NORTHWEST PSYCHIATRY

SOUTH BARRINGTON OFFICE
10 EXECUTIVE COURT, SUITE 5
SOUTH BARRINGTON, IL 60010

WINFIELD OFFICE
27W350 HIGHLAKE ROAD, SUITE 240
WINFIELD, IL 60190

OFFICE: (224) 655-2487
FAX: (716) 526 4161
visit us online: **www.NWPSYCH.us**

NEW PATIENT **INTAKE FORM**

PATIENT INFORMATION: PLEASE PRINT. USE ALL CAPS.

PATIENT NAME: *LAST, FIRST, MI*			SSN #:	DOB:	AGE:	GENDER:
HEIGHT:	WEIGHT:	ADDRESS:	CITY:		STATE:	ZIPCODE:
MARITAL STATUS:	PHONE (H):	PHONE (C):	EMAIL:			

PATIENT EMPLOYMENT INFORMATION

_____ FULL TIME _____ PART TIME _____ SELF-EMPLOYED _____ RETIRED _____ NOT EMPLOYED _____ OTHER

EMPLOYER:	POSITION:	PHONE (W):	
ADDRESS:	CITY:	STATE:	ZIPCODE:

PATIENT INSURANCE INFORMATION

_____ PLEASE BILL INSURANCE _____ SELF-PAY

PRIMARY INS COMPANY NAME:	SUBSCRIBER NAME:	MEMBER ID:	GROUP #:
SUBSCRIBER DOB:	SUBSCRIBER SSN #:	PATIENT RELATION:	COPAY (OV/SPC):
SECONDARY INS COMPANY NAME:	SUBSCRIBER NAME:	MEMBER ID:	GROUP #:
SUBSCRIBER DOB:	SUBSCRIBER SSN #:	PATIENT RELATION:	COPAY (OV/SPC):

PATIENT ACCOUNT RESPONSIBILITY

RESPONSIBLE PARTY:	PATIENT RELATION:	DOB:	SSN#
ADDRESS:	CITY:	STATE:	ZIPCODE:
DRIVERS LISENCE OR STATE ID #:	PHONE (C):	PHONE (M):	EMAIL:

AS GUARANTOR, I ACKNOWLEDGE MY RESPONSIBILITY FOR PAYMENT ON THIS ACCOUNT UNTIL REVOKED BY ME IN WRITING.

SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE:	DATE:

I HAVE READ, RECEIVED AND UNDERSTOOD THE TERMS AND POLICIES OF NORTHWEST PSYCHIATRY AND AGREE TO ABIDE BY THEM, ATTEST THAT ALL INFORMATION PROVIDED IS TRUE AND AGREE TO BE TREATED AT NORTHWEST PSYCHIATRY.

SIGNATURE OF PATIENT:	DATE:

IF PATIENT IS UNDER 18 THE FOLLOWING SECTION MUST BE SIGNED BY THE PATIENTS' PARENTS OR LEGAL REPRESENTATIVE.

I HAVE READ, RECEIVED AND UNDERSTOOD THE TERMS AND POLICIES OF NORTHWEST PSYCHIATRY AND AGREE TO ABIDE BY THEM, ATTEST THAT ALL INFORMATION PROVIDED IS TRUE AND AGREE TO HAVE MY CHILD (MINOR UNDER-18) TREATED AT NORTHWEST PSYCHIATRY.

SIGNATURE OF PARENT OR LEGAL REPRESENTATIVE:	DATE:

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OFFICE POLICIES AND CREDIT CARD AUTHORIZATION

Thank you for choosing our practice to handle your behavioral health needs. We are dedicated to providing you with the best possible care and service. To help with that understanding our office policies and your financial responsibilities will be an essential element to your care and treatment. If you have any questions regarding these policies, please feel free to contact our office staff.

APPOINTMENT POLICIES:

- Courtesy reminder calls or emails are made/sent 1 business day prior to your scheduled appointment. Please be sure to keep our office updated with current contact numbers and mailing address.
- Cancellations made less than 24 business hours prior to your scheduled appointment may result in a cancellation fee of: $25.00
- If you miss your scheduled appointment without any notice, you will immediately be charged a no show fee of: $50.00, with the credit card information provided below. Missed appointment fees are NOT covered by insurance. The office reserves the right to charge my account for any and all missed appointments.
- Patients who arrive more than 15 minutes past their scheduled appointment time may not be seen, have to wait for the next available appointment or will need to be rescheduled.
- Patients who are consistently unable to keep their scheduled appointments will receive written notification of discontinuation of care.

MEDICATION REFILLS:

- Routine prescription refills will be processed within 3 business days. You may submit refill requests online at www.nwpsych.md or by calling (224) 655-2487.
- Emergency or Special Request prescription refills will be processed as needed with the authorization of one of our providers.
- I may be charged a prescription re-write fee of $25.00 for any lost prescriptions.
- Prescription refills may require an appointment prior to filling.

INSURANCE & BILLING POLICIES:

- Our office will only submit claims and accept insurance reimbursements from insurance carriers for which we are contracted with. Patients are responsible for any coinsurance amounts, co-payments, and deductibles as outlined by the individual's insurance carrier. Our office policy is to collect coinsurance, co-payments, and deductibles when you arrive for your appointment.
- If you have insurance coverage with a carrier who we are not contracted with, we may offer to prepare a claim for you on an unassigned basis. This means that it is your responsibility to send your insurance carrier the filled out claim. As a result any reimbursements would be sent directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your insurance carrier determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- It is the Patient's responsibility to inform our office of any changes in insurance coverage at least 48 business hours prior to the scheduled appointment, this is to ensure correct benefit information and any required authorizations. Failure to do so will result in full office visit charges due by the patient at the time of the scheduled appointment.
- If you are a self-pay patient, the charges for your care and treatment are due at the time of the service.

PAPERWORK/RECORDS/DISABILITY CLAIMS:

- Our office is available to help provide you with the documentation you may need for your disability claims. An appointment may be required prior to completing the disability paperwork.
- The Authorization to Release Health Information form must be recieved by the office, prior to any information being released.
- There may be charges due to the number copies, postage and the nature and complexity of our involvement. Charges will be determined on a case by case basis.

By signing below, I authorize, Northwest Psychiatry, to process payments on my credit card for my sessions at Northwest Psychiatry and my physician's hospital fees, co-pays, co-insurance amounts, deductibles and for no show charges. I also understand that I may revoke this authorization in writing at any time.

PATIENT NAME:		**NAME ON CARD:**		
CREDIT CARD NUMBER:		**EXP. DATE:**	**CVV CODE:**	**BILLING ZIPCODE:**
BILLING ADDRESS:		**CITY:**		**STATE:**
	TODAY'S DATE:	**SIGNATURE:**		

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PATIENT CONTACTS & **CONSENT FORM**

PATIENT CONTACTS

Please list out any important patient contacts.

PREFERRED PHARMACY	**PHARMACY CITY/TOWN & PHONE #**
EMERGENCY CONTACT	**EMERGENCY CONTACT PHONE #**
PRIMARY CARE PHYSICIAN	**PRIMARY CARE PHONE #**
THERAPIST/PSYCHOLOGIST	**THERAPIST/PSYCHOLOGIST PHONE #**

Please use this area to add any information that you think might be helpful. (i.e. Allergies, Medical Problems etc...)

NOTICE AND CONSENT

As the patient or their legal representative, I hereby consent to necessary examination, procedures, and/or treatments prescribed by my physician, his/her assistants, or designee as is necessary in his/her judgment. I authorize my doctor and Northwest Psychiatry to use and disclose my personal health information to receive payment for the care I receive. I have received a copy of the Notice of Information Privacy Practices with further details on how my health information may be used.

I agree to be responsible for all charges during my treatment. I have been notified that some services may not be covered under my insurance plan and I am financially responsible for any non-covered services. If the office files a claim to my insurance carrier, I authorize payment of medical benefits to be made to my physician. In the event my insurance carrier does not pay my claim within a reasonable amount of time (90 days) I may be billed for services provided. I have read and acknowledge the receipt of office policies.

I understand that if I do not call at least 24 business hours in advance of a scheduled appointment to cancel, arrive 15 or more minutes late for the appointment or if I simply miss (no-show) a scheduled appointment I may be charged a fee or have to reschedule or wait for the next available appointment on that day. My signature below indicates I have read this Notice and Consent and agree to all terms.

PRINT NAME OF PATIENT	**TODAYS DATE**
PATIENT DOB	**PATIENT/GUARDIAN SIGNATURE**

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HEALTH INFORMATION **AUTHORIZATION FORM**

AUTHORIZATION TO RELEASE AND OBTAIN HEALTH INFORMATION

I, _____ *your name* _____ **,** **O** Patient or

O Authorized Agent **for** _____ *patient name* _____ **,**

hereby authorize **Northwest Psychiatry** to:

O release my health information **to** the below facility/clinician

O receive my health information **from** the below facility/clinician

FACILITY/CLINICIAN NAME

FACILITY/CLINICIAN ADDRESS

FACILITY/CLINICIAN PHONE

FACILITY/CLINICIAN CITY/STATE

FACILITY/CLINICIAN FAX

FACILITY/CLINICIAN ZIPCODE

AT LEAST ONE OF THE ITEMS MUST BE CHECKED

- O ACCOUNT INFORMATION
- O HOSPITAL REPORTS
- O LABORATORY REPORTS
- O OFFICE PSYCHOTHERAPY NOTES
- O PSYCHOLOGICAL TESTING REPORT
- O TREATMENT SUMMARY
- O VERBAL DISCUSSION OF CASE
- O OTHER: _____

THE PUROSE OF THIS AUTHORIZATION IS

- O AT THE REQUEST OF THE PATIENT
- O PAYMENT ON ACCOUNT
- O COORDINATION OF PSYCHIATRIC TREATMENT
- O DISABILITY CLAIM
- O OTHER: _____

- I understand that this information may be transmitted via written word, fax, or over the phone.
- I understand authorization for this release of information can be revoked at any time.
- To revoke this authorization, I understand that I must provide a statement in writing with my request unless an expiration date is provided here: _____

PATIENT NAME

TODAYS DATE

PATIENT DOB

SIGNATURE OF PARENT/GUARDIAN/AUTH.AGENT

PATIENT SIGNATURE (required for patients' aged 12 and up)

SIGNATURE OF WITNESS

NOTICE OF PRIVACY PRACTICES

This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. This notice takes effect August 25th, 2014, and remains in effect until it is replaced.

Regarding Mental Health Information

The privacy of your (i.e. you and/or your child's) mental health information is important to us. We understand that your mental health information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice.

We need this record to provide you with quality care and continuity of care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share mental health information about you. We also describe your rights and certain duties we have regarding the use and disclosure of mental health information.

Our Legal Duty

The law requires us to:
- Keep your mental health records private
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your mental health records

We have the right to:
- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
- Make the privacy practices and the new terms of our notice effective for all mental health records that we keep, including information previously created or received before the changes

Notice of Change to Privacy Practices

Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of your Mental Health Information

The following section describes different ways that we use and disclose mental health information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose mental health information. We will not use or disclose your mental health information for any purpose not listed below without your specific authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment/Evaluation. We may use mental health information about you or your child to provide you with psychiatric, psychotherapy or evaluation services. We may disclose mental health information about you to your primary care physician if it is required by your insurance or managed care company. Also, we may disclose mental health information about you to a referring or referred mental health provider if you require additional services. From time to time, it is helpful for us to consult with other professionals regarding your treatment. In such events, our consultants are also legally bound by the privacy practice policies.

For Payment. We may use and disclose your mental health records for payment purposes. We may need to supply your health insurance plan with information about treatment you received at our practice so that your health plan will pay for services that were incurred. We may also tell your health plan about a treatment you are going to receive to get approval or to determine if your plan will pay for the treatment.

Additional Uses and Disclosures. In addition to using and disclosing your mental health information for treatment, payment, and heath care operations, we may use and disclose mental health information for the following purposes:

- Notify or help notify a family member, a personal representative, or another person responsible for your care about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment.

(additional uses continued)

NOTICE OF PRIVACY PRACTICES

- Specialized Government Functions. Subject to certain requirements, we may disclose or use your mental health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for governmental programs providing public benefits.
- Court Orders and Judicial and Administrative Proceedings. We may disclose your mental health records in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your mental health records with law enforcement officials concerning the mental health records of a suspect, fugitive, material witness, crime victim, or missing person.
- Public Health Activities. As required by law, we may disclose your mental health records to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
- Victims of Abuse, Neglect, or Domestic Violence. We may disclose your records to appropriate authorities if we have reason to believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may share your mental health records if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.
- Worker's Compensation. We may disclose your mental health records when authorized and necessary to comply with laws relating to worker's compensation or other similar programs.
- Health Oversight Activities. We may disclose your mental health records to an agency providing health oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure, or disciplinary actions, or other authorized activities.

Your Individual Rights

- You have a right to look at or get copies of your mental health records. You must make your request in writing. You may request access by sending your request to the contact person(s) listed at the end of this notice. For evaluations, raw data (i.e., test forms/responses) can only be released to a qualified mental health professional. If you request copies, there may be a $1.00 per page fee. There also may also be an additional postage charge if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
- You have a right to receive a list of all the times we or our business associates shared your records for purposes other than treatment, payment and health care operations and other specified exceptions.
- You have a right to request that we place additional restrictions on our use or disclosure of your records. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- You have a right to request that we communicate with you about your mental health information by different means or to different locations. Your request that we communicate your mental health records to you by different means or at different locations must be made in writing to the contact person(s) listed at the end of this notice.
- You have a right to request that we change your mental health record information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others of the change, including people you name, and to include the changes in any future sharing of that information.
- If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person(s) listed at the end of this notice.

Questions and Complaints

If you have any questions about this notice, please contact: Northwest Psychiatry 10 Executive Court,Suite 5 South Barrington, IL 60010

If you think that we may have violated your privacy rights, contact the organization named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. DHHS. We will not take any adverse action against any patient if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.