THE ALIGN CENTER
FOR PSYCHOLOGY & COACHING

NEW CLIENT INTAKE FORM

Client

Legal Name: _____ Preferred Name:_____ Pronoun(s): _____

Age: _____ Birthdate: _____

Address: _____

City:_____ State:_____ Zip:_____

Cell Phone: _____ Email: _____

For Clients Under Age 18

Parent #1	**Parent #2**
Name: _____ Age: _____	Name: _____ Age: _____
Address: _____	Address: _____
_____	_____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Cell Phone: _____	Cell Phone: _____
Email:_____	Email:_____

Family

Status of Parents: (Circle One) Single Married Separated **Divorced*** Widowed

***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

Siblings

Name	Date of Birth	Relationship to Client

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Medical history

Does the client or a relative have a history of any of the following? (Please note relationship to the client if there is a family history.)

Depression: ☐ Yes ☐ No _____

Bipolar Disorder or Manic Depression: ☐ Yes ☐ No _____

Anxiety: ☐ Yes ☐ No _____

ADHD: ☐ Yes ☐ No _____

Autism: ☐ Yes ☐ No _____

Developmental Delays: ☐ Yes ☐ No _ _____

Self-Injury: ☐ Yes ☐ No _____

Attempted/Complete Suicide: ☐ Yes ☐ No _____

Substance Abuse: ☐ Yes ☐ No _____

Learning Disabilities: ☐ Yes ☐ No _ _____

Psychiatric Hospitalization: ☐ Yes ☐ No _____

Significant Trauma: ☐ Yes ☐ No _____

Other Medical/Mental Health Family History

_____

_____

_____

_____

_____

dradamlevin@gmail.com • 847.525.2457
www.AlignCenterforPsychology.com

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Healthcare

1. Other Therapist or Other Mental Health Provider
May we contact this person for the purposes of treatment coordination? ☐ Yes ☐ No

Name _____ Office Phone _____

2. Primary Care Physician
May we contact this person for the purposes of treatment coordination? ☐ Yes ☐ No

Name _____ Office Phone _____

3. Current Medications/Supplements (Please continue on reverse as needed)

Medication/Supplement Name	Dosage	Reason

Current School

School: _____ Grade: _____

Is there a 504 plan in place? ☐ Yes ☐ No Is there an IEP in place? ☐ Yes ☐ No

Has your child ever had psychological or psychoeducational testing? ☐ Yes ☐ No

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In Case of Emergency

Contact: _____ Relationship: _____ Phone Number: _____

How did you hear about our practice?

Referral Source:_____

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POLICIES

I look forward to working with you. This document contains important information about my policies. Please read and initial where indicated.

PAYMENT

Payment in full is expected at the time of service. In addition to weekly appointments, I charge for other professional services you may need such as report writing, telephone conversations, email dialogues, attendance at meetings with other professionals that you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. I am an out of network provider and do not submit bills to insurance companies. After each appointment, I will send you a Superbill that you can submit to your insurance company. Many clients use insurance to get reimbursed for services.

Initials

Client (18 +): _____

Parent: _____

CANCELLATION POLICY

Once an appointment is scheduled, I have a 24 hour cancellation policy. This policy allows me to better accommodate my client's needs. Except in cases of family/medical emergency and illness, I charge full fee for appointments cancelled within 24 hours. These fees are not covered by health insurance and are the client's personal responsibility.

Initials

Client (18 +): _____

Parent: _____

TREATMENT OF MINOR CHILDREN OF SEPARATED OR DIVORCED PARENTS

If treatment is sought for a minor child of divorced or separated parents (or for any person whose guardianship has been settled by Order of Court), I must receive consent in advance for my services from a party legally authorized to give consent for healthcare services. Payments of fees to my office will be the sole responsibility of the parent or guardian signing here as "responsible person" notwithstanding any court order or decree assigning financial responsibility for healthcare to any other party.

Initials

Client (18 +): _____

Parent: _____

IN CASE OF EMERGENCY

If you or your child is having a mental health emergency, please reach out to me by email at dradamlevin@gmail.com, unless we have a prior plan. I will do my best to support you. If I am not available, adults (18+) can contact a crisis line such as The Living Room crisis line at Turning Point Behavioral Health Center at 847.933.9202. In an emergency, please call 911 or go to your closest Emergency Room.

Initials

Client (18 +): _____

Parent: _____

If you have any questions, please let me know. Please sign below indicating you have read and understood these policies and agree to them.

Signature_____ Date _____
Client age 18 or older

Signature_____ Date _____
Parent/Guardian

THE ALIGN CENTER
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ILLINOIS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.

I. UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION (PHI)

As your clinician, I am required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with a notice of my legal duties and privacy practices in accordance with the Health Insurance Portability and Accountability Act (HIPPA). I am permitted by federal and state privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operation purposes with your written authorization.

Protected Health Information (PHI) is the information we create and obtain in providing my services to you. Such information may include documenting your symptoms, examination and assessment results, diagnoses, treatment, and applying for future care or treatment. In some circumstances, it may include billing documents for those services. Psychotherapy notes provide an even greater degree of protection and can only be released with a separate authorization.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

I will use your health information for treatment: As your clinician, I may use or disclose your health information with others outside my practice for the purpose of providing, coordinating, or managing your health care treatment, including others outside my practice to whom I may be referring you. I may disclose health information to other providers only with your authorization.

I will use your health information for payment: A bill may be given to you or sent to a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as the diagnosis and treatment procedures. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

I will use your health information for regular health care operations: If applicable, I may consult with colleagues about your case in order to facilitate treatment. When discussing your case in this manner, no identifying information will be disclosed in order to protect your privacy.

III. ILLINOIS – STATEMENT OF YOUR RIGHTS

The health and billing records I maintain are the physical property of Adam Levin, Psy.D., LLC, however your protected health information in them belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your personal health information. I am not required to grant the request, but will comply with any request granted.
- Obtain a paper copy of this notice.
- Inspect and obtain a copy of your personal health information record.
- Obtain an accounting of disclosures of your personal health information.
- Request an amendment to your personal health information record.
- Revoke your authorization to use or disclose information except to the extent that action has already been taken.

IV. ILLINOIS – DISCLOSURE OF INFORMATION

As your clinician, I will not disclose your protected health information (PHI) without your authorization, except as described in this notice.

Information Disclosure Without your Consent:
Under Illinois and federal law, information about you may be disclosed without your consent. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization:

Child Abuse or Neglect: If, as your clinician, I have reasonable cause to believe a child (known to me through a professional capacity) may be abused or neglected, I must report this belief to the appropriate authorities.
Elder Abuse or Neglect: If, as your clinician, I have reason to believe that an elder individual (known to me through a professional capacity) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.
Threats to Health or Safety: If you communicate a specific threat of imminent harm against yourself or another individual, or if you believe that such a risk exists, I may make disclosures that I believe are necessary to preserve your life or to protect another individual from harm.
Judicial and Administrative Proceedings: If you are involved in a court proceeding and any party requests information about your evaluation, diagnosis, or treatment, I, as your clinician, must release such information if ordered by the court. I can release PHI information directly to you upon your request, if you are being evaluated by a third party, or the evaluation itself is court ordered.
Law Enforcement: I may disclose PHI to any law enforcement official as required by law, in compliance with a valid subpoena or court order.

V. TO REQUEST INFORMATION OR FILE A COMPLAINT

If you are concerned that I have violated your privacy rights, or you disagree with a decision about access to your records, please bring this to my attention, Adam Levin, Psy.D. at dradamlevin@gmail.com. You may also send a written complaint to the Secretary of Health and Human Services. As a licensed clinical psychologist, I support your right to protect the privacy of your medical information. I will not retaliate in any way, if you choose to file a complaint.

VI. ADDITIONAL INFORMATION ON PRIVACY PRACTICES

I will maintain the privacy of your personal health record and provide you with a notice as to the legal duties and privacy practices of Adam Levin, Psy.D., LLC. I reserve the right to amend, change, or eliminate provisions in my privacy practices and to enact new provisions regarding the protected health information I maintain. If my information practices change, I will amend this notice. Should these information practices change, and your case is active or if these provisions will result in a disclosure of your health information, I will notify you of these changes. You are entitled to receive a revised copy of this notice by calling my office or sending a written request to dradamlevin@gmail.com.

RECEIPT AND ACKNOWLEDGMENT OF PRIVACY PRACTICES
I have read and reviewed this policy. I understand and agree to its contents. A copy of this document was provided to me.

Name: (Print): _____

Signature of Client: _____ Date: _____
(If over 12 years old)

Signature of Parent/Guardian: _____ Date: _____

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Adam Levin, Psy.D., LLC Chart Copy of the last page of HIPPA agreement
I have read and reviewed the HIPPA policy of Adam Levin, Psy.D., LLC. I understand and agree to its contents. A copy of this document was provided to me.

Name: (Print): _____

Signature of Client: _____ Date: _____
(If over 12 years old)

Signature of Parent/Guardian: _____ Date: _____

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