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_____

Child Patient Registration

Patient Name_____

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

Responsible Party:_____

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

Responsible Party Employed by: _____

Business Phone: _____

Address_____

City_____State_____Zip_____

Home 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 patient's physician? _____

Signature of patient's legal guardian _____

Date _____

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Child/Adolescent History Form

Name of school attended: _____

Current grade level: _____

Address of School: _____

City:_____ Zip:_____

Telephone: Day_____ Eve _____

Relationship to Patient: Mother____ Father____ Other (specify) _____

Problems you are concerned about (list briefly):_____

_____

Parents:

Who has legal custody? _____

Name of biological Mother_____

Do both parents agree with treatment and evaluation of your child?(circle one) Yes ◯ No ◯

Address, if different than above. _____

Occupation: _____

Work ph. _____ Home ph. _____

Name of biological Father: _____

Address, if different than above._____

Occupation: _____

Work ph._____ Home ph._____

Name and location of stepmother if applicable) _____

_____

Name and location of stepfather (if applicable) _____

_____

MEDICAL HISTORY

Was the pregnancy for this child planned? (circle one) ○ Yes ○ No

Were there any problems during the pregnancy or birth? (circle one) ○ Yes ○ No

If yes, describe:

_____

_____

_____

Was this child born full term, after 9 months of pregnancy? (circle one) Yes ○ No ○

If born early, how early? _____ months

What was his/her weight at birth? _____

Did he/she have severe colic or feeding problems the first 3 months? (Circle one) Yes ○ No ○

If yes, explain: _____

_____

_____

_____

Do you feel your child developed normally the first two years of life? (Circle one) ○ Yes ○ No

How old was this child when he/she did the following?

Crawled: _____ Walked: _____ Said first word: _____

Spoke in two or three word phrases: _____ Toilet Trained: Bowel_____

Toilet trained: bladder_____ Remained clean and dry all night: _____

Attended Daycare: _____ Attended Preschool or School the first time: _____

When was your child's last physical exam? _____

Does he/she have any current or past medical problems? (Circle one) Yes ○ No ○

If yes, describe: _____

_____

Has he/she had any injuries such as broken bones, head injuries? (Circle one) Yes ○ No ○

If yes, describe:

_____

Does your child have any problems with vision or hearing? (circle one) ○ Yes ○ No

When was your child's last hearing and vision screening? _____

Has he/she had any surgeries? (circle one) ○ Yes ○ No

If yes, describe:

_____

Does he/she have any allergies (including allergies to medications)? (circle one) ○ Yes ○ No

If yes, what?

_____

_____

Please list any current medications, vitamins, or herbal remedies that your child takes:

PAST PSYCHIATRIC HISTORY

Please describe any past mental health treatment that your child has received:

SUBSTANCE ABUSE HISTORY

Please describe any known substances that your child is using or has used in the past:

FAMILY HISTORY

What is the child/family's religion(s)? _____

What is the child/family's ethnicity? _____

Has any biological relative of this child been diagnosed with any psychiatric disorder, including: Anxiety Disorder, Depression, Bipolar Disorder, Manic Depression, Attention Deficit/Hyperactivity Disorder (ADHD/ADD), Obsessive Compulsive Disorder, Schizophrenia, Developmentally Disabled or Mentally Retarded, Alzheimer's Disease or Dementia, Motor Tics, Tremors, or Tourette's Disorder?

Please list relation to the child, i.e., father, mother, aunt etc. and the disorder:

_____

Has any biological relative of this child committed suicide? _____

Has any biological relative of this child had a problem with alcohol or drug abuse?

_____

Has any biological relative of this child had a learning disability?

_____

Is there any family history of neurological disorders or other medical conditions?

_____

Is there any history of cardiovascular problems in the family?

_____

SOCIAL HISTORY

FAMILY MEMBER	NAME	DATE OF BIRTH	OCCUPATION	HIGHEST LEVEL OF EDUCATION COMPLETED
Mother				
Father				
Step-Mother (if applicable)				
Step-Father (if-applicable)				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Who currently resides in the household with your child _____

_____

Has he/she ever been treated or evaluated by a psychiatrist, psychologist, or therapist? Yes ◯ No ◯

If yes, list names, dates treated:

Name: _____Date Treated: _____

Name: _____Date Treated: _____

Does he/she smoke cigarettes, drink alcohol, or use any drugs? ◯ Yes ◯ No ◯ Unsure

If unsure or yes, describe: _____

_____

Has he/she had any involvement with the police or the courts? ◯ Yes ◯ No

If yes, describe: _____

_____

_____

SCHOOL INFORMATION

School patient is attending:

NAME: _____

ADDRESS:_____

CITY/STATE/ZIP: _____

Previous Schools Attended:

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

Use the space below if you would like to clarify any of your answers above:

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NSURANCE 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

_____ _____

Child/Adolescent Signature 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

1. I authorize_____ (doctor, clinician, agency, individual) to ___disclose, ____obtain _____disclose and obtain

2. ☐ 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_____)

3. About (Patient Name)_____ Date of Birth:_____

4. For purposes of: _____Personal Use _____Continuity of Care _____Financial/Benefits
   _____Attorney _____State Law/Court _____Other
   (Please describe_____)

5. Information may be disclosed/obtained: Mail, In-person, Phone, E-Mail or by Fax (For urgent needs)
   Restrictions if any: _____

6. ___disclose to _____obtain from _____disclose to and obtain from
   Name: _____
   Address_____
   City, State, Zip Code_____
   Phone Number_____

7. This authorization is valid until calendar date _____(month/day/year)

8. 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.

9. 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.

10. Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED

11. 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 accessed 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 a 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: _____.