



**EMPOWERED &
AUTHENTIC LIVING**
Bridging Psychology & Spirituality

2500 W. Higgins Rd, Ste 260, Hoffman Estates

INTAKE

Today's Date ____/____/____

Name: _____

DOB: ____/____/____ Time of birth: _____

Place of birth: _____ Age: _____

Address: _____

City: _____ State _____ Zip _____

Cell Phone: _____ Email: _____

Please indicate if would like to receive occasional emails from EAL: YES___ NO ___

Please indicate reason for visit

Energy Healing ___

Spiritual growth ___

Personal Growth ___

Mental Health Issues ___

Physical/Medical Issues ___

Purpose in Life ___

Understanding Meaning in Life ___

Relationship Issues ___

Other Reasons

How did you hear about EAL? Check all that apply

I am a returning client ___ Another client recommendation ___

EAL website ___ Internet ___

Other _____



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INFORMED CONSENT AND CLIENT AGREEMENT

Welcome and thank you for choosing Empowered and & Authentic Living (EAL). Please carefully review the following information and sign as indicated. EAL follows HIPAA laws.

OUR MISSION

To help you live and be your most powerful and authentic self. Your path is individual to you, therefore, there are no wrong answers. There is only your truth which is honored and valued. You are the authority on you.

CONFIDENTIALITY

All communications shared will be held in strict confidence. Information, however, may be released in accordance with state law under certain situations:

- You provide a written consent
- For professional consultation if needed (identifying information will not be shared)
- You express serious intent to harm yourself or someone else
- There is reasonable suspicion of abuse or neglect of a minor, elder person, or dependent adult
- To acquire payment for services or for billing purposes
- There is a court order or subpoena directing the disclosure of information

Special Note on Electronic Communications

Please be aware that electronic communications (including phone and internet) are not secure methods of communications.

CONFIDENTIALITY WITH REGARDS TO MINORS (UNDER 18 YEARS)

For children under 12, parents/legal guardians are entitled to information regarding their child's treatment. Between 12 and 18, the minor must be informed and give permission to share information. If the minor chooses not to give consent, however, we may still provide information regarding the minor's current physical and mental health condition, diagnosis, treatment needs, services provided and need, including medication, if any.

PAYMENT AND FEES

Unless agreed otherwise, life coaching, spiritual coaching, and energy work will be billed at \$120/hour. Psychotherapy will be billed at \$150 per. Your portion (co-pays/co-insurance/deductibles) of fees is expected at the time of services. Please contact your insurance company to determine your share. Reports produced at your request or compelled by law will be billed directly to you at the rate of \$150/hr. This rate shall also apply in the event that we are asked to meet with other professionals or testify in court at your request, or compelled by law to do

so. PLEASE NOTE THAT LIFE COACHING, SPIRITUAL COACHING, AND ENERGY HEALING CANNOT BE BILLED TO INSURANCE AS THESE ARE NOT COVERERED SERVICES.

All fees are payable at the time of service. Please be prepared to pay any deductible or co-payment/co-insurance if using insurance. We will ask for a credit card to be kept on file should there be any outstanding balances.

APPOINTMENTS AND CANCELLATION POLICY

Appointments will last approximately one hour. Your appointment time is a commitment for both you and us. However, we understand that there are other activities in life that need attention. We ask that you provide 24 hours prior to your session if you need to reschedule. If sessions are cancelled less than the 24 hour notice or if you are a no show, you agree to pay the full amount of the session.

COLLABORATION POLICY

Lisa Aranas and Ana Roussev work as a team and see each client of EAL as their shared client. By being able collaborate with each other, they bring a synergistic effect from the powerful combination of their unique experiences, knowledge, and skills to help propel each individual through their journey of healing and self-discovery. Please sign here to give us permission to collaborate:

_____	_____
Client Signature	Date

Your signature below indicates that you have reviewed, understand, and agree to the policies and voluntarily consent to services with Empowered & Authentic Living. Please sign the appropriate service.

For Psychotherapy:

_____	_____
Client Signature	Date

_____	_____
Signature of parent/guardian if minor client	Date

For Energy Healing and Spiritual Coaching:

_____	_____
Client Signature	Date

_____	_____
Signature of parent/guardian if minor client	Date

For Life Coaching:

_____	_____
Client Signature	Date

_____	_____
Signature of parent/guardian if minor client	Date

CREDIT CARD INFORMATION

I, _____, agree to pay all fees related to services.

Credit Card MasterCard _____ Visa _____ Discover _____

Name: _____

Card# _____ Expiration Date: _____

3 Digit Code on back of card: _____

Cardholder's Signature _____ Date _____

INSURANCE INFORMATION

If using insurance, I hereby authorize payment directly to Empowered and Authentic Living, LLC by my Insurance Company. I understand that I am financially responsible for all charges not paid by my insurance. I understand that once information is released to Insurance companies or any other third party, that EAL cannot guarantee that it will remain confidential.

Please enter the following:

Policyholder: _____ Date of Birth: ____/____/____

Employer: _____

Policyholder Address: _____

Name of Insurance Company: _____

Insurance ID: _____ Insured Group Number: _____

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted.

_____ Date: _____



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INTAKE CHECKLIST

To serve you better, please circle your answer to each question below.

- | | | |
|---|-----|----|
| 1) Do you have any current or history of medical conditions/illnesses?
If yes, explain _____ | Yes | No |
| Are you on any current medications/treatment?
If yes, medication/treatment _____
Physician name/phone _____ | Yes | No |
| 3) Are you having difficulty sleeping? | Yes | No |
| 4) Have you/others been concerned about your alcohol or drug use? | Yes | No |
| 5) Do any family members have alcohol or drug problems? | Yes | No |
| 6) Do you have any eating disorders/concerns? | Yes | No |
| 7) Do you have thoughts about hurting yourself? | Yes | No |
| 8) Do you have any thoughts about hurting others? | Yes | No |
| 9) Do you feel you are in danger of being hurt? | Yes | No |
| 10) Have you moved in the last two years? | Yes | No |
| 11) Do you find it hard to talk about personal problems with other people? | Yes | No |
| 12) Do you have problems in your relationships with other people? | Yes | No |
| 13) Do you prefer not to participate in social activities? | Yes | No |
| 14) Have you changed jobs/schools in the last two years? | Yes | No |
| 15) Do you hate going to work/school? | Yes | No |
| 16) Do you have a legal problem? | Yes | No |
| 17) Are you experiencing financial problems? | Yes | No |
| 18) Have you lost hope that your problem can be resolved? | Yes | No |
| 19) Are you interested in spiritual growth? | Yes | No |
| 20) Are you seeking meaning and purpose to your life? | Yes | No |