, etc.)?

___ Yes ___ No

If "yes," what are you taking and current dosage?

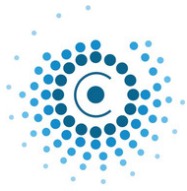
Are you currently taking any other medication (herbal or prescribed)? ___ Yes ___ No

If "yes," complete below:

Name _____ Reason _____

Name _____ Reason _____

Name _____ Reason _____



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Past psychiatric hospitalization/inpatient detox? _____ Yes _____ No

If "yes," when, where and for what reason? _____

Have you ever made a suicide attempt/gesture? _____ Yes _____ No

If "yes," when and how did you attempt? _____

Please use the scale below to indicate your current level of distress with the following items:

	No Concern	Moderate	Urgent	
Feelings over a recent loss/death	0	1	2	3
Relationship with friends /family	0	1	2	3
Relationship with romantic partner	0	1	2	3
Sexual concerns	0	1	2	3
Sexual orientation	0	1	2	3
Survivor of abuse	0	1	2	3
Racial/ethnic issues	0	1	2	3
Low self-esteem	0	1	2	3
Loneliness	0	1	2	3
Depression	0	1	2	3
Anxiety	0	1	2	3
Fears/worries	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Body image concerns	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Losing contact with reality	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3



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Consent to Treatment

- ◆ I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.
- ◆ I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- ◆ I am aware that I may stop my treatment with this therapist at any time. My only responsibility will be paying for services I have already received. The fee is **\$300.00** for the first session and **\$200.00** for subsequent sessions, due at the time of service, if private pay.
- ◆ I know that I must call to **cancel an appointment at least 24 hours before the time of the appointment**. If I do not cancel within 24 hours, or do not show up, I will be charged **\$130.00** for that missed appointment.
- ◆ I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.
- ◆ All information discussed in therapy is confidential. There are situations, however, in which I am required by law to break confidentiality. These situations are as follows:
 - a. If you are at risk to harm yourself.
 - b. If you seriously threaten to injure another person.
 - c. If you reveal information pertaining to either child or elder abuse.
- ◆ My signature below shows that I understand and agree with all of these statements.

Patient (or Guardian) Signature

Date

Printed name

I, the therapist, have discussed the issues above with the client (and/or his/her parent, guardian or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

This is a strictly confidential patient medical record. Rediscovery or transfer is expressly prohibited by law.