



**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



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?<br>If yes, explain _____                   | Yes | No |
| Are you on any current medications/treatment?<br>If yes, medication/treatment _____<br>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 |