# NEW PATIENT REGISTRATION FORM

**Child, Adolescent or Adult under 26 years of age using Parent's Insurance**

**PATIENT INFORMATION (Please Print)**

Name: _____ Birthdate: _____
(Last) (First) (Middle) (Month/Day/Year)

Address: _____
(Street or PO Box) (Apt) (City, State) (Zip)

Home Telephone Number: (_____)-_____ OK to Call? (Y/N) Sex: _____M _____F
OK to leave message? (Y/N)

Cellular or Other Number? (_____)-_____ E-Mail: _____
OK to Call? (Y/N) OK to Leave Message? (Y/N) OK to leave E-mail message? (Y/N)

Social Security Number: ____-___-_____ Grade in School: _____

Who Does Patient Live With? _____

If Patient is an Adult:
Place of Employment: _____ Occupation: _____

**PARENT/GUARDIAN INFORMATION**

**Father's Name**: _____ Birthdate: _____
(Last) (First) (Middle) (Month/Day/Year)

Father's Address: _____ Social Sec.#_____
(Street or PO Box) (Apt) (City, State) (Zip)

Father's Employer: _____ Occupation: _____

Work Telephone Number: (_____)-_____ OK to Call? (Y/N)
OK to Leave Message? (Y/N)

**Mother's Name**: _____ Birthdate: _____
(Month/Day/Year)

Mother's Address: _____ Social Sec.#_____
(Street or PO Box) (Apt) (City, State) (Zip)

Mother's Employer's Name: _____ Occupation: _____

Mother's Work Number (_____) _____ OK to Call? (Y/N)
OK to Leave Message?(Y/N)

**EMERGENCY INFORMATION**

Emergency Number: (____)-_____ Name/Relationship: _____

**OTHER FAMILY INFORMATION** **(**Others in Family—if more room is needed, please list on back)

Name: _____ Birthdate: _____ Relation: _____ Live with you? (Y/N)
Name: _____ Birthdate: _____ Relation: _____ Live with you? (Y/N)
Name: _____ Birthdate: _____ Relation: _____ Live with you? (Y/N)

Patient Name: _____
Social Security Number: ____-___-_____
or Birthdate: _____

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I request that payments of benefits for any services rendered by Educational & Psychological services, Ltd. be made on behalf of my child, adolescent, or young adult to Educational & Psychological Services, Ltd. Medicare assignment of benefits applies.

PARENT OR GUARDIAN SIGNATURE: _____ Date: _____
Patient Signature: (Ages 13-25) _____`` Date: _____

**RELEASE OF INFORMATION TO INSURANCE COMPANIES**

If required, the undersigned agrees to release to his/her insurance company:

| | |
|---|---|
| Dates of Service | General Summary of Treatment Methods |
| Diagnosis | Progress as Required to Obtain the Authorization of Additional Sessions |
| Intake Finding | Discharge Summary |
| Treatment Goals | |

Your insurance company may also request to review your child, adolescent's or young adult's records for quality assurance. Failure to give authorization to release information may result in a denial of benefits by the insurance company.

PARENT OR GUARDIAN SIGNATURE: _____ Date: _____
PATIENT SIGNATURE (13-25): _____ Date: _____

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN, PSYCHIATRIS, OR CLINICIAN**

Name of Primary Care Physician, Psychiatrist, or Clinician: _____

Address: _____
(Street or PO Box) (City, State) (ZIP)

Telephone Number: (_____)-_____

I hereby authorize my therapist at Educational & Psychological Services, Ltd. to disclose to my Primary Care Physician, Psychiatrist, or clinician all clinical information about my child, adolescent or young adult as may be necessary to permit my physician/clinician to monitor my continuity of care and/or to prescribe medicine. I understand that this authorization may be revoked by me at any time in writing, and that I am entitled to a copy of this.

☐ **Yes** PARENT/GUARDIANE SIGNATURE: _____Date: _____
PATIENT SIGNATURE (13-25): _____ Date: _____

My clinician at Educational & Psychological Services, Ltd. has requested my consent to communicate with my Physician or Clinician to coordinate my child, adolescent, or young adult's care. I understand the risks to me if I refuse to permit such communication and release my therapist from all liability for any negative results from his/her inability to work with my physician/clinician to coordinate my care. With this understanding, I hereby deny consent to communicate with my Physician or clinician.

☐ **No** PARENT/GUARDIAN SIGNATURE: _____Date: _____
PATIENT (13-25): _____Date: _____

Patient Name: _____
Social Security Number: ____-___-_____
or Birthdate: _____

**CURRENT MEDICATIONS**: Please include all prescribed medications, all over-the-counter medications, and all vitamins and supplements your child, adolescent or young adult takes:

| Drug | Dosage | When Taken | Reason for Taking | Prescriber |
|---|---|---|---|---|
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**PHARMACY**: If your child or adolescent is prescribed a medication and needs to have a refill or you agree to have it submitted electronically, which pharmacy do you prefer we use:

Name: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Number: (_____)_____
(Area Code)

If your insurance company asks that you use a mail order pharmacy, please give us this information below:

Name of Mail Order Pharmacy: _____
Patient ID: _____
Telephone Number: ( ) _____-_____. FAX #: ( ) _____-_____

**ALLERGIES**: (Allergies your child or adolescent has to the environment, foods, drugs, etc):
_____
_____

Patient Name: _____
Social Security Number: ____-___-_____
or Birthdate: _____

## RIGHTS AND OBLIGATIONS AGREEMENT

Educational and Psychological Services offers educational and psychological evaluation and treatment. Our professional staff will work collaboratively with each patient to meet his or her needs and to provide the best method of treatment. Our treatment ensures that each patient has certain Rights and Obligations spelled out below:

**Confidentiality**: All progress notes, treatment plans, and testing reports/results become part of your chart. Although our staff will have access to your chart to provide needed clinical and clerical services, we will not release the information in the chart to anyone else without your written permission. Consultation is done on an as needed basis with other clinicians. When such consultation takes place, the patient's name or other identifying information is not provided. The patient's identity remains anonymous. In couple's or family therapy or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Clinicians will utilize their best clinical judgment when revealing any such information.

**Disclosure is Required by Law**: Disclosure is required when there is a reasonable suspicion of child, dependent or elder abuse or neglect. Disclosure is also required where a patient presents a danger to self, to others, to property, or is gravely disabled.

**When Disclosure May be Required**: Disclosure may be required pursuant to a legal proceeding. If a patient places his or her mental status at issue in litigation, the defendant may have the right to obtain his or her treatment records and/or testimony by his/her clinician.

**Health Insurance**: Disclosure of confidential information may be required by your health insurance carrier in order to process their claims or to authorize further treatment sessions. Only the minimum necessary information will be communicated to the carrier. Educational & Psychological Services has no control or knowledge over what insurance companies do with the information submitted.

**Emergency Coverage**: After office hours clinicians can be reached via our 24-hour answering service by calling our direct line (630) 527-6322. We ask you to respect our staff's need for free time and to call after office hours only in the event of an emergency. If your provider is not available when you call, every effort will be made to reach another clinician on the staff and to have him or her return your call. If time is crucial, you are asked to contact the DuPage County Crisis Hotline at (630) 627-1700 or go to your nearest hospital Emergency Room.

**Telephone and School Consultations**: Clinicians are normally available during office hours and will make every effort to return nonemergency telephone calls on a timely basis. Please remember, however, that each clinician must see regularly scheduled patients and fulfill other professional obligations. Therefore, time spent on telephone calls must be limited. Matters needing to be addressed that require more than 5 minutes should be handled in a regularly scheduled appointment and/or arrangements will be made to bill patients for such consultations. Many parents request a clinician's attendance at school staffings and consultations. Such time is not normally reimbursed by insurance companies and will be billed to the patient and/or his parent/guardian.

**Patient Initials:** _____
**Patient Signature:** _____ **Date:** _____
**(Patients aged 13 and Older)**

Patient Name: _____
Social Security Number: ____-___-_____
or Birthdate: _____

**Treatment Plans**: As a patient you have the right to review or to receive a summary of your records at any time except in limited legal or emergency circumstances when the clinician assesses that releasing such information might be harmful in any way. In such an instance, the clinician will provide the records to an appropriate and legitimate mental health professional of your choice or a session will be scheduled for the clinician to discuss with you the purpose, benefits, and possible consequences of such disclosure. If you wish to review your records, a session will be scheduled for that purpose. Patients are asked to discuss any concerns that they have about their treatment with their clinicians.

**Payment and Insurance Reimbursement**: Parents or guardians of patients are expected to pay deductibles or required co-pays prior to each session unless other arrangements have been made. Lengthy telephone sessions, school or other site visits, report writing, and/or consultation with other professionals will be charged at the normal fee unless indicated and otherwise agreed. It is your responsibility as a patient's parent or guardian to pay privately for any services not reimbursed by your insurance company and to verify the specifics of your coverage. You will also be billed for, and agree to pay, any bank charges and fees for returned checks (e.g., Insufficient Funds). You also agree that you are liable for any expenses we incur in collecting your bills such as charges for use of a collection agency, attorney's fees, and/or court costs. Payment arrangements can be made through our Office Manager.

**Requests for Medical Records:** If you wish your child or adolescent's medical record to be sent to another provider, you must:

1. Submit a signed letter of request to the Front Office and/or scan and e-mail a signed letter to practice@eandps.com. This letter of request must include:

Patient's Name and Date of Birth
Patient's Provider at Educational & Psychological Services
Patient's Current Address and Contact Phone Number
If Known: The Reason for Requesting the Record
If Patient's Age is 13 through 17: Patient and Witness Signatures
If Patient is 18 or older: Signature of Patient and of Parent/Guardian if Using Their Insurance

2. Complete a Release of Information Form (found on our website) or Obtained from the Receiving Provider's Office

Please allow 3 days for records to be reviewed and processed. Records requested for personal use must be picked up at our office or mailed to an address you provide. They will not be faxed or e-mailed.

**Requests for Family Medical Leave (FMLA) or Social Security or Other Disability Forms:** Please submit requests for these forms to be completed via an e-mail to practice@eandps.com or a letter mailed or Faxed to our Front Office.

Please allow us 5 days to process and complete such forms. If an appointment is needed for your child or adolescent prior to their completion, you will be contacted to schedule the appointment. If not, the Front Office will contact you when the forms are completed and can either be picked up or mailed to you.

**There is a $45.00 fee for completion of such forms to be paid upon completion.**

Parent or Guardian's Initials: _____; Patient Initials if Ages 13-25 _____

Patient Name: _____
Social Security Number: ____-___-_____
or Birthdate: _____

## PATIENT RIGHTS AND OBLIGATIONS AGREEMENT, Continued

**Requests for Other Medical, Health, or School Forms**: Requests for such forms for your child or adolescent should be submitted to the Front Office via e-mailed or a faxed or mailed letter. Requests will be reviewed and processed within 3 days unless an appointment must be scheduled to update services. If such an appointment is needed, you will be contacted to schedule the appointment.

The Front Office will contact you when the forms are completed and can be picked up or mailed.

**Charges for completion of such forms will not exceed $25.00 due upon completion.**

**Requesting Medication Refills:** Requests for medication refills for your child or adolescent not made during a scheduled appointment are to be made by:

Having your pharmacy fax are office (FAX #: 630.548.0982) for the requested refill. Please allow up to 48 hours to process and receive a response from the Front Office.

If your requests is being made to do a missed appointment, not having scheduled an appointment, or having lost or damaged your script/s, **you are subjects to a $20.00 processing fee**. This fee is to be paid before the office contacts the pharmacy.

There is no charge when the pharmacy must be contacted to correct a script error and/or if your provider requests a medication change before your next regularly scheduled appointment.

**Cancellation and Missed Appointments**: Time has been set aside for your child or adolescent's appointment. A minimum of 24-hours is required for the cancellation of an appointment. **A $75.00 fee will be charged for each late cancellation or missed appointment with a therapist; a $45.00 fee will be charged for each cancellation or missed appointment with a psychiatrist.** Most insurance companies do not reimburse for missed sessions. This fee may be waived if there are extenuating circumstances or you reschedule and keep an appointment later in the week.

**Termination**: Termination may take place for a variety of reasons. If your clinician assesses that he or she is not effective in helping your child or adolescent reach his or her therapeutic goals, s/he will discuss this with you and, with your permission, you will be given an appropriate referral. If at any time you feel that your work together is not benefiting your child or adolescent, it is expected that you will bring this issue to the clinician's attention and request to terminate or be referred to another clinician. Finally, failure to abide by the terms of the Rights and Obligations Agreement may result in termination.

**I have received and read this Agreement. I understand my Rights and Obligations and agree to be bound by this Agreement. I further understand that if I fail to abide by the terms of this Agreement, Educational & Psychological Services, Ltd. may terminate our relationship.**

**Parent or Guardian Signature: _____ Date: _____**
**Patient Signature (Ages 13 -25): _____ Date: _____**
**Staff Signature: _____ Date: _____**

Patient Name: _____
Social Security Number: ____-___-_____
or Birthdate: _____

## PAYMENT INFORMATION

**It is our office policy that in order to keep an Initial appointment:**

This Payment Information Page be completed and signed.

Any payment due is paid at the time of service; accepted forms of payment are cash, check, or credit card.

**We require your credit card information, however, we will only charge your credit card under the following circumstances:**

- Checks are returned for Insufficient Funds (Check amount plus $25.00)
- Co-payments or co-insurance payments required by your insurance company that were not paid at the time of service.
- Insurance deductible your insurance company did not pay.
- Scheduled appointments you missed, which you did not cancel or reschedule 24 hours prior to the appointment. This charge for "no show" sessions is $75.00 for therapists and $45.00 for psychiatrists.

**Your credit card will not be charged for any deductibles or co-payment until the amount of any deductible or co-payment is provided to Educational & Psychological Services, Ltd. by your insurance company.**

If your credit card is charged, you will be notified by phone the day of the charge. If you have not authorized us to telephone you, you will be notified by mail sent within 48 hours of the charge.

## CREDIT CARD INFORMATION

**I authorize Educational & Psychological Services, Ltd. to charge my credit card, when necessary, under the conditions described above:**

CREDIT CARD TYPE: AM EXP MC VISA DEBIT

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____

SIGNATURE: _____DATE: _____

Patient Name: _____
Social Security Number: ____-___-_____
or Birthdate: _____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this Notice. You may refuse to sign this acknowledgement if you wish.

**I acknowledge that I received a copy of Educational & Psychological Services Notice of Privacy Practices:**

Please Print of Your Name: _____
Signature: _____
Date: _____

**Patient's Name _____**
**Patient's Social Security Number or Birthdate: _____**

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices from _____, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)_____
_____
_____

Employee Signature: _____
Date: _____

*This form does not constitute legal advice and covers only federal, not state law*