ASSOCIATES IN PSYCHIATRY & COUNSELING. P.C.
2050 Larkin Ave., Suite 202, Elgin, Il 60123

PATIENT INFORMATION

Name	First		M.I.	Last	
Address			City	State	Zip
Home Phone	Work Phone		Cell Phone	SS #	
Birthdate	Age	Sex (circle one) M F	Marital Status	Spouse's Name	
*Preferred Language: _____ Ethnicity: Latino other			*Race: White African American Asian Native American Pacific Islander other		
*Preferred Communication Method: Phone letter e-mail					

*** REQUIRED AREAS**

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name/ First	M.I.	Last		
Address		City	State	Zip
Home Phone	Work Phone	SS #		
Employer	Address	City	State	Zip

INSURANCE INFORMATION

Primary Insurance Company	Insured's Name		Employer	
Address	City	State	Zip	Phone#
Relationship to Patient	ID#	Group #	* Birthdate	
Secondary Insurance Company	Insured's Name		Employer	
Address	City	State	Zip	Phone #
Relationship to Patient	ID#	Group #	*Birthdate	
Patient Employer		Driver's License #		
Address		City	State	Zip

FAMILY MEMBER INFORMATION

First	Last	M/ F	Relation	DOB	School/Work

Name/Phone Number of individual to be contacted in case of an Emergency:	
Referred By:	Primary Care Physician:

Intake Questionnaire

In order for us provide accurate and essential care for you, please fill out the following questionnaire.

REQUIRED INFORMATION		
Pharmacy Name:	**Street:**	**City:**
Allergies:		
Smoking: please circle	Current - every day smoker Former smoker	Current - some days Never a smoker
E-mail:		

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____

Birth Date _____ Age _____ Sex _____

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems)

_____

_____

_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

MEDICAL HISTORY

Current medical problems/medications: _____

_____

Past medical problems/medications: _____

_____

Other doctors/clinics seen regularly: _____

Allergies/drug intolerances (describe): _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

_____

_____

SCHOOL HISTORY: Last grade completed _____ Last school attended _____

Any behavior problems in school? _____

EMPLOYMENT HISTORY: (summarize jobs you've had)

_____

_____

_____

Any work-related problems? _____

Ever Any Legal Problems? _____

_____

ALCOHOL AND DRUG HISTORY: (Please list age started and types of substances used through the years and any current usage. These include alcohol, marijuana or hash, prescription tranquilizers or sleeping pills, inhalants, cocaine, amphetamines, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

_____

_____

_____

Ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever used drugs or alcohol first thing in the morning?_____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

FAMILY/SOCIAL HISTORY

Family Structure (who lives in your current household, please give relationship to each):

Current Marital or Relational Satisfaction_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse etc.)_____

Has mother ever sought psychiatric treatment? Yes ___No ___ If yes, for what purpose? _____

Mother's alcohol/drug use history _____
Have any of **mother's** blood relatives ever had any psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

Has father ever sought psychiatric treatment? Yes ___No ___ If yes, for what purpose? _____

Father's alcohol/drug use history _____
Have any of **father's** blood relatives ever had any psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

Name of Person Completing this questionnaire:_____

Relationship to Patient:

- ○ Self
- ○ Mother
- ○ Father
- ○ Spouse
- ○ Guardian
- ○ Other

Treatment Consent and Acknowledgement

Associates in Psychiatry & Counseling offers quality psychiatric Services. Effective and efficient provision of treatment requires the following policies to enable these processes:

1) **Financial Policy:** We ask that you plan ahead to pay at time of service your co-pay, co-insurance, any deductible not met or any portion you are responsible for. You are responsible for any pre-authorization or referrals required by your insurance. If you do not have insurance or your insurance does not cover these services, you will be considered "Self-Pay" and payment is due In-full at time of service. By signing this payment policy, your agree to settle all statement balances within 30 days of receipt. You understand and agree that any past due balances may be referred to a Contracted Collection Agency. Any unpaid balance is subject to a 30% collection fee that will be added to the outstanding balance in the event your account is placed with a Contracted Collection Agency.
2) **Appointment Policy:** All appointments are to be kept to ensure consistency in the treatment process. A **fee** will be charged for cancellations without a 24 hour notice or non-appearance for a scheduled appointment.
3) **Medication Policy:** Medication renewal will occur during the medication follow-up session with the prescribing psychiatrist. No medications will be prescribed over the phone routinely. Any written script for a controlled substance which is lost will not be re-written. The patient must wait for the eligibility date of the next month for the doctor to prescribe (30 days after the original script). Any script for a controlled substance which has expired must be returned and exchanged at lhe office before a new script will be written. The Prescribing Clinician may require Point of Care testing to determine compliance with prescription/treatment and best benefits as well as safety for the patient.
4) **Phone Policy:** Phone calls to the office may be made at any time. Phone calls made for treatment purposes may be charged a fee. Phone calls for scheduling or matters of short duration will not be charged.
5) **General Office Policy:** As a service it is our policy to bill your insurance end to keep accurate and complete records. A fee will be charged for the copying and release of these records. Letters and other documents generated by your request may also be charged a fee.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Associates in Psychiatry and Counseling's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

I hereby authorize Associates in Psychiatry & Counseling, P.C. to release to my insurance company or its representative, any/all information requested to include my diagnosis and records of my mental health treatment by this practice. I also authorize and direct my insurance company to pay directly to Associates in Psychiatry & Counseling, P.C. the amount due for treatment and/or services rendered. Patient/Insured agrees to pay for any/all services that are denied by the insurance company as not medically necessary, etc.

Furthermore, I hereby give consent to Associates in Psychiatry & Counseling, P.C. to render mental health services deemed necessary for myself and/or minor child as designated in the treatment plan.

Patient Signature Date

Insured/Parent/Guardian Date
If not signed by patient, please indicate relationship to patient (e.g., spouse)

(847) 697-2400
FAX (847) 697-2438

Associates in Psychiatry and Counseling

2050 Larkin Avenue, Suite 202 Elgin,
Illinois 60123

PATIENT BILL OF RIGHTS& RESPONSIBILITIES

Patient's Rights as a Patient of Associates in Psychiatry & Counseling

1. The Patient has the right to considerate and respectful care and treatment, regardless of gender, race, sexual orientation, age, culture, disabilities, or religious beliefs.
2. The Patient has the right to have their care and treatment information kept private, and have the opportunity to have their records released only with their written permission, except required by law.
3. Patients have a right to make informed choices regarding their medications, behavioral health services, and their providers.
4. The Patient has a right to expect reasonable continuity of care.
5. The Patient has the right to examine and receive an explanation of costs for treatment as applicable.
6. The Patient has the right to know what relationship Associates in Psychiatry & Counseling has with other health care providers and facilities in regard to their health care.
7. The Patient has the right to inquire as to their provider's degree, licensure, and training.
8. The Patient has the right to inquire as to the role of the providers on the treatment team in the treatment process.
9. The Patient has the right to an explanation of their condition and the treatment options.
10. The Patient has the right to expect that Associates in Psychiatry & Counseling will make reasonable effort in providing the identified services of the treatment plan.
11. The Patient has the right to be informed if Associates in Psychiatry & Counseling is engaging in research about behavioral health care and have the right to refuse participation in that research.
12. The Patient has the right to register complaints to their behavioral health care professional and/or an administrator.

Patient's Responsibilities as a Patient of Associates in Psychiatry & Counseling

1. The Patient has the Responsibility to treat those providing care with dignity and respect.
2. The Patient has the Responsibility to ask questions regarding the diagnosis, treatment, medications, or any instructions.
3. The Patient has the Responsibility to follow instructions concerning medications, follow-up visits, and other essential components of their treatment and to notify their behavioral health care provider if the instructions cannot be followed or problems develop.
4. The Patient has the Responsibility to assist Associates in Psychiatry & Counseling in obtaining approvals for payments for treatment, referrals, and authorizations.
5. The Patient has the Responsibility to provide as much information as is possible to their provider to assist in the assessment and rendering of services.

Patient's Signature _____ Date _____ Parent/ Guardian Signature _____ Date _____

(**Patients 12 to 18 must sign in addition to the parent**)

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60123

Authorization to Disclose Protected Health Information to Primary Care/Referring Physician

In order to assist you in your treatment response, Associates in Psychiatry & Counseling can contact your **Primary Care/Referring Physician** and provide them with information as to your treatment plan, medications prescribed, and condition.

I hereby authorize, **Associates in Psychiatry & Counseling**, to release and exchange written, oral or electronically transmitted protected health information indicated below regarding:

Name: _____ DOB: _____

TO:

Name: _____

Address: _____

City/State/Zip Code: _____

For the PURPOSE of: Coordination of Services

- I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.
- I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.
- I understand that Associates in Psychiatry & Counseling will not condition treatment or payment on this authorization.
- I understand that I have a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.
- I further understand that this authorization will continue for one year from signature date and I retain the right to revoke this authorization. In order for the revocation of this authorization to be effective, Associates in Psychiatry & Counseling must receive the revocation in writing.

I fully understand and accept the terms of this authorization.

OR

☐ I **DO NOT** authorize, Associates in Psychiatry & Counseling, to release and exchange written, oral or electronically transmitted protected health information

_____ _____ _____ _____

Patient's Signature Date Parent/ Guardian Signature Date

(**Patients 12 to 18 must sign in addition to the parent**)

Medication Log

Medication Prescribed	Directions	Prescribing Doctor

(847) 697-2400
FAX (847) 697-2438

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MEDICATION INFORMED CONSENT

I give my **Consent** on _____ for _____

(date) (Doctor)

to prescribe medications to _____

(patient's name)

MEDICATIONS PRESCRIBED:

- _____
- _____
- _____
- _____
- _____

THE FOLLOWING WAS EXPLAINED/PROVIDED TO ME:

1) Benefits of Treatment and Diagnosis information.
2) Administration of Treatment
3) Alternative to Treatment modes.
4) Consequences of not receiving proposed treatment
5) I have been advised of the name, frequency, and potential side effects of the medications being prescribed to me
6) I have been advised that if I am of **Child Bearing Age** to avoid becoming pregnant while taking psychotropic medication, and to notify my psychiatrist immediately upon becoming pregnant.

_____ _____ _____ _____

Patient's Signature Date Parent/ Guardian Signature Date

(**Patients 12 to 18 must sign in addition to the parent**)

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Elgin, Illinois 60123 (847) 697-2438

Consent for TeleBehavioral Health Services

1. As a client or patient receiving behavioral services through TeleBehavioral Health technologies, I understand TeleBehavioral Health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location
2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to TeleBehavioral Health, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of TeleBehavioral Health in the course of my care at any time without affecting my right to future care or treatment.
4. I understand that I have the right to inspect all information obtained and recorded in the course of a TeleBehavioral Health interaction, and may receive copies of this information for a reasonable fee.
5. Equipment: I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.
6. In the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means.
7. This document does not replace other agreements, contracts, or documentation of informed consent.

Patient Consent to the Use of TeleBehavioral Health: I have read and understand the information provided above regarding TeleBehavioral Health, By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____
Print Name

_____
Client's Signature Date
(**Patients 12 to 18 must sign in addition to the parent**)

_____ _____
Parent or Guardian Signature Date