CHICAGO CENTER FOR WELL-BEING, INC
230 E Ohio Street, #705 Chicago, IL 60611 tel: + 1 312 539 3345

Preliminary Information Form

Name________________________________ Date ____________________________
Date of Birth _____________ Age_________ Email ____________________________
Address_________________ _______ ____________ ________ __________
(street) (apt.#) (city) (state) (zip code)

Insured's Information (if different from above)
Name___________________________ Social Security #_______________(optional)
Address_________________ _______ ____________ ________ __________
(street) (apt.#) (city) (state) (zip code)

Phone Number_________________Date of Birth ___________________

To (re)schedule appointments, where may we call?

Home_______________ Work_______________ Cell_______________

May I leave a message on the answering machine? ______Yes __________No

May I leave a message with someone at this number? _____Yes __________No

Whom may we contact in case of an emergency?
Name: ____
Address: ____
Phone: _____________________ Relationship to you: ____________________

Insurance Information: (please check one):
Blue Cross/Blue Shield PPO _______ Aetna ________ Humana __________ Other ______________
Private Pay ________
Identification/ ID # ________________________ Group #_______________
Insured's employer's name ____
Insurance Phone Number: ____

Who may we thank for referring you? ____________________________________

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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. Redisclosure or transfer is expressly prohibited by law.

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Credit Card/Debit Card On File Form

We require keeping your credit or debit card on file as a convenient method of payment when authorized.

_____ I authorize Chicago Center for Wellbeing to charge my credit/debit card for any late fees as outlined in the 'patient financial responsibility' form.

_____ I authorize Chicago Center for Wellbeing to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays/deductibles/coinsurance.

_____ I will inform Chicago Center for Wellbeing if my credit card information or expiration date changes.

Visa MasterCard Amex Discover

Card Number ____________________________________
Expiration Date ____________________________________
CVV Code ____________________________________
Name on Card ____________________________________
Address ____________________________________
Zip Code ____________________________________

I understand that this form is valid without expiration unless I cancel this authorization by notice in writing submitted to Chicago Center for Wellbeing.

Signed________________________________ Date__________________________
Client/Guarantor

_____ By signing above, the client or guarantor acknowledges that he/she has read and agrees to comply with all policies above.