

800 E. Woodfield Road
Suite 106
Schaumburg, IL 60173



• **Patient Information**

NAME: _____ TODAY'S DATE: _____

SOCIAL SECURITY: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

(INCLUDE CITY AND ZIP) _____

PHONE: HOME _____

WORK _____

CELL OR PAGER _____

EMERGENCY CONTACT NAME & PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT US? _____

• **EAP INFORMATION: Please complete this section if you are utilizing your EAP (Employee Assistance Program) benefits.**

EAP COMPANY NAME: _____

EMPLOYER: _____

AUTHORIZATION NUMBER: _____

NUMBER OF SESSIONS AUTHORIZED: _____

REFERRAL TYPE (CHECK ONE): COURT MANDATED EMPLOYER REQUESTED EMPLOYEE REQUESTED

• **INSURANCE INFORMATION: All clients must fill out this section. Please provide a copy of the front and back of your insurance card.**

INSURANCE NAME: _____ HMO OR PPO: _____

INSURED NAME (LISTED ON THE CARD): _____

RELATIONSHIP TO THE INSURED: _____

INSURED SOCIAL SECURITY: _____

INSURED DATE OF BIRTH: _____

INSURED GROUP NUMBER: _____

INSURED ID NUMBER: _____

EFFECTIVE DATE: _____

CO-PAY AMOUNT: \$ _____

CORE THERAPY ASSOCIATES, LTD.

800 E. Woodfield Rd, Suite 106
Schaumburg IL 60173

OFFICE SERVICES AGREEMENT

The session fee is the sole responsibility of the client. It is the obligation of the client to know their insurance benefits and/or EAP benefits. This includes, but is not limited to copay amounts, number of sessions authorized, pre-authorization necessity and capitation of insurance or EAP benefits. Payment of any fees, outside the portion covered by insurance, are due at time of service.

Family treatment is any session involving more than one person. Clients will be charged full fee of \$150.00 if their insurance does not cover family treatment.

Please note that insurance companies require a clinical diagnosis be provided to the insurance with billing. This information may become part of your permanent medical record. If you have any questions regarding this please speak to your therapist.

48 hours notice of cancellation is required. If cancellation is made after this time, you will be charged a \$80.00 cancellation fee. It is understood that an appointment time has been reserved for you and lack of notice prevents sufficient time to schedule other clients. Your insurance company and/or EAP cannot be billed for failed appointments. **You will be responsible for the \$80.00 fee.** Payment for the missed appointment is required prior to or at the beginning of the next session.

Any unpaid balance over 45 days will incur a 15% finance charge on the balance. *There is a \$50.00 handling and processing fee for all NSF check returned by the bank.* In addition to the principle amount owed, I agree to pay 33.33% of the unpaid balance as collection fees if my account is delinquent.

Our therapists will consider a case closed after 2 months of client inactivity.

Please note that therapists are often not immediately available to take telephone calls. Please leave a message in your therapist's voice mail and your therapist will respond to your call as soon as she is able. If there is a clinical emergency that you cannot wait for a return call please dial 911 or go to your nearest emergency room.

The communication between a client and therapist are confidential. Your therapist will only share information with others with a written release of information (ROI). There are a few exceptions to this; if there is a threat of harm to self or others, for confidential consultation reasons with another professional therapist, and general information may be required to be shared with your employee assistance program if the EAP is paying for your services.

Your signature below indicates that you have read, understand and will abide by the terms in this agreement.

Client's Signature: _____

Date: _____

Revised 01/01/12

800 E. Woodfield Road
Suite 106
Schaumburg, IL 60173



• Patient History

PATIENT NAME: _____

• Statement of Problem

I- PRESENTING PROBLEM [INDICATE PERCEIVED PROBLEM, INCLUDING SYMPTOMS AND THEIR IMPACT ON OVERALL FUNCTIONING]

II- ONSET OF PROBLEM [DESCRIPTION OF WHEN THE OBSERVED PROBLEM BEGAN AND THE PROGRESSION OF PROBLEM]

• Medical History

I- LIST PAST AND CURRENT DIAGNOSED MEDICAL ILLNESSES _____

II- INDICATE ANY KNOWN RELEVANCE TO THE PRESENTING PROBLEM _____

• Psychiatric Treatment History

I- PREVIOUS/CURRENT TREATMENT

A. PREVIOUS HOSPITALIZATION, INCLUDING PARTIAL HOSPITALIZATION PROGRAM [BEGIN WITH THE MOST RECENT HOSPITALIZATION, REASON FOR HOSPITALIZATION, MONTH/YEAR AND DURATION] _____

B. PSYCHOTHERAPY/COUNSELING [BEGIN WITH THE MOST RECENT TREATMENT, MONTH/YEAR OF THE INITIATION OF TREATMENT, DURATION OF TREATMENT, AND REASON FOR TERMINATION] _____

II- MEDICATION [LIST NAME, DOSAGE, FREQUENCY, COMPLIANCE AND NAME OF PHYSICIAN PRESCRIBING]

| Current Medications | | | | |
|----------------------|--------|-----------|------------|-----------|
| Name | Dosage | Frequency | Compliance | Physician |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Previous Medications | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Continued on next page

III- ALCOHOL/SUBSTANCE ABUSE

- A. DO YOU CURRENTLY USE ALCOHOL? **Y OR N** HOW FREQUENTLY? _____
- B. DO YOU CURRENTLY USE RECREATIONAL DRUGS? **Y OR N** HOW FREQUENTLY? _____
- C. DO YOU NOW OR HAVE YOU EVER HAD A PROBLEM WITH ALCOHOL ABUSE? **Y OR N**
- D. DO YOU NOW OR HAVE YOU EVER HAD A PROBLEM WITH SUBSTANCE ABUSE? **Y OR N**

• Abuse History

I- INDICATE PAST OR CURRENT OCCURRENCE OF THE FOLLOWING [CHECK APPLICABLE BOX/ES]:

- DOMESTIC VIOLENCE
- SEXUAL ABUSE
- VERBAL ABUSE
- CHILD ABUSE
- PHYSICAL ABUSE

II- IF YOU CHECKED ANY OF THE ABOVE: WAS THE OCCURRENCE OF ABUSE REPORTED OR DISCLOSED? **Y OR N**

• Family History

I- FAMILY MEMBERS [LIST NAMES OF IMMEDIATE FAMILY MEMBERS AND INDICATE WHETHER THEY RESIDE WITH YOU]

| Name | Relationship | Same household (Y or N) |
|------|--------------|-------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

II- FAMILY HISTORY OF MENTAL ILLNESS [INDICATE FAMILY MEMBER AND DIAGNOSED ILLNESS]

• Social Functioning

I- FAMILY SUPPORT [INDICATE EXISTENCE OF SUPPORT FROM FAMILY MEMBERS]

II- NON-FAMILIAL SUPPORT [INDICATE EXISTENCE OF SUPPORT FROM OTHER PEOPLE (E.G. FRIENDS, CO-WORKERS, ETC.)]

• Academic & Work History

I- HIGHEST LEVEL OF EDUCATION: _____

II- STATUS OF EMPLOYMENT: _____

• Treatment Goals

WHAT ARE YOUR GOALS FROM TREATMENT?

• Illinois HIPAA Privacy Notice

Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION MAY BE DISCLOSED

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

We may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes with your written authorization.

DEFINITIONS:

• **"PHI"** refers to the information in your health record that could identify you.

• **"Treatment, Payment and Health Care Operations"**

Treatment is the provision, coordination or management of your health care and other services related to your health care. An example of treatment is my consulting with another health care provider, such as a family physician.

Payment is obtaining reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• **"Use"** applies to activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• **"Disclosure"** applies to activities outside of the office such as releasing, transferring, or providing access to information about you to other parties.

• **"Authorization"** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing the information.

You may revoke such authorizations at any time, provided the revocation is in writing. You may not revoke an authorization to the extent that (1) We have relied on that authorization; or (2) If the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures Without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

• **Child Abuse:** If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the appropriate authorities.

• **Adult and Domestic Abuse:** If I have reason to believe that an individual (who is protected by state law) has been abused,

neglected, or financially exploited, I must report this belief to the appropriate authorities.

• **Health Oversight Activities:** I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

• **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

• **Serious Threat to Health or Safety:** If you communicate a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I must make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I must make disclosures I consider necessary to protect you from harm.

• **Worker's Compensation:** I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Clinician's Duties

PATIENT'S RIGHTS

• **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

• **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

• **Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request for access process.

• **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

• **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

• **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

CLINICIAN'S DUTIES:

• To maintain the privacy of PHI and to provide a notice of my legal duties and privacy practices with respect to PHI.

• To reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes we are required to abide by the terms currently in effect.

Continued on next page

• In the event of revisions of policies and procedures, you will be notified in person or by mail.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, please contact us at 847-240-5080. You may also contact the Illinois Department of Insurance Consumer Assistance Hotline at (866)445-5364, or their Consumer Services Section at (312) 814-2427.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The contacts listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is effective beginning April 14, 2003. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHIs maintained. We will provide you with a written revised notice.

I have read and understood the above information. [please check the box and sign below]

Signature of Client (if over 12 years old): _____

Signature of Parent/Guardian (if applicable): _____

Signature of Witness: _____

Date: _____