INTAKE INFORMATION:

PATIENT'S NAME: _____ _____
First **Middle** **Last** **PATIENTS' D.O.B.**

ADDRESS: _____
Street **City** **State** **Zip Code**

PARENTS(S) OF MINOR: _____
First **Middle** **Last**

ADDRESS: _____
Street **City** **State** **Zip Code**

( ) ( ) ( )
HOME TELEPHONE NO. **CELL TELEPHONE NO.** **WORK TELEPHONE NO.**

EMAIL ADDRESS: _____

INSURANCE INFORMATION:

INSURED'S NAME: _____ **INSURED SOCIAL SECURITY NO.:** _____

INSURED ADDRESS: _____

INSURED D.O.B.: _____

ID NO.: _____ **INSURANCE CO:** _____

GROUP NO.: _____ **INSURANCE PHONE:** _____

EMPLOYER NAME: _____

REFERRAL SOURCE: _____

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff and/or your psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, we are obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me/us that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and g) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Counselors of Finding Balance, ltd. will follow those emergency services with standard counseling and support to the client or the client's family.

_____ _____
Signature(s) **Date**

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS:

I/We consent that _____ may be treated as a client by counselors of Finding Balance, Ltd. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

_____ _____
Signature(s) **Date**