

LivingRite

The Center for Behavioral Medicine

Welcome _____,
(Client First Name Only)

I will be with you momentarily. If you haven't already done so, please complete the attached intake packet. Many of the forms have backsides, so please make sure to fill them out and read them completely. I will be able to answer any questions you may have regarding the contents during our session.

Sincerely,

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- New Patient Registration Form -

Patient Information

Full Name: _____ Date of Birth: _____

Street Address: _____ City/State: _____

Zip Code: _____ Social Security Number: _____

Phone Number: _____ Email: _____

***May we contact you via email in regards to administrative actions? (i.e. scheduling changes, billing questions...)

Yes No

Employer: _____ Work Number: _____

Spouse/Significant Other Information

Name: _____ Date of Birth: _____

Street Address: _____ City/State: _____

Zip Code: _____ Social Security Number: _____

Phone Number: _____ Email: _____

Employer: _____ Work Number: _____

Secondary Party Payer Information

Name: _____ Date of Birth: _____

Street Address: _____ City/State: _____

Zip Code: _____ Social Security Number: _____

Phone Number: _____ Email: _____

Employer: _____ Work Number: _____

Relationship to Patient: _____

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Who referred you to our agency?

Name: _____ Agency: _____

Address: _____ City/State: _____

Zip Code: _____ Phone: _____

May we thank them for referring you to us? Yes No

Insurance Information

Insurance Company Name & Plan Name: _____

Street Address: _____ Phone Number: _____

Zip Code: _____ City/State: _____

Identification Number: _____ Group Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance Company Name & Plan Name: _____

Street Address: _____ Phone Number: _____

Zip Code: _____ City/State: _____

Identification Number: _____ Group Number: _____

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____

By signing the statement below, I am confirming that all of the above information that I have provided is accurate and up to date.

Signature

Date

Guardian (for individuals under the age of 18)

Date

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- Individual Patient Rights -

- 1. All patients have the right to inspect and copy their own protected health information (the medical record) on request, except for mental health records, which must be reviewed with a psychologist first. In cases where exposure to the record might be harmful to the patient, the psychologist may deny the request. If you request a copy of your psychiatric record, your provider will generally review the record with you. The provider may rarely have information in the chart that a patient should or could not read, but much may require explanation.*
- 2. Patients also have the right to amend or append their medical (or psychiatric) record. Physicians, and your provider, reserve the right to deny such a request if he or she believes that the information in the medical record is accurate, but in that case the patient request must still be attached to the medical record.*
- 3. Patients have the right to an accounting of all disclosures to other parties. This means that if you ask your provider for a list of whom he or she has released psychiatric information to, they will supply it to you.*
- 4. Patients have the right to have reasonable requests for confidential communications accommodated.*
- 5. You can give your provider written authorization for him or her to disclose your psychiatric information to anyone you choose, and you may revoke authorization in writing at any time. You can send a written complaint to the Secretary of US Department of Health and Human Services. Our staff can be contacted at 815.758.8400 and can provide you with the appropriate address upon request.*
- 6. Patients can file a complaint with LivingRite or with the Office of Civil Rights in the Department of Health and Human Services about any violation of the rights listed above. There will be no prejudice for filing such a complaint.*
- 7. Patients have the right to receive a written notice of privacy practices from providers and health plans.*

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~New Privacy Provisions and Changes ~

New HIPAA (Health Insurance Portability and Accountability Act) Privacy Standards were created to protect patients' health information when it is disclosed but also to facilitate the flow of medical information between providers. With other medical providers, billing, and for safety or security reasons, there is less protection of confidentiality than there used to be. However, in other areas, such as releasing psychotherapy records, there is more privacy protection. Please read the following so that you understand your rights as a patient as well as the new rules about patient confidentiality. Feel free to ask your behavioral health provider about privacy, confidentiality, or your psychiatric record.

- 1. Permission from the patient is no longer required for transfer of psychiatric and medical information between providers as long as only the necessary information is supplied. This means that if your primary care doctor, pharmacist, or emergency room physician calls to find out if you are in treatment, what the diagnosis is, or what medications you are on, your provider can convey this information if it is medically relevant to your treatment with them. In practice, your provider will almost always discuss this with you personally before or after the fact, depending on the urgency and depth of the request. If you think this might present a problem for you, please let your provider know ahead of time.*
- 2. Permission from the patient is no longer required for transfer of psychiatric information needed for business pertaining to insurance or payment as long as only the necessary information is supplied (usually the diagnosis and type of treatment, but perhaps more). In practice, many insurance companies still require you to sign the first insurance sheet for authorization. In general, providers at LivingRite will discuss any unusual requests for information from an insurance company with the patient first.*
- 3. Remember that if all the psychiatric records are requested, a treatment summary is usually given instead, except if the treatment consists solely of psychopharmacological treatment or brief medication visits. While brief medication visits fall under HIPAA guidelines, psychotherapy visits are specifically excluded, meaning authorization from the patient is still required for release of information in those notes and a summary is given in place of the record.*
- 4. The substance abuse records from alcohol and drug programs are exempt from any disclosure without patient permission. If you are admitted to a treatment program for substance abuse, be sure to sign a release for your behavioral health provider so he or she can talk to the other providers and obtain a discharge summary and lab data upon your discharge. Without this, your provider cannot obtain any information.*
- 5. Your provider may have to disclose some of your psychiatric information when required to do so by law. This includes mandated reporting of child abuse or elder abuse (this is not new).*
- 6. National security and public health issues. Your provider may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety, or public security.*

Psychotherapy Services & Office Policies

Welcome to LivingRite, The Center for Behavioral Medicine. We thank you for choosing us as your therapy provider. The following information is provided to make you more familiar with our office policies and conduct of psychotherapy. If you have any questions, please feel free to ask any of our providers and we would be happy to answer them for you.

1. Office Visits: *Once you have been assigned to a provider, you can expect the following:*

*The Initial Evaluation will last approximately 45-60 minutes. During this time you will be asked to fill out a series of forms unless you filled out the appropriate forms located on our website, and you will also have our office policies and procedures explained to you. You will also be able to learn about your rights to confidentiality and have any questions answered during this time. Please arrive approximately 10 minutes early to your first appointment to process the necessary paperwork. Please bring your insurance card so that we can make a copy for our files. After the initial evaluation, appointments are 45-50 minutes in length. We respect the time of all of our clients. Therefore, our providers do our best to start and end all appointments on time. We require a **24-hour notice** for cancellations or changes to your appointments. Messages can be left with your provider at any time. We will waive a late cancellation or one no-show per year if there is an emergency. After the second missed appointment or late cancellation, **you will be charged \$50.00 for each missed session or late cancellation.***

2. Office Location: *We are located at 1958 Aberdeen Ct. Suite 2, Unit 3 Sycamore, IL 60178. When arriving to your appointments, please inform the front desk of your provider's name and appointment time. Please know that all providers try to start and end appointments on time. We feel that your time is valuable and you deserve to be seen promptly. Please know that if you are arriving to an appointment late, we will still end your session on time and you be charged a full fee for that session.*

3. Professional Fees: *(Doctorate/Masters Level Therapists)*

\$235/\$195 Intake Session (60 Minutes)

\$140/\$115 Individual Therapy Session (45-50 minutes)

*\$100/\$80 ½ Therapy Session (25-30 minutes) *Certain Circumstances Only*

\$165/\$135 Couples/Family Session (45-50 minutes)

*\$195/\$160 Extended Therapy Session (75-80 minutes) * Certain Circumstances Only*

\$50/\$40 Group Therapy Session

\$50/\$50 Late Cancellation/No-Show Fee

*Co-payments are due at the time of the service unless other arrangements have been made in advance with your provider. Remittance in the form of cash, credit/debit and check can be made payable to LivingRite. We now accept Visa, MasterCard, Discover and American Express. Payments are also accepted online at www.LivingRite.org. **All returned checks will result in a charge of \$25.00.***

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4. Using Insurance: If you will be using your insurance it is important for you to know your benefits before you come in for an initial office visit and if your therapy requires authorization by a managed care company. Both yourself and LivingRite will both receive a letter stating what has been authorized. If your provider is contracted with your insurance company, LivingRite will file the claim on your behalf. You will be responsible for your co-pay and services that are not covered by your insurance company. Please note that benefit quotes are not a guarantee of payment. We will not know your actual coverage until we receive payment from your insurance provider. However, in most cases, quotes made by the insurance companies reflect a fairly accurate description of coverage. You can find out these details by contacting your insurance company using the customer service number on the back of the card. **If your provider is not in network with your insurance company,** you may be expected to submit a claim on your own behalf. If you do, however, payment is expected in full to the provider at the time of each service. Your insurance company will then reimburse you for the covered amount. Often, there is a yearly maximum on either the number of visits or the amount paid for psychiatric services, unless your plan has a parity clause. A parity clause means that psychiatric illnesses with a biological cause (most depressions, many anxiety disorders, bipolar disorder, and some other illnesses) are covered as long as medically necessary without a yearly maximum, just like any other medical illnesses.

5. Confidentiality: Your confidentiality is protected by federal HIPAA and the Illinois Mental Health Law. Your records and information about your therapy can only be released with your written permission. Exceptions to this rule include current abuse of a child or elderly person, imminent threats of harming yourself or another person, and in rare circumstances, a court order. If you are involved in litigation, it is our office's policy to not be involved. If you believe there will be or might be any legal ramifications to your case, please let your provider know so he or she can discuss this with you before starting treatment. If this is something you are seeking, please notify the office and we will make appropriate referrals. LivingRite submits insurance claims electronically and we understand that this system is secure and HIPAA compliant. We do all of our own billing and your provider is responsible for scheduling your appointments with you. Your provider is the only one who has access to your records, and our billing staff is only given information required for billing purposes as allowed by HIPAA. Providers at LivingRite sometimes obtain consultation for their cases. Specific information is exchanged in meetings, but will not go beyond the consultants. If you do not want any of your records or information released, you have the option of paying for your treatment privately and not having anything sent to your insurance company.

6. Coverage: If your provider is out of town, the name and number of the covering behavioral health provider will be provided to you. Usually the covering provider is indicated during your first visit. They too will act according to the policies outlined above.

7. Phone Calls: If you leave a message your call will be returned as soon as possible. This usually means that your provider will contact you during office hours. If you have a situation that requires more urgent attention, please discuss with your provider appropriate contact options. We do not provide 24-hour emergency care. Therefore, we expect that in life-threatening emergency situations you leave a message for your provider discussing the nature of your status as well as **call 911** or go to the nearest emergency room for assistance. You

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may also call the 24 hour hotline, **(800) SUICIDE**, if you have a **life-threatening emergency** and are unable to reach your provider. If your therapist is out of the office for an extended period of time, you will be given the name and telephone number of the covering provider.

8. Notification to Primary Care Physician (PCP) is requested by many insurance companies to coordinate treatment. Please be prepared to bring the name, address and telephone number of your PCP to the first office visit. You may authorize a release of information to your PCP and insurance company at the time of the first visit to coordinate this care.

9. Our Philosophy of Care: At LivingRite we believe that change occurs from the guidance and support of a qualified, caring provider and active participation from the client. We believe that most individuals will experience some type of life event during their lifespan that requires therapeutic intervention. Therefore, we do not treat our clients as “patients,” but as active participants in their own recovery. You will be cared for and respected by a treatment team that is educated in the latest interventions and treatment options, therefore assisting you toward optimal wellness.

***We look forward to providing you with quality care that is based on the most empirically validated treatments in the field of behavioral health. It is our mission to provide a safe and welcoming environment that awards itself to continued growth and change. Again, we would like to welcome you to our practice and hope that you have found the support and guidance that you deserve!**

Informed Consent to Treatment Form

I consent to take part in treatment at LivingRite, The Center for Behavioral Medicine. I have received and read the **Intake Information** packet explaining psychotherapy practices and office policies, privacy policies, fees for services and other policies, and agree to its terms.

I have received and read the **Privacy Policies** form as required by the Health Insurance Portability and Accountability Act. I will ask for an explanation and clarification of any part of the **Intake Information** packet or **Privacy Notice** I do not understand.

I understand that **I am responsible for my bill**. While LivingRite, The Center for Behavioral Medicine will assist me in pursuing insurance reimbursement, I understand that unpaid bills will become my responsibility and that failure to make payment within 90 days may result in turning my account over to a collection agency along with accruing additional fees. I understand that insurance covers psychological testing services very inconsistently, and that LivingRite, The Center for Behavioral Medicine will do their best to verify in advance if the cost of psychological testing will be covered, but in general I understand that I should expect to pay out-of-pocket for psychological testing not covered by my insurance company. Additionally, I understand that LivingRite, The Center for Behavioral Medicine may elect to end treatment if timely payment for services is not made.

I understand that I will be charged \$50 for failing to show or failing to give at **least 24 hours' notice when canceling an appointment**. I understand that insurance companies cannot be billed for this fee and therefore this fee will be my responsibility.

If I am electing to use my insurance benefits, I authorize the release of necessary information to my insurance company so that LivingRite, The Center for Behavioral Medicine, acting as my agent, may pursue payment for the services provided to me. I authorize insurance payments to be sent directly to LivingRite, The Center for Behavioral Medicine.

Client Signature (Parent signs for clients under the age of 12 years old) Date

If the client is between 12 and 18 years old, client and parent/guardian signature is required Date

Other Family Member Date

LivingRite, The Center for Behavioral Medicine has my permission to keep the **Credit/Debit Card** below on file:

Credit Card Type: Visa MasterCard Discover American Express

Card Number: _____ Expiration Date: _____

Cardholder Signature: _____ Date

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Please check the box next to the following documents to confirm that you have received, read, understood and had any questions answered regarding their content, and sign your name below;

- New Patient Registration Form*
- Informed Consent to Treatment Form*
- Psychotherapy Practices & Office Policies Form*
- Privacy Policies Form*
- Individual Patient Rights Form*

Signature

Date

Guardian (if under 18 years of age)

Date

Witness

Date

LivingRite Psychological History Questionnaire

Client Information

Client Name: _____ Date of Birth: _____

Gender: _____ Religious Affiliation: _____ Race/Ethnicity: _____

Marital Status: Never Married Married Domestic Partnership Separated Divorced Widowed

I live with: Spouse/partner Parents Friend(s) Children Siblings Alone Other: _____

Spouse / Significant Other Information

Name: _____ Date of Birth: _____

Home Phone: _____ Alternate Phone: _____

Educational / Employment History

What is the highest level of schooling that you have achieved? _____

Are you currently in school? Yes No If yes, what grade level? _____

Please list your current or most recent school that you attended: _____

Present job: _____ Employer: _____

Length of time at present job: _____ Level of job satisfaction (1 – 10): _____

Work History: _____

General Health History

How would you rate your current physical health? Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are experiencing: _____

How would you rate your current sleeping habits? Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are experiencing: _____

How would you rate your appetite recently? Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are experiencing with your appetite/eating patterns: _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Do you experience disability or functional limitations due to your health problems? Yes No

If yes, please explain: _____

Please list any current medications (name of medication, dosage, prescribing physician): _____

Please list any family history of health problems of which you are aware: _____

Mental Health / Substance Use History

Have you previously received any type of mental health services (e.g., psychotherapy, psychiatry)? Yes No

If yes, please list dates of services and previous practitioner(s), as well as problem treated: _____

Have you ever been admitted to the hospital for mental health or addiction issues? Yes No

If yes, please list dates and locations of admission: _____

Have you ever received a psychiatric diagnosis? Yes No

If yes, please explain: _____

Are you currently taking any psychiatric medication? Yes No

If yes, please list (name of medication, dosage, prescribing physician): _____

Have you EVER been prescribed psychiatric medication? Yes No

If yes, please list and provide dates: _____

Please list any family history of mental health problems of which you are aware: _____

Please describe your use of substances over the past year (includes alcohol, illegal drugs, caffeine, tobacco, and misuse of prescription medications): _____

Have you experienced a recent increase in your use of alcohol and/or other substances? Yes No

Do you, your family, or your friends see your current usage as a problem? Yes No

If yes, when did it become problematic? _____

Current Areas of Concern

Have you recently been experiencing any of the following? (*Mark all that apply*)

- | | | |
|---|--|--|
| <input type="checkbox"/> Feeling sad/down | <input type="checkbox"/> Excessive fears | <input type="checkbox"/> Change in eating patterns |
| <input type="checkbox"/> Too much energy | <input type="checkbox"/> Feeling worthless or guilty | <input type="checkbox"/> Temper outbursts/Aggression |
| <input type="checkbox"/> Decreased interest in activities | <input type="checkbox"/> Feeling judged by others | <input type="checkbox"/> Agitation/being upset |
| <input type="checkbox"/> Being overly irritable | <input type="checkbox"/> Decreased ability to concentrate | <input type="checkbox"/> Relationship difficulties |
| <input type="checkbox"/> Decreased enjoyment | <input type="checkbox"/> Feeling uncomfortable around others | <input type="checkbox"/> Being overactive |
| <input type="checkbox"/> Feeling on top of the world | <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Being impulsive |
| <input type="checkbox"/> Significant weight change | <input type="checkbox"/> Unpleasant thoughts about an event | <input type="checkbox"/> Losing things |
| <input type="checkbox"/> Engaging in risky behavior | <input type="checkbox"/> Thoughts of death | <input type="checkbox"/> Losing track of time |
| <input type="checkbox"/> Change in sleeping patterns | <input type="checkbox"/> Obsessive or intrusive thoughts | <input type="checkbox"/> Being disorganized |
| <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Feeling disconnected from oneself |
| <input type="checkbox"/> Feeling restless, or slowed down | <input type="checkbox"/> Suicidal thoughts/behaviors | <input type="checkbox"/> Having feelings of unreality |
| <input type="checkbox"/> Feeling worried a lot | <input type="checkbox"/> Homicidal thoughts/behaviors | <input type="checkbox"/> Seeing or hearing things others don't |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Withdrawal, isolation | <input type="checkbox"/> Feeling excessively tired |
| <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Using alcohol, drugs, cigarettes | <input type="checkbox"/> Other: _____ |

Please explain how these problems are currently interfering in your life: _____

If you marked "Suicidal thoughts/behaviors," or "Homicidal thoughts/behaviors," please answer the following:

Are you presently suicidal or homicidal? Yes No

Have you attempted to commit suicide or homicide in the past? Yes No

If yes, how? _____

Is there a history of suicide in your nuclear and/or extended family? Yes No

Are there any other risk-taking or self-harming behaviors that you engage in? Yes No

If yes, please explain: _____

Please describe the history of these behaviors or thoughts:

Please describe any significant life changes or stressful events you have experienced recently: _____

Please describe your current financial situation: _____

Relationship History

Are you currently in a romantic relationship? Yes No If yes, for how long? _____

Level of relationship satisfaction (1 – 10): _____

Currently married? Yes No If yes, date of marriage: _____

Previously married? Yes No

If yes, please give name of ex-spouse(s) and date(s) of previous marriage(s): _____

History of marital problems (current or past): _____

Who can you count on for support? *Check as many as apply.*

- Parents Spouse Siblings Extended Family Employer Church Pastor Co-worker Neighbor(s)
- Close Friend Self-help Group Community Services Therapist Medical Doctor

List close friends, outside of family, if any: _____

Developmental History

Please list all individuals present in the home during your childhood/adolescence: _____

What was your birth order? I was the ____ out of ____ children. Who primarily raised you? _____

How would you describe your childhood? Traumatic Painful Uneventful Good Happy

Did you have any unusual or traumatic experiences as a child?

- Physical Abuse Mental Abuse Verbal Abuse Sexual Abuse Neglect Other None

If yes, please explain: _____

Were there any significant changes/losses in your family while growing up?

If yes please explain: _____

Are all you immediate family members still living? Yes No

If no, please indicate the date and cause of death of each family member:

Have you ever been the perpetrator of abuse, neglect, or violence toward another person? Yes No

If yes, please explain: _____

Legal History

Have you ever been arrested? Yes No If yes, what were the charges? _____

Do you have any current legal charges pending? Yes No If yes, please explain: _____

Miscellaneous

Are there any other things that would be helpful for your therapist to know about you? _____

What would you like to accomplish out of your time in therapy? _____

Client Signature: _____

Date: _____

Read and Reviewed by: _____
(Clinician)

Date: _____