Revive Psychological Services
Emotional Healing and Growth

INFORMATION FORM

NAME: _____Date: _____

Address: _____

Billing Address-if different from above: _____

Date of Birth: _____ Sex: □Male □Female

Phone: Home: _____Cell/Pager: _____

Ok to leave messages? _____

Work: _____Email: _____

Ok to contact via email? _____

MARITAL STATUS: □ Single □ Married □ Partnered □ Divorced □ Separated □ Widowed □ Minor

If individual served is a minor, who has legal custody? _____

Address:_____Phone:_____

OCCUPATION: _____

Employer/School: _____Hours/Week: _____

Employer/School Address: _____

INSURANCE COMPANY: _____

Insured Name: _____Insured ID #: _____

Subscriber Name: _____Subscriber ID#: _____

Group #: _____Provider Phone#:_____

REFERRAL SOURCE: _____

EMERGENCY CONTACT:

Name: _____Relationship:_____

Address:_____

Cell: _____Home:_____Work:_____

Signature of Individual Served: _____Date: _____

Signature of Parent/Guardian: _____Date: _____

Revive Psychological Services
Emotional Healing and Growth

MEDICAL/HEALTH HISTORY

Name of Primary Care Physician: _____

Address: _____Phone:_____

List Medical Conditions that you have been diagnosed with:

_____

_____

Check ☑ if your work exposes you to: □ Stress □ Heavy Lifting □ Hazardous Substances

Check ☑ which you use and how much:
□ Illicit Drugs _____
□ Alcohol _____
□ Caffeine_____ □ Tobacco / □ Second-hand Smoke_____

Have you or anyone close to you ever thought that you had a drinking problem? □Yes □ No

Have you ever felt you ought to cut down on your drinking? □Yes □ No

Have you ever felt bad or guilty about your drinking? □Yes □ No

Have you or anyone close to you ever thought you had a problem with drugs? □Yes □ No

Have you ever abused or misused prescription drugs? □Yes □ No If YES, which ones?

Sleep

Are you concerned about your sleep quality? □Yes □ No
Trouble falling asleep? □Yes □ No
Frequent waking during the night? □Yes □ No
Wake up in early morning and can't fall back asleep? □Y □ N
Don't feel rested in the morning? □Yes □ No
Frequently feel fatigued or sleepy during the day? □Yes □ No

Revive Psychological Services
Emotional Healing and Growth

MEDICATIONS/ALLERGIES

List **ALL *CURRENT* MEDICATIONS** (use reverse if necessary):

Medication Name:	Dosage and Frequency:	Taken When (Dates):	Prescribed For:	Benefits/Side Effects:

List ***PAST* MEDICATIONS for PSYCHIATRIC/EMOTIONAL PROBLEMS ONLY** (use reverse if necessary):

Medication Name:	Dosage and Frequency:	Taken When (Dates):	Prescribed For:	Benefits/Side Effects:

List all Allergies to Medications, Substances, and/or Food:

_____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my treatment team if I ever have a change in health.

Signature of Individual Served:

_____Date: _____

Signature of Parent/Guardian (if minor):

_____Date: _____

Revive Psychological Services
Emotional Healing and Growth

Checklist of Concerns

[ ] Abuse-physical, sexual, and or emotional
[ ] Aggression, violence
[ ] Anger, hostility, arguing, irritability
[ ] Anxiety, nervousness, fears, and or phobias
[ ] Attention, concentration, distractibility
[ ] Career concerns, goals, and choices
[ ] Childhood issues (your own childhood)
[ ] Children, child management, child care, parenting
[ ] Depression, low mood, sadness, crying
[ ] Divorce, separation, and or custody of children
[ ] Eating problems-overeating, under-eating, appetite, vomiting
[ ] Emptiness and or Loneliness
[ ] Failure
[ ] Fatigue, tiredness, low energy
[ ] Financial or money troubles, debt, impulsive spending
[ ] Gambling
[ ] Grieving, mourning, deaths, losses, divorce
[ ] Guilt
[ ] Health, illness, medical concerns, physical problems
[ ] Feelings of Inferiority
[ ] Interpersonal conflicts, relationship problems
[ ] Impulsivity, loss of control, outbursts
[ ] Legal troubles
[ ] Marital conflict, distance/coldness, infidelity/affairs, remarriage
[ ] Memory problems
[ ] Mood swings
[ ] Obsessions, compulsions, (thoughts or actions that repeat themselves)
[ ] Difficulty dealing with rejection
[ ] Perfectionism
[ ] Pessimism
[ ] Procrastination, and or difficulty making decision
[ ] School Problems
[ ] Self-centeredness
[ ] Low Self-esteem
[ ] Self-neglect, poor self-care
[ ] Sexual issues, dysfunctions, conflicts, desire differences, other (see also “abuse”)
[ ] Shyness
[ ] Stress
[ ] Suspiciousness
[ ] Suicidal Thoughts
[ ] Temper problems, self-control, low frustration tolerance
[ ] Thought disorganization and confusion
[ ] Withdrawal, isolating
[ ] Work problems

Revive Psychological Services
Emotional Healing and Growth

INFORMED CONSENT FOR TREATMENT

Name: _____(hereinafter referred to as "I," "Patient," or "Client").

SERVICE AGREEMENT

Confidentiality

I have been informed and understand that Revive Psychological Services holds as confidential all information it has received concerning me, and shall only release such confidential information through the proper procedures pursuant to Illinois law and professional ethics. Consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality, which includes situations involving threat of harm to self or others, and in instances of suspected child or elder abuse, or as may be otherwise ordered by a court of law. These exceptions are also outlined in the *Notice of Privacy Practices* (HIPAA Privacy Rule) form, and the *Rights and Responsibilities of Individual Served* form. By signing this form, I acknowledge that I have reviewed, understand, and have been offered a copy of both the aforementioned forms, and that I agree to the terms and conditions set forth therein. I understand that I will be notified of any changes that occur in regard to these forms.

Financial Responsibility, Payment Guarantee, and Fees

I understand that unless mutually agreeable alternative arrangements have been made, full payment is expected upon demand and/or at the time of each session or service, and that I will be given a receipt upon remittance of any payment. I further understand that all balances not paid or covered by my insurance company, if any, shall be my sole responsibility. Should I fail to honor this agreement, I agree to pay all collection costs and fees, including reasonable attorney fees, incurred by Revive Psychological Services and resulting from the collection of my account (s) with Revive Psychological Services. I authorize Revive Psychological Services to use all information I provide to it for collection purposes. No granting of extensions or delays by Revive Psychological Services shall in any manner release my liability.

I understand that at any time during my treatment, should my outstanding balance reach and/or exceed $500.00, Revive Psychological Services reserves the right to terminate my treatment and make the appropriate referrals without further consent from me. I understand that if I submit a check which is returned for insufficient funds or for any other reason, I may be assessed a service charge of $30.00.

Insurance Coverage

I am aware and understand that insurance coverage for Revive Psychological Services to me is a contract between me and my insurance company. I further understand that some, or all of my treatment may be covered by my insurance company and that some or all of it may not be covered by my insurance company. Regardless, of the coverage, I understand that Revive Psychological Services is not responsible for resolving disagreements over claims or negotiating settlements between me and my insurance company. Revive Psychological Services shall provide me with a receipt to submit to my insurance company. This receipt provides all information customarily required for insurance claims consideration.

Cancellations and Missed Appointments

I understand that Revive Psychological Services requires twenty-four (24) hour notice of cancellation for all appointments. If I fail to give the required 24-hour notice, or otherwise do not keep a scheduled appointment, I will be charged $50 for the scheduled session/service, unless mutually agreeable and alternative arrangements have been previously made. Charges for missed appointments will be identified on my invoice(s) as such and are not covered by my insurance company. Please call the office at 312-369-9908 to cancel or reschedule an appointment.

Locations and Hours of Operation

Revive Psychological Services is located at 2829 83rd St, Darien, IL 60561 and is generally open from 10:00am through 8:00pm, Monday through Friday, and from 8:00am through 4:00pm on Saturdays. If immediate attention is needed, please call 911.

Revive Psychological Services
Emotional Healing and Growth

TREATMENT AGREEMENT

Informed Consent

I understand that Revive Psychological Services is able to offer me a range of therapeutic services, which may include psychotherapy (individual, couples, group, or family therapy). The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. I will be involved in making decisions about my treatment. If I am unable to do so, whomever I choose to make informed consent decisions for me (by appropriate legal means) will be involved in making decisions about my treatment. I understand that a range of mental health professionals, some of whom are in training, provide services within Revive Psychological Services. All professionals-in-training are supervised by licensed staff.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees to what will be experienced. Psychotherapy calls for a very active effort on the part of the patient. I understand that in order for the therapy to be most successful, I will have to work on the goals I have set for myself both during therapy sessions and at home.

ACKNOWLEDGEMENT

I, _____, request and consent to a comprehensive assessment to determine the need for mental health services, to the development of a treatment plan and to the provision of those services.

I, _____, am the parent or legal guardian of:
(if patient is under 18 years of age)

_____, and request and consent to a comprehensive

assessment to determine the need for mental health services, to the development of a treatment plan and to the provision of those services. I voluntary request and authorize Revive Psychological Services to render care, psychological and/or psychiatric treatment, assessment, and diagnostic procedures by its authorized agents and employees. I understand that services may include psychotherapy (individual, couples, group or family therapy), medication management, and any other treatment services deemed necessary for my care and well being. I further acknowledge that no guarantees have been made as to the efficacy of such examinations or treatments for my condition or the condition of the person on whose behalf I am legally authorized to consent (collectively the "Patient"). I understand that I have the right to make decisions concerning the Patient's care, including the right to refuse psychological and /or psychiatric services.

If I have any questions regarding this consent form or about the services offered at Revive Psychological Services, I may discuss them with my therapist. I have read and understand the above. I willingly consent to participate in the assessment and treatment offered to me by Revive Psychological Services. I have been informed of all levels and types of available services offered by Revive Psychological Services. I understand that, by law, I do not have to sign this Consent Form and I may stop treatment at any time. If I refuse to sign this Consent Form, I may be denied services from Revive Psychological Services. I have received satisfactory answers to all questions I have asked in regard to the contents of this form.

Revive Psychological Services
Emotional Healing and Growth

I have read this service agreement and have received satisfactory answers to all questions I have asked regarding its contents. I agree to abide by the terms set forth herein. By signing below, I affirm that I have read, understand, and have been offered copies of Revive Psychological Services Informed Consent for Treatment form, Notice of Privacy Practices form, and Rights and Responsibilities form, and I agree to the terms and conditions set forth in these documents.

Printed Name of Individual Served _____Date of Birth:_____

Signature of Individual Served: _____Date: _____

Signature of Parent/Guardian: _____Date: _____

Signature of Witness: _____Date:_____

Revive Psychological Services
Emotional Healing and Growth

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have reviewed and received a copy of the Notice of Privacy Practices Form.

Printed Name of Individual Served:_____D.O.B._____

Signature of Individual Served:_____Date:_____
(must sign if 12 years of age or older)

Signature of Responsible Party:_____Date:_____
(must sign if patient is under 18 years of age)

Relationship of Responsible Party to Individual Served:_____