Intake Packet

IRVING & ASSOCIATES IN
BEHAVIORAL HEALTH, P.C.

Please fill in the information below and bring it with you to your first session. Please note: Information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____

Parent/Legal Guardian (if under 18): _____

Age: _____ Gender: _____

Marital Status:

□ Never Married □ Domestic Partnership □ Married

□ Separated □ Divorced □ Widowed

Referred By (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Health History

1. How would you rate your current physical health? (Please circle one)

Poor **Unsatisfactory** **Satisfactory** **Good** **Very good**

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor **Unsatisfactory** **Satisfactory** **Good** **Very good**

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently taking any prescription medication? □ Yes □ No

   If yes, please list all medicines you are currently taking in the chart below. Include prescriptions (ex: pills, inhalers, creams, shots), over-the-counter medications (ex: aspirin, antacids), and herbals (ex: ginseng, gingko). Include medications taken as needed (ex: nitroglycerin, inhalers).

Start Date	**Name of Medication**	**Dose**	**Directions** (How do you take it? When? How often?)	**Notes** (Reasons for taking?)

Mental Health Information

6. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

   If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

   If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain? □ No □ Yes

   If yes, please describe: _____

9. Do you drink alcohol more than once a week? □ No □ Yes

10. How often do you engage in recreational drug use?

    □ Daily □ Weekly □ Monthly □ Infrequently □ Never

11. Are you currently in a romantic relationship? □ No □ Yes

    If yes, for how long? _____

12. On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? _____

13. What significant life changes or stressful events have you experienced recently? _____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	**List Family Member**
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

14. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

15. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

_____

16. What do you consider to be some of your strengths? _____

_____

_____

17. What do you consider to be some of your weaknesses? _____

_____

_____

18. What are the reasons you are seeking therapy now? _____

_____

_____

19. What do you hope to gain/accomplish from therapy? _____

_____

_____

First Name	**MALE** **FEMALE** (circle one)
Last Name	**Employed** YES NO (circle one)
Address	**Student** YES NO (circle one)
City	Therapist
State	Today's Date
Zip	Insurance ID #
Home Phone	Insurance Company
Work Phone	Insured's Name
Cell Phone	Insured's relation to client
Email	Group #
Social Security #	Insured's DOB
Date of Birth	Client Signature
Person Responsible for Billing NAME PHONE ADDRESS RELATIONSHIP TO CLIENT	I, _____, understand all of this information will be used for billing purposes and may be sent to my insurance company. I understand responsibility of any claim charges not covered by my insurance. I understand all balances over 120 days will be sent to collections, unless a payment plan is arranged before my balance is 120 days past due. I certify all information on this page is correct. I understand if the client is under 18, a parent or guardian must be deemed the person responsible for billing.

Emergency Information

In case of an emergency, notify: _____ Relationship: _____

Phone: _____

Family Physician & Phone: _____

If Client is a under the age of 18 –

Parent/Guardian Name: _____ Cell Phone: _____

☐ ***I understand that any information regarding my health can be released to this person in the event of an emergency.***

Insurance Release & Client Responsibility

Insurance coverage for mental health is usually different than for medical coverage. It is **YOUR** responsibility to know and understand what outpatient mental health services your insurance policy covers. The following information will also help our office facilitate the filing of your claims and minimize the chance of billing problems.
PLEASE NOTE: VERIFICATION OF INSURANCE BENEFITS IS NOT A GUARANTEE OF PAYMENT.

I/We (the undersigned) authorize the release of any information necessary to process my claims. I/We also authorize payment of the benefits directly to the above named supplier who accepts assignment. It is understood that I/We have the responsibility for payment of services. Assignment of benefits to the insurance company does not release me/us from amount as stated above. I/We will be responsible for the remaining balance. Any outstanding insurance balance beyond **90 days** will be billed to the undersigned and be due upon receipt.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature if Client is under 18 years of Age Date

Professional Service Agreement

This agreement contains important information about professional services and business policies. It also contains a summary of information about the Health Insurance Portability Act (HIPAA), a federal law that provides privacy protections and patient's rights with regard to disclosure and use of your protected health information used for the purpose of treatment, payment, and health care operations.

The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read through them carefully. If you have any questions, please feel free to ask at any time. Your signature on this document represents an agreement between us. You may revoke this agreement at any time by providing a written request. As a client with Irving & Associate in Behavioral Health, you agree to the following:

1. **Payment for treatment is due at the time services are rendered.** If you have not met your deductible we ask that you pay a minimum of 50% of the fee at each session until your deductible is satisfied. Payments may be made by cash, check, or credit card. We accept Visa, MasterCard, and Discover cards. You may put a credit card on file for any charges not covered by insurance. If you balance exceeds $300.00, we request that you pay for services when rendered. Services may be terminated due to non-payment. Any payment received from co-insurance payers (i.e. insurance companies or any other party) will be promptly credited to your account. This office does file for secondary insurance; please provide both insurance cards so that your provider can obtain copies of the cards. At your request, documentation of your visit will be provided to you.

2. The client/guardian is and shall be primarily responsible for any amount due and owing. It is also agreed that you, as the client/guardian, shall be responsible for any legal costs and/or expenses incurred in collecting any amount past due for non-payment. These sums will be added to any outstanding balance due and owing. The fee for returned or insufficient checks is $25.00 per occurrence.

3. Assignment of benefits to the insurance company does not release the client/guardian from responsibility of payment. If for some reason your insurance company does not cover services rendered, you will be responsible for the remaining balance

4. Services may include, but are not limited to: individual, family, marital, and group psychotherapy and psychological evaluation. Other services include: report writing, any telephone conversation lasting longer than ten minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing any other service you may request. If you become involved in legal proceedings that require a therapists' participation, you will be expected to pay for all professional time, including preparation and travel expenses.

5. This office reserves the right to change, modify, or alter any of the terms of this agreement in the future, upon first giving notice to you. Any objections to the changes, modifications, or alterations, must be made promptly upon receipt of this notice. If no objections are made, it shall be assumed that you have accepted the changes, modifications, or alterations made.

6. Please be aware that insurance companies require a clinical diagnosis for billing purposes. This information may become part of your permanent medical record. If you have any questions, please discuss this with your therapist.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Irving & Associates in Behavioral Health, as well as of your individual rights and Irving & Associates in Behavioral Health's legal duties with respect to confidential information

Ways in which I may use and disclose your protected health information (PHI):
I may use and disclose at my discretion your medical records for each of the following purposes only: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services.
- **Payment** means activities, such as obtaining payment for the mental health care services I provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

I may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.

I will use and disclose your PHI when required by federal, state, or local law. There are certain circumstances in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to persons or agencies, even if you do not give permission. These situations are as follows:

a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies.
b) If you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor. I am required to inform the appropriate child welfare or social agency services which may then investigate the matter.
c) If I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing and I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Patients' Rights

- **Rights of Minors** – Patients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and unless we find that there are no compelling reasons for denying the access. Parents are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Since parental involvement is often crucial to successful treatment, in most cases, we require that minors and their parents enter into an agreement that allows parents access to certain additional treatment information. Parents will be provided with general information about the progress of their child's treatment. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving the parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

- **Right to Request Restrictions –** You have the right to request restrictions on certain uses and disclosures of PHI. However, we are 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 communication of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know you are seeing us. On your request, we will send your bills to another address.)
- **Right to Inspect and Copy –** You have the right to inspect or obtain a copy of your PHI in our mental health and billing records used to make decision about you for as long as the PHI is maintained in the clinical record. On your request in writing, we will discuss with you the detail of the access process. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them, forwarded to another mental health professional so you can discuss the contents.
- **Right to Amend –** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we 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, we will discuss the details of the accounting process.
- **Right to a Paper Copy –** You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

You have the right to refuse treatment, unless treatment is necessary to prevent you from harming yourself or others, and the right to know of the consequences of the refusal of treatment and the right to be provided with a referral for services to another clinician or agency.

Clinician's Duties: We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide the new policies in writing to our current patients. **Your rights as a consumer of Irving & Associates in Behavioral Health are protected in accordance with the *Illinois Mental Health Code and Developmental Disabilities Code (405 ILCS 5), and the American with Disabilities Act of 1990 (42 USC 12101).* In addition, your rights to confidentiality and privacy are protected by the *Illinois Mental Health Developmental Disabilities Confidentiality Act (740 ILCS 110)* and the *Health Insurance and Accountability Act of 1996 (HIPPA).* These rights also extend, where appropriate, to your family or guardian.**

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with the decision we made about access to your records, you may contact Kathleen L. Irving, PhD. at (630) 963-5390 EXT 2. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

***This notice became effective on January 1st, 2014**

Should you at any time wish to request a copy of this document, you may call us at (630 963-5390 EXT 1. We can email, fax, or mail this document upon request. You may also pick up a copy from our office.

Please sign to indicate you understand my operation use of your information for treatment, payment, and health care operations, as well as the patients' rights and clinicians' duties, as stated above.

_____	_____
Print Name of Client	**Date of Birth**
_____	_____
Client Signature (age 12 and older)	**Date**
_____	_____
Signature of Parent/Legal Guardian if client is under 18	**Relationship to Client**

HIPAA Release Form

Client Name: _____ Date of Birth: _____

Release of Information

- ☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

This information may be released to:

- ☐ Spouse
- ☐ Child (ren)
- ☐ Other: _____
- ☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Contact Information:

Please call:

- ☐ My home: _____
- ☐ My work: _____
- ☐ My cell number: _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Do not leave a message

I would like to receive text reminders:

- ☐ Yes, at this phone number: _____
- ☐ No

Signature: _____

Date: _____

Your clear understanding of the standard billing policy is important to our professional relationship. By initialing and signing this document, you are acknowledging that you have read and understand the terms of payment arrangements with our office. Please contact our office with any questions related to your account at: 630-963-5390 EXT 1.

Financial Policy:

1. All copay, co-insurance, and payment towards deductible is due at the time of service. As a courtesy to our clients, we will call your insurance company and collect information regarding patient coverage and benefits. Based on the information your insurance company provides to us, we will prepare an estimate of benefits for you so that you can anticipate any costs associated with your services. All clients are required to provide a valid, active credit card which will remain on file. You will be responsible for the remaining balance once the insurance has paid its portion. Credit cards are run weekly for client portions of balances. We are happy to provide a detailed monthly statement, upon request, to reflect all dates of service and payments.

2. You will be responsible for all charges not paid by the insurance within 120 days, regardless of your insurance. Your card will also be charged same day for a late cancel or missed appointment. **Cancellations must be made 24 hours in advance**. A **$50.00 fee** will be charged for cancellations with less than **24 hours' notice.** If you fail to show up for an appointment you will be charged **$100.00**. Insurance companies do not provide reimbursement for cancellations or no show appointments. These charges will be your responsibility. If your account is over $300.00 or 90 days late, we will be unable to schedule until the balance is paid or a payment arrangement is made. Please note that service may be terminated due to multiple missed appointments.

I have read and agree to the terms of the Irving & Associates Billing Policy _____ (initial)

Insurance Policy:

Your mental health insurance is a contract between you and your insurance company. Our office and our clinicians are not a party to this contract. If the terms of your insurance policy changes or you choose to contract with a different insurance company than we have on file, it is your responsibility to inform our office immediately. Failure to do so may result in you having to pay out of pocket for the full fee amount of each session.

1. Irving & Associates providers accept select managed care contracts. Our office will submit insurance claims for all in-network policies. You will be responsible for all co-pays, coinsurance, and deductible amounts.

2. If Irving & Associates is not in-network with your insurance company, you will be provided with a statement at the time of your visit which will include all information necessary to submit to your insurance company for reimbursement. You are responsible for coordination of benefits and collection of reimbursement money from your insurance company.

I have read and agree to the terms of the Irving & Associates Insurance Policy _____ (initial)

Print Name: _____

Signature: _____ Date: _____