The Institute of Neurobehavioral Services, S.C.

14315 S. 108th Ave. Suite # 215
Orland Park, Il 60467
Tel# 708-966-0993
Fax# 708-966-0997

Welcome and thank you for choosing our facility for your behavioral health needs.
Please read and fill this packet out completely. If you have any questions, please ask our front desk staff.

Patient Information:……

Name: _____Date: _____
First MI Last

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone: (_____)_____Cell Phone: (_____)_____

Date of Birth: _____ Social Security Number: _____

Email: _____

Gender: ___Female___Male Marital Status: ___Married___Single___Divorced___Other

Employer: _____Status: ___FT___PT___Retired___Other

Insurance Information:……

Insured's Name: _____
First MI Last

Date of Birth: _____Social Security Number: _____

Relationship to patient: Self___Parent___Spouse___Guardian___ Gender: ___Female___Male___

Employer: _____Status: ___FT___PT___Retired___Other

Primary Insurance Carrier's Name: _____Phone Number: _____

ID#: _____ Group#: _____

Secondary Insurance Carrier's Name: _____ Phone Number: _____

ID#: _____ Group#: _____

Emergency Contact Information:……

Emergency Contact 1: _____Phone: _____

Relationship: _____ Alternate Phone: _____

Emergency Contact 2: _____Phone: _____

Relationship: _____ Alternate Phone: _____

Please provide any specific information you want emergency personnel to be aware of in the event that an ambulance must be called: _____

_____

Primary Care Doctor: _____Phone#: _____Fax#:_____

May we contact your Doctor? Yes___ No___

Therapist _____ Phone#: _____Fax#: _____

May we contact your Therapist? Yes___ No ___

Notification Preferences: ……

We do provide a courtesy call to remind you of an upcoming appointment. Please be aware that while we do provide a courtesy call, it is up to you as a patient to keep track of your scheduled visits.

When calling for appointment reminders, cancellations or to speak with you about your treatment plan please indicate below your preferences so we may best protect your privacy.

I authorize The Institute of Neurobehavioral Services to do the following: (Check all that apply)

- Call ___my primary number and/or ___ my secondary number.
- ___Speak only with me ___Speak with anyone ___Speak with _____
- ___Leave messages on voice mail or answering machine *(Please keep in mind, we will only* say *we are the doctor's office in Orland Park)*
- ___It is okay to call, but do **not** leave any voice messages.
- Other instructions: _____

Charges Assessed-Failure To Attend Scheduled Visit:. ……

All patients unable to withhold scheduled appointments are required to notify the practice one business day prior to the appointment. Our reception desk accepts calls from 9:00 am until 5:30 pm Monday through Thursday and 9:00 am until 1:00 pm on Friday.
No-Shows or last minute cancellations prevent The Institute of Neurobehavioral Services from providing care to patients experiencing crisis or urgent needs for treatment. **Please consider that you may experience this at some point and will appreciate others providing ample notice of cancellation, allowing you to receive necessary help in a crisis.**

All patients who fail to notify the practice within ample time (24 hours not including weekends or holidays) of canceling a scheduled appointment will be charged a fee at a rate of **$50 for 30 min psychiatry appointments** and **$100 for 1 hour therapy or combined therapy/medication management appointments.**

If three appointments in a row are not attended, or the doctor does not see a patient for more than eleven calendar months the patient will be discharged from the clinic.

Authorization and Release: ……

I hereby give consent to The Institute of Neurobehavioral Services to release any medical information necessary to process any insurance claim(s). I also give consent for the direct payment of benefit under my health insurance plan to The Institute of Neurobehavioral Services. I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to my child, parent or myself during the period of such care to third party payers and/or other health care practitioners. This includes the forwarding of complete progress notes or initial evaluations to my primary care physician to secure referrals and/or authorizations to continue care at The Institute of Neurobehavioral Services.
I understand that my insurance carrier may pay less than the actual bill for services and therefore agree to be responsible for the balances for services rendered on my behalf or on the behalf of my dependents.

_____ _____

Signature Date

Prescription Refills:……

A prescription refill request is required at least 72 hours prior to running out of any medications. From the time our office receives the pharmacy/patient request, we still require at least 72 hours to have it approved. Multiple calls within a 72-hour time frame does not ensure that the prescription request will be processed in a timelier manner.

In order for the physician to approve the refill request, the patient must have an upcoming appointment scheduled with the physician. If an appointment has not been scheduled, there will be a prescription refill delay.

Physician will only approve 90-day prescriptions at the time of patient visit.

Pharmacy Name and Address: _____

Phone Number: _____

Completion of Forms by The Physician/Therapist:……

All forms that require the physicians and/or therapists information (e.g. return to work form, FMLA paperwork, prior authorization forms for medications), please allow a one-week minimum for the physician and/or therapist to locate all documents needed to support the form request.

Please Note: There is a documentation preparation fee.

1. The patient must be seen within one month of request for form completion.
2. A fee of $25-$75(1-2 pages $25, 3 or more $75) is to be paid at the time the form is picked up.
3. Forms will be completed within two weeks of the date they are submitted.
4. Only your primary provider, here at the office, will complete any/all forms.

The "return to work" or "return to school" notes will be given at **no** extra charge.

The Institute of Neurobehavioral Services, S.C.

Client History

Please complete the following as thoroughly as possible. Please be honest with your answers so a correct assessment can be made, and the best care provided for you. This information will remain confidential in your record. Thank you.

General Information

Patient Name: _____
First MI Last

Date of Birth: _____

How did you find out about us? _____

What is your reason for seeking treatment? _____

_____

_____

_____

Date of onset of symptoms: _____

Have you previously been treated by a psychiatric provider? ___ Yes ___ No

If "Yes", Please provide the name and address of the provider: _____

_____

Daily Functions – Can you do the following?

Bathe and dress without assistance? ___Yes ___ No

Prepare your own meals without assistance? ___ Yes ___ No

Shopping without assistance? ___ Yes ___ No

Drive alone? ___ Yes ___ No

Allergies: List any medications or other substances that you are allergic to:

_____

Psychiatric Hospitalizations:

Have you ever been hospitalized for a psychiatric condition? ___ Yes ___ No

If "Yes", Please complete the following information.

Most recent hospitalization: Which Hospital? _____

What was the reason for the hospitalization? _____

_____

Admit Date: _____ Discharge Date: _____

Previous Hospitalization: Which Hospital? _____

What was the reason for the hospitalization? _____

_____

Admit Date: _____ Discharge Date: _____

Medications:

Please list the medications (including non-prescription medications, health foods, and vitamins) you currently take. Please include the strength and dosage.

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Medication: _____Strength: _____How Often: _____

Social History: Do you smoke? If yes, how much and how often? _____

_____

Do you drink alcohol? If yes, how often and how much? _____

_____

Do you use illicit drugs? If yes, what kind and how often? _____

_____

Family History: (Immediate father, mother, brothers, sisters, grandparents)

	Alive?	**Age**	**Any Medical Problems/Cause of Death**
Father:			
Mother:			
Other:			
Other:			

Employment:

What is your occupation? _____

Has your psychiatric condition affected your employment? ___ Yes ___ No

If "YES", have you had to take time off from work? ___ Yes ___ No

Last date worked: _____ Date you wish to return to work: _____

Concerns, please check all that apply:

___ Abuse (Elder/Spousal)
___ADD/ADHD
___Adoption Issues
___Alcohol Abuse
___Anger Management
___Anxiety
___Autism
___Bipolar Disorder
___Borderline Personality
___Brain Injury
___Child Abuse
___Chronic Mental Illness
___Crisis Intervention
___Cultural/Ethnic Issues
___Dementia /Alzheimer's
___Depression
___Developmental Disabilities
___Drug Abuse
___Eating Disorder
___Gender/Gay/Lesbian Issues
___Grief Issues
___Infertility
___Obsessive Compulsive Disorder
___Parenting
___Personality Disorder
___Phobias
___Post Traumatic Stress Disorder
___Rape/Incest
___Schizophrenia
___Sexual Abuse/Molestation
___Sexual Disorder
___Sexual Harassment
___Spouse Issues
___Suicidal
___Terminal Illness
___Tourette's Syndrome
___Victims of Trauma

___Other: _____

In your own words:

What do you expect to get out of treatment? _____

_____

_____

_____

_____

Thank you for taking the time to complete this history. Our providers are dedicated to providing you with the best care available and will be with you shortly. Feel free to ask any questions you may have, we will do our best to assist you.

Consent To Treatment

I, _____(patient name) authorize and request that The Institute of Neurobehavioral Services, S.C. and it's entities provide psychological examinations, treatment and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the frequency and type of treatment will be decided between me and my psychological provider (psychiatrist, counselor or social worker) and will be fully explained to me in a verbal agreement.

I also understand that if I am covered by an insurance carrier and/or managed Care Company and they elect not to cover or authorize recommended behavioral healthcare, I may elect to continue this care at my own cost. I understand that I am responsible for payment for any services not paid by my insurance carrier and/or managed Care Company including charges for missed or cancelled appointments.

I further understand that this consent will be enforced as long as I seek care from The Institute of Neurobehavioral Services and its entities and this consent may be revoked at any time, at my request. I understand that such revocation must be presented to my provider both verbally and in writing.

If the patient is unable to consent to treatment, I attest that I have legal power of attorney/custody of this individual and I am authorized to initiate and consent for treatment and/or legally authorize to initiate and consent to treatment on behalf of this individual.

Patient Name (Print): _____

Patient Signature: _____Date: _____

The Institute of Neurobehavioral Services, S.C.

Our Financial Policy

All patients must complete our Information and Insurance form before seeing the doctor.

Patients with Insurance

You are responsible for deductibles, co-pays, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. The remaining balance should be taken care of within ten (10) days of receiving our statement. If you and your insurance carrier make a payment exceeding your balance, re-imbursement will be remitted. If payment cannot be made at each visit, notify the office manager to make other arrangements.

Financial Honesty and Ethics

In order to maintain a respectful and beneficial working relationship, it is expected that patient's be honest with this clinic in all affairs, medical and financial. This office does not accept all insurance plans or combination of insurance plans, such as the combination of Medicare and Medicaid. In the event that we do not accept a patient's insurance or combination of insurances we will suggest they become a private pay patient or look elsewhere for treatment. We promise to be as clear as possible regarding this information to allow patients to make the most informed decision regarding their treatment. In the event that a patient fails to provide their full and correct insurance information at any time, the full balance of their account will become their responsibility.

Regarding Indemnity Insurance

We may accept assignments of insurance benefits after your second visit. However, we do require 50% of the bill to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and an original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the service provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Patient Co-Pay and Balances

If your insurance requires a co-pay, this is due at the time of service. If there is a balance on your account from deductibles, coinsurance payments, or other unpaid services (same day cancel fee, no show fee, etc.) this must also be paid prior to your next appointment. Except for hardship cases discussed with the office manager, there must be payment made towards your balance or you will not be able to see a provider for any reason.

Non-Insurance Patients (Private Pay) or

Patients **Who Fail to** Provide Insurance **Information** are required to pay at time of service. A payment plan can be arranged with the office manager in hardship cases.

Payment and Collection Procedures

Statements will be sent to the patient for any unpaid balances and payment must be received within 10 days of receipt of the statement. If this is not possible, patient should contact the office to setup financial arrangements. If the balance is not paid within 90 days of receipt of the statement, and if no attempt to setup a financial arrangement has been made, the patient's account will be sent to our collection agency.

Minor Patients

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.
For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, or payment by cash or check at the time of service has been verified.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I have read and agree to the financial policies stated above that applies to me and I agree to the financial arrangements.

Patient or responsible party Signature _____Date_____

The Institute of Neurobehavioral Services, S.C.

Consent to Release Information to Primary Care Physician

Communication between your psychiatrist/therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in an event this consent shall expire two (2) years from the date of signature, unless another date is specified.

I, _____

Patient Name-Printed Date of Birth Patient SS#

Please Check One.

☐ I agree to release mental health/substance abuse information to my Primary Care Physician.

☐ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: _____

Physician Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

_____

Signature of Patient Date

_____

Signature of Parent, Guardian or Personal Representative* Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Compliance Assurance Notification For Our Patients

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you if you should choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this previously signed consent. If you have objections to this form, please ask to speak with our office manager. You may have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services to our patients.

Print Name: _____Signature:_____

Date: _____