The Resiliency Center

—Rediscovering Strength Of The Human Spirit—

SpringfieldResiliencyCenter.com

3323 Mathers Road, Suite C
Springfield, IL 62711

217-679-0356

Today's Date:_____

Welcome to our office! This packet was designed to help us get to know you so that we will better know how to help you. Please be assured that any and all information you provide here will be held in the strictest confidence. If there are any questions that are confusing or make you uncomfortable, please feel free to leave them blank and discuss them with your individual provider. If you feel, at any time, that your information or those of other clients is being compromised, please report it to your provider. ***Your signature is required in all shaded areas.***

CLIENT REGISTRATION

Please Print. NOTE: Items in *italics* are required only if you are using insurance

Client's Full Name:_____ SSN#:_____

Address:_____
(Street, Apt No.) (City) (State) (Zip)

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Date of Birth:_____ Age:_____ Sex:_____ Marital Status:_____

Employer Name and Address:_____

Doctor's Name Address and Phone Number:_____

Approximate Date of Last Physical Exam:_____

Emergency Contact:_____ Phone: ( )_____

Spouse or Significant Other:_____ Date of Birth:_____ Age:_____

Spouse or Significant Other Employer:_____ Occupation:_____ Work Phone: ( )_____

Children's Names:	Relationship to you:	Sex and Birth date:	Reside in your home?:

Whom may we thank for referring you?:_____

CLIENT REGISTRATION FOR CHILDREN/ADOLESCENTS ONLY

Family Information

Mother's Name:_____ Home Phone: ( ) _____ Day Phone: ( ) _____

Mother's Address: _____
(Street, Apt No.) (City) (State) (Zip)

Mother's DOB:_____ Employment:_____ Occupation:_____

Father's Name: Home Phone: ( ) Day Phone: ( ) _____

Father's Address: _____
(Street, Apt No.) (City) (State) (Zip)

Father's DOB: _____ Employment: _____ Occupation: _____

Married? Separated/Divorced? Current custody/Living arrangements:_____

Sibling's names	Relationship to you:	Sex and Birth date:	Reside in your home?

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HEALTH HISTORY

Please use back of page if you need more room.

How would you describe your physical health?:_____

Current physical conditions:_____

Any chronic illnesses or conditions:_____

Please list all medications you are taking (prescription and non-prescription) please indicate dosage if known:

_____

Allergies (food-drugs-environmental):_____

Serious accidents, illness or surgery (please indicate dates):_____

Hobbies:_____

Exercise and Recreation:_____

Please list previous therapy (including dates and therapist's name):_____

Please list all mental health hospitalizations (please indicate dates):_____

Please state (in order of importance) present problems, concerns or symptoms you are experiencing:

_____

Indicate how and when this problem(s) arose:_____

How do you think our office might help you with this problem?:_____

EXPLANATION OF CONFIDENTIALITY

Professional ethics and the laws of this state prevent your provider from telling anyone else what you tell them without written permission, except -under emergency circumstances. There are some times when the law requires your provider to tell things to others. If you have any questions about confidentiality, please ask your provider.

Some common exceptions to confidentiality:

- Your provider believes that you are threatening serious harm to yourself or another person.
- Your provider may always give information to another professional to protect your life in an emergency.
- Your provider has any reason to suspect abuse to a child, an elderly person, or a disabled person

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CLIENT FINANCIAL AGREEMENT

If you have any questions, please ask our office staff.

• Payment of session fees, insurance co-payment, coinsurance and deductible, or other charges are due at the time of service unless prior arrangements have been made with the provider.

• Fees for mental health services are according to each individual provider.

• If you cannot pay for services as agreed, a referral will be given to a more affordable mental health provider, and no further services will be by provided until your account has been brought current.

• There will be a $25.00 charge for all checks returned for any reason.

• There will be a charge for telephone consultations at the discretion of the provider. Most insurance plans will not cover these charges.

• Prairie Healthcare Billing manages our billing. You are financially responsible for all charges for the provider's services. This includes the balance remaining after payment of insurance benefits; charges for non-covered services or missed appointments, and any billing charges, collection agency fees of up to 60% of the delinquent balance, and legal fees related to payment of your account in full. If payments are not made as agreed, your account may be turned over to a collection agency after 90 days delinquency.

• **Mental Health Evaluations/Assessments/Consultations:** Reports for probation, court, letters to physicians, teachers, and schools are pro-rated for the amount of time taken to prepare the report. All reports and court testimony must be paid in advance of receipt of report or court testimony.

• **If you need to reschedule or cancel an appointment, we do require at least 24-hour notice.** If we have notice, we can offer the time to another client. Failure to provide notice or canceling at the time of a reminder call will result in a full charge for the missed appointment. This charge may be waived in the case of illness, unforeseen sudden circumstance or emergency. Please talk to the office staff.

INSURANCE INFORMATION

Insured Name and Address (if different than client): _____

_____ Insured Relationship to Patient: _____

_____ Insured SS#: _____

_____ Insured Date of Birth: _____

Insured Phone: ( )_____ Policy and Group Number: _____

Please allow us to make a copy of your insurance card. If we forget to ask you, please let us know.

_____

By signing here I agree to the policies set forth in this Financial Agreement, and I authorize Family Psychiatric Services to submit claims for services to Prairie Healthcare Billing, my insurance company, and authorize my insurance company to make payment for these services directly to my provider.

Print Patient/Guarantor	Name Patient/Guarantor Signature	Social Security #
Print Patient Name (if child or other)	Guarantor Relationship to Patient	Date

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form refers to the HIPAA Notice of Privacy Practices. If you would like a copy of the NPP for your records, please ask the receptionist.

This form is an agreement between you and your provider. When we use the word "you" below, it will mean you or your child, relative, or other person if you have written his or her name here:

_____

When we examine, diagnose, treat, or refer you we will be collecting what the law calls **Protected Health Information (PHI)** about you. We use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or use it to arrange payment for your treatment.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at **(217) 679-0356**, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You may list these on the Client Directives for confidentiality form in this packet. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative | Date

_____ _____
Printed name of client or personal representative | Relationship to the client

_____
Description of personal representative's authority

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CLIENT DIRECTIVES FOR CONFIDENTIALITY

The Resiliency Center will routinely contact you with an appointment reminder the day prior to your appointment, Because of the sometimes delicate nature of our practice, please indicate your preferences below so that we may protect your confidentiality.

Please read the following three sections **carefully** and indicate your preferences.

1. Telephone reminder calls:

- ☐ Check box if there are no special instructions and list preferred contact number
- ☐ Check if you have special instructions and indicate below the numbers to contact you and any special instructions to use when calling.

2. Billing statement (for statements other than those with a zero balance):

- ☐ Check if there are no special instructions
- ☐ Check if you do not wish to have the billing statement mailed to your home, and indicate the special arrangements you have made with our billing service

3. Other mailing from our office:

- ☐ Check box if there are no special instructions
- ☐ Check box if there are special instructions and indicate your preference below

I have read and check marked my preferences regarding the three items detailed above.

_____ _____
Printed name of client or personal representative Date

_____
Signature of client of personal representative

FOR OFFICE USE ONLY

Accepted: _____

Refused: _____

Reason(s): _____

Privacy Officer: Signature _____ Date: _____