2210 Midwest Road, Suite 213
Oak Brook, Illinois 60523
Phone # 630-828-8120
Fax: # 630-828-8122
Email: ethoscounselinggroup@gmail.com

New Client Information

First Name: _____ Last Name: _____

☐ Male ☐ Female Date of Birth _____/_____/_____ SS# _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Contact Information

Home Phone: _____-_____-_____ Permission to leave confidential messages: Yes ( ) No ( )

Cell Phone: _____-_____-_____ Permission to leave confidential messages: Yes ( ) No ( )
Permission to leave confidential text messages: Yes ( ) No ( )

Work Phone: _____-_____-_____ Permission to leave confidential messages: Yes ( ) No ( )

Email Address: _____

Preferred method of contact: _____

Who referred you to ETHOS Counseling Group, LTD? _____

Why are you seeking assessment or treatment? _____

_____

Insurance Information

Name of Policy holder/Insured _____

Date of Birth of Policy Holder/insured _____/_____/_____

Insured's address and phone number, if different than client: _____

_____

Insurance Company: _____

Member ID# _____ Group #_____

Insurance Company's phone number _____-_____-_____

Claims Address: _____

MEDICAL HISTORY

Family History of Mental Illness, Suicide Yes ( ) No ( )

If yes, briefly explain: _____

_____

Current Medications

Include supplements and over the counter drugs. Please additional space or attach list if needed:

Name of Medication	Dosage	Condition
1. _____	_____	_____
2. _____	_____	_____

Additional:

Relationships

How is your satisfaction with relationships? Poor ( ) Average ( ) Excellent ( )

How would you rate your support system? Poor ( ) Average ( ) Excellent ( )

Do you live with others? What is their relationship to you?

Present/Past Spouse/Partner(s)-if willing to share:

First Name	Years in Relationship	Current Status
_____	_____	_____
_____	_____	_____

Children – if willing to share:

Name	Gender	Age	Occupation	Current Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are there other significant current relationships that are of focus in your life right now? Please describe:

SELF ASSESSMENT

What are your main worries or Fears?

What are you main strengths?

What are your primary challenges right now?

What are your most important hopes or dreams?

Family History Alcohol or Drug Abuse: Alcohol Yes ( ) No ( )
Drug Abuse Yes ( ) No ( )

How did it affect you?

Relationship, age and circumstances:

Past or Present Drug or Alcohol Use: Alcohol Yes ( ) No ( )
Drug Abuse Yes ( ) No ( )

When, what and how much have you used in the ***past?***

When, what and how much are you ***currently*** using?

How has it affected your work?

How has it affected your relationships? List key relationships and effect:

Previous suicide attempts, self-destructive behaviors, or violent behaviors: Yes ( ) No ( )

What age(s) and circumstances?

Did it lead to hospitalization or legal problems?

Have you ever been hospitalized? (If yes, please provide details):

Previous counseling/psychotherapy: Yes ( ) No ( )

When and for what issues? _____

Was it helpful? Yes ( ) No ( )

Why or why not? _____

Please add any additional information such as test results, preferences, special needs that may be helpful or provide additional paperwork via hard copy, email or fax.

Release of Information forms to complete:

Name License/Specialty Location/Contact information Treatment Dates

CLIENT'S RIGHTS

Counseling Relationship: The client and clinician usually will meet weekly for approximately 60-minute session. The relationship is a professional relationship rather than a social one. Clinicians will not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture or belief system exist, the clinician and client will work to understand those differences.

Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. If you choose to end the counseling relationship, we ask that you participate in a termination session. We also have the right to refuse or to discuss modification of any counseling techniques or suggestions that you believe might be harmful. We render counseling services in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with the clinician's services, please inform the clinician so we can work to resolve your concerns.

Privacy Rights under HIPAA: You have the right to review you client file in the presence of your clinician. You may ask for a copy of your file, and will be charge a per page copy fee rate of .10 cents per page. You may ask for corrections or clarifications of the content in the file and that will be recorded in the notes. You may ask to review ETHOS Counseling Group, Ltd., HIPAA procedures.

Appointment and Cancellation: Appointments will be scheduled at a time mutually acceptable to both the patient and clinician. It is greatly appreciated that you call ASAP to cancel an appointment so that another patient can have the appointment time. If you miss three consecutive counseling sessions without notifying your clinician, services will be terminated. Also if you fail to cancel your appointment within 24 hours of your scheduled appointment you will be charged a $50.00 fee. Please refer to your clinician with questions.

Crisis: If you are unable to reach your clinician and an immediate need or crisis arises, please contact 911 or go the nearest emergency room. The National Suicide Hotline number 1(800)784-2433 or 1(800)273-8255. The hearing-impaired hotline number is 1(800)799-4889.

Condition of Ongoing Counseling: If you have been in counseling or psychotherapy during the past seven years, you may sign a release for ETHOS Counseling Group, Ltd., and your former provider to communicate and/or receive copies of records from the professional(s) from whom you received mental health services, if deemed it is important to do so. By signing this form, you are agreeing to disclose all previous mental health treatment and to reimburse ETHOS Counseling Group, Ltd., for any expenses charged by your previous mental health professional(s) for supplying copies of your records. While you are in counseling, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with this clinician and sign a release that enables this clinician to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional and treatment services are duplicated, this clinician may consider this your decision to change clinicians, and reserve the rights to terminate your counseling.

Referrals: This clinician recognizes that not all conditions presented by clients are appropriate for expertise. For this reason, you and/or I may believe that a referral is needed. In that case, some alternatives may be provided including programs and/or people who may be available to assist you. A verbal exploration of alternative to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

_____

Client's Signature or Parent/Guardian Date

CONFIDENTIALITY

Please be advised that ETHOS Counseling Group, Ltd., clinicians are mandated reporters in Illinois. They are also required to make a report if a patient is a lethal danger to himself or herself or others. Danger to self and/or others (i.e. suicide or homicide) may necessitate the breaking of confidentiality. In addition, by law suspected child abuse and/or neglect and elder abuse and/or neglect communicated by clients must be reported to appropriate agency.

To provide effective assessment and treatment, each clinician will ask many personal questions. Excluding the circumstances listed above, all personal information is kept strictly confidential. No information about you or your case will e release to anyone without your written authorization and consent.

_____

Client's Signature or Parent/Guardian Date

FEES OF COUNSELING

Fees vary based on type of service and method of payment. We accept many health insurance plans and will discuss out-of-pocket costs with you after your benefits are verified. ETHOS Counseling Group, Ltd. does offer services on a sliding scale basis for patients who require assistance. Please contact a clinician directly to discuss financial arrangements. Appointments will be scheduled at a time mutually acceptable to both the client and clinician. If you failed to cancel your appointment within 24 hours of your scheduled appointment, ETHOS Counseling Group, Ltd., reserves the right to charge you a $50.00 fee. So it is greatly appreciated that you call ASAP to cancel an appointment. If you miss three consecutive sessions without notifying your clinician, services will be terminated. Bills that are 60 days past due will be assessed a 1.5% interest fee, and will be sent to collections. You are responsible for all fees assess by the collection agency.

_____

Client's Signature or Parent/Guardian Date

CREDIT CARDS AND OTHER FORMS OF PAYMENT

I understand that I am responsible for payment of co-pay, coinsurance or deductibles at date of service and timely payment of all amounts due on my account with ETHOS Counseling Group, Ltd. I will make payment by cash, check or charge card to my clinician at time of service or with advance arrangements. I understand my therapist will not have change for cash. I understand that I can speak with my clinician directly to set up a payment plan should the need arise.

I will direct all additional insurance and billing questions and payments changes to the Office/Billing Manager at ETHOS Counseling Group, Ltd., via email, phone, or fax to update information on a timely basis to ensure no lapse in payment.

Card Holder's Name: _____

Charge Type: Visa ( ) Mastercard ( ) Medical Savings Account ( ) Flexible Spending Account ( )

Account # _____ Exp. Date: _____/_____

Security Code: _____ Billing Zip code: _____

I authorized my card to be charged by ETHOS Counseling Group, Ltd., for my co-payment or full fee at the time services are rendered. Amount charge $_____per session, If known.

_____

Client's Signature or Parent/Guardian Date

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RELEASE OF INFORMATION

I, _____, authorize ETHOS Counseling Group, Ltd.:

( ) To give information to

( ) To receive information from

Name: _____

Institution: _____

Address: _____

Phone #: _____

Fax #: _____

This information to be exchanged is regarding my treatment from _____to _____.

This release is valid until _____.

Client Signature: _____ Date: _____

Parent /Guardian Signature: _____ Date: _____