CENTER FOR PERSONAL DEVELOPMENT

Welcome to the Center for Personal Development

We are a group of dedicated professionals committed to providing quality emotional and psychological support to individuals, couples and families. It is our overall goal to help you develop a strong sense of inner personal power that comes from removing the emotional blocks and barriers that often get in the way of our life experience. We devote ourselves to serving the best interest of each client, and we will work together to co-create a more productive and fulfilling life without these barriers.

Taking the first step is often the most difficult and anxiety producing in the growth process. Congratulations on taking that step. We look forward to working with you.

Sincerely,

Dr. Steven Nakisher
Founder /Executive Director

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405 N. Wabash Ave. Suite 208, Suite 1114, Suite 4009
Chicago, Illinois 60611
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NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

This notice describes how treatment information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Right to Privacy

Health care providers are required by federal and state law to maintain the privacy of your treatment information. We are also required to give you notice about our privacy practices, our legal duties and your rights concerning your treatment information.

The Center for Personal Development (CPD) must follow the privacy practices that are described while it is in effect. CPD reserves the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. You may request a copy of the notice at any time from us.

Uses and Disclosures of Treatment Information

CPD will use information about your health care to provide you with treatment, to arrange payment for services and in conjunction with other health care providers, organizations, and other professionals. The information privacy practices in this notice will be followed by: any associate involved in your care and any business associate with whom CPD shares health information.

The following categories describes examples of the way CPD uses and discloses treatment information:

For Treatment: CPD may use and disclose your treatment information with another mental health professional. For example, CPD may provide information to your health plan or other providers to arrange for a referral or consultation.

For Payment: CPD may use and disclose your treatment information to obtain payment for services provided, including but not limited to businesses in connection with billing and collection activities. For example, CPD may contact your insurer to verify benefits and obtain prior authorization to make sure they will pay for your care.

Legal Proceedings: CPD may disclose information in response to a court or administrative order, subpoena, discovery request or other lawful process under certain circumstances.

CPD may disclose information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. CPD may disclose information to the extent necessary to protect your health and safety or the health and safety of others.

CPD will not disclose your treatment information if that disclosure is prohibited or significantly limited by other applicable law.

Your Health Information Rights

You have the right to inspect or copy treatment information that may be used to make decisions about your care with limited exceptions. You must submit a written request to CPD at the address listed below.

You have the right to request restrictions on uses and disclosures of your treatment information for the purposed of treatment, payment or healthcare operations. CPD is not required to allow your request. If we do agree with the request, CPD will comply with your request except to the extent that disclosure has already occurred or if you are in the need of emergency treatment and the information is needed to provide the emergency treatment.

You have the right to request that CPD amend or make changes to your treatment record. Your request must be in writing and it must explain why the information should be changed.

You have the right to receive a list of instances in which we disclosed information for purposes other than treatment, payment, or those disclosures you have authorized in writing.

You have the right to request that CPD contact you by alternative means or at alternative locations. For instance, you may ask that CPD contact you at work. You must inform CPD in writing that alternative means are required and provide an explanation of how payments will be handled under the alternative means.

Questions and Complaints

If you would like to request information or file a complaint, please send it to: The Center for Personal Development, 405 N. Wabash Ave., Suite 208, Chicago, IL 60611

You also have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

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CLIENT INFORMATION

Today's Date:				
DEMOGRAPHIC INFORMATION				
First Name: **Preferred Name:**	**Last Name:**		**Date of Birth:**	
Legal Gender ☐ **M** ☐ **F** **Affirming Gender** ☐ **M** ☐ **F** ☐ **Trans M-F** ☐ **Trans F-M** ☐ **Other** _____	**Address:**			
Primary Phone #: ☐ **Mobile** _____ ☐ **Landline** _____	**Apt#:**	**City:**	**State:**	**Zip Code:**
Email Address:				
Were you referred to CPD? ☐ **Yes** ☐ **No**	**If yes, by whom:**			

IN CASE OF EMERGENCY		
Name:	**Relationship to Client:**	**Phone #:**

INSURANCE INFORMATION			
Insurance Company:	**Member/Policy Number:**	**Group Number:**	**Client's relationship to subscriber:**
Subscriber's Name:	**Subscriber's Address:**	**Subscriber's Gender:**	**Subscriber's Date of Birth:**

I hereby assign, transfer, and set over to the Center for Personal Development all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and I understand that all bills are to be paid in full within 60 days of submission to my insurance company. If bills are not paid in full after 60 days, I authorize the Center for Personal Development to charge my balance to the credit card provided as part of my client agreement. I understand that I am responsible for all costs and fees from the date of my initial consultation with any therapist at the Center for Personal Development.

Client / Legal Client Representative Signature	**Date**

FOR OFFICE USE ONLY:

Date of First Visit	**Assigned Therapist**	**ICD-10 Code**

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Consent to Treatment and Notice of Privacy Practices

Client Name:_____

Legal Guardian Name:_____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Center for Personal Development, hereby referred to as the Center.

Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Center encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Notice of Privacy Practices: I certify that I have received the Notice of Privacy Practices pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from my assigned therapist and/or the Clinical Director.

Nonvoluntarily Discharge from Treatment: A client may be terminated from the Center nonvoluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Center, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge by letter. The client may appeal this decision with the Center Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of client records maintained by the Center is protected by federal and/or state law and regulations. Generally, the Center may not say to a person outside the Center that a client attends the program or disclose any information identifying a client as an alcohol or drug abuser unless: (1) the client consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a client either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their spouse's or child's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality.

I consent to treatment and agree to abide by the above-stated policies and agreements with Center for Personal Development. My signature also indicates I have received the Center's Notice of Privacy Practices and HIPPA Compliance information.

_____ _____

Signature of Client/Legal Guardian Date

_____ _____

Witness Date

CENTER FOR PERSONAL DEVELOPMENT

Financial Policy for Services

The staff at Center for Personal Development are committed to providing caring and professional mental health support to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment options to our clients.

The Person Responsible for Payment of Account is required to sign the Financial Policy for Services form, which explains the fees and collection policies of the Center.

Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company. As a service to you, the Center will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of the services provided. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 60 days are subject to collections.

Insurance deductibles, co-payments, and co-insurances are due at the time of service.

All insurance benefits will be assigned to this Center (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service.

The Center accepts cash, check and all forms of major debit/credit cards (Visa, MC, AMEX, Discover) as acceptable forms of payment. If a check is returned to the Center as NSF, a $35 fee may be charged to the client. Checks are made payable to Center for Personal Development.

Missed appointments or cancellations less than 24 hours prior may be subject to fees.

All account balances must be paid in full within 60 days of the service provided as well as upon the termination of therapy. If bills are not paid in full after 60 days, I authorize the Center for Personal Development to charge my balance to the credit card provided as part of my client agreement. I understand that I am responsible for all costs and fees from the date of my initial consultation with any therapist at the Center for Personal Development.

At any time a client may request a financial invoice that details the account balance/details with the Center.

Questions regarding the financial policies can be answered by your assigned therapist, the Office Manager, or Clinical Director.

I have read, understand, and agree with the provisions of the Financial Policy, and I agree to pay for each service provided in a timely and effective manner.

Client Name / Person responsible for payment of account: _____

Date:_____

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Debit/Credit Card Authorization

DEBIT/CREDIT CARD ACCOUNT NUMBER: _____

EXPIRATION DATE: _____

V-CODE (3 digit security code on back of card): _____

NAME AS IT APPEARS ON CARD: _____

I authorize the Center for Personal Development to keep my signature and debit/credit card account on file for purposes of payment. I understand I am entitled to all receipts of charges made to this account as well as financial invoices for services provided.

CARDHOLDER SIGNATURE: _____

PAYMENT FOR: (CLIENT NAME): _____

DATE: _____