Kimberly Boatner, LCSW, CADC

INDIVIDUAL, COUPLE AND FAMILY THERAPY

NEW CLIENT INFORMATION

Client & Insurance Information

Please complete the information below. Information is used for treatment, communication, billing, and coordination of care as applicable.

CLIENT INFORMATION

Legal Name: _____	Preferred Name: _____
Date of Birth: _____ Age: _____	Pronouns (optional): _____
Street Address: _____	City/State/ZIP: _____
Primary Phone: _____	Email: _____
Preferred Contact: ☐ Phone ☐ Text ☐ Email	May we leave a voicemail? ☐ Yes ☐ No

Gender Identity (optional): _____ Marital/Relationship Status (optional): _____

Occupation / School: _____ Employer / Grade Level: _____

PARENT / GUARDIAN INFORMATION - FOR MINOR CLIENTS

Parent/Guardian Name: _____	Relationship to Client: _____
Primary Phone: _____	Email: _____
Address (if different): _____	

Second Parent/Guardian Name (if applicable): _____ Phone: _____

Are there custody, guardianship, or court orders that affect consent, communication, or access to records? ☐ No ☐ Yes

If yes, please explain and provide applicable documentation: _____

EMERGENCY CONTACT

Name: _____	Relationship: _____
Phone: _____	Alternate Phone: _____

HEALTH CARE / REFERRAL INFORMATION

Primary Care Provider: _____	Phone: _____
Psychiatrist / Prescriber (if applicable): _____	Phone: _____
Referred By / How did you hear about the practice? _____	

INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____	Member/Subscriber ID: _____
Group Number: _____	Plan Name/Type: _____
Subscriber Name: _____	Subscriber DOB: _____
Relationship to Client: _____	Subscriber Employer: _____
Insurance Phone (if listed on card): _____	Behavioral Health Phone: _____

Please provide a copy of the front and back of the insurance card.

Secondary Insurance (if applicable)

Insurance Company: _____	Member/Subscriber ID: _____
Group Number: _____	Subscriber Name: _____
Subscriber DOB: _____	Relationship to Client: _____

RESPONSIBLE PARTY / BILLING

Responsible Party Name: _____	Relationship to Client: _____
Billing Address (if different): _____	
Phone: _____	Email: _____

INFORMATION CONFIRMATION

I certify that the information provided on this form is accurate to the best of my knowledge. I agree to notify Kimberly Boatner, LCSW, CADC, LLC of changes to my contact, guardianship, responsible-party, or insurance information.

Client / Parent / Legal Guardian Signature: _____	Date: _____
Clinician Signature: _____	Date: _____

Kimberly Boatner, LCSW, CADC

INDIVIDUAL, COUPLE AND FAMILY THERAPY

CONSENT TO TREATMENT & PRACTICE POLICIES

Please review carefully and ask any questions before signing.

Client Name _____

Date of Birth _____

1. Consent to Treatment

I affirm that I have the legal authority to consent to behavioral health services for myself and/or my dependent child, as applicable. I voluntarily consent to assessment, psychotherapy, counseling, treatment planning, and other clinically appropriate outpatient behavioral health services provided by Kimberly Boatner, LCSW, CADC, LLC.

Psychotherapy is a collaborative process. I understand that I may ask questions about treatment goals, methods, recommendations, potential benefits, possible risks, and alternatives at any time. Participation is voluntary, and I may discontinue treatment. When clinically appropriate, discussion before ending treatment is encouraged to support continuity of care.

2. Benefits and Risks of Psychotherapy

Psychotherapy may support symptom reduction, improved coping, insight, emotional regulation, relationships, and functioning; however, specific outcomes cannot be guaranteed. Treatment may involve discussing difficult experiences and may temporarily increase feelings such as sadness, anxiety, anger, grief, or distress.

3. Confidentiality

Information shared in psychotherapy and records created in connection with treatment are confidential and will be protected in accordance with applicable federal and Illinois law. Information generally will not be released to another person or organization without appropriate authorization from the person legally entitled to authorize disclosure.

Confidentiality may be limited when disclosure is permitted or required by law, including circumstances involving:

- Suspected abuse or neglect when reporting is legally required;
- A clear or imminent risk of serious harm to the client or another person;
- Emergency medical or safety needs;
- Certain court orders, legal proceedings, or other legally authorized disclosures; and
- Other circumstances specifically permitted or required under applicable law.

When disclosure is necessary, reasonable efforts will be made to limit the information disclosed to what is relevant to the purpose of the disclosure.

4. Treatment of Minors

When services are provided to a minor, the practice recognizes the importance of both appropriate parent/guardian involvement and a trusting therapeutic relationship with the child or adolescent. The nature and extent of parental involvement may vary based on the client's age, developmental needs, clinical circumstances, legal rights, and applicable Illinois law.

For adolescent clients, particularly those age 12 and older, confidentiality and access to mental health records may be governed by specific Illinois requirements. A parent or guardian may not necessarily have unrestricted access to all psychotherapy communications or the complete treatment record. Safety concerns and disclosures otherwise permitted or required by law may limit confidentiality.

Illinois law permits a minor age 12 or older, in specified circumstances, to request and receive outpatient counseling or psychotherapy without parental consent, subject to statutory limits and clinical considerations. The practice will determine consent, confidentiality, record-access, and parent/guardian involvement requirements based on the client's age, circumstances, and applicable law.

5. Parental Authority and Custody

A parent or legal guardian consenting to treatment for a minor represents that they have legal authority to authorize services. The practice may request parenting agreements, allocation judgments, guardianship documents, court orders, or other records when needed to determine authority to consent, communicate, or access information.

Parents/guardians are responsible for promptly informing the practice of any legal order or change that may affect treatment. Psychotherapy is provided for treatment purposes and is not a custody evaluation, parenting-capacity evaluation, forensic assessment, or recommendation regarding allocation of parental responsibilities unless separately agreed to in writing.

6. Communication

The practice telephone number is 630-488-6113. Telephone and approved electronic communication may be used for scheduling, administrative matters, and appropriate treatment-related communication. Email, text messaging, and electronic portals should not be used for emergency, urgent, or highly time-sensitive clinical concerns.

Electronic communication may have privacy and security limitations. An immediate response cannot be guaranteed.

7. Emergencies and Crisis Services

Kimberly Boatner, LCSW, CADC, LLC is an outpatient private practice and does not provide 24-hour crisis or emergency services.

If I or my dependent is experiencing a medical or mental health emergency, is in immediate danger, or requires immediate intervention, I understand that I should call 911 or go to the nearest emergency department. The 988 Suicide & Crisis Lifeline may also be reached by calling or texting 988.

8. Telehealth Services

When clinically appropriate, services may be provided through telehealth. Telehealth services are provided consistent with the professional standard of care applicable to in-person services and with applicable federal and Illinois privacy, security, and confidentiality requirements. I understand that telehealth can increase access and convenience but may involve technological disruptions, limitations in observation, and privacy or security risks inherent in electronic communication.

Clients are expected to participate from a reasonably private and appropriate location. The therapist may verify the client's physical location and emergency contact information when needed for safety. If telehealth is not clinically appropriate, in-person services, additional services, or referral to another provider or level of care may be recommended.

9. Referrals and Level of Care

I understand that I and/or my dependent may be referred to another clinician, physician, psychiatrist, treatment program, emergency service, or community resource when additional expertise or services are clinically indicated, when treatment needs exceed the scope of outpatient psychotherapy, or when a higher level of care is necessary for safe and appropriate treatment.

10. Coordination of Care and Release of Information

Coordination with physicians, psychiatrists, schools, treatment programs, or other professionals may be beneficial. Except when disclosure is otherwise permitted or required by law, information will be shared with outside parties only after appropriate authorization. A separate Authorization for Release of Information may be required.

11. Records, Legal Matters, and Professional Boundaries

Clinical records are maintained in accordance with applicable requirements. Requests for records or disclosure of treatment information will be handled according to applicable law. A general consent to treatment does not authorize unrestricted disclosure of mental health records.

Psychotherapy is treatment, not a forensic service. The therapist does not automatically become an evaluator, expert witness, custody evaluator, or advocate for a particular legal outcome. Requests for testimony, reports, records, or participation in legal proceedings will be evaluated according to applicable law, ethical obligations, clinical considerations, and practice policies.

To protect confidentiality and professional boundaries, the therapist generally does not communicate with clients through personal social-media accounts or accept personal social-media connection requests from current clients.

12. Ending or Transitioning Treatment

Treatment may end at the client's request, by mutual agreement, when goals have been met, or when a different type or level of care is clinically indicated. When reasonably possible, the therapist will discuss termination and provide appropriate recommendations or referrals to support continuity of care.

Consent to Treatment

By signing below, I acknowledge that I have read and understand the Consent to Treatment & Practice Policies, have had the opportunity to ask questions, understand the nature and general risks and benefits of outpatient psychotherapy, and voluntarily consent to treatment for myself and/or my dependent, as legally applicable.

Printed Name of Adult Client or Parent/Legal Guardian _____

_____ _____

Adult Client or Parent/Legal Guardian Signature Date

_____ _____

Clinician Signature Date

_____ _____

Minor Client Acknowledgment Signature (age 12 and older, when applicable) Date

_____ _____

Clinician Signature Date

Relationship of Parent/Guardian to Minor _____

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I received the current Notice of Privacy Practices for Kimberly Boatner, LCSW, CADC, LLC. The Notice explains how protected health information may be used and disclosed and describes privacy rights. I understand that this acknowledgment is separate from my consent to treatment and does not authorize a release of information.

Printed Name of Adult Client or Parent/Legal Guardian _____

_____ _____

Client / Parent / Legal Guardian Signature Date

_____ _____

Clinician Signature Date

Note: This acknowledgment does not authorize disclosure of mental health records. A separate Authorization for Release of Information is used when authorization is required. A paper copy of the Notice of Privacy Practices is available upon request.

Notice provided: ☐ Paper ☐ Electronic

If written acknowledgment is not obtained, clinician documentation of good-faith effort/reason:

Reason: ☐ Client/representative declined ☐ Emergency/other: _____

Clinician initials/signature: _____ Date: _____

Kimberly Boatner, LCSW, CADC

INDIVIDUAL, COUPLE AND FAMILY THERAPY

FINANCIAL, INSURANCE & ATTENDANCE AGREEMENT

Client Name _____

Responsible Party (if different) _____

1. Insurance and Financial Responsibility

I understand that insurance coverage is an agreement between me and my insurance plan. Kimberly Boatner, LCSW, CADC, LLC may assist with claim submission when applicable, but verification of benefits does not guarantee payment.

I am responsible for understanding my deductible, copayment, coinsurance, authorization requirements, visit limitations, exclusions, and other plan requirements. I am financially responsible for amounts assigned to me by my insurance plan and for services that are not covered, subject to applicable law and any separate written agreement.

2. Payment

Payment of copayments, coinsurance, deductibles, self-pay fees, and other client-responsibility amounts is due according to the practice's current payment policy. I agree to provide accurate insurance and billing information and to notify the practice promptly of changes in coverage or responsible-party information.

3. Cancellations and Missed Appointments

Appointments must be canceled or rescheduled at least 24 hours in advance. Appointments canceled with less than 24 hours' notice and appointments missed without notice may be charged to the client or responsible party at the applicable session rate.

I understand that late-cancellation and missed-appointment charges generally cannot be billed to or reimbursed by insurance and are my responsibility. Exceptions may be considered at the discretion of the practice based on individual circumstances.

4. Attendance and Continuity of Care

Consistent attendance supports effective psychotherapy. Repeated missed appointments, late cancellations, or prolonged gaps in care may result in a discussion about whether continued services through the practice are clinically appropriate and may lead to referral or transition planning.

5. Non-Covered or Administrative Services

Certain services may not be covered by insurance, including some forms, letters, record preparation, extensive care coordination, legal/court-related services, or other administrative work. When a separate fee applies, the practice will communicate the fee or applicable policy before completing the service whenever reasonably possible.

6. Good Faith Estimate / Self-Pay

Clients who are uninsured or who choose not to use insurance are entitled to a Good Faith Estimate of expected charges when required by federal law. The practice will provide the estimate within the applicable timeframes after scheduling or upon request. Any Good Faith Estimate or separate fee schedule should be reviewed together with this agreement.

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FINANCIAL AGREEMENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have reviewed and understand this Financial, Insurance & Attendance Agreement, including the insurance, payment, cancellation, missed-appointment, attendance, non-covered service, and self-pay policies stated above. I accept financial responsibility for charges assigned to me under these policies and applicable law.

Printed Name of Client/Responsible Party _____

_____ _____

Client/Responsible Party Signature Date

_____ _____

Clinician Signature Date

630.488.6113 | kim.boatner@therapy-stc.com | therapy-stc.com | 3140 West Main Street St. Charles, IL 60175

Kimberly Boatner, LCSW, CADC

INDIVIDUAL, COUPLE AND FAMILY THERAPY

AUTHORIZATION FOR RELEASE OF INFORMATION

This form authorizes a specific exchange of protected health information.

Client Name _____

Date of Birth _____

1. Person/Organization Authorized to Exchange Information

Name / Organization _____

Address _____

Phone _____

Fax / Secure Email _____

2. Direction of Disclosure

- FROM Kimberly Boatner, LCSW, CADC, LLC TO the person/organization listed above;
- FROM the person/organization listed above TO Kimberly Boatner, LCSW, CADC, LLC; or
- MUTUAL / TWO-WAY exchange between both parties.

Selected direction: ☐ From Practice ☐ To Practice ☐ Mutual / Two-Way

3. Information Authorized for Disclosure

Check only the information that may be disclosed or exchanged:

☐ Attendance / appointment information ☐ Diagnosis ☐ Treatment plan / goals

☐ Progress / treatment summary ☐ Medication information ☐ Discharge summary

☐ School / academic information ☐ Coordination-of-care information

☐ Other: _____

4. Purpose of Disclosure

☐ Coordination of care ☐ School collaboration ☐ Insurance/benefits ☐ Legal

☐ Personal request ☐ Other: _____

5. Authorization and Expiration

I understand that this authorization is voluntary. Except where applicable law permits otherwise, treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my signing this authorization. I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. HIPAA requires notice that information disclosed pursuant to an authorization may be redisclosed by the recipient and may no longer be protected by HIPAA; however, Illinois law may continue to restrict redisclosure of mental health records.

This authorization expires on the calendar date written below. If no calendar date is entered, Illinois law may limit disclosure based on this form to the day the practice receives the authorization.

630.488.6113 | kim.boatner@therapy-stc.com | therapy-stc.com | 3140 West Main Street St. Charles, IL 60175

Expiration Date (calendar date) _____

Right to inspect/copy: I understand that I have the right to inspect and copy the information to be disclosed, as provided by applicable law.

Consequences of refusal: I may refuse to sign this authorization. If I refuse, the requested disclosure generally will not be made unless another law permits or requires it. Refusal may limit coordination of care or another purpose identified above, but otherwise will not affect treatment or payment except where applicable law permits conditioning.

6. Specially Protected Information

Psychotherapy notes, as defined by HIPAA, are not included in this authorization unless separately and specifically authorized. Substance use disorder records protected by 42 CFR Part 2, if applicable, may require a Part 2-compliant consent, and SUD counseling notes require a separate consent. This form does not authorize disclosure beyond what is legally permitted.

Specific limitations or instructions: _____

_____

I understand that the practice will provide me with a copy of this signed authorization and will maintain the authorization in the clinical record as required by applicable law.

AUTHORIZATION AND SIGNATURES

By signing below, I authorize the disclosure or exchange of information described in this Authorization for Release of Information and acknowledge that I have had the opportunity to review this form and ask questions.

Printed Name of Adult Client or Parent/Legal Guardian _____

_____ _____

Adult Client or Parent/Legal Guardian Signature Date

_____ _____

Clinician Signature Date

For clients age 12 and older, Illinois law may give the minor recipient independent rights regarding access to and authorization of disclosure of mental health records. The minor must sign below whenever the minor is the person legally entitled to authorize the disclosure. A parent/legal guardian signs above when legally authorized or required.

_____ _____

Minor Client Authorization Signature (age 12 and older, when applicable) Date

_____ _____

Clinician Signature Date

Relationship of Parent/Guardian to Minor _____