HeartLight

a comprehensive counseling and personal growth center.

Date_____ Therapist_____

PLEASE ANSWER ALL OF THE FOLLOWING INFORMATION CAREFULLY

Client Information:

Full Name_____Age____Sex: M F DOB_____SSN_____
Address_____City_____State_____Zip____
Home Phone(___)_____Work Phone(___)_____Cell(___)_____
Email Address_____
Emergency Contact_____Relationship_____Phone_____
Who Referred You?_____
Medications/Dosages_____M.D.Prescribing_____

Payment Information:

Please circle one: Self-Pay Insurance

Insurance Company: (Skip if self-pay)Insurance Company_____
Identification#_____Insured's Name_____
Group#_____
Insured's SS#_____
Insurance Address & Phone #_____
Insured's DOB_____
Insured's Employer_____

Client's relationship to insured: (circle): Self Wife Husband Child Other

Name of Parent or Guardian responsible for bill (if other than client):

Name_____Address_____
Home Phone_____WorkPhone_____

I guarantee payment for services rendered to me.
Name_____Date_____
I authorize payment of medical services to undersigned supplier for services.

Name_____Date_____

I authorize the release of any medical information necessary to process the claim for service
rendered. Name_____Date_____

Therapy Information - Read Carefully

Description of Treatment Offered

Counseling (individual, family or group) consists of discussions between the client(s) and the therapist that are designed to understand the client's immediate problems and symptoms and to develop a plan that will aid in resolving these problems. Counseling has potential benefits (e.g. improvement in identified problems, increase insight/ understanding or increase skills to assist in coping) and potential risks (e.g. experiencing strong emotions, changes in ways of relating, or feeling worse before feeling better). Due to the variety of conditions that make therapy successful, no guarantees of outcomes can be made. Please discuss any concerns about your treatment with your therapist. Your therapist may also suggest or recommend that you be seen for a psychiatric evaluation or psychological testing if the therapist believes this will improve your progress in therapy.

Appointments and Fees

Appointments are scheduled by each individual therapist for specific dates and times. **You must provide at least 24 hours notice of cancellation or you will be billed for the full session fee.** Insurance companies can not be billed for late cancellations or missed appointments. Payment of the missed session is due at the rescheduled appointment unless other arrangements are made with your therapist. Your therapist will discuss the fees for service during your first session. Payment in full, or the client's deductible or co-payment, is due at the time of service (i.e. at each session). A $25.00 fee will be charged for any returned checks. An administrative fee of $25.00 will be applied to any past due accounts. Past due accounts will be sent to a recovery service and any fee incurred will be the client's responsibility. Should you desire for us to send a bill to your insurance company, you must complete and sign a credit guarantee form. There is a 2% processing fee for all credit card payments. Please discuss any questions or concerns with your therapist.

Confidentiality

Your treatment is confidential within the limits prescribed by the law. In general, no information will be released without your written consent. Relevant laws, however, require your therapist to contact others if you appear to be in danger to yourself or to someone else, if your therapist learns about child abuse/neglect, or if ordered by court.

If you (client) are under 12 years of age, your therapist may discuss your treatment with your parent or legal guardian. If you are between the ages of 12 and 18 years of age, your therapist may discuss your case with your parent or legal guardian with your consent. If you are engaging in behaviors that your therapist believes places you in danger of harming yourself or others, your therapist will help you to discuss this with your parent or legal guardian.

Your therapist may consult or review your case with other therapists within Heart Light Psychological Services to improve the quality of your treatment. Information may also be released to insurance companies or their agents (i.e. managed care companies) if you are using these benefits.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND THE INFORMATION ABOVE.

Client (Print Name)_____Signature_____Date_____

Parent/Guardian _____Signature_____Date_____

Therapist Name _____Signature_____Date_____

Credit Card Agreement

Insurance Assignment: As a courtesy to you, we will bill your insurance company on your behalf. Please remember that **you** are ultimately responsible for payment. At the time of service, full payment for services OR your responsibility portion (deductible, co-pay, or co-insurance), is due. Please call your insurance company and complete an **AOL insurance pre-determination of benefits** form found on our website, to determine your responsibility should you desire to use insurance. We will submit claims and any portion of the bill that is not paid by your insurance company within 60 days will be charged to your designated credit card.

Personal Balances: Payment is due at time of service. Any balances due past 60 days will be charged to your designated credit card.

Missed Sessions/Cancellation: Any missed session or cancellations without a 24 hour notice will be automatically billed to your designated credit card. Please complete and sign below;

Credit Card (Circle): Visa Master Card Discover

Cardholder Name:_____

Credit Card Number:_____

Expiration Date:_____

Security Code: _____

Email my receipt to:_____

*All credit card charges are subject to a 2% processing fee.

I agree to the terms above and authorize you to bill my credit card for unpaid balances due._____ _____
Signature Date

Heart Light NPI #1003932039

Dr. Kerri Nevin NPI#1114158508

Dr. Paul Nevin NPI#1790916658

AOL Insurance Pre-determination of Benefits

PLEASE COMPLETE THIS FORM AND FAX TO US AT (847) 374-1280

Client's Name_____DOB_____

Insured Name_____DOB_____

Insured Place of Employment_____

Insurance Company_____

ID Number_____ Group Number_____

Insurance Phone Number_____

CALL YOUR INSURANCE COMPANY AND ASK THEM THE FOLLOWING QUESTIONS TO DETERMINE YOUR BENEFITS:

1. Ask if your therapist and Heart Light Psychological Services is considered in or out of network: IN-NETWORK_____OUT OF NETWORK_____
2. Ask if your benefits are managed by any other manage care company. YES____NO____If yes, until when?_____
3. What is your effective date?_____
4. Do you have a pre-existing clause:YES_____NO_____If yes, until when?____
5. Ask what your benefits are for outpatient mental health in an office setting. Ask if you have separate levels of benefits for SERIOUS and NON-SERIOUS diagnosis .YES_____NO_____
6. What is your INDIVIDUAL deductible?_____FAMILY deductible?_____
7. If you have a deductible, how much of it is met this year?_____
8. Do you have a co-payment? YES_____NO_____How much?_____
9. Do you have a co-insurance (Percentage that you are responsible for?) YES_____ NO_____ How Much?_____

10. Do you have coverage for the following services and CPT codes?
a. INITIAL DIAGNOSTIC EVALUATION (CPT code 90801) YES_____NO_____
b. INDIVIDUAL COUNSELING 45 min (CPT code 90806) YES_____NO_____
c. INDIVIDUAL COUNSELING 75 min (CPT code 90847) YES_____NO_____
d. FAMILY/MARITAL COUNSELING (CPT code 90808) YES_____NO_____
e. GROUP COUNSELING (CPT code 90853) YES_____NO_____

11. How many sessions do you have yearly?_____ Lifetime?_____
12. How many of those sessions are already used? _____
13. Do you need pre-authorization for treatment? _____
14. If yes, how many sessions are authorized? _____
15. What is the authorization number? _____
16. Where (what address) does your insurance company want their claims to be sent?
_____

PLEASE BRING YOUR INSURANCE CARD WITH YOU TO YOUR FIRST SESSION SO WE CAN MAKE A COPY OF IT.

AS A REMINDER, ALL DEDUCTIBLES, CO-PAYS AND CO-INSURANCE AMOUNTS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND CREDIT CARDS.

THANK YOU.

NOTICE OF PRIVACY PRACTICES

The notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of is legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who will follow this notice

Any healthcare professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use And Disclose Medical Information About You

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. **We may use medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.**

For Payment. **We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to sen your protected health insurance information, such as your Name, address, office visit dates, and codes identifying your diagnosis and treatment to your insurance company for payment.**

For Health Care Operations. **We may use and disclose medical information about you for health care operations to assure that your receive quality care. Example: We may use and disclose medical information to review our treatment and services and evaluate the performance of our staff in caring for you.**

Other Uses or Disclosures That Care Be Made Without Consent or Authorization

***As required during an investigation by law enforcement agencies**
***To avert a serious threat to public health or safety**
***As required by military command authorities for their medical records**
***To workers' compensation or similar programs for processing of claims**
***In response to a legal proceeding**
***To a coroner or medical examiner or identification of a body**
***If an inmate, to the correctional institution or law enforcement official**
***As required by the US Food and Drug Administration (FDA)**
***Other healthcare providers' treatment activities**
***Other covered entities' and providers' payment activities**
***Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)**
***Uses and disclosures required by law**

***Uses and disclosures in domestic violence or neglect situations**
***Health oversight activities**
***Other public health activities**

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Uses and disclosures of protected health information requiring your written authorization

Other uses and disclosures or medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will therefore no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

Your Individual RIghts Regarding Your Medical Information

Complaints. **If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.**

Right to request restrictions. **You have the right to request a restriction or limitation on the medial information we use or disclose about you for treatment, payment, or health care operations or to someone who is involved in your care or payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.**

Right to request confidential communications. **You have the right to request how we should send communications to you about your medical matters, and where you would like those communications sent. To request confidential communications, you must make our request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.**

Right to inspect and copy. **You have the right to inspect and copy medical information that may be used to make decisions about your care Usually this includes medical and billing records but does not include psychotherapy notes, information compiles for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that denial to be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcomes of the review.**

Right to amend. **If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not included a reason to support the**

request. In addition, we may deny your request if the information was not created by us, is not apart of the medical information kept at this practice, is not part of the information which you be permitted to inspect and copy, or which we deem to be accurate and compete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an accounting of non-standard disclosures. **You have the right to request a list of disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before June 1, 2004. Your request should indicated in what form you want this list (example: on paper electronically). The first list you request within a 12 month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.**

Right to copy this notice. **You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request this in writing from the Privacy Officer at this practice.**

Change to this notice. **We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effected for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right hand corner of the first page.**

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND THE INFORMATION CONTAINED IN THIS NOTICE. I FURTHER UNDERSTAND THAT I MAY REQUEST A COPY OF THIS NOTICE AT ANY TIME.

Client Name_____ **Date**_____

Please explain why you are seeking our services at this time. As specifically as possible, describe the problem:

How long have you been experiencing these problems?

How are they affecting your daily life? Are there any limitations because of these problems?

How would you like us to help you with this problem?

Is this an emergency situation? Yes____ No____
Are you currently suicidal? Yes____ No____
Have you ever been suicidal before? Yes____ No____
Have you ever made an attempt? Yes____ No____

Are you currently under the care of a Therapist, Physician, or Psychiatrist?
Yes_____ NO_____
If so, who? _____
For what reasons?_____

Do you attend any support groups? Which ones? Yes_____ No_____

Have you ever seen a therapist, psychiatrist, or counselor before?
Yes____No_____
For what reasons?
Where and When? Was it helpful?

Are you currently taking medication for anxiety, your nerves, depression, or other mental health or emotional problems? Yes_____ No_____
Name of Physician who prescribed it: _____
What medications and dosages? _____
For what reasons and how long have you been on it?
Was it helpful?

Do you have any significant health problems your therapist should know about? (Specify)

When was your last medical examination? _____/_____/_____

<u>Background Information</u>

Are you: Single Divorced In a committed relationship
Married Separated Remarried Widowed

Do you live: Alone With a roommate With my significant other
Parents at school With my family/spouse

What is your race/ethnic origin? (optional)
Caucasian American Indian Other:_____
African American Asian
Hispanic Bi-racial

Do you have children? Yes___No____ Please list their names/ages:_____

_____

What level of education have you completed?

Do you have any specialized education or training?

Are you employed? Yes_____ No_____
What type of work do you do?_____
How long have you held this job?_____
Do you enjoy what you do?_____

Do you have any spiritual issues/concerns that your therapist should know about?(Specify)

Are there any particular family problems or situations recently or currently that are influencing your life at this time? (Specify)

Is there any family history of mental health or emotional problems? Yes____No____(Specify)

Is there a family history of alcohol or substance abuse? Yes____No_____(Specify)

Do you have any specific early childhood events, illness or problems that your therapist should know about? Yes____No_____ (Specify)

Notification to Primary Physician of Client Receiving Mental Health Services

Pursuant to Illinois law, you are informed that it is desirable that you confer with your primary care physician, if you have one. If you have a primary care physician, I am required to notify him or her that you are seeking mental health treatment unless you waive such notification. Please indicate your wishes:

O Yes, I would like you to notify my primary care physician that I am seeking or receiving mental health services. My signature below serves as an authorization to release information and permits you to communicate with my said physician and share and release information to him or her regarding my receiving treatment.

Primary Care Physician _____
Office Address _____

_____

Phone Number _____

O I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services and I direct you NOT to notify him or her.

I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

*Date*_____ _____
Client Signature

_____
Parent/Guardian Signature