Joliet Center Clinical Research
210 N Hammes Ave, Suite 205
Joliet, IL 60435
Ph: 815-729-7790/Fax: 815-725-8144

CLIENT INFORMATION

Today's Date: _____

First Name:_____ Middle Initial:_____ Last:_____

Address: _____

City, State, Zip: _____

Social Security Number: _____ Sex: _____ Date of Birth: _____

Married__ Divorced __ Single ___ Widow(er)___ Separated___ **(CHECK ONE)**

Telephone Number: _____

Secondary Phone Number: _____

Email Address: _____

I agree and give consent to be reached by telephone, email, or text for appointment reminders. **(CIRCLE ONE)**

AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government/insurance benefits to Joliet Center for Clinical Research (JCCR) for services provided.

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different from the patient, please complete and sign:

Guarantor Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Guarantor's Phone number: _____

Employer Name: _____Employer Phone: _____

Employer Address: _____

Relationship to the patient: _____Email Address: _____

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signature: _____ Date: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Policy ID#: _____ Group #: _____

Employer Name: _____ Employer Phone#: _____

Insured's Name:_____

Insured's SS#: _____ Insured's Birthdate: _____

Insured's Address: _____ City, State, Zip: _____

Patient's Relationship to the insured: Self____ Spouse____ Child____ Other____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Policy ID#: _____ Group #: _____

Employer Name: _____ Employer Phone#: _____

Insured's Name:_____

Insured's SS#: _____ Insured's Birthdate: _____

Insured's Address: _____ City, State, Zip: _____

Patient's Relationship to the insured: Self____ Spouse____ Child____ Other____

OFFICE POLICIES

Confidentiality:

- Information in your sessions is confidential EXCEPT if you are threatening to hurt yourself or someone else, or if you tell of a child or an elderly person being abused. In any of these cases, the clinician will have to act upon this information to protect your or someone else.

Appointments:

- There is a 24 hour cancellation fee. When you schedule, the clinician reserves that time for you and if you cannot attend a session, 24 hours' notice must be given or you will be charged a$100.00 fee. This fee is not payable by insurance and MUST be paid by the patient before any future appointments can be made. After 2 consecutive no shows, the patient could be terminated from the office.
- The initial visit is considered to be an evaluation only and not a guarantee that treatment will be the result of said visit. This includes the prescribing of medication.
- If you are scheduled for a medication management appointment with a psychiatrist, you understand that you are required to be on time. If you are late, you understand that you will be required to reschedule the appointment.

Medication Refills:

- All requests for prescription refills must be made **at least 3 business days** before you run out of medication. All refill requests must come from the pharmacy except those for Schedule II medications. Refills for those medications must be left for the office by dialing 815-729-7790 Ext. 2 and leaving ALL of the required information. The psychiatrist may require you to be seen before refilling a prescription. Under NO circumstances will medication be refilled early.

Payments and Billing:

- Payment is expected at the time of service unless other arrangements have been made. If health insurance covers your sessions, Joliet Center Clinical Research will help to seek reimbursement for the insurance company. ANY unpaid balance after insurance is YOUR responsibility to pay.
- It is your responsibility to inform our office if your insurance coverage changes within a timely matter. If your insurance company does not pay within a certain time limit, the professional fees are due and payable in full from the patient.
- If you do not pay your account balance, it may be turned over to collections. In that case, you will be charged an additional 33.33% finance fee.
- In the event that any check you write is retuned NSF (insufficient funds) you agree to pay a $30.00 service fee and any future payments must be made by cash or credit card.
- The parent accompanying the child to the session is responsible for any payment unless other arrangements have been made through the billing department.

Paperwork and Miscellaneous Forms:

- All paperwork is completed at an appointment and a fee up to $100.00 will be assessed by the provider completing the forms and must be paid in advance by the patient.

Conduct:

- We have **ZERO** tolerance policy for any patient who behaves inappropriately to clinical staff and will be discharged immediately. Examples are cursing, violence, verbal threats, sexual inappropriateness, etc.

By signing below, I agree to the terms and conditions of this form.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I have chosen to receive mental health services in the form of mental treatment for myself and/or my child from Joliet Center for Clinical Research. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services:

I understand that during treatment I may need to discuss material of an upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with Treatment Plan:

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision:

I understand there are certain circumstances which may require Joliet Center Clinical Research provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision.
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed.
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others.
4. Other special circumstances, such as preparation to testify in court.

Client Rights:

- The right to be treated with dignity and respect by all staff.
- The right to be involved in the planning and/or revision of my treatment plan.
- The right to know about my treatment progress or lack thereof.
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used.
- The right to be spoken to in a language that is fully understood.
- The right to a clean and safe environment.
- The right to refuse to be videotaped, audio recorded, or photographed.
- The right to end treatment at any time unless court ordered.
- The right to file a complaint or grievance about the agency or staff.
- The right to confidentiality of clinical records or personal information according to federal and state laws.

Emergencies:

I understand I may reach my Joliet Center for Clinical Research provider at 815-729-7790. If not available, I can leave a message for **nonemergency** calls and my call will be returned as soon as possible. If I have a life threatening emergency, I may call 911 or go to the nearest Emergency Room.

I have read, discussed and understood all of the above.

Print Name:_____ Date:_____

Signature of patient or responsible party if minor: _____

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Name:_____ Date:_____ Date of Birth:_____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between your JCCR psychiatrist/therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date specified.

I,_____

Patient/Client (PRINT NAME) Date of Birth Social Security #

Please check one:

- ☐ I AGREE to release mental health/substance abuse information to my Primary Care Physician.
- ☐ I DO NOT give my consent to release any information to my Primary Care Physician.

Physician Name:_____

Physician Address:_____

Physician Phone:_____ Fax: _____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

JOLIET CENTER CLINICAL RESEARCH
210 N Hammes Ave, Suite 205
Joliet, IL 60435
Ph: 815-729-7790/Fax: 815-725-8144

CREDIT CARD AGREEMENT

Maximum charge amount: $250.00

Effective date: 01/01/2019

Expiration date: 01/01/2020

I agree to all Joliet Center Clinical Research to charge my credit card for any amount not covered by insurance (up to the maximum amount), for all service provided by Joliet Center for Clinical Research to the patient(s) on or after the effective date and before the expiration date. I acknowledge that:

- My credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services provided while this agreement is in effect.
- Once a total of $250.00 has been charged to my credit card under this agreement, Joliet Center for Clinical Research which will bill me directly for any amounts not covered by insurance.
- My credit card will be stored by a secure credit card processor affiliated with Joliet Center for Clinical Research to collect payments.
- I will receive receipts detailing the amount charged.
- I may cancel this agreement at any time by contacting Joliet Center for Clinical Research; any unpaid amounts relating to services provided while this agreement is in effect that are not covered by insurance will then be paid in full upon cancelling this agreement.

Credit Card Type: Vis____ MC_____ Discover_____ Amex_____

Card# _____

Exp. Date _____/_____ Security Code: _____

I understand the above listed financial policy and agree to abide by this agreement. My signature serves as authorization to charge my credit card.

Signature_____Date_____

Patient of Parent/Guardian if patient is a minor.

JOLIET CENTER CLINICAL RESEARCH

NOTTCE OF PRIVACY PRACTICES (NPP) - SHORT VERSION

This notice describes how your medical information may be used and disclosed and how you may access this information.

Our commitment to your privacy: Our practice ls dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. This is a shorter version of the full, legally required NPP, which you received along with this so refer to it for more information. If you have questions or concerns about the privacy of your information, please contact our Privacy Officer (see the end of this pamphlet).

We use information about your health, which we get from you or from others, for treatment, to arrange payment for our services, or for other business activities referred to as health care operations. At the end of this NPP ls a Consent Form to be signed allowing us to use and share your information. If you do not consent and sign this form, we cannot treat you.

For treatment purposes, JCCR can use your health information and share it with other professionals who are treating you. For example, JCCR may disclose your personal health information to your doctor, at the doctor's request, for treatment by the doctor.

If your information ls to be disclosed (sent, shared, released) for any other purposes, we will discuss this with you and ask you to sign a separate authorization to allow this.

We will keep your health information private, but there are situations when we are required to use or share it; they are described ln the full version of the NPP. Examples of these situations are:

1. A serious threat exists to your health and safety oi the health and safety of others. We only share information with a person or. organization able to prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. When required by a law enforcement official to do so.
4. Workers Compensation and similar benefit programs.

Your rights regarding your health information:

1. You can specify how we communicate with you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell individuals (such as family and friends) who are involved in your care or the payment for your care except if it is against the law, or an emergency.
3. You have the right to look at your health information (such as medical and billing records). You can get a copy of these records but we may charge you. Contact our Privacy officer to arrange how to see your records.
4. If you believe information in your records is incorrect or incomplete, you can ask us to make some changes (called amendments) to your health information. This request must be ln writing and sent to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room, and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way

I hereby acknowledge that I have received a copy of JCCR's Notice of Privacy Practices and that I have been given an opportunity to read it. I understand that if I have questions about the Notice or my privacy rights, I can contact the Privacy Officer, Diane Harris at 815-729-7790 ext. 102.

Patient/Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Psychiatric Intake Form

All information on this form is strictly confidential

Name: _____ Date: _____

Date of Birth: _____ Primary Care Physician: _____

Current Therapist/Counselor: _____ Phone Number: _____

What are the problem(s) you are seeking help for?

1. _____
2. _____
3. _____

List ALL current medications **and how often you take them:** (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

By singing below, I agree that the above information provided is true and accurate.

Patient/Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____