Kimberly Boatner LCSW, CADC, LLC
INDIVIDUAL, COUPLE AND FAMILY THERAPY.

New Client Registration Form

Client Information

Client Name	_____ First Middle Last
Street Address	_____ _____ City State Zip Please note, all correspondence will be delivered to this address unless otherwise indicated
Client Birthday	_____
Client SSN#	_____

Client Contact Information

Email Address	_____
Mobile	_____
Home	_____
Work (please include extension if applicable)	_____

Any/All Persons Attending Initial Appointment

_____ Name	_____ Relationship to Client
_____ Name	_____ Relationship to Client

Referral Information

Please list the agency, provider, and/or persons you were referred (if applicable)	_____

Emergency Contact Information

Emergency Contact Name	_____
Phone Number	_____
Relationship to Client	_____

P:630.488.6113 • F:888.272.6605 • KIMBERLY.BOATNER@GENEVATHERAPY.COM
328 S. 3RD STREET, SUITE 2F • GENEVA, IL 60134

Insurance Information

Policy Holder Name	_____ First Middle Last
Policy Holder Street Address	_____ _____ City State Zip
Policy Holder Birthday	_____
Policy Holder SSN#	_____
Insurance Provider/Company	_____
Policy/ID Number	_____
Group/Plan Number	_____
Employer of Policy Holder	_____
Most Recent Effective Date	_____
Customer Service Phone Number (listed on the back of card)	_____

Consent to Treatment

1. I have the legal right to authorize and I herby consent for services for myself and/or dependents with Kimberly Boatner, LCSW, CADC, LLC.
2. I understand that appointments not canceled at least 24 hours in advance will be billed to the client at the session rate, and cannot be billed to nor reimbursed by my insurance company.
3. I understand that I and/or my dependents may be referred to clinicians or services outside of the practice based on treatment needs and scope of clinical training provided.
4. I understand that email will not be utilized to communicate clinical and/or urgent information. I understand that I must call the office (630-488-6113) for all clinical concerns and that I am to call 911 or go to the nearest emergency room for concerns of an urgent matter.

I,_____, have read, understand and agree to the
Printed Name of Client (18 years or older) or Parent/Guardian

Consent to Treatment and acknowledge my responsibilities as a client and/or parent/guardian of a client of Kimberly Boatner, LCSW, CADC, LLC.

_____
Client Signature (12 years old and older) *Date*

_____
Parent/Guardian Signature (for clients under 18) *Date*

Financial Agreement

1. I have completed the demographic and insurance information on the ***New Client Registration Form*** to the best of my knowledge and I authorize Kimberly Boatner, LCSW, CADC, LLC to release any medical information to process my insurance claim. The medical information released to your insurance provide may include the following: Dates of Services, Type of Service, Diagnosis, Treatment Plan, Treatment Progress, and Progress Notes.
2. I understand that I am responsible for contacting my insurance company to obtain benefit information prior to my initial appointment with Kimberly Boatner, LCSW, CADC, LLC
3. I hereby authorize all medical benefits directly to Kimberly Boatner, LCSW, CADC, LLC for any and all services provided. I understand I this assignment will remain in effect until revoked by me in writing.
4. I understand that I am financially responsible for all charges, paid or unpaid by my insurance company, and that I am financially responsible for any uncollected amounts.
5. I understand that I am responsible to stay current with payments may cause an interruption in treatment services until a financial plan and/or balance is paid in full.
6. I understand that I am responsible for informing Kimberly Boatner, LCSW, CADC, LLC of any changes in my or my dependents insurance coverage and a delay of communicating the change may result in me being liable for any unpaid claims.
7. I understand my insurance company will be billed for the provider portion of my claim but that I am responsible for any deductible, co-pays and/or applicable fees at the time of service.
8. I understand I will be charged a fee of $35 for each returned check as a result of transaction issues on my account.
9. I understand that Kimberly Boatner, LCSW, CADC, LLC is not responsible for financial agreements between parents/legal guardians of a dependent and that the parent/guardian listed on the intake paperwork under “any and all persons attending initial appointment” will send payment for ongoing services.
10. I acknowledge that if fees/balance of services are not paid within a timely manner, a collection agency may be utilized in collecting unpaid debts. In these incidents, a collection fee of 25% would be charged to my account as a result of the collection agency. I authorize Kimberly Boatner, LCSW, CADC, LLC to release the demographic information necessary to the collection agency in order to collect payment for services rendered.

I, _____, have read, understand and agree to the
Printed Name of Client (18 years or older) or Parent/Guardian

Financial Agreement policies and acknowledge my responsibilities as a client and/or parent/guardian of a client of Kimberly Boatner, LCSW, CADC, LLC.

_____
Client Signature (12 years old and older) *Date*

_____
Parent/Guardian Signature (for clients under 18) *Date*

_____
Clinician *Date*

Notice of Privacy Practices and Client Rights

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal
2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further
3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.
4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.
5. You may request corrections to your records.
6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.
7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.
8. You may request that Kimberly Boatner, LCSW, CADC, LLC restrict uses and disclosures outlined in Section 1. However, Kimberly Boatner, LCSW, CADC, LLC is not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, Kimberly Boatner, LCSW, CADC, LLC will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. Kimberly Boatner, LCSW, CADC, LLC may also revoke such restrictions but information gathered while required by law or in an emergency.
9. If you believe your privacy has been compromised, you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.
10. This agreement may be modified or amended as required by law or in the course of health care operations.

I, _____, have received, read, and understood the policies and procedures
Printed Name of Client (18 years or older) or Parent/Guardian

outlined in the ***Privacy Notice and Client Rights*** concerning use and disclosure of protected healthcare information.

_____
Client Signature (12 years old and older) *Date*

_____
Parent/Guardian Signature (for clients under 18) *Date*

_____
Clinician *Date*

Consent to Participate in Telemedicine Services

The purpose of this form is to obtain your consent for a telemedicine consultation/therapy with Kimberly Boatner, LCSW, CADC. The purpose of this consultation is to assist in the diagnosis and/or treatment of mental and behavioral needs.

1. Kimberly Boatner, LCSW, CADC has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
    - Omit specific details of my medical history/physical examination that are personally sensitive to me
    - Ask non-medical personnel to leave the telemedicine examination room and/or terminate the consultation at any time.
4. All state and federal laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

I have had direct communication with Kimberly Boatner, LCSW, CADC during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form I, _____, certify:

Printed Name of Client (18 years or older) or Parent/Guardian

- *That I have read or had this form read and/or had this form explained to me*
- *That I fully understand its contents including the risks and benefits of the procedure(s).*
- *That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.*

_____

Client Signature (12 years old and older) *Date*

_____

Parent/Guardian Signature (for clients under 18) *Date*

_____

Clinician *Date*

***Please find attached a copy of the Informational Notice from the Illinois Department of Health and Family Services issued on 3/20/2020 outlining Telehealth expansions to provide more options to both patients and providers as result of COVID-19. This is a copy for your reference only and is subject to change as determined by local, state, and federal officials.*

*****This is a copy of the informational notice for your records, no further action is needed*****

Informational Notice from the Illinois Department of Health and Family Services on March 20, 2020 regarding Telehealth Services Expansion Prompted by COVID-19

As authorized under Section 1135 of the Social Security Act, the Department is requesting waivers by the federal government of certain regulations to provide flexibility to providers during the COVID-19 pandemic. The Department has also filed emergency amendments specifically to 89 Ill. Admin. Code Section 140.403 - Telehealth Services, to formalize steps to improve provider-patient communication during this time.

Telehealth services are medically necessary and clinically appropriate services covered under the Medical Assistance Program as set forth in 89 Ill. Adm. Code section 140.3 that are delivered using a communication or technology system to a patient at an originating site by a provider located at a distant site. **To protect the public health in connection with the present public health emergency, the Department will reimburse medically necessary and clinically appropriate Telehealth services with dates of service on or after March 9, 2020 until the public health emergency no longer exists, that meet the following requirements:**
To be eligible for reimbursement, the Telehealth service must be delivered using:

1. An "interactive telecommunication system" or "telecommunication system" as described in 89 Ill. Admin. Code Section 140.403(a), or; Telehealth
2. A communication system where information exchanged between the physician or other qualified health care practitioner and the patient during the course of the synchronous Telehealth service is of an amount and nature that would be sufficient to meet the key components and requirements of the same service when rendered via face-to-face interaction.

Originating Site Changes

Any site that allows for the patient to use a communication or technology system as defined above may be an originating site, **including a patient's place of residence** located within the state of Illinois or other temporary location within or outside the state of Illinois.

An originating site will be eligible for a facility fee when it is a certified eligible facility or provider organization that acts as the location of the patient at the time a Telehealth service is rendered, including but not limited to:

- substance abuse centers licensed by the Department of Human Services' Division of Substance Use Prevention and Recovery; Supportive Living Program providers;
- Hospice providers;
- Community Integrated Living Arrangement (CILA) providers; and
- providers who receive reimbursement for a patient's room and board, including nursing facilities and Intermediate Care Facilities for the Developmentally Disabled.

*****A physician or other licensed health care professional is not required to be present at all times with the patient at the originating site.**

Distant Site Changes

The distant site provider is any enrolled provider, operating within their scope of practice, and with the appropriate license or certification. This includes, but is not limited to:

- a Practitioner listed in 140.403(b)(1)(B) or (b)(2)(B);
- a Federally Qualified Health Center as defined in Section 1905(l)(2)(B) of the federal Social Security Act;
- a Rural Health Clinic or Encounter Rate Clinic;
- a Licensed Clinical Psychologist (LCP);
- a Licensed Clinical Social Worker (LCSW);
- an Advanced Practice Registered Nurse certified in psychiatric and mental health nursing,
- a Local Education Agency (LEA)
- a School Based Health Center as defined in 77 Ill. Adm. Code, 641.10.
- a Physical, Speech, or Occupational therapist as defined in 140.457
- a Dentist
- a Local Health Department
- a Community Health Agency
- a Community Mental Health Center or Behavioral Health Clinic
- a Hospital as defined in 148.25

Reimbursement for Telehealth services will continue to be made at the same rate paid for face-to-face services provided on-site. The distant site provider and originating site provider eligible for a facility fee must maintain adequate documentation of the Telehealth services provided in accordance with the record requirements of section 140.403(d).

For more information, please visit the Illinois Department of Heath and Family Services at www.illinois.gov/hfs or call 877-782-5565.

Credit/Debit/HSA/Flex-pay Card Payment Information and Authorization Form

Client Name: _____

I authorize **Kimberly Boatner, LCSW, CADC, LLC** to charge my credit/debit/health account card for professional services. If I do not cancel before 24 hours, I recognize that **Kimberly Boatner, LCSW, CADC, LLC** will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge.

I hereby authorize **Kimberly Boatner, LCSW, CADC, LLC** to keep my credit card on file and use for payment of outstanding balance.

Cardholder Name: _____

Billing Address (if different from client information) :

_____

_____

Credit Card Type:

- ❑ Visa
- ❑ MasterCard
- ❑ Discover
- ❑ American Express

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____/_____

CVV Security Code: _____

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Printed Name: _____

Signature: _____

Initials: _____

Date: _____

Authorization and Consent for Release of Confidential Information

****Please note any provider listed will **not be contacted** unless a written release of information form has been completed****

I, _____ _____ _____
(Printed Name of Client) *(date of birth)* *(SSN)*

authorize **Kimberly Boatner, LCSW, CADC, LLC** to

- ❏ Disclose to
- ❏ Obtain from
- ❏ Disclose and Obtain from

Name of agency, facility, and/or person : _____

Phone/Fax : _____

The following information *(check all that apply)* :

❏ Psychiatric Evaluation/Assessment	❏ Psychiatric Records/Progress Notes	❏ Attendance Records
❏ Mental Health Assessment	❏ Treatment Plan/Summary	❏ Educational Records/Academic Progress
❏ Substance Abuse/Chemical Dependency Assessment	❏ Discharge Plan/Summary	❏ Financial Information
❏ Medical History/Evaluations	❏ Medication Information	❏ Physical Exam Records
❏ Psychological Evaluation (includes test results)	❏ Social Developmental History	❏ Other:_____
❏ Treatment/Assessment Recommendations		

Please initial below to authorize the following information below being obtained or disclosed:

_____Mental Health/Developmental Information/Records
_____HIV/AIDS diagnosis, treatment, and/or records
_____Chemical Dependency/Drug/Alcohol/Substance related diagnosis, treatment, and/or records

I understand that this consent will automatically expire on _____ 20____ . I acknowledge the purpose of obtaining/disclosing protected health information listed above is for

- ❏ Continuity of Care and/or Coordination of Care
- ❏ Determination of Eligibility of Provider Services
- ❏ Family/Support System
- ❏ Other _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information regarding mental health and developmental disabilities, substance use/abuse or AIDS under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Substance Abuse Confidentiality Requirements, and the Illinois AIDS Confidentiality Act. I understand that the named agency/facility/individual authorized to receive the information has the right to inspect and copy the information disclosed.
I also understand that the person I am authorizing to use the information may receive compensation for doing so. I understand that I may inspect and copy the information disclosed. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. This authorization will remain in place indefinitely until revoked in writing.

_____
Client Signature (12 years old and older) *Date*

_____
Parent/Guardian Signature (for clients under 18) *Date*

_____
Clinician *Date*

Kimberly Boatner LCSW, CADC, LLC
INDIVIDUAL, COUPLE AND FAMILY THERAPY.

Client Questionnaire

Client Name:_____ **Date of Birth:** _____

Presenting Client Concerns:

_____

_____

_____

Current Symptom Checklist

(please indicate with "X" the intensity of symptoms that are currently experiencing)

None: Symptom is not present at this time
Mild: Impacts quality of life but no significant impairment of day-to-day functioning
Moderate: Significant impact on quality of life and on day-to-day functioning
Severe: Profound Impact on quality of life and day-to-day functioning

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
Sadness/Depressed Mood					Restrictive Eating				
Appetite Disturbance					Aggressive Behaviors				
Sleep Disturbance					Grief				
Fatigue/Low Energy					Suicidal Thoughts				
Mood Swings					Suicidal Actions				
Agitation					Self-Injury				
Irritability					Anxiety				
Panic Attacks					Alcohol Use				
Bingeing					Substance Use				
Relationship Issues					Hopelessness				

Other symptoms to be noted that are not listed above (if applicable):

_____

_____

_____

Please indicate what therapeutic milestones or accomplishments you are looking to gain during counseling:

_____

_____

_____

Please identify some of your strengths:

_____

_____

Please identify some areas you are looking for growth:

_____

_____

_____

Please note any additional information and/or indicate any additional concerns:

_____

_____

_____

Medical History

Primary Care Physician (PCP): _____

Address: _____

_____

Phone: _____

Fax: _____

Current Medications

Medication	*Start Date*

Mental Health History

Previous mental health services (therapy, psychiatry, treatment programs, etc.)

Provider	*Location (city)*	*Phone (if known)*	*Outcome*