JOLIET CENTER FOR CLINICAL RESEARCH

210 N Hammes Ave., Suite 205
Joliet, IL 60435
Phone: 815-729-7790/Fax: 815-725-8144

CLIENT INFORMATION

Today's Date: _____
First Name: _____ Middle: _____ Last: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ OK to leave message? (Circle one) Yes No
Cell Phone: _____ OK to leave message? (Circle one) Yes No
Social Security Number: _____ Sex: _____ Birthdate: _____
Email Address _____
Married___ Divorced___ Single____ Widow(er) ____ Separated____ (check one)

Consent for Appointment Reminders

I Agree and give consent to be reached by home phone / cell phone / email / text / for appointment reminders (Circle One)

Print Name: _____
Signature: _____ Date: _____

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 for services provided.
Signature: _____ Date: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

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

Guarantor Name: _____ DOB: _____
Address: _____
City/State/Zip: _____ Phone: _____
Social Security Number: _____
Employer Name: _____ Phone: _____
Employer Address: _____
Relationship to 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 _____

JOLIET CENTER FOR CLINICAL RESEARCH
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 you or someone else. _____

Appointments:

- There is a 24 hour cancellation fee. When you schedule an appointment, 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 $75.00 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 will 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 for Clinical Research will help to seek reimbursement from 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 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 returned NSF (insufficient funds) you agree to pay a $25.00 service fee and any future payments must be made by cash or credit card.
- **The parent accompanying the child to 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 a ZERO tolerance policy for any patient who behaves inappropriately to clinical staff or office 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: _____

JOLIET CENTER FOR CLINICAL RESEARCH
CONSENT FOR TREATMENT

I have chosen to receive mental health services in the form of mental health treatment for myself and/or my child from Joliet Center 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 and personal information according to federal and state laws.

Emergencies:
I understand I may reach my Joliet Center 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 Hospital.

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

Print Name _____ Date _____

Signature of patient or responsible party if a minor _____

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Name_____ Date_____ Date of Birth _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between your Joliet Center for Clinical Research 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 is specified.

I, _____
Patient/Client (PRINT) Date of Birth Social Security Number

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 FOR CLINICAL RESEARCH
CREDIT CARD PROGRAM

Joliet Center Clinical Research has adopted a credit card payment system to help the practice and its patients deal with uncertainties due to insurance coverage and to provide a convenient way to pay bills. Effective January 1,2OL7 we will require all patients to have a credit card on file with our office to pay any outstanding balance.

Please choose 1 of the 3 options below:

Credit Card

_____ Most patients have insurance and if you do, your credit card information will be held securely on file until your insurance company has paid your claim. Once your Explanation of Benefits is received, any remaining Patient Responsibility will be charged to the card that is on file. A No Show Fee of $75 will also be automatically charged to the card if appointments are not cancelled 24 hours prior to any scheduled appointments. A receipt will be mailed to you on the same day the card is processed. The advantage to you is that you will no longer need to write out checks and send payments in the mail. It is like checking in to a hotel. For example: When a guest checks into a hotel the staff swipes the card of the guest and it is stored securely in a computer. When the guest checks out, the amount he/she owes is determined, the stored information is recalled, and the transaction is processed to the guest's card. Storing your credit card with us will not compromise your ability to dispute charges or question your insurance company's determination of payment. The system we use is fully HIPAA compliant and assures the highest levels of security.

Pay Balance In Full With each Visit

_____ Patient will pay remaining Patient Responsibility Balance along with Co-pay and unpaid No Show Fees with each scheduled visit.

What If I Don't Have a Credit Card?

_____ Joliet Center for Clinical Research will accept a retainer if a patient does not have a credit card or does not wish to keep one on file with the office. Our retainer amount is $300.00 and will need to be replenished when balance falls below $300.00.

By signing below, I agree to the above terms.

Print Name _____

Signature _____ Date _____

CREDIT CARD INFORMATION

Name on Card _____ Visa MC Amex Discover (please circle one)

Card Number _____ Expiration Date _____

Security Code _____ Zip Code _____

Signature _____

JOLIET CENTER FOR CLINICAL RESEARCH
NOTICE 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 is 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 is 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, Joliet Center for Clinical Research can use your health information and share it with other professionals who are treating you. For example, Joliet Center for Clinical Research may disclose your personal health information to your doctor, at the doctor's request, for treatment by the doctor.

If your information is 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 in the full version of the NPP. Examples of these situations are:

1. A serious threat exists to your health and safety or 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 in 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 Joliet Center for Clinical Research'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_____

Patient/Client Refuses to Acknowledge Receipt
Signature of Staff Member_____ Date _____

Joliet Center for Clinical Research

Cosme Lozano MD, Paulette Trum MD, Amanda Twait APRN, Kathleen Linehan APRN,
Anthony Kokalj LCPC, Angela Connor LCPC, Allison Hubbard LCPC , Lauren Mahaffey LCSW

Psychiatric Intake Form

All Information on this form is strictly confidential

Name_____Date_____

Date of Birth _____ Primary Care Physician _____Referred By_____

Current Therapist/Counselor_____ Therapist Phone_____

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

1._____

2. _____

3. _____

Current Symptoms Checklist: (Check once for any symptoms present, twice for major symptoms)

- ☐ Depressed Mood
- ☐ Unable to enjoy activities
- ☐ Sleep Pattern Disturbance
- ☐ Loss of interest
- ☐ Concentration/Forgetfulness
- ☐ Change in appetite
- ☐ Excessive Guilt
- ☐ Fatigue
- ☐ Decreased Libido
- ☐ Racing Thoughts
- ☐ Impulsivity
- ☐ Increase Risky Behavior
- ☐ Increased Libido
- ☐ Decreased Need for Sleep
- ☐ Excessive Energy
- ☐ Increased irritability
- ☐ Crying Spells
- ☐ Excessive Worry
- ☐ Anxiety Attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ _____
- ☐ _____
- ☐ _____

If you are currently having thoughts about harming yourself and feel that you may act on these thoughts or impulses, STOP filling out his form, CALL 911 OR VISIT THE EMERGENCY ROOM AT YOUR NEAREST HOSPITAL

Medical History

Allergies _____

Current Weight _____ Current Height _____

For Women Only: Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No

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

Medication Name | Total Daily Dosage | Estimated Start Date

Please check any family medical issues that apply to you and indicate the family member

	Yes	No
Thyroid Disease	☐	☐
Anemia	☐	☐
Liver Disease	☐	☐
Chronic Fatigue	☐	☐
Kidney Disease	☐	☐
Diabetes	☐	☐
Asthma/Respiratory Problems	☐	☐
Stomach or intestinal problems	☐	☐
Cancer (type)	☐	☐
Fibromyalgia	☐	☐
Heart Disease	☐	☐
Epilepsy or seizures	☐	☐
Chronic Pain	☐	☐
High Cholesterol	☐	☐
High blood pressure	☐	☐
Head trauma	☐	☐
Liver Problems	☐	☐
Other	☐	☐

Past Psychiatric History

Outpatient Treatment ☐ Yes ☐ No

If yes, please describe when, by whom, reason for treatment and nature of treatment.

Psychiatric Hospitalization ☐ Yes ☐ No

If yes, please describe for what reason, when, where, and the dates of hospitalization

Family Psychiatric History

Please check and indicate the family member who has been diagnosed or treated for:

	Yes	No
Bipolar Disorder	☐	☐_____
Depression	☐	☐_____
Anxiety	☐	☐_____
Anger	☐	☐_____
Suicide	☐	☐_____
Schizophrenia	☐	☐_____
Post-Traumatic Stress	☐	☐_____
Alcohol Abuse	☐	☐_____
Other Substance Abuse	☐	☐_____

Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No

If yes, who was treated, with what medications and how effective was the treatment?

_____

_____

Substance Use

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, please indicate the treatment, for what, and when

_____

_____

_____

Tobacco History

Have you ever smoked cigarettes? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No How many pack per day on average? _____ How many years?_____

In the Past? ☐Yes ☐ No How many years did you smoke? _____ When did you quit? _____

Do you use pipe, cigars, or chewing tobacco? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

What kind? _____ How often per day on average? _____ How many years? _____

Educational History

Did you attend college? ☐ Yes ☐ No

Where?_____ Major _____

What is your highest level of education or degree obtained? _____

Occupational History

Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired

How long in the present position? _____

What is/was your occupation? _____

Social History

Are you currently: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

How long? _____

Have you had any prior marriages? ☐ Yes ☐ No
If so, how many? _____ How long? _____

Social History Cont.

Do you have children? ☐ Yes ☐ No
If yes, list ages and gender _____
_____

Legal History

Have you ever been arrested? ☐ Yes ☐ No
Do you currently have any pending legal problems? ☐ Yes ☐ No
Please describe _____
_____

By signing below, I agree that all the information provided is true and accurate.

_____
Signature of Patient Date

_____
Emergency Contact Telephone #