Healing Center for Behavioral Health

815-570-9303 1005 Laraway Road, Suite 230
Fax 866-950-9427 New Lenox, IL 60451

REGISTRATION (Please print)

Client's Full Name:_____SS #: _____

HomeAddress:_____City:_____State:____Zip:_____

Home Phone: (_____)_____Sex:_____ Age:_____ Date of Birth: _____/_____/_____

Cell Phone: (_____)_____ Email:_____ May I contact you by email? Yes No

Employer: _____ Work Phone: (____)_____

Student: Yes___ No___ School/Grade_____

Family Physician: _____

Referred by:_____ May I thank the person who referred you?_____

Emergency Contact: _____ Phone: (____)_____

Hours and Cancellations

Psychotherapy sessions are typically 45 - 50 minutes long. Groups run about 90 minutes. If it becomes impossible for you to keep an appointment, it is important that you **call** to inform me of your cancellation. Please do not send an email. **Due to the policy of reserved appointment times, an appointment that you cannot keep must be canceled no less than** 24 **hours before the appointment time. Appointments that have not been properly canceled will be charged $150.00.** Insurance companies, probation departments and employee assistance programs **will not** pay for missed sessions, so these will be your sole responsibility. **Lack of a reminder phone call does not excuse a missed appointment. Payment for failed sessions is expected at the next scheduled appointment time.**

Communication & Correspondence

My general policy is to leave only my name and phone number when phone calls are returned. Please indicate your consent to leave treatment information: appointment changes, account information, etc.

- ☐ I authorize the Healing Center for Behavioral Health to leave treatment information on my answering machine and voice mail.
- ☐ I do **not** authorize the Healing Center for Behavioral Health to leave treatment information on my answering machine and voice mail.
- ☐ I can be contacted by phone at :_____ or by Email at _____.

Emergencies

In the event of an emergency, you may contact me by phone. However, I will not usually accept calls if in session. If I am not available in case of emergency, please call your local crisis line, contact your primary care physician, your local health department, or proceed to your local emergency room. Call 911 in immediate matters of personal safety.

Confidentiality

I am committed to making this a safe place for you to get help. To that end, I adhere to all legal protections of your confidentiality. Limitations include staff consultation, life-threatening behavior, child abuse, elder abuse and judge's orders to release information.

Good communication between us is vital to my ability to serve you well. Please tell me about problems and questions that might arise. If you don't understand an answer or if new problems arise, let me know. I want to provide you with the best possible care, and I need your cooperation to succeed. Please contact me if you have a concern. **All items have been fully explained to me; I understand them and take full responsibility for their contents.**

Client Signature(s) _____ DATE _____

Provider Signature _____ DATE_____

Insurance, Billing, Payment, and Fees Information

INSURED/RESPONSIBLE PARTY INFORMATION
Please complete applicable portions of this section regardless of insurance coverage.

Full Name of Insured:_____Relationship:_____

Occupation: _____ Date of Birth: _____/_____/_____

Home Address:_____ Phone: (_____)_____

Employer & Address:_____ Phone: (_____)_____

Insured's SS# _____Driver's Lic.#_____ State_____

Spouse's Employer & Address:_____ Phone: (_____)_____

Insured Primary Ins. Co.:_____ID#_____ Grp#_____
Secondary Ins: ___N ___Y
Company _____ Policy #_____DOB____/____/___
Job Related Injury / Workman's Comp: __N __ Y: Company: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I authorize direct payment to my service provider.
4. I hereby permit a copy of this to be used in place of an original.
5. I understand that it is my responsibility to pay any deductible, co-insurance amount or any other balance not paid by my insurance, for services provided. This payment is expected no later than 30 days after services have been provided. Please also refer to your EOB from your insurance for any other billing information from this office.
6. I hereby authorize the use of the listed credit card information for payment of accounts that have not paid within 30 days of billing.
7. I understand that it is my responsibility to pay any co-pay or co-insurance the day and time services are provided.
8. I understand that there will be a $25.00 service charge on all returned checks.
9. Please make checks payable to Healing Center for Behavioral Health.
10. I understand that there is a 24 hour cancellation policy which requires that I cancel my appointment **by telephone** (please do not email) 24 hours in advance between the hours of 8am and 4pm Monday through Friday to avoid being charged.
11. I understand that if my account is sent to collection a collection fee of 33% will be added to the total owed when sent to collection. All attorneys fees and court costs incurred by the creditor.
12. I agree that all information provided is correct.

Name: _____ Signature: _____ Date:____/____/___

Name: _____ Signature: _____ Date:____/____/___

Credit Card Information
Card Type: ___ MC (16 digits) ___ VISA (13-16 digits) ___ Discover (16 digits)

Card # _____ Card Expiration Date ____/____/____ V Code _____

Signature _____

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NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MED1CAL INFORMAT1QN ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I am required to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will Be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment: I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard, the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. I may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me at 15127 S 73rd Avenue Suite C Orland Park IL 60462.

- Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. [
- Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

COMPLAINTS: If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me at 15127 S 73rd Avenue Suite C Orland Park IL 60462, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

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NOTICE OF PRIVACY PRACTICES
Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Healing Center for Behavioral Health Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the office at (708) 586-9303.

Signature of Client(s): _____ _____

Date(s): _____/_____/_____ _____/_____/_____

Signature of Client(s): _____ _____

Date(s): _____/_____/_____ _____/_____/_____

Signature of Parent, Guardian or Personal Representative*: _____

Date: _____/_____/_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____ Patient/Client Refuses to Acknowledge Receipt

Signature of Witness: _____ Date_____/_____/_____

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Notification to Patient of Desirability of Conferring with Primary Care Physician

Pursuant to Illinois law, you are herby informed that it is desirable that you confer with your primary care physician, if you have one. If you have a primary physician, I am required to notify him or her that you are seeking or receiving mental health treatment unless you waive such notification.

Please indicate your wishes:

____ My primary physician is _____

Address: _____

____ I agree to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing this Authorization to Release Information permitting you to communicate with my said physician.

____ I agree to you providing a written progress report to my primary care physician, which may include a diagnosis and a summary of interventions and treatment goals. (Please complete Authorization form for Release of Information)

____ I **WAIVE NOTIFICATION** of my primary care physician that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.

____ I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

_____

Signature Date

_____

Parent or guardian of minor patient Date

Notification to Primary Physician of Patient Receiving Mental Health Services

Pursuant to Illinois law requiring that Licensed Clinical Professional Counselors inform their patients' primary care physicians that a patient is seeking or receiving mental health services, you are hereby notified that _____ is seeking or receiving such services from me. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your record. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. When cancellations are made with less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $150.00 Cancellation Fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show two (2) or more times in a 12 month period may be required to prepay for future appointments, or denied future appointments. Patients may be subject to a $150.00 No Show Fee.

The Cancellation and No Show Fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good provider/patient relationship is based upon understanding and good communication. Questions about Cancellation and No Show Fees should be directed to the Front Desk at 708-586-9303.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ Date of birth _____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative Date

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Coordination of Care Release

Communication between professionals that are providing care to your child is important to ensure that we provide comprehensive and quality care. This form will allow providers within our offices to share protected health information (PHI) with other providers in our offices. The information will not be shared without your signed authorization. This PHI may include but not be limited to: diagnosis, treatment plan and progress notes.

I hereby authorize **Healing Center for Behavioral Health** and **Healing Center at Silver Lake Gardens** to share verbally or in writing information relating to individual therapy, group therapy, occupational therapy and speech therapy for:

Patient Name _____ Date of Birth _____

I understand that I may revoke this consent at any time and must do so in writing. A request to revoke the authorization will not affect any actions taken before the provider receives the request. This agreement expires one year following date signed unless otherwise stated.

Parent or Guardian _____

Signature _____ Date _____