BRAINS AND BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Welcome to Brains and Business LLC!

We are an environmentally friendly company and paperless!

Your Therapy Registration (Intake) Forms are available in this document. Please fill out all the forms that apply to you, your Family Group or your child. Once you complete the forms that apply to you, send them to *amy@amywilhelmi.com*. This will allow your assigned provider to know details about you even before the first appointment.

Again, thank you for choosing Brains and Business LLC as your service provider. We strive to provide you with the best care to meet your needs.

Very Appreciative,

Amy Wilhelmi

Amy Wilhelmi
CEO/Administrator

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642
www.amywilhelmi.com

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Registration Form

Today's Date: _____

Date of First Appointment (If scheduled): _____

Client's Name: _____

Address: _____

Home Phone Number: _____

Cell Phone Number: _____

Social Security Number: _____

Date of Birth: _____

Email: _____

Authorized Method to be Contacted (mark all that apply)

☐ Call to Home Number ☐ Call to Cell Phone ☐ Text Message ☐ Email

Can we leave a voice Message? _____

Civil Status (mark all that apply)

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Living Together

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Employment Status (mark all that apply)

☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student

Employer Information

Employer's Name: _____

Employer's Phone Number: _____

Employer's Address: _____

Employer's Website: _____

Emergency Contact

Contact's Name: _____

Contact's Address: _____

Contact's Phone Number: _____

Contact's Email: _____

Relationship with client: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Friend
☐ Spouse ☐ Significant Other ☐Other _____

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Insurance Information

To avoid delays in insurance payment for your services at Brains and Business LLC, we would like to check your insurance benefits prior to your first appointment. Please provide the information as soon as possible to our secure email: *amy@amywilhelmi.com* or you could also respond via our Client Portal.

Subscriber's Full Name: _____

Subscriber's Date of Birth: _____

Subscriber's Relationship with Client: _____

Address: _____

Phone Number: _____

Email Address: _____

Insurance Company Name: _____

Insurance ID number: _____

Group Number: _____

Insurance Phone Number (as it shows in the back of your card): _____

Mental Health Insurance Name (if different from your medical Insurance): _____

Mental Health Insurance Phone Number: _____

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Credit Card Information

Brains and Business LLC requires that all patients have a working credit card on file. This assists in the collection of payments due at the time of service and balances that accrue. Account numbers are kept secure. Charges and fees are described in the Benefits Inquiry and Informed Consent.

I authorize Brains and Business LLC to process payments on my credit/debit card for any and all balances that may accrue on my behalf. I understand that there is a transaction fee of $5 for every credit or debit card transaction made to my card.

Name as it shows in the card: _____

Card Number: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Flexible Spending Account (FSA/HSA) ☐ American Express

Expiration Date: _____

Security Code (3 digits in the back of the card, 4 digits for AMEX): _____

Card Holder's Billing Address: _____

My signature authorizes this card to be billed as charges accrue, if I do not bring my payment by cash or check at the time of service:

Signature _____ Date _____

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Financial Policy

FINANCIAL POLICY - INSURANCE (THIRD PARTY) & SELF PAY

Thank you for choosing Brains and Business LLC. The billing office is located at 1500 N Halsted, 2nd Floor, Chicago, IL 60642. We are committed to providing you with the best possible services. Your understanding of our Financial Policy is important to forming a successful therapeutic alliance.

Private paid sessions rate is $180.00 per session unless otherwise discussed with your therapist.

As a courtesy to you, clients using behavioral health insurance will be informed of the fees and your sessions can be billed to your insurance company. You will be responsible for any copay, deductible and coinsurance as determined by your insurance company or any remaining fees associated with your account as detailed in your monthly statement.

You must pay your copay at the time of the visit. This may be paid in cash, by check or billed to your credit card. (We accept Visa, MasterCard, American Express or Flexible Spending Accounts).

*Brains and Business **DOES** require you provide credit card information on your first call. Brains and Business will then charge $100 as a retainer to your credit card. This $100 then acts as a credit on your account to be applied to your first visit(s). Additionally, there is a $5 service fee to complete this transaction that will **NOT** be applied to your first visit(s).* You are **REQUIRED** to keep a card on file to be a client of Brains and Business. There are no exceptions. This information is kept in the secure credit card processing company file. We do not keep copies of this information on site. Credit cards can be used to pay for deductibles, co-pays, coinsurance and invoiced charges. This prevents the possible need for collection agencies and protects the client from the treatment affecting their credit.

Your Brains and Business therapist is available for brief phone consultation and encourages you to call, especially in crisis situations. Extended therapy related to telephone contact (15 minutes or longer) is billed to your credit card on file at your agreed upon session fee.

Should you choose to use insurance benefits, Brains and Business will assist you in processing claims by providing you with a statement suitable for insurance reimbursement or by billing your insurance carrier directly, as appropriate. It is important that you understand your therapist's relationship is with you, not your insurance provider. You will be required to pay your copay via credit card at each session and this is charged to your credit/ debit card.

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Financial Policy

Any assistance from Brains and Business in processing insurance claims is provided as a courtesy to you. Payment of all charges is your responsibility. Should you switch insurance carriers or choose to use your insurance during treatment, Brains and Business will not reimburse private pay costs such as credit card transaction fees or be able to back-date insurance charges. The insurance will be billed from the date you initiated insurance billing.

A forty-five dollar ($45.00) fee is charged for returned checks. If financial issues impact your ability to pay your fee, please discuss them with the billing department.

CANCELLATION POLICY

An appointment is a commitment between us. Your session time is reserved for you. Please be aware that your credit card on file is charged for our agreed upon fee if you do not give at least twenty-four (24) hours notice of cancellation. OR your missed session is counted as one of your sessions. ***MISSED APPOINTMENT FEES ARE $75.00 PER SESSION WITH NO EXCEPTION.*** Please note: Insurance does not pay missed appointment charges. You are responsible for paying this fee.

I have read and understand the above Financial Policy. I have been given the opportunity to have my questions answered regarding this Financial Policy.

Signature _____ Date _____

BRAINS AND BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Agreed & Acknowledged by my signature: _____

BRAINS AND BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Due to COVID-19 ALL SESSIONS are virtual Telehealth video platforms until further notice.

Telehealth Informed Consent

Brains and Business will bill your IN NETWORK insurance company for these sessions.

TELEMEDICINE/TELEHEALTH INFORMED CONSENT I _____ [name of client] hereby consent to engaging in telemedicine at Brains and Business as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Illinois.

I understand that I will need to download an application and/or software to use this platform and organize which platform that I will be using with my therapist directly. I also need to have Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Brains and Business via phone to coordinate alternative methods of treatment.

Financial Obligations: Sessions associated with telemedicine appointments are payable by credit or debit card only. We are waiving the previous $5 credit card fee for ALL Telehealth appointments. I agree to have my credit/debit card information on file with Brains and Business via signing my financial policy.
(Client Initial: _____)

My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, Brains and Business will cancel my appointment and I will be charged in accordance with the cancelation policy.
(Client Initial: _____)

Clients using insurance: I authorize insurance benefits to be paid directly to Brains and Business and that they may release any information to my insurance provider required for processing my claims.
(Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment via credit/ debit card at $180 per session. I understand that I am responsible for canceled telemedicine appointments in accordance with the Brains and Business cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations. I understand that the COVID-19 outbreak is considered a National Emergency and Telehealth is the only available method of care allowed at this time.
(Client Initial: _____)

Scheduling: I understand that scheduling is conducted through Brains and Business and is based on my provider's normal clinical hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.
(Client Initial: _____)

BRAINS AND BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Video/Audio Recording: As a general practice Brains and Business DOES NOT record Telemedicine sessions without prior permission. Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine.
(Client Initial: _____)

As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. Pathways' Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the Mental Health Informed Consent, which I have signed.

I understand that I have the following rights with respect to telemedicine: 1. I have the right to withdraw my consent at any time. 2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services, I will be referred to a counselor/therapist who can provide such services in my geographic area. 3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured. 4. I understand that I have a right to access my mental health information and copies of medical records in accordance with Illinois state law. I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

_____Client

_____Date

_____ Client Guardian's Signature

_____Date

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Consent for Treatment of a Minor Child

The following statements provide your legal consent to and financial responsibility for counseling services to a minor child at Brains and Business. These statements are important to protect the child, the parent/guardian/conservator, and the therapist. Please carefully review this information and sign where indicated. You are requested to discuss any question you may have with the therapist.

Statement of Responsibility and Grant of Permission for Therapy

I am the: Natural Parent: [ ] Legal Guardian: [ ] Managing Conservator of [ ]

(Name of minor child)

_____

I am legally responsible for the child named above and grant permission to

_____

(Therapist)

At Brains and Business to conduct therapy with this child.

I accept responsibility for payment of all fees at the time of service due to Brains and Business for services provided to this child as outlined in the Financial Policy.

Signature:_____Date:_____

Duty to Warn Notice

Brains and Business is committed to the confidentiality and privileged communication with all clients. There are, however, several exceptions. According to Illinois law, any evidence of child abuse must be reported to the authorities. If any individual intends to take harmful, dangerous, or criminal action against another individual, or against himself/herself, it may be the therapist's duty to report such action or intent.

Parent/Guardian Signature:_____

Date:_____

BRAINS AND BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Notice of Privacy Practices

Welcome to Brains and Business. Privacy is a very important concern for all who come to this office. It is also complicated because of federal and state laws. Because the rules are so complicated some parts of this Notice are quite detailed and you will probably have to read it several times to understand them. If you have any questions we will be happy to help you.

Contents of this Notice

A. Introduction

This notice will tell you about how information about you is handled. It tells how this information is used in this office, how it is shared with other professionals and organizations, and how you can see it. We want you to know all this so that you can make the best decisions for yourself and your family. We are also required to tell you about this because of the privacy regulations of a federal law, the health Insurance Portability and Accountability Act of 1996 (HIPAA). Because this law and the laws of this state are very complicated and we don't want to make you read a lot that may not apply to you, we have simplified some parts. If you have any questions or want to know more about anything in this Notice, please ask for more explanation or more details.

B. What We Mean By Your Medical Information

Each time you visit us or any doctor's office, hospital, clinic, or other "healthcare provider" information is collected about you and your physical and mental health. It may be information about your past, present, or future health or conditions, or the treatment or other services you got from us or from others, or about payment for healthcare. The information we collect from you is called, in the law, **PHI** which stands for **Protected Health Information.** This information goes into your medical or healthcare record. In this office this PHI might include these kinds of information:

- Your history – as a child, in school and at work, marital and personal history
    - Reasons you came for treatment – problems, complaints, symptoms, needs, goals
    - Diagnosis – the medical terms for your problems or symptoms
    - A treatment plan – treatments and other services we think will best help you
    - Progress notes – anything written about how you are doing, what we observe about you

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

- Records we get from others who treated or evaluated you
  - Psychological test scores, school records, etc
  - Information about medications you took or are taking
  - Legal matters
- Billings and insurance information

This list is just to give you an idea. All of these may not be included and other kinds of information may go into your healthcare record here. We use this information for many purposes. For example, we may use it for:

- To plan your care and treatment
- To decide how well our treatments are working for you
- When we are talking with other healthcare professionals who are treating you
- To show that you actually received services from us
- For teaching or training other healthcare professionals
- For medical or psychological research
- For public health officials trying to improve health care in this country
- To improve the way we do our job by measuring the results of our work

When you understand what is in your record and what it is used for you can make better decisions about who, when, and why others should have this information. Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You can inspect, read, and review it. If you want a copy we can make one for you but may charge you for the costs of copying (and mailing if you want it mailed to you). In some very unusual situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or something important is missing you can ask us to amend (add information to) your record, although in some rare situations we don't have to agree to do that.

C. Privacy And The Laws

The HIPAA law requires us to keep your PHI private and give you this notice of our legal duties and our privacy practices, which is called the Notice of Privacy Practices or NPP. We will obey the rules of this notice as long as it is in effect but if we change it the rules of the new NPP will apply to all the PHI we keep. If we change the NPP we will post the new Notice in our office where everyone can see. You or anyone else can also get a copy from your therapist at any time.

D. How Your Protected Health Information Can Be Used And Shared

When your information is read by anyone in the office that is called, in the law, "use". If the information is shared with or sent to others outside this office, that is called in the law, "Disclosure". Except in some special circumstances, when we use your PHI here or disclose it to others we share only the minimum necessary PHI needed for the purpose. The law gives you the right to know about your PHI, how it is used and to have a say in how it is disclosed and so we will tell you more about what we do with your information. We use and disclose PHI for several reasons. Mainly, we will use and disclose (share) it for routine purposes and we will explain more about this below. For other uses we must tell you about them and have a written Authorization from you unless the law lets or requires us to use or disclose without your

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

authorization. However, the law also says that we are allowed to make some uses and disclosures without your consent or authorization.

1. Uses and Disclosures of PHI in Healthcare with Your Consent

After you have read this Notice you will be asked to sign a separate Consent Form to allow us to use and share your PHI. In almost all cases we intend to use your PHI here or share it with other people or organizations to provide treatment to you, arrange for payment for our services, or some other business functions called health care operations. Together these routine purposes are called TPO and the Consent form allows us to use and disclose your PHI for TPO. Reread this last sentence until it is clear because it is very important.

1a. For Treatment, Payment, or Health Care Operations

We need information about you and your condition to provide care to you. You have to agree to let us collect that information and to use it and share it as necessary to care for you properly. Therefore you must sign the Consent form before we begin to treat you because if you do not agree and consent we cannot treat you. When you come to see us, several people in our office may collect information about you and all of it may go into your healthcare record here. Generally, we may use or disclose your PHI for three purposes: treatment, obtaining payment, healthcare operations. Let's see what these are about.

FOR TREATMENT

We use your medical information to provide you with psychological treatment or services. These might include individual, couple, family/group therapy, psychological education, vocational testing, treatment planning, or measuring the effects of our services. We may share or disclose your PHI to others who provide treatment to you. We are likely to share your information with your personal physician. If you are being treated by a team, we will share some of your PHI with them so that the services you receive will be coordinated. They will also enter findings, the actions they took, and their plans into your record. We can then decide what treatments work best for you and make a treatment plan. We may refer you to other professionals or consultants for services we cannot offer such as special testing or treatments. When we do this we need to tell them some things about you and your conditions. We will get back their findings and opinions and those will go into your records here. If you receive treatment in the future from other professionals we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

FOR PAYMENT

We may use your information to bill you, your insurance, or others to be paid for the treatment we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them about your diagnosis, what treatments you have received, and what we expect as we treat you. We will need to tell them about when we met, your progress, and similar things.

FOR HEALTHCARE OPERATIONS

There are some other ways we may use or disclose your PHI which are called healthcare operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to provide some information to government health agencies so they can study disorders and treatment and make plans for services that are needed. If we do, your name and identity will be removed from what we send.

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

1b. Other Uses in Healthcare

APPOINTMENT REMINDERS

We may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange that. Just let us know.

TREATMENT ALTERNATIVES

We may use or disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of interest to you.

OTHER BENEFITS AND SERVICES

We may use or disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

RESEARCH

We may use or disclose your information to do research to improve treatments. For example: comparing treatments for the same disorder to see which works better or faster or costs less. In all cases your name, address, and other information that reveals who you are will be removed from the information given to researchers. If they need to know who you are we will discuss the research project with you. You will have to sign a special Authorization form before any information is shared.

BUSINESS ASSOCIATES

There are some jobs we hire other businesses to do for us. They are called our business associates in the law. Examples include a copy service we use to make copies of our health records and a billing service that figures out, prints, and mails our bills. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy they have agreed in their contracts with us to safeguard your information.

2. Uses and Disclosures Requiring Your Authorization

If we want to use your information for any purposes besides the TPO or those we described above we need your permission or an Authorization form. We don't expect to need this very often. If you do authorize us to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time we will not use or disclose your information for the purpose that we agreed to. Of course, we cannot take back any information we had already disclosed with your permission or that we had used in our office.

3. Uses and Disclosures of OHI from Mental Health Records Not Requiring Consent or Authorization

The law lets us use and disclose some of your PHI without your consent or authorization in some cases. WHEN REQUIRED BY LAW: There are some federal, state, and local laws which require us to disclose PHI.

- **We have to report suspected child abuse or elder abuse.**
- If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process we may have to release some of your PHI. We will do so only after telling you about the request, consulting your lawyer, or trying to get a court order to protect the information they requested.
- We have to release (disclose) some information to the government agencies that check on us to see that we are obeying the privacy laws.

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

FOR LAW ENFORCEMENT PURPOSES
We may release medical information if asked to do so by a law enforcement official to investigate a crime or criminal.

FOR PUBLIC HEALTH ACTIVITIES
We might disclose some of your PHI to agencies that investigate diseases or injuries.

FOR SPECIFIC GOVERNMENT FUNCTIONS
We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment, to Workers' Compensation programs, to correctional facilities if you are an inmate, and for national security reasons.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY
If we come to believe that there is a serious threat to your health or safety or that of another person or the public we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

4. Uses and Disclosures Requiring You to Have an Opportunity to Object

We can share some information about you with your family or close others. We will only share information with those involved in your case and anyone else you choose, such as close friends or clergy. We will ask you about who you want us to tell what information about your condition or treatment. You can tell us what you want and we will honor your wishes as long as it's not against the law.

5. An Accounting of Disclosures

When we disclose your PHI we keep some records of whom we sent it to, when we sent it, and what we sent. You can get an accounting (a list) of many of these disclosures.

1. If You Have Questions

If you need more information or have questions about the privacy practices described above please speak with your therapist whose name and telephone number are listed below. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated discuss it with your therapist. You have the right to file a complaint with us and with the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care here or take actions against you if you complain. If you have questions regarding this notice or our health information privacy policies, please talk with your therapist or contact the practice *amy@amywilhelmi.com*

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Acknowledgement

By signing below, the Representative acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Representative has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Representative's satisfaction. Representative agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, the Representative agrees to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____ _____

Patient Name (please print) Date

_____ _____

Signature of Patient (if Patient is 12 or older) Date

_____ _____

Signature of Representative
(and relationship to Patient) Date

BRAINS AND
BUSINESS LLC

331-223-4640
amy@amywilhelmi.com
1500 N Halsted, 2nd Floor, Chicago, IL 60642

Authorization to Release Confidential Information

I, [Name of Patient]_____
hereby authorize _____(therapist)
at Brains and Business LLC at 1500 N Halsted, 2nd Floor, Chicago, IL 60642 to release confidential information obtained during the course of my treatment
to_____
[name and function of the person(s) or entities to which information is to be released]

This Authorization permits the release of the following information:
____ Any and All Information Necessary
____ Diagnosis ____ Treatment Plan ____ Prognosis
____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment ____ Patient Records
____ Summary of Treatment

____ Other _____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This Authorization shall remain valid until:_____(“Expiration Date”)

By:_____

Date:_____
(Patient or Patient’s Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/ her representative: _____