

**NEW PATIENT INFORMATION FORM – ADULT**

**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)  
OK to leave message? (Y/N)

Cellular or Other Number? (\_\_\_\_)-\_\_\_\_\_ Sex \_\_\_\_M \_\_\_\_F

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_\_ Occupation: \_\_\_\_\_

E-Mail \_\_\_\_\_ Marital Status: \_\_\_\_\_

**EMPLOYER INFORMATION**

Employer Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street or PO Box) (City, State) (ZIP)

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

**EMERGENCY INFORMATION**

Emergency Number: (\_\_\_\_)-\_\_\_\_\_ Name/Relationship: \_\_\_\_\_

**SPOUSE/PARTNER INFORMATION**

Spouse/Partner Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(Month/Day/Year)

Spouse/Partner Employer: \_\_\_\_\_ Work Number: (\_\_\_\_)-\_\_\_\_\_

Spouse/Partner Social Security Number: \_\_\_\_ \_ Occupation: \_\_\_\_\_

**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)

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

Patient Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
or Birthdate: \_\_\_\_\_

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### INSURANCE AUTHORIZATION AND ASSIGNMENT

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

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

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### 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 records for quality assurance. Failure to give authorization to release information may result in a denial of benefits by the insurance company.

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

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### CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN OR PSYCHIATRIST

Name of Primary Care Physician or Psychiatrist: \_\_\_\_\_

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 or Psychiatrist all clinical information about me as may be necessary to permit my physician/psychologist 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** SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

My clinician at Educational & Psychological Services, Ltd. has requested my consent to communicate with my Primary Care Physician or Psychiatrist to coordinate my 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/psychiatrist to coordinate my care. With this understanding, I hereby deny consent to communicate with my Primary Care Physician or Psychiatrist

**No** SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

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### 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:** \_\_\_\_\_

Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
or Date of Birth \_\_\_\_\_

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**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:** 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 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.

**Cancellation and Missed Appointments:** Time has been set aside for your 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 you reach your 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 you, 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.**

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Clinician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Social Security Number  
or Birthdate: \_\_\_\_\_

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### 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.

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### 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: \_\_\_\_\_

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**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:** \_\_\_\_\_

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**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.*