Please mail or fax to:
2130 Green Bay Rd, Evanston, IL 60201
Phone: 847-425-9708 Fax: 847-448-8337

Client Registration Packet- Child/Adolescent: Today's Date: ________________

Client Name ______________________Nickname______________ Date of Birth _____ /_____ /________

Gender ________________ Pronouns ____________________ Sexual orientation __________________
(examples: man, woman, nonbinary) (examples: she, they, he)

Address ___________________________________ City _______________ State ______ Zip ________

Home Phone (_____) ____________ Work Phone (_____) ____________ Cell Phone (_____) ______________

Can I leave a message? Home ☐ Y ☐ N Work ☐ Y ☐ N Cell ☐ Y ☐ N

Email __________________________________ Fax (_____) ____________

Parent / Guardianship Information

Legal Guardian ____ Relationship __________________

Address (if different) ____

Home Phone (_____) ____________Work Phone (_____) ____________Cell Phone (_____) _____________

Referral Information

Referred by ______________________________________ Referral Contact Phone (______) ______________

Referral E-mail ____ May ITA Contact the Referral? ☐ Y ☐ N

I, ________________________, grant my permission for ITA to contact my referral source, if possible, to acknowledge and thank them for the their referral. I understand I will not be identified in any way through this contact. ____________(initial here)

Billing Information

Billing Name ______________________________________ Relationship to Client ____________________

Address (if different than above)____

City ___________________ State _________ Zip ____________ Primary Phone (______) _______________

Payment Type: ☐ BCBSIL ☐ Other Insurance ☐ Self Pay ☐ Financial Aid

Insurance Information

Name of Policy Holder _____________________________Insurance Company ______________________

Policy Number ______________________________Group Number ____________________________________

Emergency Information

Contact Name ____

Relationship to Client _____________________________________ Primary Phone (______) ______________

Primary Care Physician _____________________________________ Phone (______) ______________

Psychiatrist/Therapist ______________________________________ Phone (______) ______________

Presenting Issue

Please describe the reasons the client is seeking services: ______________________________

____

____

____

____

Please check the symptoms the client has experienced recently:

Symptom	2 Weeks	6 Months	Symptom	2 Weeks	6 Months
Anxiety	☐	☐	Hypersomnia	☐	☐
Excessive Worry	☐	☐	Fatigue	☐	☐
Restlessness	☐	☐	Excessive Guilt	☐	☐
Concentration Issues	☐	☐	Worthlessness	☐	☐
Irritability	☐	☐	Suicidal Thoughts	☐	☐
Flashbacks	☐	☐	Homicidal Thoughts	☐	☐
Intrusive Thoughts	☐	☐	Distractibility	☐	☐
Nightmares	☐	☐	Impulsive Sexual Behaviors	☐	☐
Difficulty Falling Asleep	☐	☐	Truancy	☐	☐
Difficulty Staying Asleep	☐	☐	Stealing	☐	☐
Hypervigilance	☐	☐	Lying	☐	☐
Anger Outbursts	☐	☐	Mood Swings	☐	☐
Lack of Interest in Activities	☐	☐	Delusions	☐	☐
Social Isolation	☐	☐	Hallucinations	☐	☐
Detachment	☐	☐	Communication Problems	☐	☐
Heart Palpitations	☐	☐	Fine Motor Issues	☐	☐
Sweaty Palms	☐	☐	Gross Motor Issues	☐	☐
Difficulty Breathing	☐	☐	Sensory Processing Issues	☐	☐
Panic Attacks	☐	☐	Verbal Articulation Issues	☐	☐
Repetitive Behaviors	☐	☐	Behavioral Issues	☐	☐
Obsessive Thoughts	☐	☐	Defiance Issues	☐	☐
Depressed Mood	☐	☐	Academic Issues	☐	☐
Weight Loss	☐	☐	Emotional Dysregulation	☐	☐
Weight Gain	☐	☐	Other ______________________		
Insomnia	☐	☐			

Has the client received a diagnosis for these symptoms? ______________________________

______________________________ Date__________

Was an evaluation conducted? ☐ Y ☐ N

Location of evaluation ______________________________

Diagnosing Clinician ______________________________

Significant life changes in past 6 months: ☐Move ☐ Death among family/friends ☐ Birth in family
☐ Relationship change ☐School change ☐Job Change ☐ Other

Please describe significant life changes: ______________________________

____

Medical History

Please list any current medications: Prescribing Clinician ______________________

______________________ Dosage ____________ Date Prescribed ____________

______________________ Dosage ____________ Date Prescribed ____________

______________________ Dosage ____________ Date Prescribed ____________

______________________ Dosage ____________ Date Prescribed ____________

Please list any allergies: ______________________________

Please check any of the following that apply to the client's medical history.

☐ Asthma	☐ Genetic Disorder	☐ Immune Disorder	☐ Stroke
☐ Cancer	☐ Headaches	☐ Kidney Disease	☐ Tuberculosis
☐ Cystic Fibrosis	☐ Hearing Impairment	☐ Low Blood Pressure	☐ Thyroid Problems
☐ Cerebral Palsy	☐ Heart Condition	☐ Respiratory Issues	☐ Visual Impairment
☐ Diabetes	☐ Herpes	☐ Seizures	☐ Other ________
☐ Dizziness	☐ High Blood Pressure	☐ Shortness of Breath	
☐ Epilepsy	☐ High Cholesterol	☐ Stomach, Liver or Intestinal Problems	
☐ Fainting	☐ Hypoglycemia		

Please list any past hospitalizations, including reason, date, and hospital.

____

____

Has the client been psychiatrically hospitalized? ☐ Y ☐ N

______________________________Dates: ____________

______________________________Dates: ____________

Please list previous counseling, therapy, or psychiatric treatments.

Treatment Type	Dates of Treatment	Outcome
____________	____________	☐ Poor ☐ Fair ☐Good ☐ Excellent
____________	____________	☐ Poor ☐ Fair ☐Good ☐ Excellent
____________	____________	☐ Poor ☐ Fair ☐Good ☐ Excellent

Please describe any other significant surgeries, injuries, and illnesses.

____

____

Activities of Daily Living & Development History

Task	Unable	Total dependence	Mostly dependent	Requires assistance sometimes	Needs supervision	Uses devices	Independent
Bathing	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐
Mobility/transfer in bed	☐	☐	☐	☐	☐	☐	☐
Toilet Use	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐

Did the client have any issues with motor or speech development? ☐ Y ☐ N Please Describe: ____________________

____

____

When were these issues first identified? ____

Please list previous occupational, physical, speech, developmental, creative arts therapies or alternative therapies.

Treatment Type	Dates of Treatment	Outcome
____________________	____________________	☐ Poor ☐ Fair ☐Good ☐ Excellent
____________________	____________________	☐ Poor ☐ Fair ☐Good ☐ Excellent
____________________	____________________	☐ Poor ☐ Fair ☐Good ☐ Excellent

Education History

Current School: ______________________________ Grade: ____________________

At what age did the client start school? __________

Is the client in a mainstream classroom? ☐ Y ☐ N If not, what percentage is mainstreamed? ____________

Has the client skipped or retained grades? ☐ Y ☐ N Which? __________

How are the client's grades? ☐ Poor ☐ Below Average ☐ Average ☐ Above Average ☐ Excellent

Have there been identified academic or learning issues? ______________________________

____

Does the client use any special communication devices? ______________________________

What are the client's strengths and weaknesses? ____________________________________

____

____

Social History

Please describe how the client engages socially?

Parents

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other ___________________________

Family

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other ___________________________

Friends

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other ___________________________

Others

☐ Appropriate ☐ Confident ☐ Pleasant ☐ Loving ☐ Defiant ☐ Oppositional ☐ Passive ☐ Inattentive

☐ Avoidant ☐ Ambivalent ☐ Overly attached ☐ Reactive ☐ Manipulative ☐ Other ___________________________

Does the client participate in after school activities? ☐ Y ☐ N Which? ___________________________

____

What hobbies does the client enjoy? ____

____

Does the client have peers/friends? ☐ Y ☐ N Are they: ☐ Younger ☐ Older ☐ Same Age

Please describe the nature and frequency of the client's social interaction:

____

____

Has the client experienced bullying? ☐ Y ☐ N Did someone intervene? ☐ Y ☐ N

For Adolescents:

Is the client currently in a significant relationship? ☐ Y ☐ N If yes, with whom ___________________

Family Composition

Parent 1: ____

DOB ______/______/______ Deceased ☐ Y ☐ N

Gender: _________________ Pronouns: _____________

Marital Status ____________________________________

Education ____

Occupation _______________________________________

Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Religious Affiliation ______________________________

Relationship to the Client

☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Present during Client's childhood ☐ Y ☐ N

Military ☐ Y ☐ N Division _________________________

Deployed ☐ Y ☐ N Length __________________________

Criminal Record ☐ Y ☐ N Incarcerated ☐ Y ☐ N

Parent 2: ____

DOB ______/______/______ Deceased ☐ Y ☐ N

Gender: _________________ Pronouns: _____________

Marital Status ____________________________________

Education ____

Occupation _______________________________________

Health ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Religious Affiliation ______________________________

Relationship to the Client

☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Present during Client's Childhood ☐ Y ☐ N

Military ☐ Y ☐ N Division _________________________

Deployed ☐ Y ☐ N Length __________________________

Criminal Record ☐ Y ☐ N Incarcerated ☐ Y ☐ N

Siblings

1. ____________________________Age __________Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
2. ____________________________Age __________Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
3. ____________________________Age __________ Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
4. ____________________________Age __________Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive
5. ____________________________Age __________ Relationship? ☐ Healthy ☐ Loving ☐ Strained ☐ Abusive

Additional Family Information

Was the client adopted: ☐ Y ☐ N Age: __________ Type: ☐ Domestic ☐ International ☐ Kinship ☐ Foster

Has there been a divorce in the family? ☐ Y ☐ N Between who? ______________________________________

Is there a visitation schedule: ☐ Y ☐ N Describe ____

Custody Arrangement?: ____ Court Dictated ☐ Y ☐ N

Is the family currently involved in divorce or child custody court proceedings? ☐ Y ☐ N

Additional Parental Figures ____

Trauma History

Has the client witnessed or experienced a traumatic event? ☐ Y ☐ N

Please check the events that the client has experienced or witnessed.

☐ Natural Disaster	☐ Interpersonal control	☐ Assault/Robbery	☐ Other ______________
☐ Serious Illness/Injury	☐ Physical Abuse	☐ Prejudice/Racism	
☐ Major Accident	☐ Sexual Abuse	☐ War	
☐ Parental Neglect	☐ Sexual Assault	☐ Community Violence	

What age did the client experience or witness this event? ______________________________

Did the client receive therapy or counseling for this event? ☐ Y ☐ N Describe ______________________________

____

Substance Use History

Please mark the substances used by the client or close family members.

Substance	Frequency			Ages	Last Used	By Who?
☐ Alcohol	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Marijuana	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Cocaine	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Heroin	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Barbiturates	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Valium/Xanax	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ PCP	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ LSD/Mushrooms	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Inhalants	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Pain Medication	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Sleep Aid	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Stimulants	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Cigarettes	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Caffeine	☐ Daily	☐ Monthly	☐ Socially	________	________	______________
☐ Other ________	☐ Daily	☐ Monthly	☐ Socially	________	________	______________

Has the client or parent been disciplined at work, school or by the court for substance use? ☐ Y ☐ N

Has the client or parent participated in a substance abuse program? ☐ Y ☐ N Dates ______________________

Has the client or parent participated in a 12-step substance abuse program ? ☐ Y ☐ N Frequency ____________

Relevant Cultural and Personal Information

Race/Ethnicity: ☐ White ☐ African American or Black ☐ Latinx ☐ Asian ☐ Middle Eastern/North African ☐ Pacific Islander ☐ American Indian/Native American ☐ Bicultural/Biracial

Does the client identify with a cultural, national, racial, religious, spiritual or social group? ☐ Y ☐N

Please describe their affiliation: ____

____

Is there anything you would like us to know about the client's cultural identification? ______________________

____

Does the client have any special needs or accommodations?

☐ Non-verbal or Adaptive Communication ☐ Limited motor function

☐ Use walker/wheelchair/cane ☐ Other ______________________

(which? ______________)

Goals of Therapy

Type of therapy preference: ☐ Individual ☐ Family ☐ Behavioral ☐ Group ☐ Neurological ☐ Assessment

Past experiences with the creative arts (art, music, drama, dance, other)? ________________

____

Please indicate the goals you have for the client's treatment at this time?

- ☐ Symptom Reduction
- ☐ Increased Coping Skills
- ☐ Increased Self Care
- ☐ Improved Social skills
- ☐ Improved Communication skills
- ☐ Improved Social Relationships
- ☐ Improved Romantic Relationships
- ☐ Improved Family Relationships
- ☐ Increased Physical Skills
- ☐ Increased Cognitive Skills
- ☐ Sensory Integration/Processing
- ☐ Processing Traumatic Events
- ☐ Decreased Substance Use/Triggers
- ☐ Increased Creative and Artistic Expression
- ☐ Increased Personal Insight
- ☐ Improved Quality of Life
- ☐ Complete Court Ordered Treatment

Please list any additional goals ____

____

____

____

If available, we would appreciate access to copies of psychological evaluations, IEPs, school evaluations, hospital or therapy discharge plans or any other professional reports. We will be happy to make photocopies for you.

Form Completed by ________________________________(Print Name)

Client Signature (over age 12)______________________Date__________

Parent/Guardian Signature ______________________Date__________

Relationship to Client______________________________

Mental Status Exam – Completed by Intake Clinician

Attitude

☐ Cooperative ☐ Uncooperative ☐ Cautious ☐ Passive ☐ Dramatic
☐ Manipulative ☐ Angry ☐ Domineering ☐ Evasive ☐ Overly Compliant

Appearance	Age	Grooming	Orientation
☐ Well Nourished	☐ Appears Stated	☐ Neat	☐ Person
☐ Malnourished	☐ Appears Younger	☐ Unkempt	☐ Place
☐ Overweight	☐ Appears Older	☐ Bizarre	☐ Time
☐ Emaciated			

Behavior

☐ Relaxed ☐ Restless ☐ Agitated ☐ Unusual Gait
☐ Tremors ☐ Tics ☐ Slumping ☐ Rigid

Memory

☐ Intact ☐ Impaired Remote Memory ☐Impaired Recent Memory ☐ Impaired Immediate Recall

Mood/Affect

☐ Normal ☐ Labile ☐ Elated ☐ Sad ☐ Depressed
☐ Restricted ☐ Inappropriate ☐ Suspicious ☐ Laughing ☐ Frightened
☐ Flat ☐ Frustrated ☐ Anxious ☐ Fearful ☐ Anger

Speech

☐ Unremarkable ☐ Excessive ☐ Slow ☐ Incoherent
☐ Loud ☐ Soft ☐ Stammering

Insight

☐ Good ☐ Fair ☐ No Insight ☐ Denial

Thought Process

☐ No Abnormalities ☐ Word Salad ☐ Circumstantiality ☐ Perseveration
☐ Tangentiality ☐ Echolalia ☐ Difficulty Concentrating ☐ Incoherent
☐ Flight of Ideas ☐ Loose Associations ☐ Neologism

Ideation

☐ Suicidal ☐ Thoughts ☐ Plan ☐ Intent ☐ Past Description: ______________________

☐ Homicidal ☐ Thoughts ☐ Plan ☐ Intent ☐Past Description: ______________________

☐ Self Harm ☐ Thoughts ☐ Plan ☐ Intent ☐ Past Description: ______________________

Hallucination/Delusions

☐ None ☐ Visual ☐ Olfactory ☐ Persecution ☐ Somatic
☐ Auditory ☐ Tactile ☐ Influence ☐ Grandeur ☐ Reference

Judgment

☐ Intact ☐ Impaired

____

Intake Clinician's Signature Date

institute for therapy through the arts

Welcome to the Institute for Therapy through the Arts

Thank you for selecting Institute for Therapy through the Arts (ITA) to address your needs. Our well-trained professional staff takes pride in providing quality care in a compassionate atmosphere. Contained in this document is important information regarding our services, our policies, and your healthcare rights. Please read carefully and let us know if you have any questions or concerns. When you have completed reviewing this form please sign and initial the last two pages. This document serves as an agreement between ITA and our clients.

Informed Consent for Mental Health/Creative Arts Therapy Services

About the creative arts therapies, psychotherapy, treatment plans and treatment outcomes:
By signing this form, you acknowledge that you have received, have read (or have had read to you), and understand the attached "Expectation of Client Responsibility" form and/or other information about the services that you are considering. You have had all your questions answered fully. You do hereby seek and consent to take part in the creative arts therapy rendered by your assigned therapist. You understand that developing a treatment plan with this professional and regularly reviewing your work toward meeting the treatment goals are in your best interest. You agree to play an active role in this process. You understand that no promises have been made to you as to the results of these services or of any procedures provided by this practice.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who engage in the process and actively participate. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience or how quickly progress can be made.

Training
ITA is not only a clinical practice, but we are also proud to be a training institute for many students pursuing degrees in the fields of music therapy, art therapy, drama therapy and dance/movement therapy. As part of their training, these students participate in clinical sessions in several ways, 1) Observing therapists in session, 2) Co-facilitating therapy sessions for clients alongside a therapist, 3) Leading therapy sessions while a therapist supervises, 4) Leading therapy sessions independently. The amount of leadership an intern takes in a therapy session is determined by the supervising therapist and the level of education and training of that intern. ITA is dedicated to providing professional and quality services to our clients. While we are committed to training our interns, our clients' needs are our first priority. Interns will only lead sessions once they have demonstrated proficient clinical skills. Interns leading independent sessions using insurance will be billed under the license of their supervisor as instructed by the insurance provider agreement by Blue Cross Blue Shield.

ITA also hosts administrative interns and volunteers. These individuals are not enrolled in a training program to become a creative arts therapist but are interested in supporting the work of our staff. Administrative interns and volunteers will observe and assist in therapy sessions as directed by ITA therapists. They will not engage in leading sessions.

If an intern will be observing a session, you will be asked to consent to this observation. You have the right to deny observation or revoke consent to an intern or volunteer being a part of your therapy at any time. If you have any questions about this training program or the interns, please contact Amanda Ziemba, Program Manager and Training Coordinator, at 847-448-8332 or aziemba@itachicago.org.

Safety
ITA therapists are committed to providing a safe and comfortable environment for our clients. In commencing services at the Institute for Therapy through the Arts, you acknowledge you will be waiving and releasing all claims for injuries you might sustain arising out of these services. If there are activities in which you are engaging in during therapy that physical or emotionally feel uncomfortable, please indicate this discomfort to your therapist. Do not exceed your physical limitations, and know you have the right to refuse to participate in any practice.

Sessions
ITA's services begin with an intake appointment designed for the client to experience all four creative arts therapy disciplines in order to

ascertain the best treatment modality for you. This process occurs during a 50-minute session. A therapy modality is ascertained in collaboration with the ITA therapist and client after a discussion of how each type of therapy can address the presenting issues. Once this determination is made, the ITA Intake Coordinator will recommend a creative arts therapist to work with you and will schedule your first appointment within a week or two of your intake. The first three appointments with this provider will serve as an opportunity to gather assessment data which will inform therapeutic goals, a treatment plan, and when appropriate, a clinical diagnosis. Following these sessions, the creative arts therapy process begins, and progress is noted towards the goals agreed upon by the therapist and yourself. Sessions are scheduled weekly and have a duration of 50 minutes (1 clinical hour), although in some cases the sessions may be more frequent.

Cancellation Policy and Late Fee Policy

Once a session is scheduled, you are obligated in payment unless you provide 24 hours' notice of cancelation. Clients will not be billed for sessions missed because of the therapist's absence, and therapists will make every effort to reschedule these appointments. Clients who cancel an appointment without 24-hour notice will be charged for the full amount of the session. Insurance companies and managed care companies do not reimburse for missed appointments; therefore, you will be responsible for the full fee under these circumstances.

Similarly, if you arrive more than 10 minutes late for your appointment, a late fee of $30 may be applied to your account. If you arrive more than 20 minutes late to your appointment, you are not guaranteed services for that day due to tardiness. Your session will be considered a "no show" appointment and you will be billed for the entire clinical hour session (50 minutes). As with missed sessions with less than 24 hours' notice, insurance companies and managed care companies do not reimburse for "no show" sessions, and you will be responsible for full fee of service.

We understand that unforeseeable events occur, and exceptions can be made in these cases. Your therapist will attempt to reschedule you, if possible, to avoid these charges.

Professional Fees and Payment

Our fees are determined by the therapist who is providing therapy. Some of our practitioners possess additional degrees and licensure which may offer additional benefits to you.

Fees:

Intake (1st session)	$100
Initial Assessment (2nd session)	$100-$178
Individual Therapy (art, music, dance, drama) (50 minutes)	$100-$154
Individual Therapy - Intern Rate	$100
Family Therapy	$100-154
Group Therapy	$36-$79
Parent Consultation for Group (1 time per month)	$100-154
Court/Legal Participation	$250/per hour

If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party, this includes but is not limited to depositions, awaiting testimony, or expert witness testimony. There is a fee for providing records. Pricing information is available from the Office Manager, Julie Mynatt, jmynatt@itachicago.org or 847-425-9708 x 172.

Payments are due at the time of service. Therapists will not schedule future appointments until the previous sessions are paid in full. Payment may be made by cash, check, or VISA/Mastercard/Discover/Amex. Checks are to be made payable to the Institute for Therapy through the Arts and not to your individual therapist. A $25 fee will be imposed for any returned checks. Financial aid is available to those who qualify; please request an application from your therapist or the front desk receptionist. Accounts with a positive balance of less than $30 will not be issued reimbursement. The balance will be applied to the upcoming session. If an account has a balance ongoing for 1 year, the account will be closed.

Insurance Reimbursement

It is your responsibility to file claims with your insurance company for any and all services that you receive from ITA unless we are a contracted provider with your insurance company. Institute for Therapy through the Arts is obligated to bill your insurance company *only* if it is a contracted provider. If this is unclear to you, please discuss this with the Practice Director: Marni Rosen, Psy.D, ATR-BC. She can be reached at 847-448-8336 or via email at mrosen@itachicago.org.

If you have an insurance policy with Blue Cross Blue Shield (PPO) or Blue Choice (PPO), ITA will offer to file your reimbursement on your behalf. Some, but not all, of our therapists are on the BCBSIL panel. If you would like to use your insurance, please inform us at the start

of treatment. It is very important that you are aware of what your insurance company will reimburse for services and the amount that you must meet for your deductible. It is your responsibility to contact your insurance company prior to your first appointment to request authorization for services, if authorization is necessary. Please inform our office staff of your authorized sessions and billing information. Failure to comply with this may result in loss of benefits and you being held responsible for 100% of the fee assessed. For certain clinicians, insurance will be billed under the license and name of the supervising clinician. In these instances, the client will be informed of this billing procedure.

If you have an alternative health insurance carrier, please inform your therapist or the receptionist so that a bill can be prepared for you that you can submit to your insurance company. ITA does not guarantee reimbursement for any insurance plan and you as the client are responsible for full payment of fees.

You should also be aware that in order to submit claims to the insurance company, a diagnosis is required for treatment. At times they may also require a treatment plan, summaries, or a case review. This information will be held on file by the insurance company and while insurance companies must adhere to privacy laws, ITA does not have control over the confidentiality of these files. If a report is given to the insurance company, you may request a copy of the sent report.

Contacting Your Therapist

You may not always be able to reach your therapist by phone as therapist schedules vary in terms of their availability and their presence on site. When we are unavailable, the phone is answered by a voicemail or by the office staff. We will make every effort to return your call within 24 hours with the exception of weekends and holidays. If you are difficult to reach, please leave the best times to reach you on the voicemail, so that we can attempt to accommodate your needs. If you are attempting to reach us and you feel that you cannot wait, please contact your family physician or the emergency room and ask for the psychologist or psychiatrist on call. We do not provide 24-hour crisis intervention. In the case of an emergency, please head to the nearest emergency room or dial 911. Below are a few available resources for you that may be able to provide crisis intervention.

Phone Hotlines

- Depression Hotline
  (630) 482-9393
- National Hopeline Network
  1-800-784-2433
- National Suicide Prevention Lifeline
  1-800-273-8255
- SASS CARES Line (Children and Adolescents)
  1-800-345-9049

Local Emergency in Evanston

- Saint Francis Hospital
  (847) 316-4000
  (847) 316-6262
- Evanston Hospital
  (847) 570-2000
  (847) 570-5020

Physical Accessibility of Caregiver

If a client has physical, behavioral, medical or toileting needs that are significant and require physical intervention such as physical transfer from a wheel chair, medical attention, physical restraint or any toileting assistance, you or your care provider MUST be present in the treatment facility for the duration of the appointment.

Wellness and Self Care

In the case of illness**,** a client or caregiver should call to cancel an appointment if the client is or has experienced the following communicable illnesses or symptoms within the 24 hours prior to the scheduled session. Please refer to the instructions beside each to determine when you should return.

- Fever of 100 degrees: Please cancel your session and wait to reschedule until you, or your child, have had a complete 24 hours fever free without using fever reducing medication.
- Severe cold: Please use your discretion. It may be best to cancel your session and reschedule when you, or your child, are well enough to fully participate and benefit from your session.
- Diarrhea/Vomiting/Flu: Please use your discretion. If the cause of the illness appears to be viral, it may be best to cancel your session and reschedule when you, or your child, have had a day or two without symptoms or are otherwise well enough to fully participate and benefit from your session.
- Strep Infection: Please cancel your session and reschedule when you, or your child, have been on an antibiotic, as directed by your doctor, for a minimum of 24 hours.
- Rash/Lesions: These include impetigo, ringworm, yeast infection, or other undiagnosed rash or skin lesion. If the rash is contagious we ask that you, or your child, stay home until it is resolved or no longer in an active, contagious state. If your doctor indicates in writing that the rash or lesion is not contagious and you, or your child, are otherwise well enough to

participate, please speak to your therapist.
- Conjunctivitis “pink -eye”: Please cancel your session and reschedule when you, or your child, have been on medication, as directed by your doctor, for a minimum of 24 hours.

Therapists will help with rescheduling at a time when you, or your child, is well and able to participate in the session.

Please remember to use facial tissues to blow/wipe your nose and wash your hands afterward. If you sneeze or cough please remember to cover your mouth with your elbow. These practices can reduce the spread of illness and promote health.

Cuts or Sores
All clients, caregivers and staff are expected to cover cuts or sores with appropriate bandages (including Band-Aids, wraps, plasters, dressings, etc.).

Hand Washing
We ask that clients practice hand washing regularly as part of our effort to promote self-care and to reduce the spread of illness to therapists, staff, interns, volunteers, and other clients.

Food
All food packaging must be placed into the trash can with a lid in order to maintain safety for those with allergies and to maintain a clean environment for business to be conducted.

General Safety
All equipment and furniture will be checked and cleaned by therapists and staff to ensure a safe environment in which therapy sessions can take place.
No smoking is allowed in any area of the ITA facility.

About Record Retention:
ITA retains both secured digital records and paper file records for at least seven years following the termination of treatment. You are entitled to a copy of your records unless your therapist feels that seeing the record would be emotionally damaging. If that were to occur, we would be happy to send your records to your next treatment provider. Since these records can be upsetting or confusing, we recommend that your records are reviewed with your therapist and the content discussed prior to the release of information.

About limits to confidentiality:
Your therapist needs to know a lot about you in order to effectively assist you in attempting to resolve the issue(s) that brought you to ITA. Your therapist will keep all information about you confidential. No information about you or your case will be released and/or disclosed without your written authorization and consent, except as defined below:

- If your therapist believes you are a danger to yourself or others or are in imminent danger yourself, they have an ethical responsibility to reduce and/or eliminate the danger and may have to take an action toward that end. This may include contacting the police, emergency personnel, and Illinois Department of Human Services (DHS).
- If the report has been made to the Illinois Department of Human Services (DHS), it is possible that a you or your family may be required to return your Firearm Owner Identification Card (FOID card) to the state of Illinois.
- If you and your family are involved with the Department of Child and Family Services of Illinois (DCFS), ITA is required to share information with DCFS and/or juvenile court
- Other exceptions to confidentiality as the Health Insurance Portability and Accountability Act (HIPAA) allows, see Privacy Notices Form
- Please note that email correspondence can be accessed by others across the internet, despite every effort to protect electronic communication, and therefore may not be confidential. In order to be contacted by email a waiver must be signed and kept in your medical file.

The staff of ITA abides by the stipulations regarding confidentiality as contained in the Confidentiality Act and the Mental Health Code[i], as well as the ethical codes of conduct and rules governing the credentialing of mental health professionals[1] as set forth by such professional organizations as the American Music Therapy Association[ii], the National Association for Drama Therapy[iii], the Art Therapy Credentials Board[iv], the American Dance Therapy Association[v], the American Counseling Association[vi] and the American Psychological Association[vii]. Our practice is also compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Minors

If you are an adolescent between the ages of 12 and 18, the same general rules apply as those with adults. Disclosure of information about you to your school or other professionals will generally be done only with your written consent as well as that of your parent(s). However, information may be disclosed about you to your parents without your consent, if, in the opinion of your mental health professional, the disclosure is deemed to be in your best interest.

Notice of Privacy Practices:
I hereby acknowledge that I have received and have been given the opportunity to read a copy of the Notice of Privacy Practices of the Institute for Therapy through the Arts. I understand that if I have any questions regarding the notice or my privacy rights, I can contact ITA's privacy officer, Marni Rosen, at 847-448-8336

Email Confidentiality
Electronic communications are not guaranteed to be confidential. Aside from our newsletter, ITA can only use email to communicate with you at your request. Although ITA takes precautions to keep your emails to us confidential, we cannot control what happens to the emails we send to you.

◯ I understand the risk and I would like to correspond with ITA by email.

◯ I would NOT like to correspond with ITA by email.

Please understand that we cannot send you emails, not even replies, unless you check the top box above.

By initialing by each policy and signing the form below, I indicate that:

_______I understand that ITA will release limited information to a collection agency should it become necessary if my account becomes delinquent; and

_______I consent to the evaluation/treatment process with ITA; I understand that the process may include myself and/or other family members. The procedures, requirements and rules have been explained to me and I agree to the terms therein; and

_______ I am aware that I may terminate the services being provided by my mental health professional at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may not be able to resume services or will have to take responsibility for my decision if I stop treatment (For example, if my treatment has been court-ordered, I will have to answer to the court); and

_______ I recognize and acknowledge that there are certain risks of physical injury when participating in sessions at the Institute for Therapy through the Arts, and I agree to assume the full risk of any such injuries, damages, or loss regardless of severity which I may sustain as a result of participating in any activities connected or associated with any such services. I waive and fully release all claims I may have against the Institute for Therapy through the Arts, and its officers, agents, servants, and employees as a result of participating in any of these services. I hereby fully release and discharge the Institute for Therapy through the Arts and its officers, agents, servants, and employees from any and all claims from injuries, damage or loss which I may have or which may accrue to me on account of my participation in any of these services. I further agree to indemnify and hold harmless and defend the Institute for Therapy through the Arts, and its officers, agents, servants, and employees from any and all claims from injuries, damages and losses sustained by me, and arising out of, connected with, or in any way associated with the services rendered in any session.

_______ I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel with sufficient notice or do not show up for the appointment, I may be charged for that appointment. Missed appointments cannot be charged to my insurance company.

_______ I understand that if I am 10 minutes late that I am subject to a $30 late fee and if I am 20 minutes late to my appointment that my session will be considered a "no show" and I will be billed for entire length of the session. I understand that late appointments and "no show" appointments cannot be billed to my insurance company and I am responsible for the full fee of service.

_______ I understand the wellness and self-care policy set forth in this document and I am aware that I must adhere to the policy set forth in this document in order to receive services the day of my scheduled appointment. I understand that if I, or the client in my care, become ill, I will contact my therapist within 24 hours to cancel my session.

_______ I understand that fees for individual therapy and group therapy sessions are payable in full and at the time of service. If I intend to have a third-party reimbursement entity such as insurance, trust agreements, custody settlements, or other family member make

payments for fees incurred, I understand that the fees incurred and all co-pays remain my responsibility until paid in full. If a third party does not or refuses to make payments, I am ultimately responsible for payment in full. I also understand that I may apply for financial aid but that it may not be awarded to me. I also understand that I may be charged a finance fee for seriously overdue charges.

_______I understand that I am ultimately responsible for payment of the fees for all services rendered. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment and refer me to another agency.

I understand and agree with all of these statements.

Signature of client (or person acting for client) ______________ Date ______________

Printed name ______________ Relationship to Client (if necessary) ______________

I, the Intake Coordinator or ITA professional, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature and Credentials ______________ Date ______________

☐ Copy accepted by client ☐ Copy kept by therapist

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

[i] copies of both of these documents can be obtained by contacting the Illinois Department of Mental Health at 217. 782-3591

[ii] Copies of the AMTA code of ethics can be obtained on their website at www.musictherapy.org/about/ethics/

[iii] Copies of the NADT code of ethics can be obtained on their website at www.nadt.org/about-nadt/code-of-ethics.html

[iv] Copies of the ATCB code of professional practice can be obtained on their website at www.atcb.org/code_of_professional_practice/

[v] Copies of the ADTA code of ethics can be obtained on their website at www.adta.org/Resources/Documents/ADTA%20Code%20of%20Ethics%202010.pdf

[vi] Copies of the ACA code of ethics can be obtained on the ACA website at www.counseling.org/ethics/feedback/aca2005code.pdf

[vii] Copies of the APA code of ethics can be obtained on their website at www.apa.org/ethics/code/index.aspx.

ita
institute for therapy through the arts

HIPAA Notice of Client Privacy Policy

Effective Date: 09/01/2015

This Notice describes how information about you may be used and disclosed and how you can access this information. Please review it carefully. If you have any questions about this Notice, please contact our Practice Director, Marni Rosen, at 847-448-8336.

The Institute for Therapy through the Arts (ITA) is required by law to maintain the privacy of the Protected Health Information (PHI) of our clients and to abide by the terms of this Notice. We make every effort to maintain the confidentiality of our clients. We reserve the right to change the terms of this policy at any time. We will notify you in the event of any changes to this policy and will provide you with a revised copy of the Notice of Privacy Policy either via mail or in person at your request. This Notice of Privacy Policy describes how our practice and our health care professionals, employees, volunteers, trainees and staff may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are described in this notice. This notice applies to all records of your care generated by this practice. This notice also describes your rights to access and control your PHI. Information about you, which can be shared, may include demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Your PHI may include, among other things, symptoms, assessment and examination results, diagnoses, current treatment notes and a plan for future care or treatment.

Uses and Disclosures of Protected Health Information:

ITA may use and disclose your PHI without your authorization for purposes of payment, health care operations and treatment. Your PHI may be used and disclosed by our practice and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of our practice. However, we have secure policies in place regarding the release of your PHI. Therefore, we will ask you to sign our Authorization to Release PHI form in order to disclose your PHI to any entity. Once you have signed the Authorization to Release PHI, we will use or disclose your PHI as defined by this notice and/or according to the signed Authorization to Release PHI form.

The following are examples of different ways ITA may use and disclose PHI. These are examples and this list is not exhaustive.

To Coordinate Treatment:

- appointment reminder calls to a patient’s home or work
- contacting a patient’s primary care doctor or specialists regarding a patient’s clinical care
- assisting a patient’s specialist with their treatment, payment or healthcare operations
- notifying patients of new advances or alternatives in treatment procedures that may be of benefit
- discussing a patient’s condition with other Institute for Therapy through the Arts providers in effort to coordinate treatment plans

To Coordinate Payment:

- contacting insurance companies regarding payment for services
- account statements to a patient’s home or calling about past due balances
- engaging a collection agency in the event of significantly past due balances with no attempt to make payment

For Healthcare Operations:

- Treatment review

- Employee performance review
- Student training
- Conducting or arranging other business practices (i.e. registration sign-in upon entry to the office, you may be called by name in the waiting room when your therapist is ready to see you)

Other Disclosures That May Be Made With Your Consent:

- To others involved in your healthcare decision making (i.e. parents, guardians, care givers)
- In the case of a physical or mental health emergency
- In the case of a communication barrier

Other Disclosures That May Be Made Without Your Consent:

- Where required by law when applicable legal requirements have been met
- To avert a serious threat to public health or safety
- In the case of abuse or neglect
- In the case of a court order or subpoena during legal proceedings
- To a coroner or medical examiner for identification
- In the case of a workers compensation claim
- If you are an inmate or on probation, to the correctional institution or law enforcement official
- In the case of suspected or threatened criminal activity to protect or lessen an imminent threat

In every circumstance, except where treatment is involved, our staff will only share the minimum information necessary to perform the required task. We will notify you of releases of PHI, when appropriate, and keep a record of these releases. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Your Rights with Respect to Your PHI:

Right to Inspect and Copy: You have the right to inspect and/or copy your medical records. This includes medical and billing records but, under federal law, does not include psychotherapy notes. We reserve the right to charge you a reasonable fee for copying and mailing records. After you have made a written request to our privacy officer, we will have 30-60 days to complete your request. Older records may be kept off site and may take up to 60 days to retrieve. If your treatment ended more than 7 years before your request, your records may have been destroyed. If we deny your request to inspect or copy your PHI, we will provide you with a written explanation of the denial. In some instances, you may have a right to have the decision to deny you access reviewed. In this case, another health care professional, chosen by ITA, will review the request and the denial. We will comply with the outcome of this review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. The request to amend must be made in writing and submitted to our Privacy Officer. In addition, a reason that supports the request to amend must be provided. We may deny the request if it is not in writing or does not include a reason to support the request. In addition, we may deny the request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which would be permitted to be inspected by you, or if we deem the amendment to be inaccurate or incomplete. If we deny the request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to the statement and will provide you with a copy of any such rebuttal. These statements will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of the patient's record.

Right to an Accounting: You have the right to request a list of nonstandard disclosures of PHI that were not authorized by you. A request for this list must be submitted in writing to our Practice Manager. The request must state the time period for which the disclosures should be accounted. This time period can be no longer than six years, and may not include dates

before April 13, 2003. The first list requested within a 12-month period will be free. For additional lists, we reserve the right to charge a reasonable fee for the cost of providing the list. Requests will be completed within 30 days.

Though allowed by law under certain circumstances, ITA does not participate in any marketing ventures that involve selling client information to any third parties.

Right to Revoke: If you grant us authorization to use or disclose medical information, you may revoke that authorization in writing at any time. If you revoke authorization, we will thereafter no longer use or disclose that medical information for the purposes covered by that written authorization. It must be understood that we are unable to take back any disclosures we have already made with that authorization, and that we are required to retain our records of the care we have provided to our patients.

For clients receiving mental health treatment, we are required to obtain a written authorization for every release of psychotherapy notes, except for use in our legal defense, or as required by law.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose for treatment, payment or health care operations, or to someone who is involved in your care or the payment for that care. Due to certain required payment and treatment operations, as well as legally required releases (e.g. subpoenas) not all requests can be fulfilled. If we do agree, we will comply with the request unless the information is needed to provide emergency treatment. To request restrictions, the request must be submitted in writing to our Practice Manager. The request must list what PHI to limit and to whom. ITA is required to inform you of the consequences whenever you refuse to release PHI.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. The request must be submitted in writing to our Practice Manager. We will not ask the reason for the request. We will accommodate all reasonable requests. The request must specify how or where you should be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to a Paper Copy: Even if you received this Notice electronically, you are still entitled to a paper copy of the current Notice. Copies are available at the front desk, or by writing to the Practice Manager.

Uses and Disclosures of PHI Based upon Your Written Authorization

Other uses and disclosures of your PHI not covered by this notice or required by law will be made only with your written authorization. You may revoke this authorization, in writing, at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

Complaints: If you believe that your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint. You may contact our Practice Director, Marni Rosen, at 847-448-8336 for more information about the complaint process.

All written requests regarding the above privacy information can be made to:
ITA, Attn: Marni Rosen
2130 Green Bay Rd., Evanston, IL 60201

institute for therapy through the arts

HIPAA Notice of Client Privacy Policy

I hereby acknowledge I have received and reviewed this Notice:

Client Signature ______________________ Date ______________

Client Printed Name ______________________