PATIENT INFORMATION

Date: _____ Provider Seen: _____

Patient's Last Name: _____ First Name: _____ Middle: _____

Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____ Work: (___)_____ Cell: (___)_____ Other: (___)_____

Preferred Phone: ☐ Home ☐ Work ☐ Cell ☐ Other Email: _____

Social Security # _____ Date of Birth: _____ Gender: Male Female Transgender Gender Neutral

Marital Status: Single Married Divorced Widowed Separated Referred by: _____

PATIENT EMPLOYER/SCHOOL

Employer Name: _____ Occupation: _____ Full Time Part Time

Address: _____ City: _____ State: _____ Zip: _____

School: _____ Grade/Level: _____ Student Status: Full Time Part Time

IF PATIENT IS NOT THE PERSON TO BE BILLED, PLEASE COMPLETE THIS SECTION:

Responsibility Party Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____ Work: (___)_____ Cell: (___)_____ Other: (___)_____

Preferred Phone: ☐ Home ☐ Work ☐ Cell

EMERGENCY CONTACT (*In case of an emergency or if unable to contact patient, whom may we contact or leave messages with)*

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____ Work: (___)_____ Cell: (___)_____ Other: (___)_____

PRIMARY INSURANCE *(Please keep insurance cards available as we will need a copy for our records – Thanks)*

Insurance Company: _____ Member ID: _____ Group #: _____

Effective Date: _____ Have you contacted your insurance company prior to appointment? Yes No

Authorization # (if received): _____ # of Visits: _____ Authorization Dates: _____

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____ *(required for most insurance plans)*

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Insurance Company: _____ Member ID: _____ Group #: _____

Effective Date: _____ Have you contacted your insurance company prior to appointment? Yes No

Authorization # (if received): _____ Amount Visits: _____ Authorization Dates: _____

Subscriber Name: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security Number: _____ *(required for most insurance plans)*

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

MENTAL HEALTH HISTORY *Please list any prior mental health treatment:*

Date	Doctor/Therapist	Location

MEDICAL HISTORY *List any known medical problems (including history or presence of infectious diseases):*

_____

_____

_____

_____

MEDICATIONS

CURRENT MEDICATION	DOSAGE	FREQUENCY

Medication Allergies: Yes No Please List: _____

Food/Substance Allergies: Yes No Please List: _____

Are there any special religious, spiritual, or cultural issues that may affect your treatment? If so, explain: _____

_____

Primary Care Physician: _____ Phone: (___) _____

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND/OR ALCOHOL AND DRUG ABUSE INFORMATION

Name of Patient: _____ DOB: _____

Address: _____

I (We) hereby authorize **Associates in Mental Health, SC (AiMH)**
900 Main Street, Suite 580 **Ph: 309-637-4266**
Peoria, Illinois 61602 **Fax: 309-637-9836**

☐ Karen M. Kyle, M.D. ☐ Matthew M. Preston, M.D. ☐ Baljit Singh, M.D. ☐ Hannah E. Morrissey, D.O. ☐ Ghassan Bitar, M.D.

☐ Christopher Holly, LCSW ☐ Edna Ng, LCSW, SAP ☐ Kendrick Bailey, LCPC ☐ Frandy Raso, LCSW ☐ Caleb Friedrich, LCSW ☐ Cristy Tomaszewski, LCSW

To ☐ Release ☐ Exchange ☐ Receive records or information as requested below:

Agency/Person to release/receive: _____

Address: _____

_____ Ph: _____ Fax: _____

Specific Nature of Information to be disclosed – Please initial or place check mark by each requested item:

_____ Initial Psychiatric History/Evaluation
_____ Psychological Reports/Evaluations
_____ Lab/X-ray//Test Results
_____ Consultations
_____ Other_____

_____ Progress Notes
_____ Complete Medical Record
_____ Financial Information
_____ Contact/Discuss Treatment and Progress
_____ All Information

For the purpose of: (Please check all that apply)

_____ Continuing (mental health/alcohol or drug abuse) treatment, care and continuity of care
_____ Therapist transition
_____ Other_____

_____ Billing and payment related matters
_____ Legal

This consent is **valid for one year from date signed** (unless otherwise specified). Other Date: _____

I understand that I may revoke this authorization by notifying AiMH at 900 Main St, Suite 580, Peoria, IL 61602 in writing of my desire to revoke release prior to its expiration except to the extent that action has already been taken by AiMH in reliance on the consent.

I understand that AiMH **may not condition treatment** or quality of care upon completion of this form. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization which will **prevent disclosure of information.**

I understand that AiMH may, directly or indirectly, receive remuneration from another party in connection with the use or release of disclosed information. I understand that I also will be charged for review and copying of records.

I understand that the information disclosed may be subject to re-disclosure by the person(s) receiving it and will no longer be protected by the federal privacy regulations.

I have read and understand the terms of this authorization and release and have had an opportunity to ask questions about the use and disclosure of my mental health information. By signature, I knowingly and voluntarily authorize AiMH to use or disclose my health information in the manner described above.

_____/_____ _____/_____
Patient Signature Date Witness Date

_____/_____ _____/_____
Parent/Legal Guardian Signature Date Witness Date

NOTICE TO PATIENT AND RECEIVING AGENCY:
Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be disclosure of any of the information provided pursuant to this release unless the patient and/or parent of the patient specifically authorizes such disclosure.

Associates in Mental Health, S.C.

Established 1981

Baljit Singh, MD
Matthew M. Preston, MD
Hannah E. Morrissey, DO
Ghassan Bitar, MD
Christopher P. Holly, MSW, LCSW
Edna Ng, LCSW, SAP, PCGC
Kendrick J. Bailey, LCPC
Frandy S. Raso, LCSW
Caleb H. Friedrich, LCSW
Cristy L. Tomaszewski LCSW

AUTHORIZATION FOR APPOINTMENT REMINDER SERVICE

Name of Patient _____DOB_____

Address_____

I hereby authorize Associates in Mental Health to contact the below selected in order to remind me of upcoming appointments.

PLEASE CHECK:

☐ Telephone: _____

☐ Text: _____

☐ Email: _____

☐ I elect not to receive an appointment reminder

If the above number/address changes, I understand that it is my responsibility to contact Associates in Mental Health and change my information so it does not get delivered to an unauthorized party.

Associates in Mental Health schedules appointments by a block of time for each patient. **If you are unable to attend your scheduled appointment, we reserve the right to charge the full office fee for any late notice cancellations or missed appointments.** Your insurance will generally not cover this charge. If you have any questions regarding this policy, please discuss them with your clinician.

I understand that only information regarding my future appointments will be delivered, and that my information will not be given to any third party.

_____/_____ _____/_____
Patient/Legal Guardian Signature Date Witness Signature Date

Associates in Mental Health, SC

Consent for Release and Use of Confidential Information And Receipt of Notice if Privacy Practices

I, _____, (name of patient or legal or personal representative), hereby give my consent to Associates in Mental Health, SC (AiMH) to use or disclose for the purpose of carrying out treatment, payment or healthcare operations, some basic information contained in the patient record of _____ (patient's name).

I understand that by law and professional ethics, what is shared in psychotherapy remains confidential unless permission has been given to share it, or except as the law or my managed care company requires.

I consent to the release of basic/identifying information and the amount of the unpaid balance to a collection service or an attorney for purposes of collecting a debt if this becomes necessary.

I understand and consent to the release of information about my condition and care (including access to my chart) to the managed care company for their review for purposes of payment or quality assessment. If seeing a therapist as opposed to a psychiatrist, I understand that some insurance companies require the therapist be supervised by a psychiatrist. I understand the supervision will involve a review of the treatment plan and confidential discussion of my progress.

I understand and consent to the release of information about my condition and care (including access to my chart) to all the providers, both doctors and therapists, of AiMH. I understand that they provide on-call coverage for each other as well as for continuity of care should I see multiple providers within AiMH.

I acknowledge that Associates in Mental Health's Notice of Privacy Practices and consent to the uses and disclosures therein.

I understand that Associates in Mental Health reserves the right to change the privacy practices described and that a copy of any Revised Notice will be made available to me at my next visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent by giving written notice of my desire to do so to my provider. I also understand that I will not be able to revoke this consent in cases where the provider has relied on it to disclose my health information.

Signed: _____ Date: _____

By signature below, I consent and understand that a courtesy letter will be sent to my primary care physician to aid in the continuity of my care.

Primary Care Physician: _____ Phone: _____

Practice Name: _____

Address: _____

Signed: _____ Date: _____

*If you have no primary care physician or do not wish to disclose this information to your primary care physician, please sign here.

_____

Associates in Mental Health Consent for Treatment & Financial Policy

TREATMENT

You and you clinician will work together to identify goals and options. The length of time in treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problems you are experiencing so that your clinician can better assist you in treatment planning. Your clinician will inform you about treatment options and will include potential benefits and risks associated with those options. You do have the right to refuse treatment. As mental health treatment is an inexact science, no guarantees can be made as to the success of such treatment.

PAYMENT POLICIES

We accept cash, personal checks, debit cards, MasterCard, Visa, American Express and Discover. Payment of copays and deductibles are due at the time of service.

Associates in Mental Health schedules appointments by a block of time for each patient. **If you are unable to attend your scheduled appointment, we reserve the right to charge the full office fee for any late notice cancellations or missed appointments.** Your insurance will generally not cover this charge. If you have any questions regarding this policy, please discuss them with your clinician.

As insurance is a contract between you and your insurance carrier, you are ultimately responsible for payment of all charges. You must provide proof of insurance at the time of your initial visit and are responsible for providing this office with changes in insurance coverage. Failure to do so may result in denial of you claim. As a matter of courtesy to our patients, we will submit charges to your insurance company. Any amount that your insurance company will not be paying such as co-pay or deductible is due from you at the time service is rendered. If your insurance company has not paid within sixty days or denies coverage, the balance will be billed to you for immediate payment. **If you do not have insurance, payment in full is required at the time of service.** If there are any problems with meeting your financial obligations, please speak with your clinician.

Some managed care companies require the patient to get **PRIOR** approval and an authorization for their visit. If you fail to get necessary prior approval for your visit, payment in full is required at the time of service.

If someone other than the patient, or the parent/legal guardian who is bringing the patient to the initial appointment and that person is not responsible for the account balance, then legal documentation **MUST** be provided in order for us to send statements to the responsible party.

If a patient's bill remains unpaid, Associates in Mental Health reserves the right to provide your name, basic identifying information and the amount of the unpaid balance to collection services or an attorney.

ASSIGNMENT OF BENEFITS

Insurance Authorization/Release: By signature below, I hereby authorize Associates in Mental Health to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to Associates in Mental Health for any and all services rendered.

Medicare Authorization/Release: By signature below, I request that payment of authorized Medicare benefits by made on my behalf to Associates in Mental Health for any and all services rendered to me by their providers. I hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

My signature below indicates that I have read and understand the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required to process claims and benefits to which I am entitled.

Patient Signature: _____ Date: _____

Patient Name Printed: _____ DOB: _____

On behalf of a minor child or guardian:
Responsible Party: _____ Date: _____

Associates in Mental Health, SC

NOTICE OF PRIVACY PRACTICES

THIS 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.

This Notice describes the privacy practices of Associates in Mental Health, SC (AIMH) and all business associates with whom we may share your protected health and medical information. We provide the Notice of Privacy Practices to every patient we have a direct treatment relationship with after the September 23, 2013 effective date. This Notice is also available to any member of the public and is posted within our reception area. Every effort will be made to obtain a signed Receipt of Notice of Privacy Practices from each patient that will be kept on file. If the patient refuses to sign the form, it will be noted that the Notice was given but the patient refused to or could not sign the Receipt.

We understand that your medical or PHI ("protected health information") is confidential and we are committed to maintaining its privacy. Federal law requires that we provide you with this Notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice when we use or disclose your PHI and are also required by law to notify you if you are affected by a breach of your secured PHI.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION OR PHI ABOUT YOU

Treatment Purposes. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. In addition, we may contact individuals through telephone, mail and email with appointment reminders and may utilize facsimile transmissions for specific authorizations and prescription refills through pharmacies. We may also disclose your PHI to other providers involved in your treatment.

Payment Purposes. We may use and disclose PHI to obtain payment for the treatment services provided. For example, we send PHI to Medicare, Medicaid, your health insurer, HMO, or other company or program that is to pay for your health care so they can determine if they should pay the claim. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

Health Care Operations. We may also disclose PHI to other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, and peer review. We may share your PHI with third parties that perform various business activities such as an outside billing company, appointment reminder service or electronic practice management vendor provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Disclosure to Family, Close Friends and Other Caregivers. In an emergency situation, we may disclose PHI to those involved in a patient's care when the patient approves or, when the patient is not present or not able to approve, when such disclosure is deemed appropriate in the professional judgment of the practice or such as necessary. When the patient is not present, we determine whether the law requires the disclosure of the patient's PHI, and if so, disclose only the information directly relevant to the person's involvement with the patient's health care.

Disclosures Required by Law. As a behavioral health provider, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. However, we may also use or disclose PHI about you without your prior authorization, subject to certain requirements and as required by law.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If PHI is disclosed for this reason, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. We may disclose PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Health Oversight Activities. We may use and disclose your PHI to state agencies and federal government authorities when required and as authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control. We may use and disclose your PHI in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs.

Judicial and Administrative Proceedings. We may use and disclose your PHI in judicial and administrative proceedings such as pursuant to a subpoena, court order, administrative order or similar process. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement. We may use or disclose PHI to law enforcement to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Specialized Government Functions. We may review requests from US military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Dept of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Work-Related Injuries. We may use or disclose PHI to an employer to evaluate work-related injuries.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm or to provide treatment in an emergency situation. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Uses and Disclosures Required by Law – DO NOT APPLY TO PRACTICE. We may disclose information as required by law for the following purposes although generally these do not apply to AIMH: **marketing and research studies; fundraising; coroner or medical examiner and funeral directors for death certificate; disclosures to facilitate organ, eye and tissue donations.**

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

For any purpose other than the ones described above, we will only use or disclose your PHI when you give us your written authorization. For instance, we will obtain your written authorization before we send your PHI to your employer or health plan sponsor, for underwriting and related purposes for a life insurance company or to the attorney representing the other party in litigation in which you are involved.

Highly Confidential Information. Federal and Illinois law requires special privacy protections for highly confidential information about you. Highly Confidential Information consists of PHI related to: psychotherapy notes; mental health and developmental disabilities services; alcohol and drug abuse services; HIV/AIDS testing, diagnosis or treatment; venereal disease(s); genetic testing; child abuse and neglect; domestic abuse of an adult with a disability; or sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS REGARDING YOUR PHI

Right to Receive an Accounting of Disclosures. You have the right to request an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization. If you request an accounting more than once during a twelve (12) month period, we will charge you $25. A request for disclosures must be made in writing to the Privacy Officer.

Right to Inspect and Copy Your PHI. You have a right to inspect or get a copy of your medical record file and billing records maintained by us. In some circumstances, we may deny you access to a portion of your records. If you desire access to your records, submit your request in writing to the Privacy Officer. A reasonable fee, not to exceed limits allowed under Illinois law, will be charged for the copying and mailing.

Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please submit your request in writing to the Privacy Officer. We are not required to agree with your request to amend.

Right to Request Restriction of Disclosures. You may submit a request in writing to the Privacy Officer to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Receive Confidential Communications. We accommodate all reasonable requests to keep communications confidential and to allow you to receive your PHI by alternative means of communication or at alternative locations. A request for confidential communications must be in writing, must specify an alternative address or other method of contact and must provide information about how payment will be handled. The request should be submitted to the Privacy Officer. We will determine the reasonableness based on the administrative difficulty of complying with the request. We will reject a request due to administrative difficulty if no independently verifiable method of communication (such as a mailing address or published telephone number) is provided for communications; or if the requestor has not provided information as to how payment will be handled.

Authorization. We obtain written authorization from a patient or a patient's representative for the use or disclosure of PHI for reasons other than treatment, payment or health care operations. We will not, however, get an authorization for the use or disclosure of PHI specifically allowed under the Privacy Rule in the absence of an authorization. We do not condition treatment of a patient on the signing of an authorization, except disclosure necessary to determine payment of claim (excluding authorization for use or disclosure of psychotherapy notes); or provision of health care solely for the purpose of creating PHI for disclosure to a third party (pre-employment or life insurance exams). A specific written authorization is required to disclose or release mental health treatment notes, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

Right to Revoke Your Authorization. You have the right to revoke your written authorization, except to the extent that we have taken action in reliance upon it, by submitting your request in writing to the Privacy Officer.

Effective Date and Changes to this Notice. This Notice is effective September 23, 2013. We reserve the right to revise this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new Notice. Any new Notice will be posted in the reception area of Associates in Mental Health.

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of the breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this Notice which may be obtained by contacting the Privacy Officer.

For Further Information or Complaints. If you have questions, are concerned that your privacy rights have been violated, or disagree with a decision made about access to your PHI, you may contact our Privacy Officer who serves as the contact person for all issues related to the Privacy Rule. Complaints must be addressed to the attention of the Privacy Officer at Associates in Mental Health, 900 Main Street, Suite 580, Peoria, IL 61602; telephone (309) 637-4266. Written complaints may also be filed with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, D.C. 20201. Complaints must name the practice, describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time you became aware or should have become aware of the violation. We will not retaliate or take any adverse action against you if you file a complaint.

Associates in Mental Health, SC.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient's Last Name	Patient's First Name	Patient's DOB

By signing below, I hereby acknowledge receipt of Associates in Mental Health's Notice of Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

Signature of Patient (Legal or Personal Representative)	Date

Signature of Parent/Guardian/Legal or Personal Representative	Date

(Please indicate your legal authority to act for this patient) _____

_____ Patient Refuses to Acknowledge Receipt:

Signature of Staff Member	Date