Northern Illinois Counseling Associates, P.C. (NICA)

Client Information Form

Welcome to our office! *****Please P-R-I-N-T Clearly***** **Today's Date:** ____________

Full Legal Name of Client: ____
(Last) (First) (Middle)

Address: ____
(Number and Street) (City) (State) (Zip Code)

Home Phone: (______) ______________________________; **Alternate Phone:** (______) ______________________________ ext.____________

Cell Phone: (______) __________________________; **E-mail Address:** ______________________________

Date of Birth: __________________; **Age:** ________; **SS#:**__________-__________-___________; **Marital Status:** ______________________

Name & Address of Client's Employer: ____

Whom May We Thank For Referring You To Our Office? ____

Name of Responsible Party, If Different From Client: ____
(Last) (First)

Address of Responsible Party: ____
(Number and Street) (City) (State) (Zip Code)

Home Phone #: (______) ______________________; **Work # :**(______) ______________________; **Cell # :**(______) ______________________

In Case of Emergency Authorization is Hereby Provided by Client and/or their Responsible Party(ies) to Release and/or Release Information to:
Name of Contact Person: ____; **Relationship:** ______________________________
Contact Phone: H: (______) _______________________; C: (_______) _______________________; W: (_______) _______________________

Primary Insurance (Please Note: Only "Primary" insurance is courtesy-filed by NICA; we no longer file "Secondary" insurance):
☐ **Check if Primary Insurance Information has been provided to our office, in writing, via telephone, electronically or via "Xerox" copy**
Name of Insured: ____
Name of Insurance Company: ____ **Insurance Co. Phone #:** (______) _________________________
Policy #: ____________________________________ **Group #:** ____________________________ **ID#:** ________________________________

PAYMENT POLICY*
Please specify which method of payment you will be using at each service by making a check mark (✓) in one of the boxes immediately below:
☐ **Cash;** ☐ **Personal Check;** ☐ **Business Check;** ☐ **Money Order;** ☐**; Cashier's Check;** ☐ **Credit Card;** ☐ **Debit Card;** ☐ **Other**_________________

***NOTE: If payment is not made at the time of each service, for any reason, you will be required to sign an *additional* written Authorization for Payment Guarantee (which NICA retains confidentially on-file) as a fiduciary condition of your receiving our professional services. If a Payment Guarantee via credit card, debit card or other method acceptable to NICA is not provided for current and subsequent professional services, then all applicable charges, deductibles, co-insurance and/or co-pays will be required at the time of each service. Please be further advised that all Payment Guarantee charges are applied following each service without any prior notice or concurrent notification by NICA to the Client and/or their Responsible Party(ies). If you prefer not to provide a Payment Guarantee then payment is expected and due at the time of each service.**

CREDIT or DEBIT Card Only: ☐ **VISA;** ☐ **MasterCard**; ☐ **Discover** **Valid Thru**: ____________________ **Three Digit Code**: ___________

Name as it exactly appears on Card: ______________________________________; **16 Digit Card #:** ______________________________________

I understand, accept and agree that all fees charged for services rendered are the full responsibility of the client [or their Responsible Party(ies)] and are payable, in-full, at the time of each service. I understand, accept, agree to be bound by and authorize, in entirety, the conditions and fees as determined or charged by NICA, and/or as specified on this form (front and back) and on all subsequent forms, as may be indicated, for any services rendered. I assume complete responsibility and liability for all reasonable recovery costs and all reasonable attorney fees. I authorize all payments (including applicable deductible, co-insurance and co-pay amounts) via continuous payment guarantee. In lieu of payment guarantee, I agree to pay, in-full, at the time of each service, via cash, check, money order, cashier's check, credit card or debit card.

Print Full Legal Name of Client: ____

Client (or their Responsible Party(ies) Signature(s): ____ **Date:** ___________________________

Optional NICA Witness Signature ____ **Date:** ___________________________

➔ ➔ ➔ **Important !!! Please see other side for additional signatures required** ➔ ➔ ➔

THE ATTENDING PROVIDER'S STATEMENT

EACH CLIENT AND/OR THEIR RESPONSIBLE PARTIES, NOT THE INSURANCE COMPANY, IS RESPONSIBLE FOR PAYMENT TO THIS OFFICE WITHIN THE USUAL TERMS OF OUR POLICY.

Furthermore, there is NO GUARANTEE that your insurance company will necessarily reimburse you for charges incurred for any services rendered. In addition, there is NO GUARANTEE that any benefits which may have been verified by you and/or our office with your insurance company are necessarily accurate or will necessarily be honored by your insurance company.

Consequently, it is the client's sole, full and complete responsibility and accountability to verify the nature, limit(s) and accuracy of all their insurance benefits and to provide verification, in writing, to NICA, inclusive of pre-certification and/or pre-authorization of and for any and/or all services rendered.

PLEASE NOTE THAT INSURANCE REPRESENTS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, NOT WITH THE PROVIDER. SINCE WE ARE TYPICALLY NOT A PARTY TO THE INSURANCE COMPANY'S CONTRACT WITH YOU, WE CAN NOT AND WILL NOT BECOME INVOLVED IN ANY DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY OTHER THAN TO SUPPLY FACTUAL INFORMATION AS NECESSARY FOR WHICH YOU MAY INCUR A CHARGE.

ADDITIONALLY, OUR OFFICE CAN NOT AND WILL NOT ACCEPT RESPONSIBILITY FOR COLLECTING YOUR INSURANCE CLAIM OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM, REGARDLESS OF ANY CLAIM PENDING. IF THERE IS AN OPEN BALANCE, A STATEMENT WILL BE SENT TO YOU AND MUST BE PAID WITHIN FIVE (5) DAYS UPON RECEIPT.

FOR ALL NON-INSURANCE CLAIMS, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE AND IN WRITING, PAYMENT IN-FULL IS EXPECTED AT EACH SERVICE.

All NICA accounts which are delinquent forty-five (45) days or more from the date of each NICA-rendered service may be subject to legal recovery and collection action. It is the full, sole and complete responsibility of the client or their responsible party(ies) to remain current with their NICA accounts and to follow-up with their insurance company(ies) to ensure non-delinquency with respect to balances due.

The client or their responsible party(ies) agree to assume full and complete liability for any and/or all reasonable recovery costs and any and/or all reasonable attorney fees and further agree to hold harmless, Northern Illinois Counseling Associates, P. C. (NICA) [including its officers, directors, employees, independent contractors, agents, assigns, designees, and/or interns], in perpetuity, from any and/or all claims resulting from recovery and/or legal actions taken.

Since the practice of clinical diagnosis and mental health is an inexact science, no assurances can be made regarding assessment, diagnostic and/or therapeutic outcomes. Consequently, no assurances are made and the client or responsible parties will hold harmless, Northern Illinois Counseling Associates, P.C. (NICA) [including its officers, directors, employees, independent contractors, agents, assigns, designees, and/or interns] in perpetuity, from any and all claims resulting from any and/or all services rendered.

Your signature on this form will attest to your having received, read, discussed, understood, accepted, agreed to be bound by and authorized the conditions and fees, as specified herein and henceforth.

In addition, you agree to authorize Northern Illinois Counseling Associates, P.C. (NICA) [including its officers, directors, employees, independent contractors, agents, assigns, designees and/or interns], to discuss pertinent aspects of your case (including, but not limited to: diagnosis, history, course, assessment, treatment, progress notes, recommendations, collateral information and the clinical record), in the sole discretion of NICA, unless specifically NOT authorized, in writing by the client and/or their responsible party(ies), with clinical, consultative and/or supervisory personnel for the duration of your treatment, in accordance with the prevailing Illinois Department of Mental Health and Developmental Disabilities Mental Health Confidentiality Act, as applicable.

You further agree to provide, maintain and honor a continuous payment guarantee via credit card, debit card or other method of payment and continuous authorization acceptable to NICA following each professional service for the duration of all professional services rendered, unless payment is made by cash, check or other acceptable manner, in NICA's sole discretion, at the time of service.

AUTHORIZATIONS, ASSIGNMENTS, ACKNOWLEDGEMENTS AND ADDENDA

I authorize NICA to contact my insurance company (including any of its representatives, adjusters, agents, intermediaries, third-party administrators and/or case reviewers) to verify benefits due me for mental health and related health care services and/or for NICA to bill my insurance company for charges resulting from NICA rendered services and/or for NICA to furnish my insurance company (including its representatives, adjusters, agents, intermediaries, third-party administrators and/or case reviewers) all necessary information to facilitate prompt payment of my claim(s). Unless otherwise directed to the contrary, *in writing*, NICA is expressly authorized by client and/or their responsible party(ies) to communicate with client and/or their responsible party(ies), contact and/or leave telephonic, facsimile, and/or electronic messages at client's home, place of work or with family member, as indicated in NICA's sole discretion. I authorize, assign and direct that all benefits due me for NICA rendered services are to be made payable to and mailed to NICA. This is a direct assignment to the insured but specifically payable to and mailed in care of NICA. If my current insurance or other third-party payor policy prohibits direct assignment of benefits, then I direct that all benefits due me for NICA rendered services are to be made payable to the insured and mailed c/o NICA. Authorizations shall occur in accordance with the prevailing Illinois Department of Mental Health and Developmental Disabilities Mental Health Code and Confidentiality Act. All authorizations, assignments and acknowledgements shall remain in full force and effect, concurrent with and subsequent to the completion of all services until such time as payment for services rendered by NICA is satisfactorily made in full. I certify that the person to whom services are rendered is an eligible claimant entitled to benefits provided by my insurance company. ____

NOTE: In situations of separation or divorce, where either parent presents a minor for treatment, the presenting parent (whether "custodial", "joint custody" or "non-custodial") is responsible for the fee. Northern Illinois Counseling Associates, P.C. (NICA) can not and will not be involved in attempting to collect money from the non-presenting parent and/or either parent's insurance company(ies). It is the responsibility of the parent presenting the minor for services to pay the fee and seek reimbursement from the other parent. In the event there is more than one responsible party, the person(s) signing as the "RESPONSIBLE PARTY" herein, certify that they are the eligible and duly authorized responsible party(ies) and will assume full and complete responsibility for any and all services rendered consonant with the aforementioned.

A photocopy of this form (front and/or back) shall be considered as valid as the original________________

1. Diagnostic interview services (90791) are approximately forty-five (45) to fifty (50) minutes in duration.
2. Psychotherapy sessions, if coded (90834) are thirty-eight (38) to fifty-two (52) minutes, or, if coded (90837) are fifty-three (53) to sixty (60) minutes in duration. For non-contracted or non-insurance services, NICA, in its sole discretion, will pro-rate charges for length of services rendered.
3. Psychological and neuropsychological testing services are billed at a rate of two hundred ($200.00) dollars per unit and are pro-rated for fractions of units as pre-determined by NICA. (NOTE: *Substantially higher rates apply to all legal, probation and/or forensic psychological services*). Psychological testing services may or may not be covered by your insurance company and, if covered, may decrease the available number of your treatment sessions, at least historically. Any fees for psychological testing services, which you agree to be administered to you (or the client for whom you are their "responsible party(ies))", which are not reimbursed by your insurance company, are your sole, full and complete responsibility.
4. Additional professional services by NICA, *either as a treating clinician and/or as expert witness*, requested or required by any court, court services, a probation department officer and/or an attorney-at-law (including subpoena and/or deposition and/or other forensic psychological services will be billed at a rate of up to seven-hundred and fifty dollars ($750.00) per hour, with a three (3) hour minimum, PAYABLE IN ADVANCE, regardless of whether or not report, deposition, interrogatory, testimony or consultation is given. (NOTE: Travel is billed both to and from by NICA at the rate of two hundred ($200.00) per half-hour or fraction, thereof). **[Please note that any and/or all legal expenses (including, but not limited to legal consultation) incurred by NICA, in its sole discretion, on behalf of the client (and/or their responsible party(ies)) are the client's sole expense and direct responsibility and PAYABLE TO NICA IMMEDIATELY UPON NOTICE].**
5. Phone consultation in excess of five (5) minutes will be billed at the provider's prevailing rate, pro rata. Please note, these services are virtually never reimbursed by your insurance company and are therefore your sole, full and complete responsibility, and payable within five (5) days upon receipt, whichever is sooner.
6. **Twenty-four (24) hour cancellation notice (unless otherwise specified) is REQUIRED for sixty (60) minute or briefer appointments and seventy-two (72) hour cancellation notice (unless otherwise specified) is REQUIRED for appointments lengthier than sixty (60). Session (or service) will be charged IN-FULL if respective notice is not given to our office. SORRY, NO EXCEPTIONS!**
7. NSF and other bank stopped checks will be assessed a twenty-five dollar ($25.00) fee payable within five (5) days upon receipt and/or notification by our office.
8. **Please be aware that your merchant charge card numbers will be kept on file and applicable fees will be charged automatically, without notification to the client (or to their responsible partiy(ies)), if there is any balance due to NICA by the client (and/or their responsible partiy(ies), in-full, at the time of service.**
9. Additional fees and charges may apply, with or without notice, for various requested and required reports, summaries, correspondence and/or communications payable in-full within five (5) days upon receipt.
10. All fees-for-services subject to change without notice, in NICA's sole discretion.
11. Progress notes are generally *limited* to the following information: name of client, their responsible party, others present, date of service, CPT and/or service code, charges, payments, balance due, diagnosis, predominant generic focus/foci of session, name of provider , provider's initials and date of service.
12. To protect confidentiality of records, clinical files shall be completely destroyed seven (7) years after termination of services and/or following age of majority without client/responsible party notification.

Make all checks payable (and please include your phone number) to:

Northern Illinois Counseling Associates, P.C. (or NICA)

14 Brink Street Crystal Lake, IL 60014

➔ ➔ ➔ **Print Full Legal Name of Client:** ____

➔ ➔ ➔ **Client (or their Responsible Party(ies) Signature(s):** ______________________ Date______________

➔ ➔ ➔ **Optional NICA Witness Signature**: ______________________________Date______________

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