Belleville Counseling Associates **Kara Jacob, ATR, LCPC**
5 Executive Woods Ct., Lower Level
Swansea, Illinois 62226

Consent to Treatment

I acknowledge that I have received, have read (or have had explained to me), and understand the information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment with Kara Jacob, MA, ATR, LCPC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that ***I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged a $50.00 cancellation fee***.

I am aware that **an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive**. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed name Relationship to client (if necessary)

Agreement to Pay for Professional Services

I, _____ request that Kara Jacob, LCPC provide professional services to me I understand that the standard fee for individual therapy is $150.00 per hour but may be negotiated based upon my income and ability to pay. My therapist and I have agreed upon a rate of $_____.
My insurance provider is _____ and I have a co-pay payment of $_____.
I understand that my signature below also signifies my authorization to release information to my insurance company necessary to proceed with billing for services rendered.
I am aware that my payments need to remain current. To avoid getting behind on my bill I understand that I am required to make payments for each session, to maintain the agreed upon fee. If my payments fall behind I will need to wait to schedule a follow up appointment pending the ability to bring my account up to date.
I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, my intent to end therapy. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.
I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

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Client Information Form 1

Today's date: _____

Identification

Child's name: _____DOB _____Social Security #: _____
Home street address: _____ Apt.:_____
City: _____ State: _____Zip: _____
Parent: Home/evening phone: _____ Can we leave a message at this number? ___YES ___NO
Parent: Cell Phone: _____ Can we leave a message at this number? ___YES ___ NO
Do you agree to text reminder of appointments at cell number? ___YES ___ NO
If YES then who is your cell phone company: (Verizon, AT&T, T-Mobile, etc.):

Do you agree to reminders/messages on your email? ___YES ___NO
Email address: _____
Parent: Name of Employer:_____Occupation:_____
Address: _____
Street Suite# City State Zip
Work phone: _____ Can we leave a message at this number? YES NO

Spouse: _____ **Emergency Contact:** _____/_____
Address if different than above: _____
Apt.:_____
City: _____ State: _____Zip: _____
Home/evening phone: _____ Can we leave a message at this number? YES NO
Spouse's Employer: _____ Work Phone:_____

Payment Information

Responsible Party: _____ Relationship to the Client:_____
Address if different than above: _____Apt.:_____
City: _____ State: _____Zip: _____

Insurance Information

_____

_Insurance Company **Subscriber No.** **Policy No.**

Primary Policy Holder Name Social Security Number Date of Birth

_____

Billing Address Phone Contact

_____

Secondary Insurance Company Subscriber No. Policy No.

_____

Billing Address Phone Contact

Referral: Who gave you my name to call?

Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? • Yes • No
How did this person explain how I might be of help to you? _____

_____

Client Signature Date

Belleville Counseling Associates
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Swansea, Illinois 62226
618 277-7570

Kara Jacob, ATR, LCPC

Brief Health Information Form

A. Identification

Client's name: _____ Case #: _____ Date: _____

B. History

1. Please list any illnesses that may be interfering with your current functioning. Be sure to include any head trauma, history of seizures, and significant adult or childhood illnesses.

Age	Illness/diagnosis	Treatment received	Treated by	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. What are your primary reasons for seeking counseling? _____
_____
_____
_____
_____

Primary Care Physician (Name, address & Phone)

_____
_____
_____
_____
_____

Please check the appropriate box below:

May I have your permission to inform him/her of your involvement in counseling? • Yes • No

May I have your permission to discuss with your physician any treatment concerns, evaluations, needs and/or progress? • Yes • No

_____

Client Signature Date