

Northlight Counseling, LLC
Frequently Asked Questions

Do you treat ALL Issues and problems?

No, Northlight does not provide counseling for the following issues: Homosexuality Support, Sexual Perpetrators, current Drug and Alcohol users and Divorce Mediation. However we can provide counseling services to victims or loved ones of those struggling with these issues, as well as those who have been in successful recovery for over 12 months. If necessary, consult your local yellow pages or insurance provider for a specialized counselor in your area. In addition, we may be able to refer you to someone we know, who specializes in treating your needs.

How long are the sessions?

Most insurance companies realize that the first session takes longer than the subsequent sessions, to get an accurate diagnosis. Therefore, the first session will probably be about 55-65 minutes, but future sessions will be 45-50 minutes each. We respectfully ask for your cooperation in this matter. Please be aware that there may be clients waiting for the next appointment.

How often will we meet? And for how long?

Each situation is different, requiring differing amounts of intervention. This will best be determined upon your first meeting. We typically would meet once a week. If, in a few months, once a week seems to be too much, we will develop a plan that works best for you--perhaps meeting every 2 weeks.

Some issues can take as little as 6 months, while others can take as long as 5 years. Each situation and person is different, and each requires its own time frame. It is difficult to guess how long therapy may take, and a lot depends upon you!

Will you maintain my personal privacy and confidentiality?

We give the strictest attention to confidentiality and privacy. We never take it for granted that you have chosen our counseling practice. We will never reveal to anyone that you are a client. We take strict measures to ensure your privacy, such as locked file cabinets, private voice mail service, private email, secure websites, etc.

How much does each session cost?

Northlight Counseling, LLC accepts Blue Cross/Blue Shield of Illinois, Value Options, Magellan, Private Health Care Systems (PHCS), Cigna, and others. In-network benefits vary per each member's plan, however, a large percentage of the fee is covered (typically 80-100%). Out of Network insurance typically covers 50% of the fee. The initial session fee is \$175, and subsequent sessions are \$150 each. If you have no insurance, or choose not to use your insurance, the initial fee is \$90 and subsequent sessions are \$70, and must be paid in full before each session, unless other arrangements are made.

What is your therapy approach?

- *Thought processes that result in unhealthy beliefs must be challenged and replaced with truth.
- *A healthy view of life lines up with God's perspective.
- *We can change only ourselves, not others.
- *We need to grieve our losses.
- *Be real, honest and truthful.
- *Learn to get your deepest needs met from God alone.
- *Learn good self-care.
- *Focus on the positives. Don't dwell on the negatives.
- *Optimism can be learned.
- *Life is a journey; we must continue to change, grow, move on, and leave the past behind.

What can I do to enhance my success from counseling?

- *Be willing to take risks and try new things.
- *Value the counseling process. 90% of your success will come about outside the time we spend together, doing the homework, and keeping any and all commitments.
- *Be self-motivated and ready to make lasting changes.
- *Accept direct and honest feedback.
- *Adapt any or all of the information/ideas to make it fit best for you and your situation.

Please read the list carefully and mark an **X** next to the problem(s) you are experiencing.
Circle those statements you feel are the most important at this time.

If the problem sentence repeats, mark it again. If any sentence is not worded the way you want, rewrite it the way you want using the space to the right or below.

Section I

1. My appetite is poor.
2. I am over-eating.
3. I am having difficulty sleeping.
4. I sleep a great deal of the time.
5. My energy level is low.
6. I have difficulty concentrating.
7. I feel hopeless about the future.
8. I am having suicidal thoughts.
9. I have a plan to commit suicide.
10. I feel sad most of the time.
11. I do not enjoy life the way I used to.
12. I feel like a failure.
13. I cry more than usual.
14. I have lost interest in sex.
15. I have lost interest in work.
16. I have lost interest in social activities.

Section II

1. Sometimes I get out of breath.
2. At times I feel like I'm being smothered.
3. I sometimes feel dizzy.
4. At times I have an unsteady feeling.
5. I experience heart palpitations.
6. Sometimes I find myself trembling or shaking.
7. I break out in a cold sweat for no apparent reason.
8. I experience numbness or tingling sensations.
9. I get hot flushes.
10. I get chest pain or discomfort.
11. I think a lot about dying.
12. I have a fear of going crazy or losing control.
13. I am afraid to drive.
14. I am afraid to leave my house.

Section III

1. I have constant fears that I may do something that will be embarrassing or humiliating.
2. I am afraid to speak in public.
3. I am afraid that I will choke on food when eating in front of others.
4. My hand trembles when writing in the presence of others.
5. I am afraid that I will not be able to talk or answer questions in a social situation.
6. I consistently avoid some situations or activities because of fear of embarrassment.
7. I recognize that my fears are excessive or unreasonable.

Section IV-A

1. I have persistent ideas that I can't get off of my mind.
2. I have recurrent thoughts that make me unhappy.
3. Images repeatedly go through my mind, which are disturbing.
4. I try to ignore or suppress disturbing thoughts, but with little success.
5. I know that the disturbing thoughts I experience are a product of my own mind.

Section IV-B

1. I feel compelled to do things even though they are not logical.
2. I check the locks and windows in the house a number of times before going to bed.
3. I feel that something horrible will happen if I don't check on things.
4. I do things that are excessive or unreasonable, but I can't help it.

Section V

1. Something very disturbing has recently happened to me.
2. I almost lost my life recently.
3. I was in a serious accident.
4. Someone recently hurt me.
5. I saw someone I care about seriously injured or killed.
6. I cannot help think about what happened to me.
7. I cannot help think about what I have been through.
8. I have nightmares about what happened.
9. I have difficulty falling asleep.
10. I wake up in the middle of the night or too early in the morning.
11. I sometimes have the sudden feeling that what has happened to me is recurring. I have a sense of re-living the event.
12. When I'm near anything that reminds me of what happened, I get upset.
13. If I see anybody who looks like the person or people who hurt me, I get upset.
14. I try to avoid thinking about what happened to me.
15. I try to avoid activities or situations that remind me of what occurred.
16. I have recently lost interest in a number of significant activities.
17. I cannot remember important aspects of what happened.
18. I am more withdrawn from other people.
19. I feel like my life has changed permanently.
20. I have outbursts of irritability.
21. I have outbursts of anger.
22. I have difficulty concentrating.
23. I feel like I'm always on guard.
24. I startle easily.

Section VI

1. I worry a lot.
2. I'm excessively anxious.
3. I am frequently afraid that something terrible will happen.
4. I worry about money for no good reason.
5. I constantly worry about a possible misfortune to people I care about.
6. I sometimes find myself trembling.
7. I experience uncontrollable twitching.
8. I feel shaky a lot.
9. I have a great deal of muscle tension.
10. I have a lot of aches and pains.
11. I am constantly restless.
12. I tire easily.
13. I suffer from shortness of breath.
14. My heart beats faster than normal.
15. I sweat a lot.
16. I have cold, clammy hands.

17. I experience a sensation of being smothered.
18. I suffer from dry mouth.
19. I get dizzy or light-headed.
20. I have diarrhea on a regular basis.
21. I feel nauseated and have stomach troubles.
22. I frequently have to go to the restroom.
23. I frequently feel keyed up or on edge.
24. I startle easily.
25. I have trouble concentrating.
26. I have trouble falling asleep.
27. I have trouble staying asleep.
28. I have been more irritable lately.

Section VII

Growing up, the kids in my family (**including yourself**) in birth order:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Religious Background: _____

I would like for Faith to use the Bible and Scripture verses in our sessions: _____ Yes _____ No

(Circle all that apply.) Were you raised by: Both Parents? Single Parent? Relative? Other?

In your family was there a history of : Alcoholism? Substance Abuse? Mental Illness?
Physical Abuse? Sexual Abuse? Prolonged physical illness? What Kind: _____

Current Medications (any and all) _____

Significant Medical Problems, Surgeries or Medical Procedures (any and all) _____

Have you had previous psychiatric care and/or counseling? Yes No

If yes, give: Name of clinician _____

Sessions from (date): _____ to _____

Have you ever been hospitalized for substance abuse, physical abuse, sexual abuse, alcoholism, eating disorders anxiety, depression, or other mental health issues? Yes No Details (use back if necessary):

Have you ever been convicted of a crime, other than a minor traffic violation? Yes No Details (Use the back if necessary):

CLIENT RIGHTS

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.

You have the right to inspect and obtain a copy of your information contained in our medical records. To request to access your billing or health information, contact the office manager. Under limited circumstances we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or, in some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.

You have the right to request an accounting of disclosures, if any, which is a list of certain disclosures such as child or elder abuse, disclosures related to suicidal or homicidal threats, disclosures to the U.S. Dept. of Health and Human Services to evaluate compliance.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Northlight Counseling, LLC has been and will always be totally committed to maintaining clients' confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information that do not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services; If you provide information that informs us that you are in danger of harming yourself or others; Information to remind you of/or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

I have read the above thoroughly and understand everything.

Signature

Date

Basic Information

Client Name: _____ Client Date of Birth: _____

Client's Home Address: _____

City, State, ZIP: _____

Home Phone, with Area Code: () _____

Email: _____

Would you like to receive the Northlight Newsletter on Email? _____ Yes _____ No

Employer's (Company) Name: _____

Employer's (Company) Address: _____

Employer's City, State, ZIP: _____

Employer's Phone number, including Area Code:

Name of Insured (Policy Holder) Person (If different): _____

Insured's Date of Birth: _____ Insured's Gender: _____

Insured's Address: _____

Insured's City, State, ZIP: _____

Insured's Phone, with Area Code: () _____

Insured's Employer's (Company) Name: _____

Insured's Employer's (Company) Address:

Insured's Employer's City, State, ZIP:

Insured's Employer's Phone, with Area Code: () _____

Insured's Plan Name or Program Name: _____

Insured's ID Number: _____

Is there any other Health Benefit Plan? _____

If so, please give Other Insured's full Name: _____

Other Insured's Date of Birth: _____ Other Insured's Gender: _____

Other Insured's Policy or Group number: _____

Other Insured's Employer Name: _____

Other Insured's Insurance Plan Name or Program Name: _____

INFORMED CONSENT

Thank you choosing Northlight Counseling, LLC. Today's appointment will take approximately 45 – 50 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try our best to give you all the information you need.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims/verify treatment or information necessary to collect payment; b) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, we are obligated to report this to the Department of Children and Family Services; c) where you sign a release of information to have specific information shared; e) if you provide information that informs me that you are in danger of harming yourself or others; f) and as outlined in the HIPAA Notice of Privacy Practices. I only maintain clinical records and do not keep psychotherapy notes. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community for those services. Jaril Faith Gallup, LCSW will follow those emergency services with standard counseling and support to the client or the client's family. Any threat to your, or another person's, well being requires me to warn that person, under the ethical guideline called "duty to warn."

Signature(s) _____ **Date:** _____

FINANCIAL/INSURANCE ISSUES: As a courtesy, I will bill your insurance company, responsible party or third party payer for you, if you wish. I ask that at each session you pay your co-pay, depending on your insurance policy. If your insurance company denies payment or does not cover counseling, I request that you pay the balance due at that time. If the balance due at any time is more than \$100, we will require that you pay for services before services are rendered for subsequent sessions. After 60 days any unpaid balance will be charged 1.75% interest per month (21% APR). You will be subject to numerous phone calls and numerous mailed statements of account, if the balance is not paid in full, with the administrative fees of \$10 per phone call, and late fee maximum allowed by the law, every 30 days. In the event that an account is overdue by 60 days, we will contact Illinois Small Claims Court, and you will be liable for all of the following, but not limited to, administrative fees, late fees, court fees, monies paid to file the action, including gasoline and car depreciation costs to and from the court, costs to have the summons and complaint mailed or personally served, any and all attorneys' fees and statement of account interest charges, and you are subject to garnished wages from your place of employment, or the employment of the insured. Checks that are returned for insufficient funds are subject to a fine of \$30.00, or the maximum allowed by law. I ask that every client authorize payment of medical benefits directly to Jaril Faith Gallup, LCSW. The initial fee is \$175.00 and subsequent sessions are \$150.00, unless other arrangements are made. If you have no insurance, or choose not to use your insurance, the initial fee is \$90, and the subsequent sessions are \$70, and must be paid in full at each session. Payment by credit card is available by Pay-Pal, at www.northlightcounseling.com and must be paid in full before each session.

Lastly, please be aware that any and every appointment is considered a "Set Appointment," whether it is made by phone, email, in writing, or in person. You will NOT receive a reminder phone call for set appointments. If you need to cancel or reschedule an appointment, you must give 24 hours notice, otherwise a charge of \$100.00 will be charged to your account. Insurance companies cannot and will not pay the charge for a cancelled appointment.

I/We, the undersigned, have read the above very carefully, and fully understand the financial requirements and, if not followed, the consequences, and I/we agree to all of them.

Signature(s) _____ **Date** _____

Signature(s) _____ **Date** _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read, and/or received a copy of, the HIPAA Notice of Privacy Practices and Client Rights document.*

Signature(s) _____ **Date** _____

May we contact you at home (circle one) **yes no**?

Home Phone _____

May we contact you at work **yes no**?

Work Phone _____

May we contact you by cell phone **yes no**?

Cell Phone _____

Where may we contact you? _____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent(s) that*

_____ *may be treated as a client by Jaril Faith Gallup, LCSW.*

Printed Name of Minor Client

_____ **Date** _____
Signature of Parent or Guardian

_____ **Date** _____
Signature of Parent or Guardian

If there is a legal separation, a divorce pending, or a finalized divorce, I understand that I need to disclose a copy of the Separation Decree or Divorce Decree, including the Custody Stipulations to Jaril Faith Gallup, MSW, LCSW. I, the undersigned, will forward a copy to Northlight Counseling, LLC, 4180 S. Route 83, #10, Long Grove, IL 60047, as soon as possible. I understand this needs to be done before the next session.

_____ **Date** _____
Signature of Parent or Guardian

I, the undersigned, do testify under penalty of law, that there is no Custody pending, finalized or authorized. If there is a change in the current Custody arrangements, I understand that ALL persons sharing custody need to agree to Mental Health Services for the patient who is a minor.

_____ **Date** _____
Signature of Parent or Guardian