Referred by_____ Print **DX:** _____

DEPENDENT CLIENT INFORMATION

PATIENT: _____ BIRTH DATE: _____

ADDRESS: _____ PATIENT SEX: _____

CITY, ST., ZIP_____ PHONE NUMBER: _____

OK TO LEAVE MESSAGES ☐

SCHOOL: _____ GRADE: _____

SIBLINGS:

NAME_____ AGE_____ SEX_____ NAME_____AGE_____ SEX_____

FOR PARENTS / GUARDIAN TO COMPLETE

CONCERNS YOU HAVE ABOUT YOUR CHILD_____

_____ PRIOR THERAPIST_____

PARENT / GUARDIAN INFORMATION

MOTHER'S NAME_____ MARITAL STATUS_____

ADDRESS_____SPOUSE'S NAME_____

(IF DIFFERENT THAN CLIENT)

CITY, ST., ZIP_____

PHONE (H) _____PHONE (C) _____

OK TO LEAVE MESSAGES ☐ OK TO LEAVE MESSAGES ☐

EMPLOYER_____ PHONE (W) _____

OK TO LEAVE MESSAGES ☐

FATHER'S NAME_____ MARITAL STATUS_____

ADDRESS_____ SPOUSE'S NAME_____

(IF DIFFERENT THAN CLIENT)

CITY, ST., ZIP_____

PHONE (H) _____ PHONE (C) _____

OK TO LEAVE MESSAGES ☐ OK TO LEAVE MESSAGES ☐

EMPLOYER_____ PHONE (W) _____

OK TO LEAVE MESSAGES ☐

EMPLOYEE ASSISTANCE PROGRAM

DO YOU HAVE EAP BENEFITS THAT YOU PLAN ON USING? _____ AUTH #_____

OF VISITS APPROVED _____EAP COMPANY_____PHONE NUMBER _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR BILL_____RELATIONSHIP TO CLIENT_____

INSURANCE COMPANY_____ PHONE NUMBER_____

ID#_____ GROUP #_____ POLICY HOLDER _____

POLICY HOLDER SOCIAL SECURITY _____ POLICY HOLDER'S DATE OF BIRTH_____

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I UNDERSTAND THAT EVEN THOUGH I HAVE SOME TYPE OF INSURANCE COVERAGE, I AM RESPONSIBLE FOR THE PAYMENT OF SERVICES. I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE CLINICAN OF THE CLAIM. I request that payment of authorized benefits be made either to me or on my behalf to the clinician indicated on the claim for any services furnished to me by that clinician. I authorize any holder of medical information about me to release to my insurance and its agents any information needed to determine these benefits or the benefits payable for related services. If my insurance requires case management, I authorize my clinician to release the appropriate clinical information.

Signature of Patient required if 12 years or older: _____ **Date:** _____

Signature of Parent/Guardian required if less than 18 years of age:_____ **Date:**_____

FINANCIAL POLICY

We will gladly bill your insurance for services provided to you if we have the necessary information. Please bring your most current insurance card with you to each visit. You are responsible for giving us full and accurate insurance information (including secondary, if applicable) at your first visit and immediately thereafter whenever there are any changes with your insurance coverage. If this information is not given in a timely manner and claims are denied, you will be responsible for the balance due.

You are responsible to know the mental health benefits on your insurance plan. If authorization is required, and you have not obtained it or notified the provider, your claims may be denied and you will be responsible for the entire fee.

Copays are due at each visit. Patient statements are mailed every four weeks for any other balance that may be due. Account balances that have exceeded 90 days with no payment are turned over to our collection agency and your credit history may be impacted. Our desire is to work with our clients to have balances paid in a timely manner and avoid this process.

I have read and understand the above policy _____

(Please Initial)

MISSED APPOINTMENTS AND CANCELLATIONS:

- We do not call you to remind you of your appointment, so please make note of when your next appointment is scheduled.
- Twenty-four hour notice is required to cancel an appointment. This allows your therapist adequate time to schedule another client. To cancel, call 630-305-0464 and speak directly with the office staff or leave a voice mail with your clinician. This voice mail line is available 24/7 and has a date/time stamp.
- You will be charged the clinician's full rate for a missed appointment and/or cancellation with less than 24-hour notice.
- These charges cannot be billed to your insurance company.

I have read and understand the above policy _____

(Please Initial)

RATES FOR SERVICES NOT COVERED BY INSURANCE

Returned Check Fee	$40.00
Missed appointment/Late Cancellation Fee	Full Hourly Rate of Clinician
Disability Forms	$50 minimum up to Full Hourly Rate of Clinician
Workers Compensation Forms	$50 minimum up to Full Hourly Rate of Clinician
School/Work Forms	$25.00
Dictated Letter (1-2 pages)	$25.00
Dictated Letter (2+ pages)	$40.00
Extended Phone Calls	$50.00
Court Reports	$50 minimum up to Full Hourly Rate of Clinician

I have read, understand and agree to the above financial obligations.

Signature:_____ Date:_____

Print Name:_____

If under the age of 18, we need the signature of the responsible party:

Signature:_____ Date:_____

Print Name:_____

AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 12 months from the date signed.

_____ _____

(Please print patient's name) (Please print treating clinician's name)

Please check one of the choices below:

☐ Release any applicable information to my Primary Care Physician

☐ Do not release information to my Primary Care Physician

☐ I do not currently have a Primary Care Physician

PRIMARY CARE PHYSICIAN INFORMATION (please complete if you indicated above to release information to your doctor)

Physician Name_____ Phone_____

Address _____

City, State, Zip code_____

_____ _____

Signature of Patient required if 12 years of age or older *Date*

_____ _____

Signature of Patient, Parent, Guardian or Authorized Representative *Date*

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Available on our website or in office)

I hereby acknowledge that I have been provided with the opportunity to view a copy of the Notice of Privacy Practices (the "Notice"). The Notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA") that may be made by the Practice, and of my rights and the Practice's legal duties with respect to my protected health information.

Print Patient's Name

Patient's Signature *Date*