Full Advocate Behavioral Health Services

10540 S. Western, Suite 402
Chicago, IL 60643
VM: (773) 509--5055
Fax: (773) 509-5010

PATIENT INFORMATION

Name_____ D.O.B._____

Address_____

Phone (home) _____ (Cell/work) _____

Marital Status: (check one)

☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Partnership ☐ Widowed

Employment Status: (check one)

☐ Full-time ☐ Part-time ☐ Unemployed

Occupation: _____

How were you referred? _____

Have you been in counseling/therapy before? _____

If yes, when and where? _____

_____

Have you ever been hospitalized for psychological reasons? _____

If yes, when, where, and for how long? _____

_____

Are you currently taking any medication(s), please be specific: _____

_____

Prescribing doctor: _____ For Treatment of: _____

Please describe your reasons for seeking counseling at this time:

Primary Concerns (check all that apply):

☐ Anxiety
☐ Depression
☐ Anger/aggression
☐ Painful Memories
☐ Trauma
☐ Confusing Thoughts
☐ Chronic Illness/pain
☐ Nervous Tension
☐ Drug/Alcohol abuse Trouble at work
☐ Sleep problems
☐ Sexual issues
☐ Food/Body image
☐ Friendship conflicts
☐ Intimate/Partner issues
☐ Family Concerns
☐ Sexual Orientation
☐ Finding Balance
☐ Time Management
☐ Acculturation problems
☐ Academic problems

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Insurance Information

Name: _____

Name of Health Insurance Co.:_____

Insured's Name:_____

ID#_____ Plan_____

Group:_____ Effective Date:_____

Insured's D.O.B._____ SSN#:_____

Insurance Mailing Address _____

_____

Insurance Phone _____ Fax_____

Relationship to Insured _____

Do you have any other health insurance policy in effect? _____
(If yes, please use another sheet to provide complete information)
Have you met your annual insurance deductible? ☐ Yes ☐ No

I hereby authorize Full Advocate to release any and all information to the above insurance carrier to their representatives for the purpose of claims administration and evaluation, utilization review and financial audit.

_____ _____
Patient's Signature (Guardian) Date

_____ _____
Witness Date

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ACKNOWLEDGEMENT STATEMENT AND AGREEMENT

Insurance Disclaimer

Most insurance companies require its members to pay a monthly premium; copayment for office visits, an annual deductible, and in some cases a co-insurance payment. This document attempts to explain these terms so that you can better understand your financial obligations as it relate to services being rendered.

Monthly Premium - Is a monthly payment that you pay either through your employer or if you are on Medicaid this is paid through the State. If you buy your insurance through the health insurance exchange then you are responsible for ensuring that the monthly payments. If this payment is not made, your insurance will lapse.

Copayments for Office Visits – Most insurance companies have a copayment for office visits. This is different from co-insurance in that the copayment is established as part of the members' insurance package.

Annual deductible – Most insurance companies require its members to pay an out-of-pocket annual deductible. It is important for you to know what your annual deductible is and whether you have met that annual deductible because if you have not met this deductible then the insurance company will not pay out for claims that providers put in for services they have rendered. **If you have not met your deductible all or part of the claim submitted by the provider will be your responsibility.**

Co-Insurance – Most insurance companies have a co-insurance portion. Co-insurance is determined (in most cases) after the annual deductible has been met. After the annual deductible has been met most insurance companies will pay a percentage of the claim (usually 85 to 90 percent of the claim); the remaining percentage is the member's responsibility.

There are at least four financial obligations that the member is responsible for paying. Please contact your insurance company to find out what your obligations are. If these obligations are not met, you will be responsible for part or the entire bill depending your circumstance.

IF YOU CAN NOT MAKE YOUR APPOINTMENT PLEASE CALL AND RESCHEDULE

I have read the above policy regarding missed appointments and tardiness to sessions:

Date: _____

Print Name: _____

Signature: _____

Legally Authorized Representative (if applicable) _____

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Consent for Treatment

Patient's Name_____ D.O.B_____

Patient's Address_____ APT_____

City_____ State_____ Zip code_____

Telephone_____ In case of emergency_____

Name of person to contact in case of emergency_____

Address_____ Relationship_____ Phone_____

HMO _____ Effective _____ HMO#_____

I the undersigned hereby acknowledge that I have voluntary requested the Medical/ Health care services of Full Advocate, and further consent to any and all Medical procedures and / or treatment which is deemed basically necessary by the attending physician and/ or other Health care professionals.

<u>Release of Medical Information</u>

I hereby authorize Full Advocate to release to insurance companies or other Health Care Facilities, medical information for processing and sustaining my health care claims and to request release of medical records from the Health Care Providers.

Date_____

Signature_____ Witness_____
Patient or Legal Guardian

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Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of this office's Notice of Privacy Practices.

Date: _____

Print Name: _____

Signature: _____

Legally Authorized Representative (if applicable) _____

For Office Use Only

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

- _____ Individual refused to sign.
- _____ Communication barriers prohibited obtaining the acknowledgement.
- _____ An emergency situation prevented us from obtaining acknowledgement.
- _____ Other (Please Specify)_____

Witness: _____

A copy of this document must be maintained in the patient's medical record.

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Notice of Privacy Practice

Full Advocate Behavioral Health Services is committed to protecting your privacy. This privacy statement explains data collection and use practices of Full Advocate BHS. By signing the Acknowledgement of Receipt of Notice of Privacy, you are consenting to the information collection and use practices described in this privacy statement.

Data Collection and Uses

The collection of health and mental health history is important for the development of appropriate behavioral health services; this is part of the initial and ongoing assessment process. The information collected will be used in developing a treatment plan, transitional services related to discharge aftercare planning, continuity care related to medical and specialty consultation with other providers, and referral and linkage to additional services recommended by Full Advocate BHS providers. Your information will not be disclose unless you were informed of the reason(s) for the disclosure and written consent to release information if given by you. Illinois and Federal law prohibits the release of your personal and medical information without your consent. Federal and State laws allow for certain circumstances for disclosure without consent.

Changes to this Statement

We may occasionally update this privacy statement. When we do, we will also revise the "last updated" date at the top of the privacy statement. For material changes to this privacy statement, we will notify you by directly sending you a notification. We encourage you to periodically review this privacy statement to stay informed about how we are helping to protect the personal information we collect. Your continued use of the service constitutes your agreement to this privacy statement and any updates.

The Privacy Rule: The Privacy Rule took effect on April 14, 2003, with a one-year extension for certain "small plans." It establishes regulations for the use and disclosure of Protected Health Information (PHI). PHI is any information about health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted rather broadly and includes any part of a patient's medical and mental health record or payment history.

Full Advocate BHS must disclose PHI to the individual within 30 days upon request. They also must disclose PHI when required to do so by law, such as reporting suspected child abuse to state child welfare agencies, or when patient is assessed and it is determined that they are a danger to themselves or others; and it is necessary to involve the proper authorities.

Full Advocate BHS may disclose PHI to facilitate treatment, payment, or health care operations or if Full Advocate BHS has obtained authorization from the individual. However, when Full Advocate BHS discloses any PHI, it must make a reasonable effort to disclose only the minimum necessary information required to achieve its purpose.

The Privacy Rule gives individuals the right to request that Full Advocate BHS correct any inaccurate PHI. It also requires Full Advocate BHS to take reasonable steps to ensure the confidentiality of communications with individuals. For example, an individual can ask to be called at his or her work number, instead of home or cell phone number.

The Privacy Rule requires Full Advocate BHS to notify individuals of uses of their PHI. Covered entities must also keep track of disclosures of PHI and document privacy policies and procedures. They must appoint a Privacy Official and a contact person responsible for receiving complaints and train all members of their workforce in procedures regarding PHI.

An individual who believes that the Privacy Rule is not being upheld can file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

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Acknowledgement of Receipt of Member's Rights and Responsibility

I have received a copy of this office's Statement of Member's Rights and Responsibility.

Date: _____

Print Name: _____

Signature: _____

Legally Authorized Representative (if applicable) _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Statement of Member's Rights and Responsibility, but acknowledgment not to be obtained because:

- _____ Individual refused to sign.
- _____ Communication barriers prohibited obtaining the acknowledgement.
- _____ An emergency situation prevented us from obtaining acknowledgement.
- _____ Other (Please Specify)_____

Witness: _____

A copy of this document must be maintained in the patient's medical record.

Member's Rights and Responsibilities

A member has the right to:

- be treated with dignity and respect.
- fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- easily access timely care in a timely fashion.
- know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- share in developing their plan of care.
- information in a language they can understand.
- have a clear explanation of their condition.
- a clear explanation of their treatment options.
- information about Magellan, its practitioners, services and role in the treatment process.
- information about clinical guidelines used in providing and managing their care.
- ask their provider about their work history and training.
- give input on the Members' Rights and Responsibilities policy.
- know about advocacy and community groups and prevention services.
- freely file a complaint or appeal and to learn how to do so.
- know of their rights and responsibilities in the treatment process.
- receive services that will not jeopardize their employment.
- list certain preferences in a provider.

Statement of Member's Responsibilities

- treat those giving them care with dignity and respect.
- give providers information they need. This is so providers can deliver the best possible care.
- ask questions about their care. This is to help them understand their care.
- follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- follow the agreed upon medication plan.
- tell their provider and primary care physician about medication changes, including medications given to them by others.
- keep their appointments. Members should call their providers as soon they know they need to cancel visits.
- let their provider know when the treatment plan isn't working for them.
- let their provider know about problems with paying fees.
- report abuse.
- report fraud.
- openly report concerns about the quality of care they receive.

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Missed Appointments

The nature of the clients we serve at Full Advocate Behavioral Health are distress. In an effort to improve accessibility, it is the providers' responsibility to negotiate appointment times with clients. Moreover, it is the clients' responsibility to notify the provider within 48 hours (two days) prior to the appointment if they are not able to be present for the scheduled appointment. Any missed appointments without proper notification pursuant to this policy will result in the client being charged the full cost of the session.

Tardiness for Sessions

Full Advocate BHS encourages all its clients to ensure that they are present for their appointments on time. It is a good idea to show up at least 15 minutes before your initial appointment to allow time to complete any necessary paperwork prior to seeing the provider. Full Advocate BHS will allow a 15-minute grace period from the scheduled time of the appointment; after which, the client will have to reschedule the appointment; and will be charged the full cost of the session. At the discretion of the provider this policy may be waived.

TIPS FOR PREPARING FOR YOUR NEXT APPOINTMENT

- Call First to Confirm Your Appointment
- Always have Your Medical History (if necessary)
- Always have Your Medication History Available (if necessary)
- Write Out Your Questions
- Schedule Follow-up appointments
- Be Patient

IF YOU CAN NOT MAKE YOUR APPOINTMENT PLEASE CALL AND RESCHEDULE

I have read the above policy regarding missed appointments and tardiness to sessions:

Date: _____

Print Name: _____

Signature: _____

Legally Authorized Representative (if applicable) _____

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Acknowledgement Statement and Agreement

EAP Disclaimer

Because Full Advocate BHS has a relationship with your employer (e.g. brief treatment model): and the information that you provide to Full Advocate BHS is confidential in nature, Full Advocate BHS will not disclose your information to your employer unless express written consent is provided by you. The following is important information you should know:

- Full Advocate BHS providers are EAP providers which means that they assess, coordinate services through your insurance, or treat the identifying problem(s) within the authorized sessions under your EAP plan. Once your EAP sessions have been exhausted, if you wish to continue treatment, Full Advocate providers will bill your respective insurance company.

- Providers working for Full Advocate BHS have limited authority as it relate to making determinations about fitness for duty. Such concerns are considered medically related and should be addressed through your primary care physician. This includes making a determination on whether you should return to work or whether you should take off work. These matters should be discussed with your primary care physician and a comprehensive plan can be developed which may include, your EAP provider (Full Advocate BHS).

The signers of this acknowledgement statement and agreements understand that Full Advocate BHS will not provide information regarding fitness of duty unless they are under the direction of the patient's primary care physician.

Acknowledgement of Receipt of EAP Disclaimer

I have received a copy of this office's Notice of Privacy Practices.

Date: _____

Print Name: _____

Signature: _____

Legally Authorized Representative (if applicable) _____

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- _____ Other (Please Specify)_____

Witness: _____

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Authorizations for Release of Patient Records or Information

Patient's Full Name _____ D.O.B. _____

Address _____

I hereby authorize LaMont Taylor, DSW, LCSW, ACSW_____

Address _10540 S. Western, Suite 402, Chicago, IL 60643_____

To Release: _____ Verbal _____Written

__X__Verbal and Written information to:_____

Address _____

Information to be released: (check all that apply)

- ☐ Medications
- ☐ Labs and Diagnosis
- ☐ Admission records
- ☐ Educational Information
- ☐ Progress Notes
- ☐ Discharges Summary
- ☐ History and Physical
- ☐ Treatment Plans
- ☐ Medical Consults
- ☐ Substance Abuse History
- ☐ Development/Social History
- ☐ Other(please specify):_____

For the purposes of:_____

This authorization is valid from the date signed and expires on: _____

I understand I have the right to inspect and copy any written information to be disclosed. I understand I can revoke this authorization at any time, in writing. However, written notice shall have no effect on information previously released in good faith. I understand that failure to sign this authorization may hinder the above indicated purpose being achieved.

_____ _____

Signature of Patient Witness

_____ _____

Signature of Parent or Guardian Relationship to Patient

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Authorizations for Release of Patient Records or Information

Patient's Full Name _____ D.O.B. _____

Address _____

I hereby authorize _LaMont Taylor, DSW, LCSW, ACSW_____

Address _10540 S. Western, Suite 402, Chicago, IL 60643_____

To Release: _____ Verbal _____Written

_X___Verbal and Written information to:_____

Address _____

Information to be released: (check all that apply)

- ☐ Medications
- ☐ Labs and Diagnosis
- ☐ Admission records
- ☐ Educational Information
- ☐ Progress Notes
- ☐ Discharges Summary
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- ☐ Other(please specify):_____

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Signature of Parent or Guardian Relationship to Patient