Northwest Behavioral Health Services, PC

NEW PATIENT REGISTRATION FORM

Patient Information (please print clearly)

Patient Name_____ Patient home phone ( )_____
Patient Home Address Patient work phone ( )_____
_____ Patient cell phone ( )_____
_____ Patient date of birth ___/___/_____
_____

Patient gender: ☐ Male ☐ Female Patient marital status: ☐ Single ☐ Married ☐ Other

Patient employed: ☐ Employed ☐ Student Employer/school:_____

Billing Information:
Name of responsible party: *_____
Last First Middle Initial
Address: _____ Home phone ( )_____
_____ Work phone ( )_____
_____
*No third party billing. Responsible party must be present to sign for financial responsibility

Billing Information: Bill my insurance? ☐ Yes ☐ No Please provide a copy of your ins. card
PRIMARY INSURANCE
Insurance co. name: _____ Insured's name: _____
Insurance co. address: _____ Insured SS # _____-____-_____
_____ Insured's employer: _____
Insured's date of birth ___/___/_____ Group # or name:_____
Insured's phone number ( )_____ Policy #: _____
Authorization #: Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Billing Information: Bill my insurance? ☐ Yes ☐ No Please provide a copy of your ins. card
SECONDARY INSURANCE
Insurance co. name: _____ Insured's name: _____
Insurance co. address: _____ Insured SS # _____-____-_____
_____ Insured's employer: _____
Insured's date of birth ___/___/_____ Group # or name:_____
Insured's phone number ( )_____ Policy #: _____
Authorization #: Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

OFFICE USE ONLY: ☐ Self Pay ☐ Insurance
Clinician's Name: _____ Account #: _____
Diagnosis Code: _____ Statement sent to home? ☐ Yes ☐ No
Referral Source: _____
Special Notes: _____

Last updated 08.13.2018

Northwest Behavioral Health Services, PC

Patient Email/Texting Informed Consent Form

To ensure the highest level of confidentiality, it is the preference of NWBHS to speak via telephone call and to send reports to patients through our EMR patient portal and/or fax. However, it is up to the discretion of you as the patient or patient's guardian to engage in communication via email and/or text with proper expressed written consent. Please carefully consider the following and indicate your preferences.

1. **Risk of using email/texting:**

   The transmission of patient information by email and/or texting has a number of risks that patients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

   a. Emails, texts, and attachments can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   c. Backup copies of emails, texts, and attachments may exist even after the sender and/or the recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect emails and its attachments sent through their company systems.
   e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f. Emails, texts, and attachments can be used as evidence in court.
   g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. **Conditions for the use of email and texts:**

   Clinicians cannot guarantee, but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Clinicians are not liable for improper disclosure of confidential information that is not caused by their intentional misconduct. Patients/Parents/Legal Guardians must acknowledge and consent to the following conditions:

   a. Email and texting is not appropriate for urgent or emergency situations. Clinician cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   b. Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   c. Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   d. Texts should be primarily used to make or change appointments and emails can be used to communicate lengthier information.
   e. Emails, texts, and attachments may be filed into the patient's medical record.

f. A clinician will not forward patient's/parent's/legal guardian's identifiable emails, texts, and/or its attachments without the patient's/parent's/legal guardian's written consent, except as authorized by law.
g. Clinicians cannot respond to "all" if a parent/guardian/patient chooses to include other parties not covered in a signed consent for release of information.
h. A clinician is not liable for breaches of confidentiality caused by the patient or any third party.
i. All parties shall respect each other's assumed confidential communication by not forwarding, carbon copying, or blind carbon copying other parties.

3. Patient Acknowledgement and Agreement:

- I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my clinician(s) and me.
- I consent to the conditions and instructions outlined as well as any other instructions that my clinician(s) may impose to communicate with me by email or text. Northwest Behavioral Health Services, PC may communicate with me via email and/or text to the following (Do not list a contact if you do not wish to communicate via one or both methods)

Phone number(s):_____

Email address(es)_____

☐ I decline to communicate via email or text as outlined in this document

Signature of Patient:_____ Date:_____

Parent/Guardian:_____ Date:_____
(Please specify relationship to patient)

Signature of Clinician:_____ Date:_____

Northwest Behavioral Health Services, PC

VOICEMAIL MESSAGE CONSENT:

In order to best serve your mental health needs, Northwest Behavioral Health Services, PC will confirm your appointment one business day in advance via an automated service. Additionally, your clinician will return your call/message if they are not presently available.

☐Northwest Behavioral Health Services, PC may leave a message on patient's/family voicemail confirming your appointment and/or information you request regarding your treatment.

☐Northwest Behavioral Health Services, PC may **not** leave a message on patient's/family voicemail.

I understand that I have the right to revoke this authorization at any time without penalty.

Signature of Patient:_____ Date:_____

Parent/Guardian:_____ Date:_____
(Please specify relationship to patient)

Signature of Clinician:_____ Date:_____

Northwest Behavioral Health Services, PC

FEES FOR CLINICAL SERVICES

INDIVIDUAL PSYCHOTHERAPY 30 minutes	$100
INDIVIDUAL PSYCHOTHERAPY 45 minutes	$137
INDIVIDUAL PSYCHOTHERAPY 60 minutes	$200
COUPLES/MARITAL PSYCHOTHERAPY	$165
FAMILY PSYCHOTHERAPY	$165
GROUP PSYCHOTHERAPY	$50
DIAGNOSTIC INTERVIEW (AND TREATMENT PLAN)	$220
FUNCTIONAL BEHAVIORAL ANALYSIS	$200/Hour
PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL ASSESSMENT ACADEMIC TESTING	$220/Hour
*LETTER WRITING AND DOCUMENT PREPARATION	$35/15 minutes
*IN PERSON REPRESENTATION IN LEGAL MATTERS	$500/Hour portal to portal
*LEGAL DOCUMENT REVIEW AND PREP	$350/Hour
*ACADEMIC RECORD REVIEW	$40/15 minutes
*COLLATERAL CONTACTS	$40/15 minutes
*DOCUMENT PREP (NON-TEST REPORT WRITING)	$40/15 minutes
*IEP REPRESENTATION	$200/Hour
*TRAVEL 10-25 MILES	$35
*TRAVEL 26-50 MILES	$70
*TRAVEL 51-75 MILES	$105
*TRAVEL 76-100 MILES	$140
*TRAVEL 101-125 MILES	$190
*TRAVEL 126-150 MILES	$250

***NOT BILLABLE TO INSURANCE**

- I understand that these rates may increase periodically, and that I will be informed prior to any rate changes.
- If using insurance for payment, I understand that if my clinician is in my network he/she has agreed to the usual and customary rate deemed appropriate by his/her contract with the insurance company. Further, I understand that my clinician may not charge me for the difference between the fees listed above and the agreed upon usual and customary rate, beyond the co-pay required by my insurance.
- I understand that my co-pay or co-insurance is _____. I understand that this fee is due at the time of service. If not using insurance for payment, I understand that I am responsible for the full charges of each session at the time of service, unless an alternate arrangement is made with the clinician.
- If using insurance for payment, I understand that my insurance company reserves the right to refuse payment for services they previously pre-certified. I understand that in such a case, I have the right to appeal to my insurance company for payment. I understand that I am ultimately responsible for services provided which are not covered by my insurance company.

Signature of RESPONSIBLE PARTY: _____ Date:_____

Signature of Clinician:_____ Date:_____

Last updated 08.13.2018

Northwest Behavioral Health Services, PC

Consent to Release Information for Processing Benefits and Financial Agreement

- I understand that Northwest Behavioral Health Services, PC (NWBHS) will bill my insurance company for clinical services rendered to me and/or a relative for whom I am legally responsible *IF* NWBHS has an active contract with my insurance company. I authorize NWBHS to release essential clinical information to my insurance company required to process claims (e.g., diagnosis, service code, treatment plans, progress notes, reports, etc.) I hereby assign, transfer and set over to NWBHS all rights to collect payment for services rendered from my insurance company. I understand that this consent will remain in effect until all claims have been settled.

  _____ (initials of responsible party)

- I understand that any money that is considered PATIENT RESPONSIBILITY is due at the time of service (e.g., copays, coinsurance, deductible, or private pay) and is different from amounts that are expected by insurance responsibility.

  _____ (initials of responsible party)

- I authorize NWBHS to charge my credit card for any outstanding balance due at time of service

  _____ (initials of responsible party)

Patient Name:_____

Cardholder Name

(if different from the patient):_____

Cardholder Billing
Address:_____

Type of Credit Card : ☐Visa ☐MasterCard ☐Discover

Credit Card
Number:_____

3 digit security code:_____. Expiration Date: _____

_____ _____

Signature Date

Last updated 08.13.2018

Northwest Behavioral Health Services, PC

CONSENT FOR THERAPY

I, _____, freely give my consent to take part in psychological treatment. I believe I understand the basic ideas, goals, and methods of this therapy. With enough knowledge, and without being forced, I enter into treatment. The clinician has addressed my questions and/or concerns regarding confidentiality and the therapy process. I understand that no guarantees regarding the outcome of therapy can be given. This agreement shows this clinician's willingness to use and share his or her knowledge and skills in good faith. Periodically during treatment, we will evaluate progress and may change treatment goals as needed. If it becomes clear that there is a need to transition care to another clinician for any reason (e.g., the nature of symptoms being addressed, misfit of personality, lack of progress etc.) I agree to discuss these concerns with my clinician and to participate in planning for transition to a new clinician if the issues cannot be resolved.

This agreement also shows my commitment to pay for services. I agree to pay the full disclosed amount per session, and to pay at each session. I understand and accept that I am fully responsible for this fee, but that my clinician will help me in obtaining payment from any insurance coverage I have. I also understand that in order to bill a third party (insurance) confidential information such as my diagnosis, treatment goals, and treatment progress may have to be released to the third party.

I understand that 24-hour notice is required for the cancellation of a session. If 24-hour notice is not given, I understand that I am responsible for a fee of $50, which is not reimbursable by my insurance. I understand that this charge is due in full at the time of my next session. The only exceptions are unforeseen or unavoidable situations arising suddenly.

My signature below means that I understand and agree with the points above

Signature of Patient:_____ Date:_____

I have discussed the issues above with this patient. My observations of this patient's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Clinician: _____ Date:_____
This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Northwest Behavioral Health Services, PC

Child Treatment Contract

(Please complete if the patient is a minor)

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Clinician Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and clinician regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having at least one closing session to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. In the state of Illinois, a child over the age of 12 is considered to have the legal right to refuse to have their parents inspect mental health treatment records. If your child is over this age, by signing this agreement, you will be waiving your right of access to your child's treatment records.

It is the policy of our practice to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.
If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the parents, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in

any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $500 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Parent/Guardian:_____ Date:_____

Parent/Guardian:_____ Date:_____

Clinician:_____ Date:_____

Northwest Behavioral Health Services, PC

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

(Note: Please make copies of this page for each party to whom you would like us to release information. If you were referred by your doctor, please at least complete this for your doctor for coordination of care)

I, _____, hereby authorize **Northwest Behavioral Health Services, PC** to release regarding any and all records or information regarding_____

Name of Patient

_____

(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

☐ _____ Mental Health Information ☐ _____ Psychology Notes ☐ _____ Drug/Alcohol Diagnosis, Treatment/Referral
☐ _____ HIV/AIDS Status ☐ _____ Sexually Transmitted Diseases

TO: _____ Date of next follow up appointment if scheduled:_____
(Receiving Agency or Person)
Phone:_____ Fax: _____

Address: _____

FOR THE PURPOSE OF: (Check All That Apply)

☐ _____ Continuing Mental health/alcohol and/or drug abuse Treatment or care and continuity of care
☐ _____ Billing, payment and financial matters and arrangements
☐ _____ Clinician transition
☐ _____ Consultation, advise and representation Regarding my condition and needs
☐ _____ Housing and other arrangements and services
☐ _____ Other _____
_____

This consent is valid until (Calendar Date): _____
I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not re-disclose it without my written authorization

I also understand that if I refuse to consent to the release of information my clinician will not be able to coordinate care on my behalf

_____ _____ _____
(Minor Recipient, 12-17 years. Inclusive) (Signature of Adult Patient or Parent) (Date)

WITNESS:_____ DATE:_____

NOTICE TO PATIENT AND RECEIVING AGENCY

Under the provisions of the Mental Health and Developmental Disabilities Act, HIPPA, and applicable Federal and State Alcohol and Substance Abused Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. **A separate release is required for psychotherapy notes if not indicated on this form.**

Last updated 08.13.2018