Janice B. Footlik, MA, LCPC, NCC, CCCJS
INTAKE INFORMATION

PATIENT'S NAME----------
FIRST MIDDLE INITIAL LAST

PARENTS OF MINOR----------

ADDRESS----------CITY ---------- STATE ---------- ZIP---------

HOME PHONE--------- CELL---------- PATIENT'S BIRTHDAY ----------

INSURANCE INFORMATION

INSURED'S NAME AND ADDRESS----------
SS#---------- **INSURANCE COMPANY**----------
ADDRESS---------- **PHONE NUMBERR**----------
WORK NUMBER---------- **REFERRAL SOURCE** ----------

CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS: I/We consent that _----------may be treated as a client or clients by **JANICE B. FOOTLIK, MA, LCPC, NCC, CCCJS**

CONSENT FOR TREATMENT OF ADULTS: I/We consent to treatment provided by **JANICE B. Footlik, MA, LCPC,NCC, CCCJS.** _____

The purpose of this treatment is: ----------
This release allows Janice B. Footlik to consult with appropriate medical, school or other professionals as needed.

I/We understand that I/We may revoke this consent at any time but if I/We do so the person authorized to provide treatment cannot effectively do so.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal and written communications and clinical records are strictly confidential except for information you or other family members report about physical or sexual abuse. Illinois State Law obligates me to report this information to the Illinois Department of Children and Family Services. Only information required to process your claim will be shared with your insurance company. Information will be shared when you sign a release to have specific information shared. Information will be shared with appropriate authorities if you provide information indicating you are a danger to yourself or others. If an emergency arises for which the adult client or the guardian of a child feels immediate attention is necessary the adult client or guardian of a child understands they are to contact emergency services in their community immediately. **JANICE B. FOOTLIK** will

follow these emergency services with standard counseling and support to the client and the client's family.

Signature_____ Date_ _____
This consent is valid for one yearfrom the date of signature.

Financial/insurance issues: As a courtesy, we will bill your insurance company, HMO, or responsible party if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible the full fee is due until the deductible is satisfied. If your insurance company denies payment or does not cover counseling we request that you pay the balance due at that time. If your balance exceeds $400.00 you will need to pay for services when rendered. If the account is turned over to a collection agency the client will be held responsible for any collection fee charged to our office in order to collect the debt. We ask that the client authorize payment of medical benefits (sign a 1500 form) for insurance benefit payment directly to **Janice B. Footlik.** We sincerely appreciate your cooperation. If you have any questions about insurance, fees, balances or payments please feels free to ask. **Sliding scale is available. No patient is refused service for lack of ability to pay.**

Signature(s) ---------- Date----------

Signature(s) _____ Date_____