ABI JOY NIX Clinical Psychotherapist

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BIOPSYCHOSOCIAL HISTORY

In preparation for our first appointment, please complete the following information to the best of your ability. This information will help me to better understand your current life circumstances, your concerns, your strengths, and your goals for seeking psychotherapy at this time. Feel free to leave blank any questions that are not relevant to you or that you would prefer not to answer. In all cases, if more space is needed, please use side or back. Please print all answers.

IDENTIFYING INFORMATION:

Name:	Date of Birth:	Age:
Current Address:	Billing Address: (Only if different from current)	Phone:
Sex:	Place of Birth:	Ethnicity:
Primarily Raised (city/country):	Occupation: Full time or Part time?	Employer:

Present Relationship Status (please select): Single Married Co-Habitating Widowed Separated Divorced Dating	Length of Relationship:
Partner's Occupation:	Partner's Employer:

Please list the people with whom you presently live.

Name	Age	Relationship to You

In case of emergency, please list the name and phone number of the person Ms. Nix may contact:	Relationship to You:

Phone & Address of Emergency contact:

PSYCHOTHERAPY GOALS:

How did you become aware of my services? (Referral name/source)?
What would you like to work toward while in psychotherapy?
How did you decide that now is a good time to begin psychotherapy?
What do you anticipate being most helpful in relationship with your therapist?

HEALTH AND WELLNESS:

Please indicate which wellness or lifestyle practices you engage in regularly by checking those that apply and elaborating to the right.		
	Exercise:	
	Nutrition Practices:	
	Time in Nature:	
	Contemplative Practices:	
	Community Engagement:	
	Community Service/ Volunteer Activities:	
	Supportive Relationships:	
	Creative Outlets/Play:	
	Recreational Activities:	
	Relaxation:	
	Other	

Present State of General Health (please select one):	**(e.g.) Excellent Good Fair Poor**
Medical Provider: please list the contact information of your present internist or physician:	
Please provide the approximate date of your last complete physical exam:	
Physical Exam results:	
Please state significant medical problems for which you have been or are being treated:	

Sleep: Please describe your present sleeping pattern (e.g. hours per night; restful or not; problems getting to sleep or waking early).
Diet: Please describe your eating patterns (e.g. number of meals & snacks per day, restrictions).
Allergies: Please list which allergies you have and indicate whether they are mild, moderate, or severe:
Head Injuries (if any), please list approximate date and describe:
Please list any accidents or serious injuries you experienced:
Please list approximate dates and nature of any surgical procedures:
Please describe disabilities (education, physical, cognitive) and their accommodation.

Number of pregnancies:	Number of children?
Please describe the current state of your sexual health/functioning.	
If you have ever experienced or been a partner to someone who has experienced pregnancy loss, please elaborate.	
If you or a partner has ever experienced infertility or infertility treatment, please elaborate.	

Please indicate the amount and frequency of use of the following.

	Present Use		Past Use, if Different	
	Amount/Type	Frequency	Amount/Type	Frequency
Alcohol				
Nicotine				
Caffeine				
Video Games:				
Other Substances				

MENTAL HEALTH:

Have you worked with a psychotherapist in the past? (Mark w/ "X") _ _______Yes. _ ___No.

If so please give the approximate dates, type (i.e. individual, couple, family) and duration of the therapy(ies):

What was most useful to you in this work?

Please list all medications you are currently taking:

Medication	Dose	Start Date	End Date	Was it helpful?

Name and contact information of current psychiatrist or prescribing physician:

Have you ever had a psychiatric hospitalization? (Mark w/ "X") _______Yes. ___No.

Dates of hospitalization:

Please describe reason & outcome.

Have you ever made or threatened to carry out a suicide attempt? (Mark w/ "X") ____Yes. ___No.

If so, please give approximate date(s) and describe.

Have you ever harmed or threatened to harm another person? (Mark w/ "X") _ ____Yes. ___No.
If so, please give approximate dates(s) and describe.

Has substance abuse ever been a problem for you? (Mark w/ "X") _ ____Yes. ___No.

If yes, please indicate which substance(s) of preference and duration of use.

If you have ever received treatment for substance abuse, please describe (e.g. inpatient, outpatient, approximate dates, outcomes).

Do you have a history of other addictive behaviors (e.g. food, gambling, sex, video games, pornography, media/technology)? (Place a "X" next to answer) _ ____Yes. _ ___No.
If so, please describe.

Please list any history of trauma, abuse or neglect.

FAMILY OF ORIGIN:

Please provide information about your parents/caregivers.

	Parent	Parent	Step Parent or Other Caregiver	Step Parent or Other Caregiver
First Name				
Age				
City, State				
No. of Children				
Marital Status				
Education Level				
Occupation				
Physical Health*				
Mental Health*				
If Deceased, Cause/Age/Date				

*** E = Excellent, G = Good, F = Fair, P = Poor**

Please provide information about your siblings in order of birth, including step/half siblings. Please use side or back if necessary.

	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
First Name					
Age					
City, State					
Relationship Status					
No. of Children					
Education Level					
Occupation					
Physical Health*					
Mental Health*					
If Deceased, Cause/Age/Date					

*** E = Excellent, G = Good, F = Fair, P = Poor**

Identify and describe a primary caregiver (e.g. mother, father, relative, step-parent) as you remember her/him during your life at home, including her/his characteristics as a person.

In general, how was your relationship with this primary caregiver?

Identify and describe another primary caregiver (e.g. mother, father, relative, step-parent) as you remember her/him during your life at home, including her/his characteristics as a person.

In general, how was your relationship with this additional caregiver?

How did your parents or caregivers get along with each other while you lived with them?

How are your relationships with each of your parents/caregivers now?

If you had siblings, describe your relationship with them during childhood.

Please describe your current relationships with your siblings:

While growing up, were you ever frightened by a family member? (Mark w/ "X") _ ____Yes __No If so, please describe, including frequency and intensity.
Did you ever witness a family member(s) being frightened? (Mark w/ "X") _ __Yes. ___No If so, please describe, including frequency and intensity.
Please indicate relatives with a history of emotional or mental disorder or suicide. If known, please include diagnosis and treatment.
Please note relatives with a history of alcoholism, substance abuse or excessive alcohol use.
Have you ever experienced abuse or harassment? (Mark w/ "X") _ ____Yes. _ ___No If so, please describe (e.g. physical, sexual, emotional), including when and by whom.
Growing up, what were your favorite rituals or traditions?

RELATIONSHIPS AND CURRENT FAMILY:

If applicable, please give the approximate date your present partner relationship began.

If applicable, please provide information about your partner and/or children.

	Partner	Child	Child	Child	Child	Child
First Name						
Age						
City, State						
Relationship Status						
No. of Children						
Education Level						
Occupation						
Physical Health*						
Mental Health*						
If Deceased, Cause/Age/Date						

*** E = Excellent, G = Good, F = Fair, P = Poor**

If you have a current relationship with a significant other or partner, please describe your experience of the relationship.
What are the strengths of your relationship?
If you have any concerns about your partner relationship, including safety, fear or sexual concerns, please describe them.
Please describe your partner, including her or his characteristics.
Please list any previous marriages or long-term relationships, including first name, year relationship began, year ended, and any children from this relationship.

If you are a parent, please describe your relationship with your children.
What has been most satisfying to you as a parent?
What has been most challenging to you as a parent?

RELATIONSHIP WITH SELF AND OTHERS:

To whom, if anyone, do you typically turn for emotional support?
Briefly describe the nature and quality of your closest friendship(s).
Please describe any concerns you have about your friendships or friendship patterns.
What do you believe to be your strengths as a friend?
Describe your personality and temperament.
How do you prefer to seek comfort when you are distressed?

EDUCATION:

Please state your highest level of education, including discipline and degree.

Please describe the following for grade school, high school, and any higher education.

	Grade School	High School Year graduated_ _	College/Grad School Year(s) graduated:
How were your grades?			
Describe your involvement in extra-curricular activities.			
Describe your relationship with other students, in general.			
Describe your relationship with teachers.			
If ever diagnosed with a learning disability or attention difficulty, please describe.			
*** E = Excellent,**	**G = Good**	**F = Fair**	**P = Poor**

EMPLOYMENT:

How long have you worked at your present job?
What are your specific work responsibilities?
How satisfied are you with your present job?
What aspects of your present job do you enjoy the most?
How are your relationships with your peers at work?
How are your relationships with supervisors?
Please list other significant jobs you have had along with approximate dates.
Please describe any significant problems in past/present job situations.

SPIRITUALITY/RELIGION:

If applicable, describe the role spirituality/religion has played in your life.
In what spiritual/religious faith, if any, were you raised?
If you have a present spiritual/religious community, please describe.
How often do you attend religious/spiritual services or activities?
Please describe any spiritual/religious practices you may have.
If applicable, please describe your spirituality or philosophy of life?

LEGAL:

Have you had any past litigation or legal problems? (Mark w/ "X") _ ____Yes. ___No If so, please explain.

OTHER:

Is there anything else you would like me to know about you?
Do you have any questions for me that relate to our work together?

Therapy:

The clinical relationship is central to the work I provide. As such, I work to establish safety in the therapy relationship, working to earn your trust, so that we can honestly address your concerns and co-create a plan which best addresses your purpose in seeking treatment at this time. Psychotherapy can be tremendously beneficial to some individuals while, at the same time, there are inherent risks in the course of treatment as well. It is my practice to be as transparent as possible about risks to reduce the anxiety new clients have to treatment and to provide a 'roadmap' to identify symptoms in order to be best informed about the new experiences you notice. A significant part of therapy is to become curious about your own process of development. This elevated curiosity creates a necessary and meaningful connection with your own experiences, helping you feel more empowered in the choices you make in your own care.

While each person's response to therapy is unique, generally speaking several risks you may notice in therapy include: an intensity of painful and unwanted feelings such as sadness, anger, guilt, fear, or

anxiety. Many of these feelings, while painful and difficult, are natural and to be expected. In fact, they are a necessary and important part of the therapeutic process, as I believe it is necessary to address these risks in order for growth to happen. Other risks may be recalling unpleasant memories, recalling painful losses, and acknowledging our responses to them. Another common concern is the risk of opening up to a new clinician. This concern is valid. I hope as we progress in therapy, the trust assuages the caution and you find ease in communicating your progress toward your goals and improved authenticity in your relationships. When the “client” is a child, it is important to share with Ms. Nix any changes in behavior, mood, or routines following therapy so that she will know the best rate at which to work with the child in therapy so that the child is not overwhelmed.

Abi J. Nix is a Licensed Clinical Professional Counselor (LCPC) whose practice includes children, adults, couples, and families. She specializes in treating children with a variety of emotional difficulties. In addition to her expertise in working with children, Ms. Nix is also trained to provide therapy to adults and couples. Ms. Nix’ goal is to enhance the functioning and well-being of the families, couples, and individuals with whom she provides therapy. Ms. Nix’s primary approach is relational focused psychotherapy, which utilizes the clinical relationships as a way of addressing relational patterns and dynamics outside of the clinical office. I am very sensitive to developmental factors that impact how a person may be presenting.

When the client is a child, play & art therapy techniques will be used because children express their thoughts, feelings, hopes, and fears better through play than through words. Depending on the age of the client, therapy may look different. For example, when the “client” is a child, therapy may involve play therapy sessions for the child, consultation and coaching for their parents or caregivers, and family therapy. For adults, therapy may be individual therapy or couples therapy for relationship related concerns. While goals for therapy differ from case to case, some reasons people seek therapy include:

- ❖❖ To care for any person affected by early trauma (abuse, physical, sexual, emotional, spiritual)
- ❖❖ Grief and loss
- ❖❖ To repair troubled relationships
- ❖❖ To improve communication, problem-solving, and coping skills
- ❖❖ To address child behavioral issues
- ❖❖ To manage family and parenting issues

Initial Contact:

The first appointment is a time for you to discuss your concerns and the problem from your point of view. It is a time to discuss a plan for therapy. When children are clients the child’s parents or guardian are involved in the treatment, and their participation is expected to support the agreed upon therapy goals. Parents may decide to come to the first appointment without the child, especially if the child is very young, so that the parents may share their concerns candidly without the child hearing their parents’ worries. *Children may not be dropped off for therapy.

Minors and Parents:

In the state of Illinois, children less than 15 years of age cannot independently consent to or receive mental health treatment without parental consent. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment and this may require that some private information be shared with parents or guardians. However, adolescents 15 and older are given legal privilege to seek services independent of parental consent, and this privacy is honored in therapy with the only exception being risk of harm to self or others (see section on risk of harm).

Children and Treatment Consent:

To provide consent for treatment for a child you must either have sole legal custody OR shared legal custody OR legal guardianship. If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, my services fall under this, and you may be in violation of a court order if you fail to inform the other parent of my services with your child. By signing this form you are stating that you have the legal right to consent for this child.

Confidentiality & Patients' Rights:

Confidentiality is your expectation that the information you disclose to Ms. Nix will be kept private, including the fact that you consult with her at all. Please note that Ms. Nix does discuss cases in peer supervision (though identifying patient information is not disclosed). By signing this consent to treatment, you give permission for these discussions when consultation is to aid Ms. Nix in providing effective therapy. All peer supervision consultations abide by the same ethical guidelines pertaining to mental health professionals and are bound by the same parameters of client privacy and confidentiality to maintain client confidentiality. As a general rule, outside of peer supervision, clinical information is not disclosed unless otherwise consented by authorized and signed document regarding other disclosures as a means to protect your privacy. One exception to this is if she employs outside services to collect past due accounts; by signing this form you give permission for such disclosure if necessary. There are also legal exceptions to confidentiality; these are described in the attached Notice of Privacy Practices, The Health Insurance Portability and Accountability Act. HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations (See HIPAA handout). The law requires she obtain your signature acknowledging she has provided you with this information; by signing below you are certifying that you have been given a copy of the Notice. You may revoke this Agreement in writing and that will be binding on her unless: she has taken action in reliance on it; if there are obligations imposed on Ms. Nix by your health insurer in order to process or substantiate claims; or if you have not satisfied any financial obligations. Please understand that all files are kept confidential. Your written consent is required for any release of information. There are important exceptions to confidentiality that are legally mandated. Exceptions include: (1) If Ms. Nix believes there is elevated risk that you/client intends to harm himself or someone else; (2) if there is suspected child abuse, elder abuse, or neglect; and, (3) if subpoenaed and ordered to share confidential information. In addition, when the client is a child in the custody of DSS or when DSS is conducting an investigation, DSS and the Guardian Ad Litem Program have the legal authority to access any confidential records related to the child.

Phone Messages:

Often, you will get my voicemail when you call as I am frequently in session during the day. Please leave a message and I will return your call promptly, usually within 24 business hours but sometimes up to 48 business hours. However, if you call with an emergency, my response time will reflect the urgency of the call to the best of my ability. Please call back a second time if the nature of your call is urgent. If there is immediate or imminent risk for you or someone you know, it is your responsibility to call your local emergency room or 911 for medical professionals to evaluate the person in crisis thoroughly and promptly. If you leave a message to cancel an appointment, Ms. Nix trusts you will call back when you are ready to reschedule.

Ending Therapy:

Ending therapy may occur at any time and be indicated by either the client or the therapist. If you are unhappy with therapy, please share your concerns and perhaps changes can be made to make therapy more helpful to you. It is not unusual for an individual to meet with more than one therapist before they find the "best fit." Please share your preferences and Ms. Nix may be able to help you find a therapist who may be a better match for you. Generally, therapy ends when you have accomplished the goals you

established at the beginning of therapy. If you stop attending sessions, Ms. Nix generally does not call out of respect for your choice. Do not interpret her not calling as Ms. Nix not caring about you. If you decide at a later date that you are ready to become involved in therapy again, please feel free to call her and ask to resume therapy. She understands that sometimes other circumstances need priorities and trusts you to call when you are again ready to prioritize therapy.

Sometimes unexpected life events happen causing people to take an unanticipated break from therapy. People are invited to communicate directly with me about ways these breaks align with the stated therapy goals. This communication is a direct extension of the therapeutic relationship I seek to establish throughout our work together in therapy. However, there are times when this notification is not given. Please note that for all practical purposes, clients who fail to attend therapy for 3 weeks without a clear acknowledgement of termination or intention of taking a break have, by default, terminated the clinical relationship. In other words, you will no longer be under my care and cannot cite or in any way indicate you are receiving treatment by Ms. Abi J. Shields-Nix. That said, I continue to remember you and the relationship is not nullified, to the contrary, if you would like to come back for services at a later date, please contact me and we can schedule a session. However, I leave the initiation of resuming therapy services in your hands as an indication of my trust in your ability to listen to and respond responsibly to your needs. Please know that rescheduling results in beginning again with a Diagnostic Interview. In my experience, the above scenario this is an anomaly. However, due to liability, it is necessary to document your consent and understanding that I cannot be referenced as your therapist if you are not in regular attendance.

Rates:

Therapy sessions are by appointment only. One “clinical” hour is 50-55 minutes in session and 5-10 minutes for the therapist to write the progress note. Sometimes I let myself go over the allotted time if you are the middle of something pressing, but this is the exception more than the rule. The rate for individual and family therapy is $135 per session. Couples are billed at the rate of $160 per clinical hour. The initial diagnostic assessment is $180. Payment is expected at the time of service. Clients report and are observed to benefit the most from therapy if they participate in therapy on weekly or bi-weekly basis. A regular appointment time helps ease your planning and mine. However, no charge will be made if: (1) you are ill, (2) you have an emergency, or (3) driving conditions are hazardous due to inclement weather. All other services, including phone calls, letters, telephone consultation, meetings attended on your behalf and at your request (including travel time) are billed at the same hourly rate. Payment is expected in full at the time of service. Note that the Diagnostic Interview is $180. This payment is required in full at the time of service. Often there are billing discrepancies, and in order to avoid this, the therapist asks that clients are prepared to pay for the Initial Diagnostic Evaluation at the time of service (cash, Quick Pay, Credit/Debit Card). This ensures the therapist is paid in full for services rendered as insurance benefits vary and are often unknown at the time of intake. If a balance exists in your favor, future session’s co-pay will utilize this balance. There is a charge of $126 for missed appointments and appointments canceled for non-emergencies when notice is given with less than 24 hours.

Important Insurance Information:

Generally, mental health benefits are reimbursed differently than general medical benefits so it is important that you check on your benefits by calling your insurance company prior to the initial appointment. If you have not called prior to arriving at the appointment today, please take a few minutes to make the call now so that you know how much to pay today and are not surprised by an unexpected bill. There are many different plans and Ms. Nix may not be able to answer specific questions related to your insurance. It is always best to address this question directly with your insurance provider as each plan differs slightly. Some insurance cards read that mental health services are “covered.” This is misleading because it does not mean that sessions are covered at 100%. As a therapist, my relationship is with you and not your insurance company. All charges are your responsibility from the date services are rendered, and payment for services is due in full on the date services are rendered. Payment is expected

at the beginning of each session. Checks are easies however, I can and do accept credit/debit card payments as needed.

At your request, Ms. Nix may agree to file the claim to your insurance plan. If she agrees, Ms. Nix will need a copy of your insurance card. Your signature & consent is needed to allow her to do so. She will release relevant information to facilitate reimbursement. **Please complete the following information only if you would like Ms. Nix to file the claim with your insurance please get her consent to do so.** If the child is in foster care & has Medicaid, the insurance information is not needed here as it was provided on page one; however, the legal guardian's signature is needed at the bottom of the page to give authorization to Ms. Nix to file the claim.)

Client's Name: _____
Insurance Plan: _____
(For example: BCBS, Cigna, Aetna, etc)
Insurance identification number: _____
Insurance group number: ____________

Insured's Name & Date of Birth (For instance, if a child has coverage through their parent's insurance plan, then information is needed related to the parent who holds the policy):
Name: _______
DOB: _______
Relationship to client: (parent, grandparent, guardian) ______

Late Fees and Returned Checks:

The returned Check fee is $30. For therapy, if you do not pay in full on the date services are rendered and no prior arrangements were made, 10% of the original charge will be added each week you are late. Regarding delinquent accounts, you are responsible for full payment and will be charged in full any and all time we spend trying to collect on the account (billed at $126/hour), and/or any and all fees of any outside services, such as an attorney or credit collector, hired to collect the debt.

Testifying:

Participating in court for custody or any other matter is not an expected service. If you are seeking therapy in any way related to a legal matter (current or anticipated), this may not be the best fit. Instead, inform Ms. Nix immediately and she will do her best to refer you to an appropriate professional. Should Ms. Nix be subpoenaed, the rate is $500 per hour for all time related to responding to the subpoena regardless of whether she is called to testify. This may include time reviewing notes and talking with attorneys, as well as any phone calls or letters written on your behalf. If required to appear in court, she must cancel all other clients for that day, even when she is on "stand-by" status. You will be charged for the entire day. The rate is the same for depositions of fact or expert witness, as well as testimony.

Consent for Therapy:

Please sign below to indicate that you have read the preceding information in full and understand the information. Please ask for clarification of any information you are unclear about. Your signature indicates that you have read this document & agree to its terms in its entirety throughout our professional relationship.

I have also read and understand the policies and agree to the conditions. I agree to the statements herein and terms of payment, to include payment of all fees listed. I was offered a copy of these documents. If minor patient, I certify that I have the legal right to consent to treatment. Further, I acknowledge receipt of HIPAA Notice of Privacy Practices.

____ ____________________

Signature Date

Abi J. Nix, M.A., LCPC
Clinical Psychotherapist 1603
Orrington Ave; Suite 651
Evanston, IL 60201
abijoynix@gmail.com

The parties agree that neither party shall ever, under any circumstance, utilize nor request Abi J. Nix to testify in any format (including a request for his records, personal communications, depositions or court appearances) regarding themselves or the children. Both parties understand that to do so would compromise the effectiveness of the counseling services being provided.

Name of Child/ren: ___________________________________

_____________________________	_________________________
Parent	Witness
_____________________________	_________________________
Parent	Witness
_____________________	_________________________
Date	Date
_____________________	_________________________
Abi J. Nix, MA., LCPC	Date

Abi Joy Nix, M.A., LCPC 1603 Orrington Avenue. Suite 651 Evanston. Illinois. 60201
abijoynix@gmail.com p. 847.644.8523 f. 847.892.0517

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you may be used and disclosed and how you can get access to your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY.

Our practice is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the diagnosis, treatment and services we provide to you. We are required to:

- Maintain the privacy of your health information.
- Provide you with a notice of our legal duties and privacy practices with respect to information we collect.
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you have to communicate health information by alternative means or at alternative locations.

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times and you may request a copy of our most current Notice.

B. USE AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS.

The following categories describe the different ways in which we may use and disclose your health information.

1. **Treatment.** We may use your health information to treat you and reach a diagnosis. Additionally, we may disclose your health information to others who may assist in your care.
2. **Payment**. We will use and disclose your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs. Also, we may bill you directly.
3. **Health Care Operations**. We may use and disclose your health information to operate our business. For example we may use and disclose your information to evaluate the quality of care you received from us.
4. **Release of Information to Family/Friends**: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, and general condition.
5. **Disclosure required by Law**. We will use and disclose your health information when we are required to do so by federal, state or local law.

C. SPECIAL CIRCUMSTANCES FOR DISCLOSURE OF YOUR HEALTH INFORMATION.

The following categories describe unique scenarios in which we may use or disclose your health information.

1. **Public Health Risks**: Our practice may disclose your health information to public health authorities for the purpose of:
   -reporting child abuse or neglect.
2. **Lawsuit and Similar Proceedings**: Our practice may use and disclose your health information in response to court or administrative order, if you are involved in a lawsuit or similar proceedings. We may disclose your health information in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

3. **Military:** Our practice may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
4. **National Security**: Our practice may disclose your health information to federal officials for intelligence and national security activities authorized by law.
5. **Workers' Compensation**: Our practice may release your health information for worker's compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding the health information we maintain about you:

1. **Confidential Communications**: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. In order to request a type of confidential communication, you must make a written request to Abi Nix, LCPC specifying the requested method of contact of the location where you wish to be contacted. Our practice will accommodate reasonable requests.
2. **Inspection and Copies**: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to Abi Nix, LCPC in order to inspect/obtain a copy of your health information. A service charge of $40 may be applied for the cost of copying, mailing, labor and supplies associated with your request. Your request may be denied to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another health care professional chosen by us will conduct the review.
3. **Requesting Restrictions**: You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction you must make written request describing the following:
   - the information you wish restricted;
   - whether you are requesting to limit our practice's use, disclosure or both, and
   - to whom you want the limits to apply.
4. **Amendmen**t: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. You must make this request in writing and must provide us with a reason to support your request for amendment. Our practice will deny your request if it is not in writing and you fail to provide the reason for your request. Also, we may deny your request if you ask us to amend information that is in our opinion (a)accurate and complete; (b) not part of the patient information kept by our practice; (c) not part of the patient information which you would be permitted to inspect or copy, or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information
5. **Accounting of Disclosures**: You have the right to request a list of certain non-routine disclosures our practice has made of your patient information for non-treatment or operations purposes. All requests for this information must be made in writing and must state a time period which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. Our practice may charge you for lists of more than a 12 month period. Our practice will notify you of the costs involved and you may withdraw your request before you incur any costs.
6. **Right to a paper copy of this Notice**: You are entitled to receive a paper copy of our notice of privacy practices. To obtain a copy contact Abi Nix, LCPC.
7. **Right to File a Complaint**: If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact your therapist. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures**: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing.

Abi Joy Nix, MA, LCPC
1603 Orrington Ave. Suite 651. Evanston IL 60201. P:847.644.8523

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, ____________________(Parent/guardian), understand that as part of my healthcare, Abi J. Nix, M.A., LCPC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Abi J. Nix, M.A., LCPC reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Abi J. Nix, M.A., LCPC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept / decline the terms of this consent.
(Please circle either accept or decline)

____ ____________________
Client/Parent/Guardian (circle one) Date

Abi Joy Nix, M.A., LCPC
Clinical Psychotherapist
1603 Orrington Ave., Suite 651
Evanston, IL 60201

PATIENT INFORMATION FOR MINOR CHILD

Name: ____

Address:____
Street

____
City State Zip

Phone: ( ) ________________________ Sex: Male_____ Female______

School:____ Grade:______________

Date of Birth:__________________

Diagnosis: ____________________

MEDICAL HISTORY:

Significant Illnesses, Physical Conditions, Hospitalizations (include dates):

____

____

____

Medications currently using: ____

Name of Clinic/Doctor ________________________Phone: ( )__________________

Location of Medical Doctor: ____

REFERRAL INFORMATION:

Whom were you referred by: ____

Church:___________________________Pastor:_______________________________

BILLING INFORMATION

Name of Responsible Party____

Address of Responsible Party ____
City State Zip

Date of Birth of Responsible Party___________

Relationship to client:_________________ Social Security Number:_____________

Employer:____

Name of Insurance Company:____

Address of Insurance Company____
City State Zip

Group/Plan Number:_____________________________

Name of other Parent:____

Address:____
City State Zip

Social Security Number:_______________________ Date of Birth:_________________

I hereby authorize the release of medical information necessary to process my claims:

____ Date:________________________
Signature of Client (for Patients 12 years old and above)

I authorize Abi J. Nix, Clinical Psychotherapist to release information concerning
my Self/Child regarding stated claims, diagnosis and treatment to:
____.

Relationship and Contact Information: _________________________________.

I further consent and understand that this information will be kept in my confidential file for one year from signed date.

_____________________________________ Date:________________________
Signature of Client

I authorize payment of medical benefits to Abi J. Nix, MA, LCPC and understand that I am responsible for charges not covered by my insurance.

_____________________________________ Date:______________________
Signature of Responsible Party

Abi J. Nix, MA, LCPC
1603 Orrington Ave
Suite 651
Evanston, IL 60201

Clinical Psychotherapist
Phone: 847.644.8523
Fax: 847.892.0517
E-mail: abijoynix@gmail.com

Request/Authorization to Release Confidential Records and Information

I, ___________________________________ hereby authorize:

[x**] Abi Joy Nix, M.A., LCPC of 1603 Orrington Ave, Suite 651, Evanston IL 60201** to contact the named provider:

[ ] ____

of (Address): ____

Phone: ____________________ Fax: _____________________to release information from records about

patient (name): _________________________________, DOB: _____________and whose Social Security

number is_____________________, for the following purpose(s):

[x]Further mental health evaluation, treatment, or care [ ] Rehabilitation program development or services [x] Treatment planning [ ] Research [ ] Other: ______________________________

These records concern the time between ________________ and **Current date** inclusively.

The information to be disclosed is marked by an X in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate.
[x] Intake and discharge summaries [x] Medical history and evaluation(s) [x] Mental health evaluations [x] Developmental and/or social history [x] Educational records [x] Psychological Evaluations
[ ] Progress notes, and treatment or closing summary [x] Other: **case consultation as needed.** I have a right to inspect a copy of any and all materials that will be disclosed.

Should I refuse to disclose, the consequence could be: Limitation of care due to limited patient history.
Select:
[ ] Please forward the records ***to* Abi Joy Nix** at the above address
[ ] Please forward the patient records ***from*** Abi Joy Nix to the address written above.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

________________________________	________________________________	______________________
Signature of patient	Printed name	Date

________________________________	_______________________	________________	_______________
Signature of parent/ guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____________________________________	_____________________________________	___________
Signature of witness / therapist	Printed name	Date

[ ] Copy for patient or parent/guardian [ ] Copy for source of records [ ] Copy for recipient of records