# Yachnin Counseling Group

# Client Information

# 72 S. Lagrange Rd #6 405 N. Wabash Ave #3209

Lagrange IL 60525 Chicago IL 60611

(312) 409-4960 info@yachnincounseling.com

Your Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION:**

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where can I leave you a message? \_\_\_\_ cell phone \_\_\_\_home phone \_\_\_\_email

**FINANCIAL/INSURANCE INFORMATION:** Generally, we ask that you pay for services rendered at each appointment, although alternative arrangements can be worked out if necessary. Fees for counseling are $150.00 for individuals (50 minute session) and $225.00 for couples (60 minute session), with some sliding scale appointments available during the day for those who need it. **All clients must leave a credit/debit card on file with us to cover any copays or deductibles or sessions cancelled within the 48-hour window before the session is scheduled.**

**Insurance Information:**

Name of Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group or Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit/Debit Card Information:**

Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# INFORMED CONSENT

We realize that starting counseling is a major decision and that you may have some questions. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and we will try to give you all the information you need. I am Melinda Yachnin, the founder of Yachnin Counseling Group, and earned a BA in history from the University of Colorado, and an MA in pastoral counseling from Loyola University Chicago. I am licensed by the state of Illinois as a Licensed Clinical Professional Counselor and have over 25 years of clinical experience treating individuals and couples in therapy.

**YOUR RIGHTS AS A CLIENT**

You have the right to ask questions about any procedures used during therapy.

Your have the right to decide at anytime not to continue treatment with Melinda Yachnin. If you wish, I will provide you with the names of other qualified professionals whose services may be useful to you.

You have the right to end treatment at any time without legal or financial obligations, other than those already accrued.

**FEES AND INSURANCE**

Generally, we ask that you pay for services rendered at the end of each appointment, although alternative arrangements can be worked out if necessary. Fees for counseling are $150.00 for individuals (50 minute session) and $225.00 for couples (60 minute session).

You must leave a credit/debit card on file with our office, so that your sessions can be billed in that manner.

**CANCELLATION POLICY**

In starting therapy with Melinda Yachnin, you will have a session time that is yours for the duration of treatment, to be negotiated or updated with your therapist as needed. If you need to cancel your appointment for any reason, you will be charged $75 the first time; subsequent cancellations will be filled at the full session rate of $150.00. If you are able to reschedule your appointment with your clinician, within 48 hours of the scheduled appointment, there will be no charge.

If you decide to use the on-line scheduling portal to set up or change your appointments, these same charges will apply to cancelled or rescheduled appointments.

**MINORS**

**If you are the guardian of a minor, or are a minor, please read the following:**

By signing below, you give your consent for your therapist to conduct therapy sessions with the minor listed below. We will inform you of the limitations of confidentiality around certain topics like substance use and sexual activity. You accept your therapist’s judgment about which information to release, and understand that if they believe this minor is in danger of hurting him or herself, you will be notified immediately.

**CONFIDENTIALITY**

Your verbal communication and clinical records are strictly confidential except for:

a) Information shared with your psychiatrist, other therapists or health care professionals

b) Information (diagnosis and dates of service) shared with your insurance company to process your claims

c) Information you report about child physical or sexual abuse, which by Illinois state law we are obligated to report to DCFS

d) When you sign a release of information to have specific information shared with another person

e) If you share information that informs us that you are in danger of harming yourself or others

f) Information necessary for case supervision or consultation. In this case, you would be notified before your therapist shared any information about you, and have the option to say no.

h) Information shared with your parent or guardian if you are under 18

i) When required by law.

**CONTACTING YOUR THERAPIST**

While your therapist will make every effort to maintain your privacy, in the event that we do need to contact you, we cannot guarantee that email/cell phone/text messages are 100% secure.

When you leave a voicemail, or send a text or email, you will receive a response within 12-24 hours. It may be sooner, but if you need immediate help, you should call 911 or go to the nearest emergency room.

Please use email and text for scheduling purposes only, and leave clinical content for sessions.

**EMERGENCY SITUATIONS**

If an emergency situation for which you feel immediate attention is necessary, you understand that you are to contact the emergency services in your community for those services, by calling 911 or going to the nearest emergency room. Your therapist will follow those emergency services with standard counseling and support you or your family.

**SIGNATURES**

By signing below, you agree to accept the therapy services provided by your therapist at the Yachnin Counseling Group in accordance with the terms and conditions described above. If you would like a copy of this consent form, just let us know.

Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENTING CONCERN:**

In your own words, please describe why you are seeking treatment at this time.

**TREATMENT HISTORY:**

Have you ever sought counseling in the past? Yes No

If Yes, was treatment effective, or not? Yes No

Have you ever been hospitalized for psychiatric reasons? Yes No

Have you ever been treated at a residential treatment center? Yes No

Please check all that apply, more often than not, in the past 4 weeks:

* + I worry a lot of the time.
	+ I often feel depressed and down.
	+ My sleep is a problem.
	+ I have panic or anxiety attacks.
	+ There are places that I avoid.
	+ I experience frequent pain.
	+ I am shy and nervous with people.
	+ I have bad or upsetting thoughts.
	+ I have to do things over and over again.
	+ It is difficult to concentrate at school or work.
	+ My family and/or friends notice my anxiety.

*All information recorded here is confidential, and will be seen only by your therapist.*