

ADVANCED BEHAVIORAL CENTERS OF DUPAGE

Terrace Executive Center
1 S. 376 Summit Ave., Court D, Unit 5B
Oakbrook Terrace, IL 60181
Physicians: (630) 629-6550
FAX: (630) 629-6558

Hinsdale Professional Office Center
501 W. Ogden Ave., Suite 1
Hinsdale, IL 60521
Therapists: (630) 986-0599
Fax: (630) 986-1477

Date of 1st Visit _____

Adult Patient Registration

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone _____

Sex: Male _____ Female _____ Age: _____ DOB: _____

Marital Status: (check one) Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Patient Employed by: _____

Business Phone: _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified?

Name: _____ Phone # _____

Family Physician: _____ Phone # _____

Past/Current Therapist _____ Phone # _____

If necessary may we contact your physician? _____

Patient Signature: _____

Date: _____

Medical History

Have you ever been treated or evaluated by a psychiatrist, psychologist, or therapist?

___ Yes ___ No

If yes, list names and dates treated

Do you currently use substances or have you used any illicit substances in the past?

If yes, have you received treatment for chemical dependency before? (Please explain)

Have you ever had any surgical procedures? ___ Yes ___ No

If yes, what surgeries, when and why:

Have you ever had any injuries such as broken bones, head injuries etc.? ___ Yes ___ No

If yes, please describe:

Have you ever had any medical problems of any type? ___ Yes ___ No

If yes, please explain:

When was your last visit with a Primary Care doctor/internist? _____

When did you last have labs (blood work) performed? _____

When was your last dental visit? _____

Do you have any allergies (including allergies to medications)? ___ Yes ___ No

If yes, please describe:

MEDICATIONS

Please list any current medications (prescription or over the counter), vitamins, or herbal remedies that you regularly use:

FAMILY HISTORY

Has any biological relative been diagnosed with any psychiatric disorder? Please list the relation, Father, Mother, Aunt, etc. and the disorder.

Examples include: Anxiety Disorder, Depression, Bipolar Disorder, Manic Depression, Attention-Deficit/Hyperactivity Disorder (ADHDS/ADD), Obsessive Compulsive Disorder, Schizophrenia, Developmentally Disabled or Retarded, Alzheimer's Disease or Dementia, Motor Tics, Tremors, or Tourette's Disorder:

Has any biological relative ever committed suicide? _____

Has any biological relative had a problem with alcohol or drug abuse? Please list the relation, Father, Mother, Aunt, etc. and the substance abused.

Has any biological relative had a learning disability? _____

Is there any family history of neurologic disorders or other medical conditions (e.g., cardiovascular disease, etc)?

SOCIAL HISTORY

What is your occupation? _____

What is your ethnicity? _____

What is your primary language? _____

Second language (if any)? _____

What is your educational background?

____ Elementary School ____ GED ____ High School Graduate

____ Some College ____ College Graduate ____ Graduate Degree-Masters Degree, Ph.D., M.D., J.D., etc.

Who currently lives in your home with you?

Briefly describe what brings you in today?

Anything you wish to clarify:

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INSURANCE AND BILLING INFORMATION

Primary Insurance Company _____

Name of Policy Holder _____

Member I. D. # _____ Group No. _____

Date of Birth of Insured: _____ SSN: _____

Effective Date of Policy: _____

Relationship of Insured to Patient: _____

Occupation and Employer of policy holder: _____

Address of policy holder: _____

In order to keep our billing expenses down so that we will not have to raise our procedure charges to you, we are requesting payment for services at the time they are rendered. We ask that we can keep a credit card on file for you so that we can collect payment for services once your portion of payment is determined by your insurance company. Your information will be kept secure and transactions will only be made for services already rendered.

PAYMENT ACKNOWLEDGEMENT: (circle one): American Express Visa MasterCard Discover Debit

CREDIT CARD NO: _____

NAME ON CREDIT CARD: _____

3 DIGIT CODE ON BACK OF CARD: _____

EXPIRATION DATE: _____

I, _____, AUTHORIZE AN IMMEDIATE PAYMENT OF _____ (E.G., CO-PAYMENT) AGAINST THE ACCOUNT(S) LISTED ABOVE. I ALSO AUTHORIZE A CHARGE OF UP TO _____ (E.G., MAXIMUM PROCEDURE CHARGE, BALANCE DUE) AGAINST THE ACCOUNT(S) LISTED ABOVE IN ANTICIPATION OF SETTLEMENT ONCE THE FINAL PRICING AND EXPLANATION OF BENEFITS HAS BEEN ISSUED BY MY INSURANCE CARRIER.

Patient or Legal Guardian Signature

Date

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PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I am voluntarily requesting a diagnosis and treatment for a condition from which I am suffering. I understand my treatment may involve a referral for medication management, individual, family or group therapy, or hospitalization.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the practice. I authorize Advanced Behavioral Centers of DuPage to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Advanced Behavioral Centers of DuPage may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to Advanced Behavioral Centers of DuPage for insurance benefits payable to me. I understand that I am financially responsible to Advanced Behavioral Centers of DuPage for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

PRIVACY POLICY. I acknowledge having received the Disclosure and Informed Consent policies, describing my Right to Privacy; including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, which is explained in the Disclosure. I understand that I may revoke, in writing, my consent for release of my health care information, except to the extent Advanced Behavioral Centers of DuPage has already made disclosures with my prior consent.

Patient or Authorized Person Signature

Relationship

Date

Witness Signature

Date

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COMMUNICATION OF CONSENT

Patients Name: _____ DOB: _____

Most patients have family members and friends who occasionally become involved in their care. For example, your spouse calls to confirm your appointment time; **OR** your adult child calls with questions about your medication; **OR** a friend calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

If you have anyone with whom you would allow us to communicate, please list them below. Due to privacy regulations, we cannot speak to anyone except the patient unless we have your written permission.

I give the staff of Advanced Behavioral Centers of DuPage my permission to speak with the following individuals regarding my care:

(If you prefer that we not speak with ANYONE, please write NO ONE across the lines)

NAME OF FAMILY OR FRIEND

RELATIONSHIP

Restrictions to Communication: _____

I request that all communications (by telephone, mail or otherwise) by the staff of Advanced Behavioral Centers of DuPage be handled in the following manner:

*For written communications Address to: _____

*For oral Communications Call: _____

(Telephone Number)

May we leave message: yes ____ No ____

I understand that I have the right to revoke this authorization **in writing** at any time. I request that my confidential information be handled in the following manner and authorize the staff of Advanced Behavioral Centers of DuPage to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

Signature of Patient/Legal Guardian (Minors 12-17 Must sign)

Date

Signature of Staff Member,

Date

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Authorization to Disclose/Obtain Information

- I authorize _____ (doctor, clinician, agency, individual) to ___disclose, ___obtain
_____disclose and obtain
- Discharge Summary Psychiatric Evaluation Psychological Test Report
 Psychological Evaluation Progress Notes Medical Administration Records
 Consultations History and Physical Social History
 Behavioral Plans Treatment Plans Other (please describe _____)
- About (Patient Name) _____ Date of Birth: _____
- For purposes of: Personal Use Continuity of Care Financial/Benefits
 Attorney State Law/Court Other (please describe _____)
- Information may be disclosed/obtained: Mail, In-person, Phone, E-Mail or by Fax (For urgent needs)
Restrictions if any: _____ disclose to
_____ obtain from _____ disclose to and obtain from

Name: _____
Address _____
City, State, Zip Code _____
Phone Number _____

- This authorization is valid until calendar date _____ (month/day/year)
- I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.
- I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to Advanced Behavioral Centers of DuPage staff. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.
- Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED
- It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDS unless specifically checked below for exclusion:

Mental Health Alcohol/Substance Abuse HIV/AIDS Developmental Disabilities

_____	_____
(DATE/TIME)	(PATIENT SIGNATURE) REQUIRED if Patient is 12 years or Older
_____	_____
(DATE/TIME)	(SIGNATURE OF PARENT OR GUARDIAN) If Patient is Under 18 or Disabled
_____	_____
(DATE/TIME)	(SIGNATURE OF WITNESS) second parent/guardian, if co-custodial, may sign here)
_____	_____
(DATE/TIME)	(SIGNATURE OF STAFF PERSON DISCLOSING/OBTAINING INFORMATION)

ADVANCED BEHAVIORAL CENTERS OF DUPAGE FINANCIAL POLICY

It is required that all clients read and sign the Financial Policy Form. By signing the policy you are agreeing to the terms and conditions set out in it.

For your information please note that:

- FULL PAYMENT IS DUE AT TIME OF SERVICE WHEN NOT UTILIZING INSURANCE.
- Our fees are based on the treatment of a patient and not on the outcome.
- We reserve the right to stop treatment for non-payment.

For those of you who will be utilizing Insurance:

We accept assignment of insurance benefits for our providers who are in your insurance network plan. However, confirmation of benefits is not a guarantee of payment. In the event that your insurance Company denies your claim for payment, you are responsible for payment in full.

You are responsible for:

- Deductibles, co-insurances, copayments at time of service and any services not covered by your insurance.
- As a courtesy, our office will obtain benefits and Eligibility from your insurance company. However, you are responsible to obtain your own benefits and authorization, when required, prior to treatment. If you fail to obtain authorization you may be responsible for the full fee.
- Notifying our office if your insurance coverage changes. If you fail to do so, you will be responsible for any charges that your insurance company denies.

Minors

- The adult accompanying a minor is responsible for full payment at the time of service.
- Full payment must be sent with an unaccompanied minor.

Additional Charges

- There will be a \$40.00 charge for bounced checks.
- There will be a \$10.00 additional fee for copayments not paid at time of service.

Missed Appointments:

Our office requires that you give us a full 24 hour notice for cancellation!

- Missed appointments with no call, no show will be assessed a \$60.00 fee, not billable to Insurance.
- Late cancellations (Less than 24 hours), there will be a \$30.00 fee, not billable to insurance.

Please Note: (Monday's appointments must be canceled by Saturday at 4PM). Cancellations must be made during office hours of operation only.

By signing this form I affirm that I have read the Financial Policy, and understand and agree to honor the terms of this Financial Policy:

Sign: _____ Date: _____

Signature of Client or Responsible Party

Witness: (Staff for ABC DuPage): _____ Date: _____

ADVANCED BEHAVIORAL CENTERS OF DUPAGE
ACKNOWLEDGEMENT OF THE HIPAA PRIVACY NOTICE

By signing below I acknowledge that I was offered the opportunity to review the Advanced Behavioral Centers of DuPage HIPAA Privacy Notice.

_____ I would like to have a copy of this office's HIPAA Privacy Notice.

_____ I would not like to have a copy of this office's HIPAA Privacy Notice.

_____ I refuse to sign because: _____.

Print Patient Name: _____ Date: _____.

Patient Signature: _____ Date: _____.

Parent or Guardian Signature: _____ Date: _____.

Witness By: (Staff Name): _____ Date: _____.