PAT BARDENETT, LCSW, CADC, RYT,CHT
151 North Michigan Avenue Suite # 911
Chicago, Illinois 60601
312-201-9002

# APPLICATION FOR SERVICES

Date_____

Name_____Date of Birth_____

Spouse_____Date of Birth_____

Address_____City_____Zip Code_____

Telephone(H)_____(W)_____(Cell)_____

Employer_____

Insurance Company_____Ins. ID_____

Group #_____Insured's Employer_____

## CONSENT AND AGREEMENT FOR MENTAL HEALTH SERVICES

Appointments: Each appointment, whether in the office or on the telephone, represents a specific amount of time reserved for you. If a problem arises and you are unable to keep this time, I require 24-hour notice of cancellation. You will be charged for late cancellations or failed appointments unless there is a clear emergency.

Insurance and Payments: All fees/copays are due at the time that services are rendered unless other specific arrangements have been made with the therapist. I will be happy to provide an extra copy of your statement for your insurance company so that you may be reimbursed.

Consent: I/We hereby consent to treatment at the office of Pat Bardenett for myself/ourselves. I/We understand that we may choose to terminate at any time and I/We understand that our communications are protected by relevant state and federal laws and by Pat Bardenett's firm committment to ethical standards.

Signature_____ Date

PAT BARDENETT, LCSW, CADC, RYT, CHT
151 North Michigan Avenue Suite # 911
Chicago, Illinois 60601
312-201-9002

# PRESENTING PROBLEMS

Name:

Date:

Please circle any of the following problems or issues that pertain to you.

Sleep Difficulty
Nightmares
Fatigue
Memory
Concentration
Productivity
Appetite, Eating
Impulsiveness
Fears
Confusion
Alcohol Use
Drug Use
Stress
Hopelessness
Bothersome Thoughts
Sadness
Loneliness
Isolation
Change
Friends
Relationships
Marriage
Parenting
Family
Menopause
Stomach Problems
Pain
Criticism
Dissatisfaction
Acceptance
Jealousy
Career Choices
Embarrassment
Pressure
Rejection
Recognition
Sexual Concerns
Headaches
Legal Issues
Grief/Loss
Nervousness
Shyness
Separation
Relaxation
Financial Issues
Occupation
Education
Temper
Children
Health
Bowel Trouble
Helplessness
Co-dependency
Worthlessness
Frustration
Anger
Resentment
Standard Problems

I may use or disclose information from your record if I believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. I may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

I may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, I may disclose information in response to a subpoena or other legal process, even if a court does not order this.

## Use or disclosure of your protected health information that I am allowed to make without your permission

There are certain situations where I am allowed to disclose information from your record without your permission. In these situations, I must use my professional judgment before disclosing information about you. Usually, I must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

I may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. I may disclose information from your record to a medical examiner or coroner. I may disclose information to funeral directors to allow then to carry out their duties upon your death. I may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation.

I may disclose information from your record as authorized by workers' compensation laws.

I may disclose information from your record to law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it. If a crime is committed on our premises or against our personnel, I may share information with law enforcement to apprehend the criminal. I also have the right to involve law enforcement when I believe an immediate danger may occur to someone.

If you tell me that you have committed a violent crime that caused serious physical harm to the victim, I may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, I may not disclose the information to law enforcement officials.

Under certain conditions, I may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

I may contact you to provide appointment reminders as a courtesy. However you are responsible for remembering your appointment.

I may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

# PAT BARDENETT, LCSW, CADC, CEAP

## NOTICE OF PRIVACY PRACTICES

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

This Notice is effective as of April 14, 2003.

I am required by law to maintain the privacy of protected health information and must inform you of my privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

I am required to abide by the terms of the Notice of Privacy Practices that is most current. I reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that I maintain. You may request a copy of the revises Notice ant any time.

I can answer your questions about my privacy practices and will ensure you that I am complying with applicable laws and regulations. I will also take your complaints and can give you information about how to file a complaint.

Contact Pat Bardenett, LCSW at 312-201-9002.

### Use and disclosure of your protected health information that I may make to carry out treatment, payment, and health care operations.

I may use information in your record to provide treatment to you. I may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if I want an opinion about your condition from a specialist, I may disclose information to the specialist to obtain consultation.

I may use or disclose information from your record to obtain payment for the services you receive. For example, I may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

I may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordination care with other providers.

## Your Rights

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. I do not have to agree to these restrictions.

You have a right to receive confidential communications from me. For example, if you want to receive bills and other information at an alternative address, please notify me.

You have a right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have a right to request an accounting of certain disclosures made by me.

Your have the right to complain to me about my privacy practices. You have the right to complain to the Secretary of the Department of Health and Human Services about my privacy practices. You will not face retaliation from me for making complaints.

Except as described in this Notice, I may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by me before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

## Use or disclosure of your protected health information that I am required to make without your permission

In certain circumstances I am required by law to make a disclosure of your health information. For example, state law requires me to report suspected child abuse or neglect. Also, I must disclose information to the Department of Health and Human Services, if requested, to prove that I am complying with regulations that safeguard your health information.

If you receive mental health care, including treatment for substance abuse, information related to that care might be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others. I am also required to report suspected abuse to an elderly person.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient_____

Given to patient on: _____ Version/Effectiveness Date: _____

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to Patient:_____

_____

Patient_____

Given to patient on: _____ Version/Effectiveness Date: _____

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to Patient:_____

_____

Patient_____

Given to patient on: _____ Version/Effectiveness Date: _____

_____ _____
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to Patient:_____