

# CENTER FOR PSYCHOLOGICAL SERVICES, LLC

465 Central Ave. • Suite 201 • Northfield, Illinois 60093 • (847) 446-4617 ext. 331 • Fax: (847) 446-4673  
www.cps-chicago.com

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ May I text you? \_\_\_\_\_

Email Address: \_\_\_\_\_

Who referred you to CPS? \_\_\_\_\_

Why are you seeking assessment or treatment? \_\_\_\_\_

\_\_\_\_\_

List any medical conditions patient has \_\_\_\_\_

\_\_\_\_\_

List prescription medications \_\_\_\_\_

Who lives at home with you?

**Name**

**Age**

**Relationship**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Personal Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**I hereby authorize treatment for the patient named on the other side of this form and accept the responsibility for the charges incurred for this treatment or assessment, regardless of any other arrangements with third parties, including insurers.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## INSURANCE INFORMATION (if being utilized):

Insurance Company \_\_\_\_\_

Member ID # \_\_\_\_\_

Group Number \_\_\_\_\_

Name of policy holder/insured \_\_\_\_\_

Date of birth of policy holder/insured \_\_\_\_\_

Insured's address and phone number (if different than patients) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Find on back of your card:*

Insurance Company's phone number \_\_\_\_\_

## CONFIDENTIALITY

All therapists at Center for Psychological Services are mandated reporters in Illinois. They are required by law to report any suspected child abuse or neglect. They are also required to make a report if a patient is a lethal danger to him or herself or others.

To provide effective assessment and treatment, your therapist will ask many personal questions. Excluding the circumstances listed above, all personal information is kept strictly confidential. No information about you or your case will be released to anyone outside of the practice of Center for Psychological Services without your written authorization and consent.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that all communication with other providers or individuals can be made by Center for Psychological Services only by my signed or verbal consent.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## FEES FOR SERVICES

Fees vary based on type of service and method of payment. We accept some health insurance plans and will discuss out-of-pocket costs with you after your benefits are verified.

Center for Psychological Services does offer services on a sliding scale basis for patients who require assistance. Please contact us and/or your therapist directly to discuss financial arrangements.

Appointments will be scheduled at a time mutually acceptable to both the patient and the therapist. It is greatly appreciated that you call, text, or email ASAP to cancel an appointment. For your convenience, appointments can be scheduled, cancelled, and re-scheduled directly at <http://www.genbook.com/bookings/slot/reservation/30091038?bookingSourceId=1000>. Please use this system to view your therapists' availability and to schedule appointments within 24 hours of the start time of the appointment. At this time, we not charge a fee for missed or cancelled appointments. We just appreciate that you cancel appointments as soon as is possible for you to do so.

## RELEASE OF INFORMATION FOR INSURANCE PURPOSES

I understand that Center for Psychological Services will verify my insurance benefits and coverage. I understand that I am solely responsible for any out of pocket costs that may be incurred. I understand that my name, address, insurance information, diagnosis, and dates and type of service will be shared with my insurance company to receive reimbursement for services rendered. I understand that my insurance company will provide me an Explanation of Benefits for services rendered and that Center for Psychological Services will be listed as the provider of those services. I understand that Center for Psychological Services will mail me a statement monthly that will detail dates of services billed to my insurance company, amounts paid by my insurance company, and any out-of-pocket costs that remain due. Payments should be made directly to Center for Psychological Services. I will contact Center for Psychological Services and/or my therapist directly if my financial circumstances prevent me from making payments in a timely fashion. I authorize the release of any medical or other personal information necessary to process my insurance claim. I also authorize payment of medical benefits to the supplier of services provided to myself, child, or family.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## CREDIT CARDS

All patients have the opportunity to keep a credit card (Mastercard or Visa are accepted) on file for convenient payment. If you prefer not to keep a card on file, please read and initial the following statement:

### **OPTION #1:**

**I prefer NOT to place a credit card on file:**

Initials \_\_\_\_\_

I understand that I am responsible for timely payment of all amounts due on my account with Center for Psychological Services. I understand that I can speak to Center for Psychological Services directly to set up a payment plan should the need arise.

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### **OPTION #2**

**I DO want to keep my credit card information on file:**

Initials \_\_\_\_\_

Card Holder's Name \_\_\_\_\_

Visa or Mastercard (circle one)

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_

Billing Zip Code \_\_\_\_\_

Signature \_\_\_\_\_

Please sign which option you would prefer: A receipt will be provided to you.

1. I authorize my card to be charged by Center for Psychological Services for my co-payment or full fee at the time services are rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

2. I authorize my card to be charged only after Center for Psychological Services. contacts me to verify the amount owed and the amount that will be charged on my card.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## **HIPAA NOTICE FORM—PROTECTION OF PRIVACY**

### **Notice of Psychologist’s Policies and Practices to Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment, and Health Care Operations*”
  - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my 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 my practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my practice group, 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.

#### **II. Other Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. “*Psychotherapy Notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures without Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.
- *Health Oversight Activities* – I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent

risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

#### **IV. Patient's Rights and Psychologist's Duties**

##### Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, I will discuss with you the details of the request for access process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by mail.

## **V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Dr. Paul Kredow, Director and Chief Compliance Officer at (847) 446-4617.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

## **VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on April 14, 2003

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I have received a copy of the HIPAA form concerning privacy protection from the Center for Psychological Services.

Signature\_\_\_\_\_

Date\_\_\_\_\_

Printed Name\_\_\_\_\_

If for child, child's name\_\_\_\_\_

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## Permission for Release of Confidential Information

Professional requesting Information: \_\_\_\_\_

Provider of Information: \_\_\_\_\_

Person Authorized to give permission: \_\_\_\_\_

Relationship to patient/client/student: \_\_\_\_\_

I give permission for \_\_\_\_\_ of *Center for Psychological Services, LLC* to communicate with \_\_\_\_\_ and exchange information, if necessary, regarding \_\_\_\_\_.

This information will be used for evaluation, treatment, or psychological consultation regarding \_\_\_\_\_.

The above permission includes oral communication, request for summaries of treatment, and copies of records, when necessary. This permission is granted for \_\_\_\_\_ days.

\_\_\_\_\_  
Authorized Person Granting Permission  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date