Behavioral Healthcare Providers, LTD

NEW CLIENT REGISTRATION

PATIENT INFORMATION

First Name ______________________________ Middle Int._____ Last Name ____________________________________

◯M◯ F Birthday:____/____/_____ Marital Status: ____Single ____Married ____Other Ph:(____)_____________

Street Address:_________________________________City:________________________State:______Zip:______________

Email:____Preferred form of contact: ☐ Phone ☐ Email

Person completing form:___________________Relationship:________________*(If different than patient complete below)*

Street Address:______________________________City:_____________________State:______Zip:_________________

Home Ph:(_____)_____________________________Cell Ph:(_____)_____________Email:___________________________

BILLING INFORMATION

Please provide front desk a copy of: ☐ INSURANCE CARD ☐ CREDIT CARD ☐ LICENSE/ID

Bill my insurance? ☐ Yes ☐ No -- If no; *must sign self-pay contract*

Insurance Company: ___________________________________

ID/Policy #___________________________________Group# ____________________________

If it is a HMO Insurance: Site Name________________________ Site#__________

Insured's Name:________________Relationship:______________________________Birthday:______/___ /_____________

Billing address same as the patient: ☐ Yes ☐ No ***(If different than patient complete below)***

Street Address:__________________________City_______________State_____Zip_____________Ph: (_____) _____________

Secondary Insurance (If applicable):

Insurance Company: ___________________________________

ID/Policy #___________________________________Group# ____________________________

If it is a HMO Insurance: Site Name________________________ Site#__________

Insured's Name:________________Relationship:______________________________Birthday:______/___ /_____________

Billing address same as the patient: ☐ Yes ☐ No ***(If different than patient complete below)***

Street Address:__________________________City_______________State_____Zip_____________Ph: (_____) _____________

REFERRAL/CONTACT INFORMATION

Who may we thank for your referral: ____

*Please notify us immediately upon any changes to your address, phone numbers, and/or insurance coverage. Failure to promptly notify us of changes may result in future billing and/or treatment difficulties.

CONSENT TO RELEASE INFORMATION FOR PROCESSING BENEFITS

Behavioral Healthcare Providers, LTD

I hereby authorize Behavioral Healthcare Providers to release any of the following requested information for the purpose of obtaining reimbursement of treatment services provided directly to my dependents or me. Information may include: Admitting Diagnosis; Final Diagnosis; Discharge Summary; Designated clinical records (e.g., treatment plans, progress notes, test results, etc.)

Information may be released to any or all of the following as needed: Any third party payer having responsibility for payment of charges for treatment; Review agents/auditors; Managed Care agents.

This consent is valid until such time that all claims have been settled to the satisfaction of BHP or up to one year from the date of discharge from treatment, whichever is longer.

I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize BHP to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate the consent any time before the expiration date so long as I submit my revocation in writing to this office. Finally, the agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written consent.

I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will be responsible to pay for any and all charges incurred.

I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me or to my dependent, I hereby assign, transfer, and set over to BHP all of my rights, title, and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to BHP for charges not covered by this assignment.

____
Print Patient's Name

______________________________ ______________________________
Signature of Patient (or Authorized Representative) **Date**

______________________________ ______________________________
Signature of Staff **Date**

Behavioral Healthcare Providers, LTD

NOTICE OF PRIVACY PRACTICES (NPP)

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

Our Commitment to Your Privacy

Please note Behavioral Healthcare Providers is providing this document to you subsequent to the Health Insurance Portability and Accountability Act (HIPAA). Our office has always and will continue to maintain the highest standards regarding our patients' personal information. You can be assured that our practice goes beyond what is required by HIPAA. Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This form is a summary of the full NPP which is available if you would like more information.

We will use the information regarding your health, which we obtain from you or from others mainly to provide you with treatment, to arrange payment for our services and for some other business activities which are called, in the law, health care operations. After you have read this NPP and discussed it with your doctor and/or therapist we will ask you to sign a Consent Form to allow us to use and share your information as needed. Please note that BHP will continue to have you complete releases of information in addition to this document. If you do not consent and sign this form, we cannot treat you.

Behavioral Healthcare Providers utilizes an electronic billing service to process claims via the internet. Rest assured that our office has taken great care in selecting the billing company with whom we have contracted. Each step in the process is encrypted to ensure the highest standard in privacy regarding sensitive personal information.

If there is a need to disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow this.

Of course we will keep your health information private, but there may be times when the law requires us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit program

*There are some other situations like these, which do not happen very often.

PATIENT COPY

Behavioral Healthcare Providers, LTD

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place whichever is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. All medical records requested with the proper release of information form will be processed within a reasonable and legal time frame with reservations provided by Illinois State Law. You have the right to look at the health information we have about you, such as your medical and billing records. You may request a copy of these records. All copies of medical records will be charged at the maximum as allowed by Illinois State Law. Copies of these charges are available from our business office. This charge is not billable to your insurance or managed care payer. Contact our Privacy Officer to arrange to see your records or request their release.

4. If you believe the information in your record is incorrect or missing important information, you can ask us to make changes (called amending) to your health information. You must make this request in writing to your doctor and/or therapist or our Privacy Officer. In your request, you must tell us the reason(s) you want to make the changes.

5. You have the right to a copy of this notice. If we change the NPP we will notify you as soon as possible and you can always get a copy of the NPP from our Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our office at 847-895-4540. (The Effective date of this Notice is May 1, 2019)

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I, hereby acknowledge receipt of *Behavioral Healthcare Providers* Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information.

I understand that Behavioral Healthcare Providers has reserved the right to change its privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be provided

Signature of Patient (or Authorized Representative) **Date**

Signature of Staff **Date**

Behavioral Healthcare Providers, LTD

Voice Message/Email Consent

In order to best serve your mental health needs, Behavioral Healthcare Providers will confirm your appointment one business day in advance via an automated reminder system. This system utilizes voice and text messages, or email. Additionally, our staff may leave voicemails when contacting you for clinical, scheduling, or billing information.

Voicemail

☐ **YES -** Behavioral Healthcare Providers may leave a message on client's/family voicemail confirming your appointment and/or information you request regarding your treatment.

☐ **NO -** Behavioral Healthcare Providers may **not** leave message on client's/family voicemail.

Email

☐ **YES -** Behavioral Healthcare Providers may communicate with me via e-mail that is *not* password protected. I understand that because e-mail is not a secure form of communication, confidentiality cannot be ensured of any information sent via e-mail.

☐ **NO -** By checking this box to the left, I am indicating that I DO NOT grant permission for email communication as described above.

Please indicate your preference for appointment reminders below.

Please be aware, appointment reminders are provided as a courtesy to our patients. If for any reason you do not receive a reminder, you are still responsible for keeping any and all scheduled appointments.

I would like to receive reminders via (please check all that apply):

___Email ___Text ___Voice Call ___Opt out of appointment reminders

Email Address:________________________________ Phone number:___________________________

____ ___________________________

Signature of Patient (or Authorized Representative) **Date**

Behavioral Healthcare Providers, LTD

Psychiatry and Psychotherapy Fees

I understand that the arrangement for payment is as follows:

- PSYCHIATRY INTAKE ………………………………………………………………$375.00/SESSION
  - *With Initial Treatment Plan*
- PSYCHIATRY FOLLOW UP SESSION…………………………………………….$160.00/SESSION
- PSYCHOTHERAPY INTAKE ………………………………………………………$227.00/SESSION
  - *With Initial Treatment Plan*
- FOLLOW UP SESSION …………………………………………………………….$160.00/SESSION
- PSYCHOLOGICAL TESTING…………………………………………………….$175.00 FIRST HOUR
  - *Each Additional Hour……………………………………………………………………$115.00*
- NEUROPSYCHOLOGICAL TESTING………………………………………………$200.00 FIRST HOUR
  - *Each Additional Hour……………………………………………………………………$140.00*
- TEST ADMINISTRATION AND SCORING…………………………………$80.00 FIRST 30 MINUTES
  - *Each Additional 30 Minutes…………………………………………………………………$75.00*
- LETTER WRITING and DOCUMENT PREPARATION……………………………..$35.00/10 MIN
  - *Additional documentation beyond evaluation report*

I understand that these rates may increase periodically, and that I will be informed prior to any rate changes. If using insurance for payment, I understand that if my clinician is in my network he/she has agreed to the usual and customary rate deemed appropriate by his/her contract with the insurance company. Further, I understand that my clinician may not charge me for the difference between the fees listed above and the agreed upon usual and customary rate, beyond the co-pay required by my insurance.

I understand that my co-pay and /or co-insurance is due at the time of service. If not using insurance for payment, I understand that I am responsible for the full charges of each session at the time of service, unless an alternate arrangement is made with Behavioral Healthcare Providers. If using insurance for payment, I understand that my insurance company reserves the right to refuse payment for services they previously pre-certified. I understand that in such a case, I have the right to appeal to my insurance company for payment. I understand that I am ultimately responsible for services provided which are not covered by my insurance company.

DIVORCE/CUSTODY POLICY:

I understand that in the case of a divorce or custody agreement, as the signer of this form I am taking responsibility for the full balance for services rendered. I will need to independently seek restitution from the other parent or guardian for their percentage of the medical costs per the custody agreement. Payment is due at time of service, regardless of who brings the child to the appointment. It is the responsibility of the parent who initially brings the child/adolescent to Behavioral Healthcare Providers to provide all proper insurance information at the time of service. Behavioral Healthcare Providers is unable to withhold any information related to insurance claims and processing from the insurance policy holder. Behavioral Healthcare Providers requires the policy holder's authorization to bill for services rendered at Behavioral Healthcare Providers regardless of who brings the child.

CANCELLATION POLICY:

Cancellations made with less than 24 hours notice will be charged a missed appointment fee of $75. Insurance does not cover missed appointments.

WORKER'S COMPENSATION:
We do NOT accept worker's compensation insurance/claims. If your condition is related to an incurred work injury and you wish to be treated, you must pay in cash or by credit card in advance of treatment. If you use your mental health insurance coverage, Behavioral Health Care Providers cannot be held responsible for any financial liabilities resulting from an existing worker's compensation claim. By signing below, you acknowledge and agree to take full responsibility for balance if you are found to an existing worker's compensation claim related to your treatment release Behavioral Healthcare Providers of any financial encumbrances as a result of your claim. Additionally, you acknowledge and agree that balances are patient responsibility if your insurance fails to pay for your visit.

PATIENT RESPONSIBILITIES CONCERNING INSURANCE COVERAGE:
It is your responsibility to understand your insurance policy. As a courtesy, Behavioral Healthcare Providers will submit claims to your disclosed health insurance. If your insurance requires that a pre-authorization or referral be obtained for services, you must check with our office, your primary care provider, and/or insurance company as applicable in advance to ensure the pre-authorization or referral is secured prior to the services being rendered. If you choose to receive services without pre-authorization or referral secured, you agree to be responsible for full payment for services at the self-pay rate independent of your insurance. Should your insurance policy terminate (with or without notice to Behavioral Healthcare Providers), your policy's annual/lifetime maximum for benefits is reached, you obtain new health insurance without prior notice to Behavioral Healthcare Providers, or your insurance fails to cover your visit balances in full for any reason not limited to those explicitly listed here, you agree to pay the full payment for services at the self-pay rate independent of your insurance carrier.

REFILLS WITHOUT APPOINTMENT
It is your responsibility to schedule your appointment prior to you medications running out, keeping in mind that schedules may fill up well in advance of your requested appointment date. Your prescriber reserves the right to charge a fee for administrative costs if your prescription needs to be refilled prior to your visit. This charge is not billable to your insurance or managed care payer. Please review our prescription policy. Telephone calls outside of your appointment time may be subject to an additional charge at the discretion of the clinician for which you agree to be responsible for the payment made in full prior to the call. This charge is not billable to your insurance or managed care payer.

____________________________________ ________________
Signature of Patient (or Authorized Representative) Date

____________________________________ ________________
Signature of Staff Date

Behavioral Healthcare Providers, LTD

WHY A URINE SPECIMEN IS NEEDED FROM YOU

As part of your clinical care it has been determined that today we need a urine specimen as part of your treatment plan. Please provide a small sample of urine in the cup provided and tightly screw the lid on, then hand it to the lab assistant.

As part of the care and monitoring of all psychiatric, substance abuse, or pain management patients it is good clinical care to periodically check the urine for drugs and medications for several reasons. These tests may be used as a baseline on a new patient or one who has never had a screen before; may be random, designed to sample what a person is using at that moment in time; or targeted to ensure that you are taking what is prescribed and not something else or due to changes in behaviors or because of a history of abuse.

You are not singled out but rather a good clinical care program is applied to all patients similar to how your family doctor may get your weight, blood pressure and temperature on all patients regardless of why they go to the doctor and will run routine blood work every year or so as well as more often if needed. Special circumstances in your care such as taking a controlled medication/s or testing positive for an illicit substance/s may require more frequent checks.

The Federal Drug Enforcement Agency (DEA) has asked for all practitioners to carefully monitor their patients to avoid diversion of controlled substances.

The results of today's testing are given to your Clinician to help them in their management of your care and are confidential. Please ask to speak with the Medical Director if you have any further questions. We thank you for your cooperation in your care.

If your insurance does not cover Urine Drug Screen, you will liable to pay a **Ninety-Five Dollar ($95.00) fee.**

I, ____________________________ confirm that I have read the above notice and I understand my
(PRINT NAME)
responsibilities as a Client at Behavioral Health Care Providers LTD (BHP).

______________________________ ________________
Patient Signature **Date**

______________________________ ________________
Signature of Parent/Guardian **Date**

______________________________ ________________
Witness **Date**

Prescription and Refill Policy

In order to provide the highest level of care to all our patients, we must all follow a clear, fair prescription and refill policy.

1. Call your pharmacy and ask them to fax your medication request to (847) 895-4544 or electronically transmit your medication request to our office.
2. Leave your contact information on the prescription medical assistant's voicemail in case there are any questions regarding the medication fill/refill. Be advised that your medications will only be filled until your next appointment, so please follow your doctor's treatment plan. (i.e. If you are to return in 1 month, ensure that your follow-up is scheduled within 30 days.)
3. Medication refill requests that are received by **2PM** will be processed by close of business on that day. Requests received after **2PM** will be processed on the next business day. Please take into account recognized holidays.
4. A **$75** service charge will be assessed to any refill granted for your convenience because you missed or cancelled an appointment. You are expected to make and keep appointments before your prescriptions run out. This is to allow for medication adjustments and review of symptom relief.
5. A **$75** service charge will be assessed to any prescription or refill written to replace one that was lost or stolen. You must present a police report describing the circumstances surrounding the loss of your medication or prescription.
6. Prescriptions for SCHEDULE II Controlled Substances MUST be brought to your pharmacy and filled within ninety (90) days. These include, but are not limited to the following:
   - amphetamine/amphetamine salts (ADDERALL)
   - methylphenidate (RITALIN, CONCERTA, METHYLIN, METADATE)
   - dextroamphetamine (DEXEDRINE)
   - dexmethylphenidate (FOCALIN)
   - buprenorphine (SUBUTEX/SUBOXONE)

   **(depending on medication, some prescriptions, by law, must be filled within sixty (60) days)*
7. A **$75** service charge will be assessed if SCHEDULE II prescriptions are not filled within ninety (90) days and a new written prescription is reissued (or sixty (60) days, for prescriptions expiring sixty days from date written).
8. Please monitor your medications and call us 5-7 days before your last dose to avoid any delay or lapse in your treatment.
9. A **$200** service charge will be assessed to any refill requests requiring the prescriber to authorize an emergency refill outside of practice office hours.

By signing below you certify that you have read and agreed to the above prescription and medication refill policy.

______________________________ ________________
Patient Signature **Date**

______________________________ ________________
Signature of Parent/Guardian **Date**

______________________________ ________________
Witness **Date**

Patient Name: ______________________________ Date of Birth________________

Date: ___________________

Reason for your appointment/chief complaint: ____

History of Present Illness **Write down your problem/s and tell us about them in Detail below:**

Problem/s	Location	Quality	Severity	Duration	Timing	Modifying Factors	Associated Signs & Symptoms
1							
2							
3							

Is the condition due to a work related Injury? ☐ Yes ☐ No Is the condition due to an auto accident? ☐ Yes ☐ No

New Medications: Prescription and non-prescription medications, inhalers, birth control, vitamins, and supplements

Medication Name	Dose	Frequency

New Allergies

Drug Name	Reaction Type	Severity (Mild,Moderate, Severe)

Social Changes	
Medical and Surgical Changes	

Are you Currently experiencing any of the following symptoms? Please check **ALL** that apply.

Constitutional		Cardiovascular		HEENT		Hematology / Lymphatic	
Weight loss	☐	Chest pain	☐	Headache	☐	Anemia	☐
Weight gain	☐	Irregular heartbeat	☐	Vision loss / eye pain	☐	Bleeding issues	☐
Poor appetite	☐	Elevated blood pressure	☐	Dry eyes / irritation	☐	Low blood count	☐
Binging	☐	Heart disease	☐	Decreased hearing/ear pain	☐	Easy bruising	☐
Fever	☐	Shortness of breath	☐	Sinus pain	☐	Swollen lymph nodes	☐
Night sweats / chills	☐	Swelling of limbs	☐	Hoarseness	☐	Transfusions	☐
Fatigue / no energy	☐	Genitourinary		Trouble swallowing	☐	Musculoskeletal	
Insomnia	☐	Frequent urination	☐	Sore throat	☐	Trauma	☐
Memory loss	☐	Urinary retention	☐	Pulmonary		Aches and Pain	☐
Gastrointestinal		Frequent UTIs	☐	Chronic cough	☐	Muscle Cramps	☐
Abdominal pain	☐	Pain urinating	☐	Wheezing	☐	Joint Pain	☐
Bloody stool	☐	Blood in urine	☐	Shortness of breath	☐	Psychiatric	
Constipation	☐	Incontinence	☐	Coughing up blood	☐	Paranoia	☐
Diarrhea	☐	Menstrual irregularities	☐	Excess sputum production	☐	Poor memory	☐
Frequent heartburn	☐	Endocrine		Skin		Loss of interest	☐
Jaundice	☐	Diabetes	☐	Rash	☐	Sexual activity Changes	☐
Kidney stones	☐	Excessive thirst	☐	Hives	☐	Loneliness	☐
Nausea	☐	Excessive/painful urination	☐	Skin sores / ulcers	☐	Panic attacks	☐
Vomiting	☐	Libido change	☐	Eczema	☐	Suicidal thoughts	☐
Neurology		Allergic / Immune		Psychiatric		Irritability / agitation	☐
Blackouts	☐	Hay fever	☐	Poor concentration	☐	Hallucinations/ delusions	☐
Seizures	☐	Frequent infections	☐	Anxiety	☐	Violent behavior	☐
Stroke	☐	Hepatitis	☐	Depression	☐	Not attending school/work	☐
Sleep issues	☐	HIV positive	☐	Mood swings	☐	Crying spells	☐
Tremor	☐	Positive TB/PPD skin test	☐	Drug Abuse	☐	Alcohol dependence	☐

______________________________ ______________________

PATIENT SIGNATURE **DATE**

To the Client - PLEASE DO NOT COMPLETE THE QUESTIONNAIRE BELOW

Height __'__" Weight ______lbs. Temp ____F Pulse ______ RR______ Pulse OX___% Labs ________________

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RISK ASSESMENT

Suicidal Ideation:	□ No Evidence	□ Denied	□ No Intent	□ Ideation	□ Plan
Homicidal Ideation:	□ No Evidence	□ Denied	□ No Intent	□ Plan	□
ETOH/ Substance Use	□ No Evidence	□ Denied	□ Social Etoh	□ Other	□
Appearance	□ Clean	□ Well Groomed	□ Fair Hygiene	□ Disheveled	□ Bizarre
Motor	□ Normal	□ Agitated	□ Retardation	□ Restless	□
	□ Akathisia	□ Tremor	□ Other		
Speech	□ Normal	□ Loud	□ Pressured	□ Impoverished	□
	□ Slurred	□ Mumbled	□ Stutters	□ Rapid	□ Other
Affect	□ Appropriate	□ Labile	□ Expansive	□ Blunted	□
	□ Flat	□ Tearful/Sad	□ Anxious	□ Angry	□ Other
Mood	□ Euthymic	□ Depressed	□ Euphoric	□ Angry	□ Manic □ Anxious
Judgment	□ Logical	□ Critical	□ Impaired	□ Other	
Insight	□ Appropriate	□ Limited/Concrete	□ Impaired	□ Lacking	□
Thought Process	□ Organized	□ Disorganized	□ Goal Directed	□ Irrational	□ Rigid
	□ Obsessive	□ Tangential	□ Circumstantial	□ Preoccupied	□
	□ Flight of Ideas	□ Blocking	□ Loose Associations	□ Other	□
Thought Content	□ Relevant	□ Hallucinations □ Yes □ No If Yes, Type:			
	□ Reality Based	□ Delusions □ Yes □ No If Yes, Type:			
Oriented	□ Fully Oriented	□ Disoriented (time, place, person, location)			
Intelligence	□ Average	□ Above Average	□ Below	□ Other	□
Language	□ Names Objects	□ Repeats Words	□ Impairment	□ Other	□
Memory	□ Intact	□ Immediate	□ Short	□ Long	□ Impaired
Gait	□ Normal	□ Decreased Swing	□ Ataxic	□ Other	□
Concentration	□ Sustain Focus	□ other	□	□	□
Attention	□ Well Focused	□ Easily Distracted	□ Other	□	□
Abstract	□ Can Do Proverbs	□ Can Name Off of List	□ Impaired	□ Other	□
Fund of Knowledge	□ Average	□ Above Average	□ Below	□ Other	□
Muscle Strength	□ 5/5	□ Impaired	□ Other	□	□

A/P____

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Patient was examined and History and ROS reviewed with patient by ______________________________Date:____________

Provider Signature