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Springfield Psychological Center, LLC

ADULT REGISTRATION FORM

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: _____ Gender: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE #: _____ WORK #: _____ PRIMARY CARE: _____

EMAIL ADDRESS: _____

INSURANCE INFORMATION:

Primary Coverage

INSURANCE COMPANY: _____ EMPLOYER: _____

ID#: _____ GROUP #: _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ ZIP: _____

□ CHECK IF SAME AS LISTED ABOVE

Secondary Coverage

INSURANCE COMPANY: _____ EMPLOYER: _____

ID#: _____ GROUP #: _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ ZIP: _____

□ CHECK IF SAME AS LISTED ABOVE

I will take full responsibility for payment for services. I will take full responsibility due to any third-party payment failure for a carried balance on my account. I give permission for the release of any information necessary for billing my insurance, and, if necessary, the recovery of funds by a collection agency or attorney. If the utilization of a collection agency and/or attorney is needed, I agree to pay the additional fees and costs of a fee of 33.3% of the unpaid balance as an authorized percentage collection fee. I authorize payment of medical/ psychological/social work benefits to the undersigned psychologist/social worker or supplier for services rendered. Person(s) completing this application consent to evaluation and treatment given by this psychology office using commonly accepted outpatient procedures. I understand that I will be billed a $1.00 or 1.5% service charge, whichever is higher, for monthly billing if my account is 60 days past due.

_____ _____

DATE SIGNED (Patient/Guardian)

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ADULT HISTORY

Name: _____ Nickname: _____ Pronouns: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Work #: _____

DOB: _____ Age: _____ Occupation: _____

Referred by? _____

Reason for making appointment? _____

_____

With whom are you now living? (list people):
Name Age Relationship Occupation

_____
_____
_____
_____

Medical History (include past and present conditions): _____

_____

Medications: _____

_____

Primary Physician: _____

Previous Mental Health Treatment
When? With Whom? Outcome

_____

Any prior mental health hospitalizations: _____

_____

_____

3416 Liberty Drive ● Springfield, IL 62704 ● (217) 793-3949 ● FAX (217) 793-3995

Family History of mental or emotional problems, including alcohol or substance abuse:

_____

_____

Educational History (Briefly describe school experiences, including highest grade level attained.)

_____

_____

Employment History

1. Present employment status and where: _____

_____

2. Work-related concerns? _____

_____

Talents and skills: _____

Symptom Check List **(check all that apply to you):**

___Depression	___Feeling that you are not real	___Lose track of time
___Low energy	___Anger control problems	___Defies rules
___Poor concentration	___Blames others	___Argues
___Hopelessness	___Alcohol/drugs	___Blackouts
___Worthlessness	___ Stomach/bowel problems	___Headaches
___Guilt	___Spousal abuse	___Sadness/loss
___Anxiety/panic	___Heart pounding/racing	___Chest pain
___Trembling/shaking	___Chills/hot flashes	___Sweating
___Tingling/numbness	___Phobias	___Racing thoughts
___Nausea	___Delusions/hallucinations	___Relationship issues
___Confusion	___Sleep disturbance (more/less)	___Intrusive thoughts
___Self-injury	___Loneliness	___Marital/family
___Dizziness	___Impulse control problems	___Social withdrawal
___Nightmares	___Thoughts of hurting yourself (past/present)	
___Physical abuse (past/present)	___Thoughts of hurting others (past/present)	
___Sexual abuse (past/present)	___Appetite disturbance (more/less)	

___Excessive behaviors (spending/gambling/sex)

___Other (specify)_____

_____ _____

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Text Reminder Authorization Form

By signing this form, I authorize Springfield Psychological Center to send text messages to my cell phone. I understand the messages will be sent three days prior to the scheduled appointment date. I will be responsible for any cancellations that need to be made if I cannot make the scheduled appointment date and time. I also understand that by signing this form I will no longer receive a reminder phone call the day prior to the scheduled appointment date. I understand that text messaging rates may apply to any messages received from Springfield Psychological Center. I also understand that I may revoke this permission in writing at any time. I agree not to hold Springfield Psychological Center liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my contact/cell phone number changes that I will inform Springfield Psychological Center or be liable for any fees or charges incurred.

Patient's Name: _____
Please Print

Parent Guardian's Name: _____
Please Print

Cell phone Number: (_____)_____

This authorization form will remain in effect until revoked in writing by me or Springfield Psychological Center.

Signature: _____ Date: _____

Privacy Disclaimer: Text messaging is provided as a service to members. Your information will not be shared or distributed in any way

Telehealth Informed Consent

Here are some key issues regarding telehealth psychotherapy sessions. SPC clinicians do not do psychotherapy over text or email.

1. We have a video chat session when we are both in Illinois due to licensing requirements.
2. As with any psychotherapy session, you are ultimately responsible for payment. Please check with your health insurance policy to see whether phone or video chat sessions are covered.
3. No method of communication is completely confidential. However, the standard for video chat services is end-to-end encryption and saving only the metadata (who was called and how long the call lasted). It is important to use a secure internet connection rather than public/free wi-fi.
4. Patients need to use a webcam or smartphone during the session for video appointments.
5. SPC has reviewed the technologies and determined that Doxy.me has end-to-end encryption, a business associate agreement, and is HIPAA compliant. This platform is preferred for video chat.
6. At the time of your video session, please be in a quiet place where you will not be distracted or interrupted and your session will not be overheard.
7. Potential benefits to video chat sessions:
    a. We may need to temporarily resort to alternatives to face-to-face appointments if restrictions associated with COVID-19 precautions are in place.
8. Potential risks and costs of video chat sessions:
    a. There may be less nonverbal communication than for an in-person session.
    b. With any technology, there is always the risk of being inadvertently disconnected. If a chat session is disrupted at any time, your SPC clinician will attempt to re-establish a connection.
9. You will need to assume responsibility for maintaining confidentiality at the end of the session. You accept responsibility to secure any phone or computer you may use for our session.
10. We need a phone number where you can be reached, at least one emergency contact, and the closest ER to your location, in the event of a crisis situation.

I understand the above information, I consent to use phone or video chat for psychotherapy, and I understand that I can withdraw my consent to phone or video chat sessions at any time.

_____	_____
DATE	SIGNED (Patient 12+ years)
_____	_____
EMAIL ADDRESS	SIGNED (Parent/Guardian)
_____	_____
PHONE NUMBER	EMERGENCY CONTACT NAME & RELATIONSHIP
_____	_____
PREFERRED EMERGENCY ROOM	EMERGENCY CONTACT NUMBER

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Policies for Our Practice

Please read this information carefully. It describes policies we have adopted for our practice. Be sure to raise any questions you may have at your first meeting.

Psychological Services

The Springfield Psychological Center (SPC) offers psychological evaluations, psychotherapy and consultation. Psychological evaluation and psychotherapy are unlike visits with a medical doctor where a symptom may dictate a particular treatment. In our practice, every person's situation is unique.

Psychotherapy may be characterized as a series of discussions between you and your therapist for the purpose of understanding your emotional discomfort and making your life more manageable. At times, psychotherapy will be directive with specific instructions, tasks and homework assignments. To be truly successful, psychotherapy requires active participation by the client, both during and between sessions. Unfortunately, there is no guarantee psychotherapy will resolve your problems. However, most people who undertake treatment report significant and enduring reduction in their feelings of distress, resolution of specific problem issues, and more satisfying relationships.

Psychological evaluation and consultation, like therapy, have both risks and benefits. Although the results may clarify one's levels of intellectual functioning or personality traits, the findings may be different than those anticipated.

Psychological Testing

For any psychological testing, your insurance benefits might be specific to this procedure. After completion of testing, there will be a psychological report compiled by the clinician. During the testing process, additional time is needed for the psychologist to score, interpret, and draft psychological reports. This time will be billed separately from an office visit. If you carry insurance, the insurance will be billed for the report. You are responsible for any copay, coinsurance, or deductibles that the insurance finds you responsible for. If you do not have insurance and are requesting testing, you will be responsible for the whole amount. A completed financial agreement is required prior to scheduling testing appointments after the initial visit. Options include paying a $500.00 retainer that will apply to psychological testing services provided (with the patient paying any balance over the retainer at the end of testing) or placing a credit card on file with a minimum balance established that will be processed monthly.

Appointments and Cancellations

Please bring the signed form to our first session. Every effort will be made to schedule appointments that are mutually convenient. If it becomes necessary for you to cancel, at least 24 hours' notice must be given. If less than 24 hours' notice is given, you will be expected to pay for that appointment. (Insurance companies will not reimburse for canceled or missed sessions.) In the event of a crisis necessitating an emergency visit, please inform the office manager so she can consult with the psychologist/counselor toward the timely creation of an appointment. Our office manager will attempt to remind you of your appointment with a call the day before unless you request otherwise.

Payment and Insurance

Please know your insurance coverage. Pay special attention to annual limits, deductible amounts you must pay yourself, percentages of charges your insurance pays, and any waiting period if your insurance is new.

We will complete your insurer's claim forms, but it remains **your** responsibility to guarantee payment and to follow up with your insurance company if there are any questions. Billing is generally by the month. It is expected that payments will be made on a timely basis -----within one month of billing.

Although optional, we request you leave a credit card on file for therapy appointments. With your written consent, SPC will charge your card when there is a balance on the patient's account. Our policy is that if a patient account has a balance of over $500 after insurance has been processed, a credit card on file is required, along with a payment plan that is worked out with our office manager. We accept Master Card and Visa. For testing, a financial agreement is required prior to scheduling appointments.

You should be aware that for claims to be processed, insurance companies require a diagnosis and, occasionally, other information. By law, such information cannot be released by insurance companies without your specific, informed consent. By signing the registration form, you are agreeing to the release of this information.

If you request, it is our policy to send a brief letter to referral sources at no extra cost; however, occasionally a longer report is needed. There is an extra charge for such reports. Insurance sometimes does not cover these costs. You should check with your insurance company regarding their policies.

Confidentiality

Communications between clients and staff of the SPC are confidential, in accord with professional ethics and in compliance with the law. However, there are some exceptions to this rule. While these limits may not be at all relevant to your particular situation, we are legally obligated to inform you about them. The following are conditions in which disclosure can be made without your consent.

1. In order to protect you or others if:
a. you present an immediate danger to yourself;
b. you share an actual plan to harm another person;
c. there is cause to believe you pose a danger of physical violence to another.
2. In case of child or elder abuse, which must be reported to the appropriate State agencies.
3. In order to collect debts or to protect SPC or the representation thereof in a court action.
4. In certain legal proceedings should a court of law issue an order requiring the release of confidential information.
5. With colleagues about my work with you (never revealing your identity) for professional consultation. In any case, only appropriate and necessary information will be provided.

In accordance with HIPAA, patients:

1. Have the right to restrict certain disclosures of Protected Health Information (PHI) to a health plan if they pay out-of-pocket in full for the healthcare service.
2. Have the right to be notified if there is a breach of their unsecured PHI.
3. Must sign an authorization before you can release their PHI for any uses and disclosures not described in the Privacy Notice.

Breach Notification

1. What is a breach? The HITECH Act added a requirement to HIPAA that psychologists (and other covered entities) must give notice to patients and to The U.S. Department of Health and Human Services (HHS) if they discover "unsecured" PHI has been breached. A "breach" is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule. Examples of a breach include: stolen or improperly accessed PHI; PHI inadvertently sent to the wrong provider; and unauthorized viewing of PHI by an employee. PHI is "unsecured" if it is not encrypted to government standards.
2. When the practice becomes aware of or suspects a breach, the practice will conduct a risk assessment. The practice will keep a written record of that risk assessment.

3. Unless the practice determines that there is a low probability that PHI has been compromised, the practice will give notice of the breach.
4. The risk assessment can be done by a business associate if involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in their control, the practice will provide any required notice to patients and HHS.
5. After any breach, particularly one that requires notice, the practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

There are a number of additional less common situations in which Illinois law permits or mandates disclosure. While the goal is informed consent, SPC is obligated to comply with such mandated disclosures. Of course, whenever you wish to give expressed written consent, we are able to share information about you. (Please refer to NOTICE OF PRIVACY PRACTICES for more detail)

Confidentiality for Children

We are all parents and fully understand the desire of parents to know what their children discuss in psychotherapy in order to be able to help their children. In addition, Illinois law allows full access of parents to the treatment records of children under 12 years of age and limited access of parents to the treatment records of children who are between the ages of 12 and 18. However, it is the philosophy of SPC that all children should be able to confide in therapists without the possibility of their statements being reported to others, including their parents, except in cases of child abuse, very dangerous behavior, or other circumstances that are in the best interest of the child and that comply with the Illinois State statutes.

Often parents want to obtain records, as they believe that this will be helpful to their children. We recommend against this, as we find that this is a betrayal of the trust between the child and the therapist, potentially leading to distrust of adults and a reluctance to use and benefit from counseling. Instead, we recommend that parents/guardians talk to the child's therapist and obtain parenting advice geared to the needs of their child.

Many times, parents request access to information, often on the advice of their attorneys, for use in mediation or court proceedings regarding custody or visitation. We believe that children whose parents are having marital stresses, are separated, or are divorced, have even a greater need to talk to an unbiased person about their concerns regarding the family. They need to talk without the fear of their statements being reported to their parents and/or used in court. Use of a child's statements, which have been made in confidence in a court proceeding is a significant betrayal that is potentially damaging to the child.

I have read and agree to the policies of the Springfield Psychological Center.

(Signature of Patient)_____

(Signature of Guardian)_____

(Date)_____

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CONSENT TO USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION

This form is an agreement between you and your mental health professional at The Springfield Psychological Center. When we use the word "you" it will mean your child, relative, or other person if you have written his/her name here (**patient's name**): _____.

When we examine, diagnose, treat, or refer you, we will be collecting private mental health information about you. We need to use this information here to decide what treatment is best for you and to provide the treatment to you. We may share this information with others, when permitted by law, who provide treatment to you. We may also share this information to arrange payment for your treatment or for business or for other government functions.

By signing this form, you are agreeing to let us use your information here. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read the Notice of Privacy Practices before signing this consent form.

If you do not sign this consent form agreeing to what is in our Privacy Practices, we cannot treat you.

In the future, we may change how we use and share information and so may change our Notice of Privacy Practices. If we do change it, you will be advised of this at your next appointment. A copy will be available for you to review in the waiting room at any time. You may also request a paper copy to take with you.

If you are concerned about some of your mental health information, you have the right to ask us not to use or share some of the information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. We will try to respect your wishes, but we are not required to agree to any limitations. If we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it in writing. We will comply with your wishes about using or sharing your information from that time on; however, we may already have used or shared some of your information and cannot change that.

_____ _____

DATE SIGNED (Patient 12+ years)

_____ _____

DATE SIGNED (Parent/Guardian)

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Financial Agreement for Psychological Testing

Fees:

90791 – New Patient Diagnostic Evaluation	$200.00
96136 – Psychological Testing Primary Code – first 30 minutes (includes test administration and scoring)	$90.00 – first 30 minutes
96137 – Psychological Testing Secondary Code – 31 minutes and over (includes test administration and scoring)	$90.00 - each additional 30 minutes of testing
96130 – Clinical Decision Making, Record Review, Test Selection, Report Writing, and Parent Feedback – Primary Code - first 60 minutes	$170.00 - first hour
96131 – Clinical Decision Making, Record Review, Test Selection, Report Writing, and Parent Feedback – Secondary Code – 61 minutes and over	$170.00 – each additional hour

Agreement:

- I request that Springfield Psychological Center, LLC, provide services to me or my child and agree to pay the fees in accordance with the fee schedule listed above.
- I agree that this financial relationship with Springfield Psychological Center, LLC will continue as long as the practice provides services to me or my child or until I inform the practice that I wish to end the assessment.
- I agree to allow Springfield Psychological Center, LLC to submit the testing to my insurance, and I will be responsible for any amount the insurance deems my responsibility.
- I agree to pay any fees that accumulate during the assessment if I choose not to finish the testing. I agree to pay the full price of the testing time rendered and understand that any noncompleted testing will not be submitted to insurance.
- I agree that testing appointments will not be scheduled after the initial intake until I agree to the payment plan below.

Insurance:

- I give permission to Springfield Psychological Center, LLC, to bill my insurance for services rendered, and I will be responsible for any balance once processed through insurance.
- I understand that some insurances do not cover certain diagnoses, and I will be financially responsible for any amount insurance deems my responsibility. For example, learning disabilities are not covered by some insurance plans.

Payment:

- I agree to be financially responsible for any balance incurred and to set up a credit card to be processed once a month after testing services have been completed and the insurance has determined the patient responsibility amount. I agree to fill out the credit card form today with a guarantee of future monthly payments of my choice. _____ (please initial)

My signature below shows that I, _____, understand and agree with all these statements.

_____ _____

Responsible Party (Patient or Parent of Child Patient) Date