Authentic Self
"Supporting the Essence of You!"
Dr. Africa L Rainey, LCPC, EdD.
3255 Arlington Heights Rd Suite 502
Arlington Heights, IL 60004
847-373-3357

If you have any concerns regarding confidentiality, PLEASE discuss them prior to completing any section of this document.

DEMOGRAPHIC INFORMATION
(Please write legibly)

Name: ______________________________________ Date: __________________

Address: ___________________________________ Age: __________ DOB: _________

City: ______________________________________ Gender: _______________

State/Zip Code: __________________________ Phone: _________________________

How may we contact you?

Voicemail: Y N Text: Y N E-mail: Y N Mail: Y N

Email address: ____

Complete this section if utilizing insurance coverage for your sessions.

We will need a copy of your Insurance Card and Drivers License

Is the insurance coverage under your name? Y / N **IF NO Please complete the information below:**

Subscriber's name: ______________________________ DOB: _________________

Address: _______________________________________ Phone______________________

Relationship to the patient: _________________________

If you are being referred through an Employee assistance program Compsych please indicate reference number below.

Employee Assistance Program ________________________Phone__________________

I authorize the staff at Authentic Self to bill my insurance company for services rendered.

I understand I will be charged for any appointments cancelled without 24 hours notice.

Signature: ____________________________________ **Date:** _________________

AUTHENTIC SELF

COUNSELING AGREEMENT

I understand I am entering into this counseling relationship of my own free will.

I understand that I have the right to terminate at any time.

I understand the services I am receiving will be within the training and professional capabilities of my counselor.

I agree to abide by the financial agreement between Authentic Self and myself.

I understand that should my counselor feel this level of treatment is not the appropriate level of care, I will be referred to a level of care that will meet my needs. I understand if I refuse to attend or explore these options/referrals, my counselor may have an ethical duty to suspend or terminate treatment.

This counselor abides by State and Federal confidentiality law (s) {42CFR}. *I understand the only times confidentiality laws do not apply are in cases of child abuse or neglect, elder abuse or neglect and in cases where I may present as suicidal or homicidal.*

I do have a choice to sign a release allowing my counselor to speak to someone I deem appropriate. This release can be as specific as I choose. Signed releases can be rescinded at any time.

I understand that should there be a time where appointments have not been made within a period of time, which is determined on a case-by-case basis, I may receive a letter of “termination”. This letter only means that you are choosing to not be an active client of Authentic Self. You are always welcome to return to services at any time. We often have clients that utilize services on an “as needed” basis, similar to perhaps an arrangement of a general practice medical doctor.

By signing this document I am indicating I have read and understand the contents. I have been given the opportunity to ask questions regarding this document.

Client signature/date___________________________________

Guardian (under 18)___________________________________

AUTHENTIC SELF
FINANCIAL AGREEMENT
(CLINICIAN COPY)

Name of Client (Guardian)____

Payment is due each time services are rendered. The staff at Authentic Self Psychological Services will make every attempt to utilize my insurance company or employment assistance program in terms of reimbursement for services. However, should my insurance company deny benefits for any reason, I understand that I (the client) am responsible for all fees incurred. Moreover, I am of the agreement that I am responsible for any applicable copays, co-insurance and/or deductibles consistent with my insurance plan and may be required to pay fees while following up with my insurance company.

I will keep the staff at Authentic Self updated for any change in coverage, including providing copies of a new insurance card, changes and/or updates with my credit card I may have on file, etc. insurance company. If I am utilizing EAP services, I may responsible for making sure I have authorization for services. If I have been provided an authorization number, please make this available to administrative staff. We offer the option of having a credit card on file which would only require you to fill out a form which would include an authorization to debit your card each time you see your counselor. Please ask your counselor to provide you this form if you are interested in this arrangement. We also accept cash as well as checks. Note: that should there be insufficient funds in your checking account; you are responsible for the amount of the check and a $60 bank fee incurred by Authentic Self.

Payment MUST be made within 30 days of my statement; it is my responsibility to follow up with any problems with funding from my insurance company or Employment assistance program. All balances in excess of 60 days past due are subject to collections. Statements are NOT routinely sent out to clients. If you should need a statement, please contact the administrative staff.

Please initial here ____________FOR ALL APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF THE SCHEDULED TIME, A "NO SHOW FEE" WILL BE CHARGED UP TO THE AGREED RATE REIMBURSED BY YOUR INSURANCE CARRIER OR THE AMOUNT PER SESSION FOR SELF-PAY CLIENTS. ALL NO SHOW FEES MUST BE PAID ***PRIOR*** TO YOUR NEXT APPOINTMENT.

____ ____________________________
Client Signature **Date**

AUTHENTIC SELF
FINANCIAL AGREEMENT
(CLIENT COPY)

Name of Client (Guardian)____

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Client Signature **Date**