

For Your Information
PLEASE KEEP THIS FORM

We're different. As you can see below, we are utilizing many different modes in order to ensure that our clients have access to as many resources as possible. We work closely with many of them, and will be happy to help whenever possible.

Edgewood is devoted to serving the needs of the kids, couples, individuals and families that we serve. Below is a list of crisis line phone numbers that may be utilized in a situation that requires an urgent response. If there is an emergency, please call 911 for an immediate response.

Crisis Line Phone Numbers

Crisis Line of Will County serves a geographical area which includes Will, Grundy, Southern DuPage, and portions of Southwestern Cook Counties. The numbers below (with the exception of the DuPage number) fit into this category.

Will County Crisis Line: 815-727-8521 and select option #2 before 4pm
815-722-3344 after hours

DuPage County Crisis Line: 630-627-1700

Stay Updated on the Latest Events and News

Facebook: facebook.com/edgewoodclinicalservices

Twitter: @Adam_Russo_LCSW

Groupon: Store under construction - please visit our website for details

Our Partners

Sovereign Pediatric Therapy: Occupational, Physical, and Speech Therapy
Debbie Denniger, Executive Director - 630.585.PEDS (7337)

ABC Moms: Short-term, in-home, behavioral counseling and infant sleep training
Jennifer Schuler: 630.299.4909

Lifetime Health and Wellness: Chiropractic and Nutrition Enhancement
Dr. Michelle Dougherty: 630.904.6700

Sullivan Taylor and Gumina: Family Law - 630.665.7676

PLEASE KEEP THIS FORM

NEW CLIENT INFORMATION

Client's Full Name: _____

Date of Birth: _____ *Social Security #: _____

Street Address: _____ City: _____

State: _____ Zip Code _____

*Home Phone: _____ Cell: _____ Email: _____

**Required for billing purposes*

Family Member Names	Dates of Birth (mm/dd/yy)	Relationship	Phone &/or Email if Different From Above

INSURANCE INFORMATION If not being utilized please check here

Name of Insurance Plan: _____

ID Number: _____

Group Number: _____

Policy Holder's Name: _____ Person Responsible for Charges: _____

Policy Holder Date of Birth: _____ Policy Holder's Social Security # _____

Policy Holder's Address and Phone if different from client's contact information: _____

Policy Holder's Employer: _____

How were you referred to Edgewood Clinical Services, Inc? _____

Please list medical conditions that the identified client has: _____

Please list any prescription medications that the client takes: _____

A Copy of Your Insurance Card Will Be Requested Upon Your First Visit

FOR OFFICE USE ONLY

Clinician Assigned:	
Date of First Session:	Scheduled Time:
FFS Rate if Insurance Not Being Utilized:	
Clinician Comments/Notes:	

INFORMED CONSENT

SERVICES

Edgewood Clinical Services, Inc provides counseling services to all age groups. We also provide psychological testing and case coordination for families who would like to utilize these services. All clinicians strive to be accessible by phone or email, but please be advised that we DO NOT offer 24 hour emergency crisis coverage. Please leave a message or send an email to a clinician to keep contact with them on an ongoing basis. If there is an emergency, please visit your nearest emergency room, or call 911.

Initials _____

FEES

The fees for service will be:

- \$600 per extended behavior management consultation
- \$165.00 per 50 minute session
- \$175.00 per 50 minute family session
- \$50 per 50 minute session for groups
- \$225 for Initial Assessments
- \$185 for sessions greater than 65 minutes in length
- \$175 per hour for psychological testing (interviews, testing, scoring, report writing, and feedback)

I understand that all fees with the exception of the extended behavior management consultation can be billed to my insurance carrier.

Initials _____

APPOINTMENTS

Appointments will be scheduled at a time mutually acceptable to both the client and the therapist. 24-hour advance notice of cancellation is required, except in cases of extreme emergency.

Appointments missed or canceled with less than 24 hours notice will result in a charge of \$40.00.

If a check is returned for insufficient funds, the client is responsible for any bank fees assessed, and an alternative method of payment will be required.

All co-payments are due at the time of service.

_____ Initials

CONFIDENTIALITY

In order to provide effective treatment for the client’s needs, the therapist will ask many personal questions. You can be assured that all personal client information is kept STRICTLY CONFIDENTIAL. Absolutely NO INFORMATION about your case will be released to anyone without your written authorization and consent.

Licensed Psychologists, Clinical Social Workers, and Counselors in the state of Illinois are required by law to report any suspected child abuse or neglect. They are also required to make a report if a client is a lethal danger to themselves or others.

As a client, I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that all communication with other providers or individuals can be made by Edgewood Clinical Services, INC, only by my signed or verbal consent.

_____Initials

INSURANCE

As a Client, I understand that Edgewood Clinical Services, Inc, will verify my insurance benefits and coverage. I understand that I am solely responsible for out of pocket costs that may be incurred, and the benefit information that Edgewood Clinical Services, INC, may relay to me from my provider is not a guarantee of coverage or benefits.

As a Client, I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical benefits to the supplier of services provided to myself, child, or family.

_____Initials

ELECTRONIC COMMUNICATION

By initialing below, client is agreeing to allow the staff at Edgewood to communicate with them through the email address provided, and is also giving Edgewood permission to email the monthly e-newsletter to this address (client can opt out at any time). I understand that electronic communications are not completely secure, and that any information that may be stolen is not Edgewood’s responsibility. Client will also understand that if they choose to communicate with Edgewood staff via text messaging, facebook, or other modes of communication that they assume all risks associated with their chosen method of communication.

_____Initials

CONSENT FOR TREATMENT

As a Client, I consent to the evaluation and treatment process with Edgewood Clinical Services, and I understand that this process may include myself, my spouse, my children, and/or other family members. I understand that I have the right to withdraw from treatment at any time.

In general, your number of visits will depend on the type(s) of issues that exist, the recommendations made, and the effort that the client(s) put forth into following through with suggested recommendations.

_____Initials

Client Signature (12 & over): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Financial Statement

Edgewood Clinical Services, Inc, is committed to providing the highest quality of counseling and psychological services to all of its clients. In order to do so, Edgewood Clinical Services, Inc, and its clients must understand the benefits provided to the client through their insurance provider, or, clearly outline a fee structure for services that will be paid in full by the client directly.

Many insurance plans have deductibles, co-insurance, and co-pay amounts that are the client's responsibility; deductibles must be met before insurance will begin to cover the cost of counseling. These deductibles apply to ALL medical providers; they are not isolated to mental health.

Edgewood Clinical Services, Inc, wishes to ensure that all families can have access to services. If there are circumstances that prevent a client from meeting the financial obligations of obtaining services, they should contact Adam Russo, LCSW, Executive Director, to explore payment options.

Edgewood Clinical Services, Inc, does require prompt payment for services provided, and all accounts that have not received a payment towards the account balance within 90 days of the date of service will have the credit card on file charged accordingly. If an account, for any reason, goes beyond 90 days past due, and a payment plan has not been arranged, your balance may be forwarded to a collections agency without your notice.

My signature below reflects my understanding of the financial policy at Edgewood Clinical Services, Inc.

Client/Parent/Guardian Signature _____ (date)

CREDIT CARDS

All Clients are required to keep a credit card on file with Edgewood Clinical Services in order to receive services. Simply because there is a credit card on file does not mean that we will bill your card every month. If you wish to pay by check, cash, or paypal, that is acceptable. The credit card that is on file will be charged for all outstanding balances greater than 90 days past due if no payment arrangement has been made. It can also be used should a payment plan be arranged with our staff. Please initial the choice of how you would like your credit card used below:

_____ 1) Please charge my card for all balances in full that are past due for
Initials greater than 90 days (a courtesy call will be made if the balance is
larger than \$250 to ask if you would prefer to set up a payment plan)

_____ 2) Please charge my card on or about the first of each month for all
Initials copays, co-insurances, or deductibles that have accrued for the previous
month

Credit Card Information

Please be sure to complete all sections:

1) Card Holders Name _____

2) Credit Card Number _____

3) Expiration Date _____

4) Security Code (3 digits on back of card, 4 digits on front if AmEx) _____

5) Billing Zip Code of Credit Card _____

4) Visa, Mastercard, AmEx, or Discover (circle one, flex spending accepted)

5) Card Holders' Signature _____ Date _____

6) Card Holder Phone number _____ Email _____

I understand that by signing above, I am authorizing Edgewood Clinical Services, Inc, to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, or deductibles. I understand that Edgewood Clinical Services will mail me a printed statement as well as the receipt from my credit card as proof of payment.

Consent to Release Information to Other Medical Professionals

I hereby give my consent to communicate with my own or my child's Primary Care Physician (PCP) or other relevant health care provider about treatment. Other providers will only be contacted after it is discussed directly in session between the client and the counselor.

Initials _____

OR

I choose to refuse permission and do not prefer to have any other medical providers contacted regarding my care at Edgewood Clinical Services.

Initials _____

If Consent Is Given, Please Complete Below:

Health Care Provider #1 Contact Info:

Name: _____

Address: _____

Phone: _____

Email: _____

Specialty: _____

Health Care Provider #2 Contact Info:

Name: _____

Address: _____

Phone: _____

Email: _____

Specialty: _____

Health Care Provider #3 Contact Info:

Name: _____

Address: _____

Phone: _____

Email: _____

Specialty: _____

*This form is not required. Please complete if there is anyone you would like your clinician to be able to exchange information with such as a School Social Worker, Ex-Spouse, Occupational Therapist, or other treatment providers

RELEASE OF INFORMATION

I, _____, authorize Edgewood Clinical Services, Inc:

to give information to

to receive information from

Name: _____

Organization: _____

Address: _____

Phone: _____ Email: _____

Regarding (Client Name): _____

This information to be exchanged from _____ to _____.

This release is valid until end of treatment.

Client Signature: _____ Date: _____

Parent/guardian Signature: _____

Date: _____

GENERAL GROUP INFORMATION:

FOR YOUR INFORMATION

In order to ensure the best experience and attendance possible for groups, group members are required to commit to attend the group for six weeks. Consistency is very important to the success of the group at any age level but especially for children.

ATTENDANCE POLICY

We understand that issues may arise that will prohibit group members from participating in a session. Therefore, within a six week period, we will allow for two absences uncharged only if a 24-hour cancellation has been given. Any absences beyond two will be charged the full session fee of \$50 per absence or result in the member being removed from the group regardless of the reason.

SECURITY DEPOSIT

Edgewood Clinical Services requires that a credit card be kept on file for a security deposit of \$100 (two session fees). The security deposit will only be collected if a client fails to attend by the 2nd session or terminates services prior to completing at least 2 sessions. If the group is not a good fit after two sessions, we will not charge your credit card and would be glad to assign you or your child to a more appropriate group if possible. Scheduling conflicts will not be considered valid reasons to avoid the \$100 deposit collection.

If you cancel your participation in a group prior to two sessions having been attended or do not give appropriate notice to the group leader or our office that you will not be attending, your credit card will be charged the \$100 fee and may result in the inability to participate in future groups.

I HAVE READ THIS GROUP INFORMATION SHEET, I UNDERSTAND THE REQUIREMENTS OF THIS OFFICE, AND AGREE TO THE TERMS THEREIN.

Client Signature: _____ Date: _____

Therapist: _____ Date: _____