INFORMED CONSENT PACKET

Alex E. Mc Kibbin, MS, LCPC, LSOTP, SEP
Somatic Experiencing Practitioner
24402 West Lockport Street, Suite 224
Plainfield, Illinois 60544
Tele: (630) 456-2519
Fax: (815) 556-8603
Web: alexemckibbin.com

Initial DX: _____

CLIENT REGISTRATION INFORMATION

First Name _____ Initial___Last Name _____
Street Address _____
City State Zip _____
Birth Date _____Age _____SSN _____
Employer/School _____
Home Phone _____Work Phone _____
Cell Phone _____ Email _____
Relationship to insured: □Self □Spouse □Child □Other
Employment Status: □Employed □Unemployed □ Student □ Retired
Marital Status: □Single □Married □***Separated** □***Divorced** □Co-habiting □Widowed

POLICY HOLDER/GUARDIAN'S INFORMATION (□SAME AS ABOVE)

First Name _____Initial_____Last Name _____
Street Address _____
City State Zip _____
Birth Date _____Age _____SSN _____
Employer/School _____
Home Phone_____ Cell Phone _____
Email _____Work Phone _____

***IF SEPERATED/DIVORCED OTHER PARENT'S INFORMATION (MUST HAVE SIGNATURE)**

First Name _____Initial_____Last Name _____
Street Address _____
City State Zip _____
Birth Date _____Age _____SSN _____
Employer/School _____
Home Phone_____ Cell Phone _____
Email _____Work Phone _____

INSURANCE NAME*: _____ *HMO PPO POS

Insured's ID # _____

Group # _____

Assignment of Benefits and Release of Information

I hereby assign, transfer, and set over to Alex E. Mc Kibbin, M.S., LCPC LSOTP all my rights to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

X_____ X_____

Signature of Responsible Party Date

X_____ X_____

Signature of Responsible Party Date

Hours and Cancellations

Psychotherapy sessions are typically 45 - 50 minutes long. If it becomes impossible for you to keep an appointment, it is important that you call to inform me of your cancellation. Due to the policy of reserved appointment times, an appointment that you cannot keep must be canceled no fewer than 24 hours before the appointment time. Appointments that have not been properly canceled will be charged the regular session fee. Insurance will not pay for missed sessions, so these will be your sole responsibility. Unfortunately, I cannot call to remind people of appointments.

Initials:_____

Phone Calls

My general policy is to leave only my name and phone number when phone calls are returned. Please indicate your consent for my office to leave treatment information: appointment changes, account information, etc.

O I **authorize** Alex E. Mc Kibbin, M.S., LCPC to leave treatment information on my answering machine and voice mail.

O I **do not authorize** Alex E. Mc Kibbin, M.S., LCPC to leave treatment information on my answering machine and voice mail.

Initials:_____

Fees and Insurance

Charges for sessions are consistent with standard psychotherapy fees in the community. PAYMENT IS REQUESTED AT THE TIME OF SERVICE. Please make checks payable to Alex E. Mc Kibbin, M.S., LCPC**.**

Many insurance plans will reimburse you for some or all the charges for psychotherapy. If you are eligible for reimbursement under your plan, you will be required to pay any co-pays or co-insurance at the time of your visit. If you have a deductible that has not been met, you will be required to pay the full session fee until your deductible has been met. If your insurance requires prior authorization or a physician referral for mental health services, it is your responsibility to make sure this is in place prior to the session. Any visits not authorized will be charged to you at full fee.

Initials:_____

Emergencies

In the event of an emergency, you may contact my cell phone. However, I do not usually accept calls if in session. **If I am not available in case of emergency, please call your local crisis line, contact your primary care physician, or proceed to your local emergency room.**

Initials:_____

Confidentiality

I am committed to making this a safe place for you to get help. To that end, I adhere to all legal protections of your confidentiality. Limitations include staff consultation, life-threatening behavior (to yourself or someone else), suspicion of or disclosure child abuse, elder abuse, and judge's orders to release information.

Good communication between us is vital to my ability to serve you well. Please tell me about problems and questions that might arise. If you do not understand an answer or if new, problems arise, let me know. I want to provide you with the best possible care, and I need your cooperation to succeed. Please contact me if you have a concern.

Initials:_____

Client Signature _____Date _____

Parent Signature _____Date _____

Parent Signature _____Date _____

Provider Signature _____Date _____

All items have been fully explained and I understand and take full responsibility for their contents.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MED1CAL INFORMAT1QN ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. The information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the APA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I am required to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will Be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment: I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI to support my business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging for other

business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard, the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. I may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me at 24402 W. Lockport St. #224, Plainfield, IL. 60544:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. [
- **Right to Amend**. If you feel that the PHI, I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is May 1, 2005.

NOTICE OF PRIVACY PRACTICES
(HIPAA)
Receipt and Acknowledgment of Notice

Client Name: _____

DOB: _____/_____/_____

SSN: _____-_____-_____

I hereby acknowledge that I have received, in addition, given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Alex E. Mc Kibbin, M.S., LCPC.

CLIENT SIGNATURE: _____ DATE: ___/___/___

PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE SIGNATURE*: _____ DATE: ___/___/___

PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE SIGNATURE*: _____ DATE: ___/___/___

*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 WITNESS: _____ DATE: ___/__/___

Alex E. Mc Kibbin, M.S., LCPC, LSOTP, SEP

24402 West Lockport Street, Suite 224
Plainfield, Illinois. 60544
Phone: (630) 456-2519 / Fax: (815) 556-8603
E-Mail: alex.mckibbin@sbcglobal.net

I hereby authorize ***Alex E. Mc Kibbin, M.S., LCPC LSOTP*** to release to/or secure from:

_____
(Name of Health Care Facility, Physician, Agency, School, etc.)

_____
(Street Address,)

_____
(City, State and Zip Code)

The following information contained in the client record of

_____
(Patient's Name:) *(DOB:)*

To be disclosed, the following items must specifically be checked:
O Account Information O Treatment Summary O Psychotherapy Notes
O Verbal Discussion of Case O Psychological Testing Report O Other _____

The purpose(s) of the authorization is (are):
O At the request of the individual O Coordination of Mental Health Treatment
O Payment of Account O Other (specify):_____

I understand that the practice may not condition treatment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the therapist has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.

Signature of Client _____ Date: ____/____/____

*Signature of Parent or Guardian _____ Date: ____/____/____

*Signature of Parent or Guardian _____ Date: ____/____/___

*Signature of Witness_____ Date____/____/____
*Client signature is required in addition to the parent or guardian signature for clients ages 12-17.

Alex E McKibbin MS., LCPC, LSOTP, SEP
24402 W Lockport Street, Suite 224
Plainfield, Illinois 60544
Office: 630-456-2519 / Fax: 815-556-8603

Mandated Reporter Notification

Exceptions to Confidentiality

I am considered a mandated reporter under state law. That means that I am required to report any suspected incidents of child abuse or neglect to the Department of Children and Family Services' Hotline in accordance with the Abused and Neglect Child Reporting Act.

In addition, should I discover a client's intent to harm another person, I must make every attempt to alert that person of the peril.

I want you to know that these provisions of the law abridge the usual practice regarding confidentiality. I must report incidents of abuse and/or neglect, which are disclosed to me. I must attempt to alert the intended victim.

Please Sign below to indicate that you have had these exceptions to confidentiality explained to you in clear and understandable language.

Signed: _____ Date: _____
(Client 12 years or Older)

Signed: _____ Date: _____
(*Parent/Guardian, if applicable)

Signed: _____ Date: _____
(*Parent/Guardian, if applicable)

Signed: _____ Date: _____
(Witness)

*Client signature is required in addition to the parent or guardian signature for clients ages 12-17.

Alex E. Mc Kibbin, M.S., LCPC, LSOTP SEP
24402 W Lockport Street, Suite 224
Plainfield, Illinois 60544
Office: 630-456-2519 / Fax: 815-556-8603

Office Hours:

Mondays	10:00 AM to 7:00 PM
Tuesdays	10:00 AM to 7:00 PM
Wednesdays	10:00 AM to 7:00 PM
Thursdays	10:00 AM to 7:00 PM
Fridays	OFF
Saturdays	9:00 AM to 3:00 PM
Sundays	OFF

All **appointments** are scheduled and are always on the hour.

You may leave **messages** 24 hours per day, 7 days per week.
You may **fax** me anything at any time.

You may also wish to communicate with me via e-mail. My e-mail address is alex.mckibbin@sbcglobal.net

Respectfully,

_____
Alex E. Mc Kibbin, MS, LCPC, LSOTP, SEP
Licensed Clinical Professional Counselor
Somatic Experiencing Practitioner
Clinical Therapist

Alex E McKibbin MS LCPC LSOTP SEP
24402 W Lockport Street, Suite 224
Plainfield, Illinois 60544
Office: 630-456-2519 / Fax: 815-556-8603

INSURANCE OR BILLING QUESTIONS:

For questions regarding your insurance or the status of your bill, please contact ***Jessica*** at **Compliance Medical Billing**

Compliance Medical Billing

Office/Cell: 630-418-5457
Fax: 815-346-5320
E-mail: medbill06@gmail.com

She will be happy to assist you in whatever matter you have concerning your insurance, deductible, co-payment, etc.….