Name (First, MI, Last):_____ Date of Birth: _____

Name (First, MI, Last):_____ Date of Birth: _____

Name (First, MI, Last):_____ Date of Birth: _____

Address: _____

City, State, Zip: _____

(____)_____	(____)_____	(____)_____
Phone Number	Work Number	Cell Number

Which phone number is best to contact you at and/or leave a message at? _____

Email Address: _____

Emergency Contact: _____Phone Number: _____

How did you hear about my services (please be as specific as possible)?

_____

If there is a referring person or agency, may I have your permission to thank them? _____

Informed Consent

Thank you for choosing Robin N. Heffernan, MS, LMFT, LCPC of Marriage and Family Solutions LLC. Today's appointment will take approximately 53 – 55 minutes. We realize that starting therapy is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Robin N. Heffernan, MS, LMFT, LCPC has earned a Bachelor of Science in Family and Individual Development and a Master of Science with Specialization in Marriage and Family Therapy from Northern Illinois University. She is licensed by the State of Illinois as a Licensed Marriage and Family Therapist and a Licensed Clinical Professional Counselor. She has over 15 years of clinical experience in treating adolescents, adults, couples and families using individual and family therapy. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

Confidentiality and Emergency Situations

Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call me directly. If no return call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Robin N. Heffernan, MS, LMFT, LCPC will follow those emergency services with standard therapy and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

Signature(s) _____ Date: _____

Financial/Insurance Responsibilities

Name of the person who has the insurance policy: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Plan Name: _____

ID #:_____

Group #:_____

EAP Information (if applicable):_____

As a courtesy we will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $150.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Robin N. Heffernan, MS, LMFT, LCPC

Fees Schedule:

Initial Consultation: $140.00

Individual of Family Therapy: $130.00

Phone Consultations (phone sessions are not reimbursable by insurance companies, you will be responsible for the fees acquired if requesting phone consultations): (10-15 minutes.) $30.00 (15-30 minutes.) $60.00

Lastly, if you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

Signature(s) _____ Date_____

Coordination of Treatment

It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no inform will be shared.

_____You may inform my physician(s) _____I decline to inform my physician

Physician Name: _____

Clinic: _____

Address: _____

Phone/Fax: _____

Signature(s) _____ Date_____

Notice of Privacy Practices and Clients Rights

I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s) _____ Date_____

May we contact you at home (circle one)? yes no May we contact you at work? yes no

May we contact you by cell phone? yes no

Where may we contact you _____?

Consent for Treatment of Children or Adolescents

I/We consent that _____ maybe treated as a client by Robin N. Heffernan, LMFT, LCPC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature(s) _____ Date_____