KENNETH GATES AND ASSOCIATES
8600 US Rt. 14, Suite 110
Crystal Lake, IL 60012

Client Information

Last Name: _____

First Name: _____

Middle Initial: _____

Home Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Cell Phone: _____

Birth date: _____ Age: _____ Sex☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W

Email Address: _____

How were you referred to our practice? _____

_____

Guarantor, If Other Than Client

The Parent/guardian requesting services for a child, and signs the authorization for treatment on the first visit, is the responsible payor. If payment of the account is to be someone other than the authorized signature, we need a signed letter stating that this individual does accept responsibility for payment of the account.

Last Name: _____

First Name: _____

Home Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____

Birth date: _____ Age: _____ Sex☐ M ☐ F

Marital Status: ☐ S ☐ M ☐ D ☐ W

Relationship to Client: _____

Email Address: _____

Insurance Information

PRIMARY:

Insurance Company: _____

Mental Health Carrier: _____

ID #: _____ Group #: _____

Name of Insured: _____

Relationship to Client: _____

Birth date: _____

Social Security #: _____

Employer: _____

Work Phone: _____

****Please be advised, we will submit to your insurance company on your behalf however it is the client's responsibility to verify coverage and benefits for counseling services.****

SECONDARY (If Applicable):

Insurance Company: _____

ID #: _____ Group #: _____

Name of Insured: _____

Relationship to Client: _____

Birth date: _____

Social Security #: _____

Contact Phone: _____

For Office Use Only

Treating Clinician: _____

Primary Diagnosis: _____

Please continue on the back

Authorization to Release Information & Assignment of Benefits

Kenneth Gates and Associates (the practice) may disclose all or part of this client's records to any insurance company or association, either by mail or electronically, as may be necessary for the completion of all practice claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records. I understand that the information to be release may include information pertaining to mental or psychological related conditions and/or drug or alcohol abuse. A copy of this shall be as valid as the original.

I hereby authorize payment to Kenneth Gates and Associates benefits herein specified and otherwise payable to me for any services rendered by the practice subsequent to this date, and for such other charges as may be made by said practice. I hereby agree that in the event that medical coverage is not sufficient to apply to the indebtedness incurred, and should there be any money over and above that is necessary to pay this debt, I agree that said practice may apply coverage against any which is owed by myself, my spouse or legal dependents of myself or spouse at the time, to the practice. I hereby transfer all interest in and title to my reimbursement monies from my insurance company to the practice.

Client (age 13 & Older): _____ **Parent/Guardian:** _____

Consent to Mental Health Treatment:

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety, confusion, sadness, grief and/or discomfort. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Your therapist is available to support you throughout the counseling process But, there are no guarantees as to what you will experience.

The first few sessions of therapy will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with your therapist. At the end of the evaluation period, your therapist will notify you if they believe that they are not the right therapist for you and, if so, will give you referrals to other practitioners whom they believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, please discuss them whenever they arise. If you believe your therapist is not the best fit for your needs, please let them know and they will assist you in finding other practitioners who may be better suited for your needs.

By signing this Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form and duly authorize Kenneth Gates and Associates to execute said terms. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I certify that the information provided on this form is correct to the best of my knowledge.

_____	_____	_____
Client (age 13 & older)	**Date**	**Parent/Guardian**