Kind Living Therapy, LLC

Date: _____

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

Address: _____

_____

Birth Date: _____/_____/_____

Preferred Phone Number: _____ (Cell, Home, Work)
circle

Can a message/text be left at this number? YES / NO

email address: _____ can I email you? Yes / No

Secondary Phone Number: _____
Can a message/text be left at this number? YES / NO

Physician: _____

Address: _____ Phone: _____

_____

Current Medications: _____ , _____

_____, _____ , _____

Emergency Contact: _____

Phone Number: _____

- - - -

Your current Employer: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Policy/ID Number: _____ Group Number: _____

*Address of policy holder: _____ *Phone: _____
*if different from client address/phone

_____

Policy Holder Name: _____

Policy Holder Date of Birth:____/_____/_____

Employer:_____

Authorization to release information:

I give permission to Kind Living Therapy, LLC to release any information necessary (including diagnosis) to:

_____
(Name of Insurance Company)

for the purpose of determining my eligibility and/or coverage for pending services. If services are covered, I authorize release of any information necessary to process my claim.

Signature:_____ Date: _____
(or parent if client is a minor)

Kind Living Therapy, LLC
210 W. Water St. Suite 1, Pontiac, IL 61764

CONSENT FOR TREATMENT/SERVICES, I hereby consent to the treatment/services provided by Kind Living Therapy, LLC. I authorize the treatment/services deemed necessary to address my needs. (_____) *Initial*

AUTHORIZATION FOR RELEASE OF PESONAL HEALTH INFORMATION,
I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care or for the purposes of conducting the healthcare operations of the agency. I authorize Kind Living Therapy, LLC to release any information required in the process of application for financial coverage for the treatment/services rendered. This authorization provides that Kind Living Therapy, LLC may release objective clinical information related to my diagnoses and treatment which may be requested by my insurance company or its designated agent. (_____) *Initial*

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to Kind Living Therapy, LLC for insurance benefits payable to me. I understand I am financially responsible to the agency for any covered or non-covered treatment/services, as defined by the insurer. I understand if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. (_____) *Initial*

PRIVACY POLICY. I acknowledge having been offered the agency's "Notice of Privacy Policies and Client Rights" statement. I understand as a client of Kind Living Therapy, LLC my rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5], the Confidentiality Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. My right including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to record, is explained in the Policy. My right to make a complaint and file a grievance under Illinois laws has also been explained. I understand I may revoke in writing my consent for release of my health information, except to the extent the agency has already made disclosures with my prior consent. (_____) *Initial*

Guardian must initial if client under the age of 18

Signature: _____ Date: _____

Witness:_____ Date: _____

affirming these rights have been explained to the client/guardian in a language or method of communication they understand

Kind Living Therapy, LLC

Client Rights

As a client of Kind Living Therapy, LLC, your rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5], the Confidentiality Act, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights include, but are not limited to the following:

1. You have the right to be provided with mental health services in the least restrictive setting.
2. You have the right to be free from abuse, neglect, financial and other exploitation, retaliation, and humiliation.
3. Justification for restriction of your rights as cited in Chapter 2 of the mental Health and Developmental Disabilities Code [405 ILCS 5], the Confidentiality Act, and the Health insurance Portability and Accountability Act (HIPAA) of 1996 shall be documented in your clinical record. You have the right to be notified of that restriction(s) of your rights. Your parent or guardian and any agency you designate shall also be notified of the restriction.
4. You have the right to contact the Guardianship and Advocacy Commission and Equip for Equality.
5. You have the right to contact the public payer.
6. You are entitled to have your rights explained to you using a language or method of communication you understand, with such explanation placed in your record.
7. You have the right not to be denied, suspended or terminated from services or have services reduced for exercising any rights.
8. You have the right to be free from involvement in any research projects.

I verify I have read, understand, and have been offered a copy of my client rights.

_____ _____

Client/guardian signature Date

I verify I have been presented with, read, and understand my HIPAA rights.

_____ _____

Client/guardian signature Date

I affirm I have explained these rights to the client in a language or method they understand and believe these rights to have been understood.

_____ _____

(Amy's signature)