8745 W. Higgins Rd, Suite 110 • Chicago, IL 60631
Telephone: (312) 388-4273 • Fax: (312) 268-5044
www.gosoinc.com

Welcome to our practice. We look forward to helping you reach your goals. This intake form requests information about your needs. The questions on the following pages are designed to help us best meet your treatment needs. If the person seeking care is a child, the parent or guardian should complete this form. If you have any questions, we will be happy to assist you.

Name_____DOB _____Age_____
Address _____
City, State, Zip Code _____
Cell phone (_____) _____
Email_____

Gender Identity _____Sexual Orientation_____
Ethnicity _____
Relationship Status (circle) single married domestic partner separated divorced widowed

Significant other _____ DOB _____ Age_____
Address _____
City, State, Zip Code _____
Cell phone (_____) _____
Gender Identity _____Sexual Orientation_____
Ethnicity _____
Email_____

Emergency contact _____ Relationship to client_____
Phone (_____) _____

REASON FOR SERVICE (Circle One)

Psychotherapy/Counseling Hardship Evaluation Updated Evaluation VAWA Evaluation

U-Visa Evaluation Asylum Evaluation Other _____

If seeking therapy, please list reason:

_____
_____

Is this first time seeking psychotherapy or counseling? ____ Yes ____ No

For Immigration cases only:

Name of Attorney _____
Law Firm Name _____
Address City, State, Zip Code _____
Phone (___) _____ Email _____

INSURANCE INFORMATION

Primary Insurance Information

Insured Name _____
Insured DOB _____
Member Number _____
Group Number _____
Co-pay fee _____
Deductible
_____
Deductible Met _____
Authorization Number_____

Note: We ask you to make a copy of the front and back of your insurance card and email it to your therapist.

FOR ONLY LYRA HEALTH CLIENTS

Are you a dependent or the insured LYRA Health member?_____
Sponsoring company: _____
Employee: _____
DOB: _____

INFORMED CONSENT

This document is intended to inform you of our policies. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for: **a)** information shared with consultants, **b)** information (diagnosis and dates of service) shared with your insurance company to process your claims, **c)** information you and/or your child or children report about physical or sexual abuse (Illinois State Law requires that this be reported to the Department of Children and Family Services), **d)** where you sign a release of information to have specific information shared and **e)** if you provide information that informs me that you are in danger of harming yourself or others **f)** information necessary for case supervision or consultation and **g)** or when required by law.

TREATMENT PHILOSOPHY:

We believe in providing goal-directed treatment that is culturally responsive manner with sensitivity and respect toward religion, spirituality, gender, sexual orientation and cultural background. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal(s) in mind and progress is made towards accomplishment of that goal(s) in a time-efficient manner. If you ever have any questions about the nature of treatment or anything else about your care, please don't hesitate to ask.

I authorize and request that my treating provider carry out mental health examinations, treatment and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of psychotherapy is designed to be helpful, it may be difficult.

I further understand that as a result of seeking a hardship, VAWA, U-Visa, asylum evaluation or updated evaluation, my therapist may also recommend mental health services and/or concrete resources.

Please note that our therapists will consider a case closed after 60 business days of client inactivity.

EMERGENCY PROCEDURES:

This practice is not equipped to handle emergency telephone calls. Your therapist will return your phone call within one business day. If you are in a life threatening emergency situation, you agree you will go to your nearest emergency room or call 9-1-1.

Please note that therapists are often not immediately available to take telephone calls. If you have an urgent matter and need to contact us, please leave a message in your therapist's voice mail and state that your situation is urgent. **Please do this for true emergencies only.** There is a charge for lengthy telephone consultations.

LEGAL PROCEEDINGS: I agree to not request my therapist to appear, on my behalf, in any legal proceedings.

FINANCIAL/INSURANCE ISSUES:

The psychotherapy session fee is the sole responsibility of the client. As a courtesy we will bill your primary insurance company if you wish. We do not bill secondary insurance. We will provide you with any necessary paperwork for you to submit to your secondary insurance. We will also provide you with a receipt should you forgo using your insurance.

It is the obligation of the client to know their insurance. This includes, but is not limited to co-pay amounts, number of sessions authorized, pre-authorization necessity and capitation of insurance. Payment of any fees, outside the portion covered by insurance, are due at time of service. ***We ask that at each session you pay your co-pay fee.*** In the event you have not met your deductible, the full fee is due at each session 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 mental health plan changes due to new employment or for any other reason, please call us immediately to determine eligibility of services and fees.***

Please note that insurance companies require a clinical diagnosis be provided to the insurance with billing. This information may become part of your permanent medical record. If you have any questions regarding this please speak to your therapist.

If you are coming in for a Hardship, Updated Hardship, VAWA, U-Visa, Asylum Evaluation or an updated evaluation:

The cost of the evaluation price range is $1,600.00 - $3,800.00 depending on the family size. For updated evaluations the price range is $800.00 - $1,900.00. We expect payment of $700.00 (cash is preferred) on the initial interview (see other forms of payment below). ***Note: There is a $700.00 non-refundable fee. Additionally, insurance does not pay for these types of evaluations.***

24 hours notice of cancellation is required. If cancellation is made after this time, you will be **charged your full session fee** for the cancellation. It is understood that an appointment time has been reserved for you and lack of notice prevents sufficient time to schedule other clients. Your insurance company cannot be billed for failed appointments. ***You will be responsible for the full fee.*** **Payment for the missed appointment is required prior to or at the beginning of the next session.**

Three consecutive no shows in a calendar year will result in patient termination.

If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 90 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed.

Forms of payment:

We accept quick pay/Zelle at Adriana@gosoinc.com or Mayra@gosoinc.com, personal or business checks, money orders and credit cards. ***However, there is a 5% convenience fee per***

credit card transaction (credit card billing is done in person and by phone). All checks and money orders are to be made to GoSo Consulting.

We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to call our office.

NOTICE OF PRIVACY PRACTICES:

I have read and received a copy of the Notice of Privacy Practices.

E-mails, text messages and social networking sites are not confidential and your therapist may not be able to respond. For true emergencies we ask that you contact our office number and leave a confidential voicemail to your therapist (Please refer to our Emergency Procedures listed above).

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that_____may be treated as a client of GoSo Consulting. It is understood that children over the age of 12 have confidentiality protected by law. We ask for your cooperation to provide opportunity for timely treatment for your child. This consent to treat expires at the end of treatment or if revoked in writing.

Signature: _____ **Date:** _____

My signature confirms I have read the Informed Consent Form and agree to all terms.

Signature: _____ **Date:** _____

NOTICE OF POLICIES AND PRACTICES
TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, and in accordance with the NASW Code of Ethics, this notice describes how health information about you may be used and disclosed and how you can access this information. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

Effective Date: January 1, 2015

GoSo Consulting has been and always will be totally committed to maintaining our client's confidentiality. We will only release healthcare information about you according to Federal and State laws and ethics of the social work profession. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your mental health information. If you have any questions about this Notice, please contact our office listed above.

GoSo Consulting collects health information about you and stores it in a chart, on a computer, and in electronic health records. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. For example, we may share your information with other health care providers who will provide services that we do not provide or for consultation purposes.

2. Payment. We use and disclose mental health information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

3. Health Care Operations. We may use and disclose mental health information about you to operate this mental health practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, and business planning and management. We may also share mental health information about you with other health care providers, health care clearinghouses and health plans that participate with us.

4. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report child abuse and/or neglect or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

5. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; and reporting disease or infection exposure. When we report suspected elder or dependent adult

abuse, we will inform you promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm.

6. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process.

7. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

8. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

9. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws.

10. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law.

11. Psychotherapy Notes (Includes Evaluations). We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of Health Human Services or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety.

B. When This Mental Health Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this mental health practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this mental health practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Inspect and Copy. You have the right to inspect and copy your health information. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because

we believe allowing access would be reasonably likely to cause substantial harm to the client, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

3. Right to Amend or Supplement. You have a right to request that we amend your health information. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this mental health practice's denial and how you can disagree with the denial.

4. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this practice.

5. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our office.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We will provide you with a copy of the revised Notice of Privacy Practices.

Complaints

Complaints about this Notice of Privacy Practices or how this mental health practice handles your health information should be directed to our office listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Name: _____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of GoSo Consulting's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact GoSo Consulting at (312) 388-4273.

_____ _____

Signature Date

_____ _____

Signature or Parent, Guardian or Personal Representative Date

Note: If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Client Refuses to Acknowledge Receipt:

_____ _____

Signature of Staff Member Date

Credit Card Payment Consent Form

Client Name: _____

Print Name on Card:_____

First Middle Last

Card Holder's Billing Address for Monthly Card Statements:

_____

Street City State Zip

I authorize GoSo Consulting to charge my credit card for professional services as follows:

I acknowledge that my credit card will be charged $100.00 for no show for new clients (immigration) and clients who come for therapy will be charged their rate ($130.00 to $190.00) _____**Client Initials**

24 hours notice of cancellation is required. If cancellation is made after this time, you will be charged your **full session** for the cancellation. It is understood that an appointment time has been reserved for you and lack of notice prevents sufficient time to schedule other clients. Your insurance company cannot be billed for failed appointments. ***You will be responsible for the full fee.*** I acknowledge that my credit card will be charged for the full amount of psychotherapy rate _____**Client Initials**

Type of Card: □**VISA** □**MasterCard** □**Discover**

Card Number: _____-_____-_____-_____

Exp. Date _____/_____

DVV Number _____ (3 digit # from back of card)

Card Holder Signature: _____

Date: ____ /____ /____