IRVING & ASSOCIATES IN BEHAVIORAL HEALTH, P.C.

5151 Mochel Drive, Suite 307
Downers Grove, IL 60515

Date: ______/______/______

Client Name: ________________________________ SSN: _______/______/_______

Date of Birth: ________________ Age: ___________ Sex: Male_____ Female_____

Address: ____

City/State/Zip: ____

Home Phone Number__________________ Is it okay to leave a message here? Y/N

Work Number_______________________ Is it okay to leave a message here? Y/N

Cell Number________________________ Is it okay to leave a message here? Y/N

Email: _____________________________ Is this an acceptable form of communication? Y/N

Student: YES____NO____ IF YES: FULL TIME_____ PART TIME_____

Highest level of education____

Employer____

Occupation____

Who referred you? How did you learn about our services? _____________________

Have you ever consulted a Psychotherapist or mental health professional before? YES / NO

If so, when, with whom, and for how long?

____

What are the reasons you are seeking therapy now?

____

____

What do you hope to gain/accomplish from therapy?

____

____

Emergency Information

In case of an emergency, notify: ___________________________________

Relationship: ______________________ Phone: ______________________

Family Physician__________________________________ Physician Phone: ___________________

Relationship Status

_____Single _____Married/committed relationship

_____Widowed _____Divorced/separated

How long have you been married/in a committed relationship? ___________________________

Spouse/Partner's Name: __________________ Spouse/Partner's Employer: ____________________

Spouse/Partner's Cell Phone: _________________ Spouse/Partner's Work Phone: _______________

If Client is a Minor (under the age 18)

Parent/Guardian Name: ______________________ Cell Phone: _____________________

Employer: __________________________________ Work Phone: ___________________

Name of Individual Responsible for Billing: ____

Address (if different from above): ____

Home Phone: Work Phone: ____

Medical History: List all prescriptions, OTC, and herbs.

Medication	Dosage	Start Date	D/C Date		
				Last History and Physical	Date
				Chronic Medical Conditions	Onset
				Surgical Procedures	Date

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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

Client Name: ________________________ Age: _________ DOB: _____/_____/_______

ID/Social Security Number: ________-______-________

Name of Insured: _______________________ DOB: _____/_____/_______

Relationship to Client: ___________________ ID/Social Security Number: ________-______-_______

Employer: ______________________________ Work Phone: ___________________

PLEASE GIVE YOUR INSURANCE CARD TO YOUR CLINICIAN TO COPY

Name of Insurance Company: ___________________ Member ID: _____________________

Group Number: ________________________________ Policy Number: ___________________

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

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Professional Service Agreement & Notice of Privacy Practices

This notice describes important information about professional services and business policies.

AND

This notice describes how medical information may be used and disclosed, as well as how you can get access to this information.

PLEASE REVIEW IT CAREFULLY

I ________________________ (print name) have received the attached service agreement and notice of privacy.

________________________________	____________________________
Client Signature (age 12 and older)	Date
________________________________	____________________________
Print Name of Client	Date of Birth
________________________________	____________________________
Signature of Parent/Legal Guardian	Relationship to Client
________________________________	____________________________
Witness	Date

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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. Once an appointment is scheduled, you will be expected to pay for this time. If you choose to cancel your appointment, we require **24 hours** advance notice. 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 your full fee for the appointment. **INSURANCE COMPANIES DO NOT PROVIDE REIMBURSTMENT FOR CANCELLATIONS OR NO SHOW APPOINTMENTS. THIS WILL BE YOUR RESPONSIBILITY. Payment for the missed appointment is required prior to or at the beginning of the next appointment.** Please note that service may be terminated due to multiple missed appointments.

2. **Payment for treatment is due at the time services are rendered.** We ask that you pay your co-pay/co-insurance 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. Visa, Master, and Discovery cards are acceptable forms of payment for amounts $50.00 and over. 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.

3. 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.

4. 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. Any outstanding insurance balance beyond 90 days will be billed to the appropriate responsible party and is due upon receipt.
5. 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.
6. 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.
7. 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.

COORDINATION OF TREATMENT:

It is important that health providers communicate and work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year, but can be revoked at any time. If you prefer to decline consent, no information will be shared.

______ YOU MAY INFORM MY PHYSICIAN(S)

______ I DECLINE TO INFORM MY PHYSICIAN

PHYSICIAN NAME: ____

ADDRESS: ____

PHONE: ____

____ ______________________

CLIENT SIGNATURE DATE

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Notice of Clinician's Policies and Practices to Protect the Privacy of Your Health Information

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

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

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposed with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  –Treatment is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  –Payment is when we obtain reimbursement for your healthcare. 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 our 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 only to activities within our practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of our practice group 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 specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health operations when your appropriate authorization is obtained. In those instances, when we are asked for information for purposes outside of treatment, payment, or health operations, we will obtain an authorization from you before releasing your information. We will also need to obtain authorization before releasing your Clinical Records. The laws and standards of our profession require that we keep PHI about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals we set for treatment, your progress towards those goals, your medical and social history, your treatment history and past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports sent to your insurance carrier.

You may revoke all such authorizations (of PHI) at any time, provided each revocation is in writing. You may not revoke 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

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

- Child Abuse – if we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or neglected, or financially exploited, we must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If we have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, we must report this belief to appropriate authorities.
- Health Oversight Activities – We may disclose PHI 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 we must not release such information without a court order. We can release 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 communicated a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.
- Workers Compensation – We may disclose PHI regarding you as authorized by and to the extent necessary to comply with laws relation 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. Patients' Rights and Clinician's Duties

Patient's 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 the, 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.

V. 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.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