

Sally Frau LCSW

INTAKE INFORMATION AND INFORMED CONSENT

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: () May we leave a message? ☐ Yes ☐ No

E-mail: _____ May we email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: ____/____/____ Age: ____ Gender: ☐ Male ☐ Female ☐ X

____/____/____ Age: ____ Gender: ☐ Male ☐ Female. ☐ X

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Please list any children/age: _____

Emergency Contact: _____

Phone Number: _____

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Referred by (if any): _____

Have you ever seen a mental health professional (psychiatrist, social worker, psychologist or counselor)? ☐ Yes ☐ No

If yes, when? _____

Please briefly list the reasons: _____

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please explain: _____

Briefly, what concerns would you like to address in counseling/therapy? _____

Thank you for choosing to work with me for your counseling and therapy needs. Today's appointment will take between 50 and 90 minutes. Starting counseling 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 I will try my best to give you all the information you need. I, Sally Frau, LCSW, have earned a Bachelor of Arts Degree in Psychology from Macalester College and a Master's Degree in Social Work from the University of Chicago, School of Social Service Administration. I am licensed by the State of Illinois as a Clinical Social Worker and have over 30 years of clinical experience in assessing and treating, adults, children, adolescents, and families using individual and family therapy. I also have over 15-years' experience in supervising and providing training to counselors and social workers. In ongoing practice I provide Solution Focused Therapy, Family Systems Therapy, Eye Movement Desensitization and Reprocessing (EMDR), and uses other experiential treatment approaches as appropriate, based on the needs of the person seeking services. My services, philosophy, and 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 that you and/or your child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, b) where you sign a release of information to have specific information shared, c) if you provide information that informs me that you are in danger of harming yourself or others, and d) or when required by law. No information will be shared with a referral source without your written consent. If an emergency situation occurs, in which you feel immediate attention is necessary, please contact the emergency services in the community (911) or local emergency room for those services. I will follow those emergency services with standard counseling and support to you or your family until an appropriate referral to an ongoing community-based provider can be made. E-mail, text messages and social networking sites are not confidential, and I may not be able to respond.

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SOCIAL MEDIA: I maintain a professional “web presence” via my website at www.sallyfraulcsw.com as well as via Facebook, and Linked In. In order to ensure client confidentiality as well as in order to adhere to professional ethical standards I will not engage in personal communications and networking with past, current, or potential future clients. Although connecting through Linked In or being followed or liked on Facebook is acceptable I will not acknowledge you as a client or respond to your comments on any of the aforementioned social media sites or any others that I may engage in the future. You are welcome to access resources provided through these sites, but please note that I will not respond to “friend requests” or other web connections that extend beyond my professional work.

FINANCIAL/INSURANCE ISSUES: Sally Frau, LCSW is able to bill insurance as a form of payment for services for those clients with an Aetna PPO or with Blue Cross Blue Shield PPO. I do not accept any other insurance as a form of payment for services at this time. My standard fee for service is \$225 for the initial assessment appointment and \$200 for all ongoing in-person and remote appointments. This standard fee may be adjusted for clients with limited incomes. This will be agreed upon prior to the initial assessment session. I ask that at the end of each session you pay your full fee for the session. Payment can be made by cash, check, or credit card.

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours’ advance notice. You will be billed the full rate of your session cost (copay/coinsurance + insurance share of session cost if using insurance) for any sessions that are missed or cancelled with less than 24-hour’s notice. I 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.**

THIS CONSENT FOR SERVICES EXPIRES AT THE END OF SERVICES OR IF REVOKED IN WRITING.

Signature(s) _____ Date _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I hereby acknowledge that I have received and have been given an opportunity to read a copy of Sally Frau, LCSW’s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Sally Frau, LCSW at 773 372-4111 or at sfrau@compatiblecounseling.com

Signature(s) _____ Date _____

Credit Card Payment Consent Form

NOTE: DEBIT AND FSA/HSA CARDS CANNOT BE USED TO COMPLETE THIS FORM.

Client Name: _____
Last First Middle Initial

Payer* Name (if different than client):

<i>Last</i>	<i>First</i>	<i>Middle Initial</i>
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*** If client and payer are not the same person, then a valid consent for release of protected health information must be completed.**

Billing Address:

Street	City	State	Zip
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Phone Number: _____ E-mail Address: _____
☐ Send e-Receipt with Charge

By initialing and signing below, I authorize Sally Frau, LCSW, to charge my card for professional services as follows, and only when I am not physically present with card in hand, for (please initial ONLY ONE option):

Recurring charges, until my account is paid in full, and I am no longer participating in services, not to exceed the negotiated rate of \$ _____ per session^{1 3}.

INITIAL HERE

(Choose this option ONLY if you are a self-paying client not using insurance.)

or

Any charges not paid by my insurance company^{2 3} within 90 days of charges being incurred.

INITIAL HERE

(Choose this option **ONLY** if insurance coverage will be used for reimbursement.)

1 This amount will not exceed the per-session rate(s) negotiated with me prior to your first session, except as outlined in #3 below.

2 Charges may include deductibles, co-pays and co-insurance payments, and other fees (see #3 below).

3 Penalty fees: The no call/no show fee and late (less than 24-hours) cancellations fee for all clients will equal the lesser of \$85.00 or your negotiated session rate.

Penalty fees may be waived, at my discretion, on a case-by-case basis. You will always be notified prior to your card being charged.

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Expiration Date: ____ / ____ (must be valid for at least one (1) year from today)

CVV #: ____ (3 digits on back of card)

Name on Card: _____

Card Holder Signature: _____ Date: _____



Expiration Date: ____ / ____ (must be valid for at least one (1) year from today)

CVV #: ____ (4 digits on front right of card)

Name on Card: _____

Card Holder Signature: _____ Date: _____