THE PLAINS CLINIC

PATIENT REGISTRATION FORM

Provider: _____ Date: _____

PATIENT'S INFORMATION:

Name: _____ Birthdate: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell/Work Phone: _____ May we leave message? Y or N Home/ Y or N Cell

School: _____ Grade: _____

Email: _____

Guarantor Information (Who is financially responsible for this account)

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Relationship to patient: _____

Contracted Insurance Plans The Plains Clinic will file claims to insurance companies with which we are under contract. We are only contracted with Blue Cross Blue Shield of Illinois. Other applicable co-pay and deductible amounts are due at time of service. Your signature is required at the bottom of The Plains Clinic policies form.

Non Contracted Insurance Plans The Plains Clinic does NOT file claims to insurance companies with which we are not under contract. In this situation, full payment is required at time of service. In the event that your insurance company requests clarifying information from The Plains Clinic to process reimbursement to you, your signature is required at the bottom of The Plains Clinic Office Policies Forms.

Primary Insurance

Primary Insured Person: _____ Birthdate: _____

Address: _____ Employer: _____

Insurance Company: _____ ID#: _____ Group # _____

Secondary Insurance

Secondary Insured Person: _____ Birthdate: _____

Address: _____ Employer: _____

Insurance Company: _____ ID# _____ Group # _____

THE PLAINS CLINIC

Notice of Policies and Practices to Protect the Privacy of Your Health Information
Effective April 14, 2003

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization.

- "PHI" refers to information in your health record that could identify you.
- Treatment is when we provide, coordinate, or manage 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 health care. 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 this 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 this office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of this office, 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.

If you have any questions regarding this statement or would like a copy of same for your records, please see the business office.

THE PLAINS CLINIC

Effective April 14, 2003

I have read the "Notice of Policies and Practices to Protect Privacy of Your Health Information" provided by The Plains Clinic.

_____

Signature of Patient

_____

Signature of Parent/Guardian

_____

Date

This will be placed in your patient file.

The Plains Clinic Office Policies

(630) 214-1082 **fax (630) 214-1083**

Welcome To Our Office

We are committed to you as our client in offering our services to help you achieve your personal growth through our mental health services. Because many of you will have common questions about office procedures and financial arrangements, we have prepared this general information sheet.

Hours and Cancellations

Full sessions are typically 50-60 minutes long. Each therapist keeps his or her own schedule and will arrange appointments directly with you. Psychologist/Psychiatrists appointments are scheduled by the business office. If it becomes impossible for you to keep an appointment, it is important that you call to inform us of your cancellation. Due to the policy of reserved appointment times, you must notify us no less than 24 hours before appointment time. The patient/guarantor may be charged the full appointment fee and will be financially responsible for any missed appointments that have not been properly cancelled. We cannot bill an insurance company for a missed appointment – it is not reimbursable.

Please print and sign your name indicating that you agree to and understand this cancellation policy.

_____	_____	_____	_____
Patient printed name	Guarantor printed name	Guarantor signature	Date

Fees and Insurance

Charges for sessions vary according to the individual therapist and are consistent with standard psychotherapy fees in the community. PAYMENT IS REQUESTED AT TIME OS SERVICE. Other arrangements may be made with your therapist in the event of financial hardship; however, you hold the ultimate responsibility that full payment is made. Please make checks payable to The Plains Clinic. Visa, MasterCard and Discover charge cards are accepted for your convenience. The Plains Clinic will file claims to insurance companies **with which we are under contract.** For patients whose insurance plans we are contracted with, **APLLICABLE CO-PAY AND DEDUCTIBLE AMOUNTS ARE DUE AT THE TIME OF SERVICE.** It is the client's responsibility to contact their insurance company to learn about qualifications, limitations and benefits available to them through their insurance contract. Many insurance plans for which we are nonparticipating providers will reimburse you for some or all of the sessions obtained by The Plains Clinic. If you are eligible for reimbursement under your plan, you may attach a receipt from each session to your insurance claim form when you submit your claim **(we suggest you send a photocopy, retaining the original for your records).** Any specific questions about your bill may be discussed with your therapist or our business office.

Emergencies and Phone Calls

In the event of an emergency, you may leave a message for your therapist on our voicemail. We ask that any calls regarding medication refills be made between the hours of 9:00am to 4:00pm, Monday through Friday; with the following information – patient name/medication name/dosage/# of pills. Please allow two full working days for your medication refill request to be processed. A nominal charge may be made for such calls made outside of normal work hours. Extended phone consultations may also be subject to a fee.

Confidentiality

We are committed to making this a safe place for you to get help. To that end, we adhere to all the legal protections of your confidentiality.

Communication

Good communication between us is vital to our ability to serve you well, so do tell us about problems and questions that might come up. If you don't understand an answer, or a new problem arises, let us know. We want to provide you with the best possible care, and we need your cooperation to succeed. Please contact our business office if you have a concern.

Agreement/Assignment and Release

I, the undersigned, certify that I have read and agree to the above policies of The Plains Clinic. I also agree that I am personally and wholly financially responsible for all charges incurred, and will ensure that full, timely payment is made to The Plains Clinic for all services.

I further hereby authorize the doctors/clinician of office representative to release to my insurance company or its affiliates all information necessary to process my service claim to secure the payment of benefits and assign those benefits directly to The Plains Clinic, including authorized Medicare benefits. If The Plains Clinic is not under contract with my insurance company, however, and I submit a claim for reimbursement, I authorize the doctors/clinicians or office representative to release to my insurance company of its affiliates all information necessary to process my claim for reimbursement to me. I authorize the use of this signature for this purpose and a copy of this signature is a valid as the original

_____	_____	_____	_____
Patient Printed Name	Guarantor Printed Name	Guarantor Signature	Date

The Plains Clinic

Patient Information form

Patient Information

Name: _____ Date: _____

Address: _____
Street City State Zip

School: _____

Phone: _____ Cell: _____

Email: _____
If patient is a minor, provide email of parent

Personal and Family Information

Patients's Birthdate: _____ Age: _____

___Single ___Married ___Widow/Widower ___Divorced
If previously married, list date(s) and duration: _____

_____

If parents divorced, describe custody arrangement: _____

_____

Current spouse's name: _____ DOB _____
Occupation: _____ Phone _____

Natural father's name: _____ DOB _____
Occupation: _____ Phone _____

Natural mother's name: _____ DOB _____
Occupation: _____ Phone _____

Stepfather's name: _____ DOB _____
Occupation: _____ Phone _____

Stepmother's name: _____ DOB _____
Occupation: _____ Phone _____

The Plains Clinic

Patient Information form

Name: _____ Date: _____

Children/Siblings

	Name	Living arrangement	Occupation	Age
1				
2				
3				
4				

List other individuals residing in the home: _____

By whom were you referred? _____

Presenting problem(s): _____

_____

_____

Health Information

Appetite: ___Above Average ___Average ___Poor

Sleep difficulties: ___Yes ___No

If yes, please describe: _____

Alcohol Use: ___Current ___Past ___No History

# of drinks per week: _____ Duration: _____

Drug Use: ___Current ___Past ___No History

If yes please describe: _____

Allergies: _____

Present medical conditions: _____

_____

Date of last physical: _____

Serious accidents, illnesses, or surgeries (please list, including dates): _____

_____

Current medications/purpose: _____

_____

Personal Physicians 1 _____ Phone _____

2 _____ Phone _____

Previous Therapy/Counseling: ___Yes ___No Dates _____

With whom? _____

Purpose of treatment: _____

The Plains Clinic

Patient Information form

Name: _____ Date: _____

Hospitalizations:

Nature of hospitilzation: ___Medical ___Psychiatric ___Substance Abuse
Facility, Location: _____
Dates, length of stay: _____

_____

Long-term/residential treatment: ___Yes ___No
Facility/Location: _____

Developmental History

Prenatal/Postnatal complications ___Yes ___No If yes, please describe: _____

_____

___Delayed Motor Development ___Delayed Speech ___Premature Birth
___Physical/Occupational/Speech Therapy

Please Describe: _____

_____

Areas of Concern

Indicate if you (or your child, if minor is the patient) have a history or current concerns regarding:

__Social skills
__Toileting accidents
__Tics
__Frequent headaches
__Restlessness/hyperactivity
__Unusual/troublesome thoughts
__Withdrawal/isolation
__Violent/aggressive behaviors
__Suicidal thoughts
__History of trauma
__Academics/learning
__Bedwetting
__Nail biting
__Mood fluctuations
__Stomach aches
__Hallucinations
__Poor concentration
__Dangerous behaviors
__Attempted suicide
__History of abuse (physical, sexual, emotional)
__Nightmares
__Anxiety
__Fatigue
__Depressed mood
__Racing thoughts
__Attention
__Self-injury

If yes, please describe: _____

_____

_____

Has the Department of Child and Family Services (DCFS) been involved with your family (currently or past)?
___Yes ___No If yes, please describe: _____

_____

_____

The Plains Clinic

Patient Information form

Name: _____ **Date:** _____

List recent family stressors, losses, transitions (e.g., moves, death, etc.) _____

_____

_____

Family history of psychiatric/psycholigical problems: _____

_____

_____

List patient's strengths (what are you good at, what do you enjoy?) _____

_____

_____

_____

_____