Associates in Behavioral Science

6201 W. Cermak · Berwyn, IL 60402 · (p)708.788.8808

ALL INFORMATION IS CONFIDENTIAL

Client's Name: First MI Last	Gender: Male Female	Today's Date:
Home Address	City State Zip	
Home Phone # ___OK to use and leave message	*Cell Phone # Carrier: ___OK text/ leave message	Partner/Parent # ___OK to use and leave message
* Cell phone, e-mail, or other forms of electronic or wireless communication are not considered to be secure.		
Date of Birth: **Age:**	**Social Security Number** ______- _____ - ______ **(may be required by your insurance carrier)**	*Language: Spanish ____ English ____ Other _____ ___________________________________

WILL YOU BE USING INSURANCE? No Yes IF YES, PLEASE LET US PHOTOCOPY YOUR INSURANCE CARD
Method of Payment: Cash
INSURANCE NAME:_______________________________________ID:__________________Group:_________________

PATIENT'S OR AUTHORIZED PERSONS SIGNATURE -

- I authorize the release of any medical or other information necessary to process this claim.
- I authorize payment of medical/psychiatric benefits from all insurances, including Medicare, to Associates in Behavioral Science for services rendered.
- ***I ACCEPT THE FINANCIAL RESPONSIBILITY OF ANY BALANCE REMAINING ON ACCOUNT AFTER INSURANCE HAS PROCESSED THE CLAIM***

PLEASE SIGN____ **DATE**____________________________

PERSON RESPONSIBLE FOR THIS ACCOUNT **(Client name or parent/guardian name if the above client is a minor)**
Name: ____ Relationship to Client: Parent Spouse

Social Security Number of insured cardholder, if not client: _________-_______-_________

Date of birth of insured cardholder, if not the listed client: ____

Address/Phone (if different from client address above): ____

Name of Insurance Company:____

ID Number:______________________________________ Group Number:_____________ Effective Date: __________

Office Use Only:
PPO: Yes POS: Union Other Authorization Required: Yes No Reference Number: ________________________

EMERGENCY CONTACT

Please provide the name of someone that we could contact in case of a medical or psychiatric emergency.
Name: ____ Relationship: ___________________________________

Home Ph.______________________ Work Ph.________________________ Cell Ph.______________________________

ACKNOWLEDGMENT OF REFERRAL

It is the practice of Associates in Behavioral Science to acknowledge and thank members of the professional community for their trust in referring persons to us. Your signature below gives us permission to make such contact by phone or letter.

Name of Referring Physician or Agency: ____

Street Address: ____________________________________ City ____________ State: ___________Zip ________ Phone: ______________

Your Signature: ____

Quality Behavioral Healthcare

6201 Cermak, 2nd Floor · Berwyn, IL 60204 · (p)708.788.8808 · (f)708.788.8549

Welcome to Associates In Behavioral Science!

Thank you for choosing Associates in Behavioral Science for your mental health needs. Today's appointment will take approximately 50 minutes. We realize starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies. If you have other questions or concerns, please let us know and we will try our best to give you all the information you need.

In order for us to serve you better please be aware of our practice guidelines and policies which are the following:

- Please provide us with your current address, phone number, and/or insurance coverage. Failure to promptly notify us of any changes may result in future billing and/or treatment difficulties.
- In the patient is a minor, the legal guardian or parent needs to be present for the first session. If you are not a biological parent, you will need to provide proof of guardianship.
- Copayments, deductibles and account balance payments should be made at the time of your appointment. We accept cash or debit/credit. We do not accept personal checks at this time.
- We do not accept cases which have DCFS involvement, court mandated therapy, immigration proceedings, as well as any legal proceedings such as divorce or civil suits
- We require a 48 hour notice of cancellation or a $75 fee will be assessed which is due at your next therapy appointment.
- Please note that our therapist will consider a case close after a month of patient inactivity. A letter will be sent to your home address after 3 missed appointments, regardless of cancellations.
- We will recommend services to you and provide referrals as needed.

We hope to provide you with the best service. If you have any questions or concerns, please feel free to contact us at 708-788-8808.

Patient's Signature:_______________________________ Date:____________

Therapist's Signature: _____________________________ Date: ____________

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CONSENT FOR TREATMENT

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:
All interactions with Associates In Behavioral Science, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.
- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.
- Illinois state law requires that staff of Associates in Behavioral Science who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services. We are also required to report any elderly and animal abuse.
- A court order, issued by a judge, may require that Associates In Behavioral Science staff release information contained in records and/or require a therapist to testify in a court hearing.

Be informed that if you sign a release of information, the information you specify in the release will be released.

We appreciate prompt arrival for appointments. Therapist may ask you to reschedule your appointment if you are late. After 3 missed/no show appointments, you may risk being terminated as a patient. Please notify us at 708-788-8808 if you will be late or need to reschedule your appointment. Twenty-four hour notice of cancellation allows us to use the time for others. There is a $75 fee for late cancellations, no shows and repeated rescheduling.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Counseling Services. I give consent to Associates in Behavioral Science to treat and diagnose me as one of their patients. I can revoke this consent at any time in writing by presenting it to the administration office. I also agree that I have reviewed and received a copy of the Notice of Private Practices.

______________________________ ______________________________

Signature of Client *Signature of Intake Therapist*

____

Date

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Billing Practices

The session fee is the sole responsibility of the patient

As a courtesy we will bill your primary insurance company if you wish. We do not bill secondary insurance. We will provide you with any necessary paperwork for you to submit to your secondary insurance.

It is the obligation of the client to know their insurance and/or EAP benefits. This includes, but it is not limited to co-pay amounts, number of sessions authorized, pre-authorizations and capitation of insurance or EAP benefits. If you need assistance with this, please call Associates in Behavioral Science and ask to speak with our billing department. Payment of any fees, outside the portion covered by insurance, are due at time of service. We ask you pay your co-pay or 50% of the fee at each session. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at the time of services

Family treatment is any session involving more than one person. Clients would be charged a full fee if their insurance does not cover the family treatment.

Please note insurance companies require a clinical diagnosis be provided to the insurance with billing. This information may become part of your permanent medical record. If you have any questions regarding this, please speak to your therapist.

You will receive a call and/or a text message the day before your appointment and you are required to respond and confirm your attendance to the scheduled appointment. **48 HOURS NOTICE OF CANCELLATION IS REQUIRED**. If cancellation is made after this time, you will be charged a $75 cancellation fee. It is understood an appointment time has been reserved for you and lack of notice prevents sufficient time to schedule other clients. Your insurance company and/or EAP cannot be billing for failed appointments. You will be responsible for the $75 fee. Payment for the missed appointment is required prior to or at the beginning at the next session.

E-mails and text messages are not confidential and your therapist may not be able to respond.

Please note therapists are not immediately available to take phone calls. Please leave a voicemail and your therapist will respond to your call as soon as he/she is able to. If there is a clinical emergency and you cannot wait for a return call, please dial 911 or go to your nearest emergency room.

If your balance exceeds $100.00 we will ask that you pay first for your services before sessions begin. In the event an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. You may put a credit card on file to pay for charges not covered by your insurance.

We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balance or payment please feel free to ask the office manager.

I understand that it is my sole responsibility to provide Associates in Behavioral Science with my insurance information as well as pay any fees that it is not convered by my insurance. If I do not have insurance, I agree top ay all fees associated with my treatment at this facility.

Patient's Signature: ________________________ Date: _________

Therapist's Signature: ______________________ Date: _________

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COORDINATION OF TREAMENT

It is important all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no inform will be shared. This authorization may be revoked at any time.

_____ You may inform my physician(s)/psychiatrist(s)

_____ I decline to inform my physician(s)/psychiatrist(s)

PHYSICIAN/PSYCHIATRIST NAME:____
CLINIC:____
ADDRESS:____
PHONE:____

Patient's Signature ____ Date ___________________

This consent must be signed in order for any associate with Associates In Behavioral Science to communicate or discuss protected health information about the patient with a guardian or family member. This includes information related to the care or changes to the care a patient has received.

CONSENT FOR COMMUNICATION

You may contact me by (please check all that apply) ___Phone ___Email ___Text
Best numbers to contact me at are: ____
I consent for ABS to leave me a voicemail __Yes __No

I, __________________________________, consent to all associates of Associates In Behavioral Science staff to disclose information with the following individual(s) which may include family or friends:

Name __________________________________ Relationship______________________________

Name __________________________________ Relationship______________________________

E-mails and text messages are not confidential and your therapist may not be able to respond

Patient's Signature:__________________________________ Date: _______________

Therapist Signature: _________________________________ Date: _______________

Associates in Behavioral Science

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Notice of Privacy Practices

Associates in Behavioral Science
6201 W Cermak, 2nd Floor
Berwyn, IL 60402
708-788-8808

Amended Effective Date: September 04, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Associates in Behavioral Science has been and always will be totally committed to maintaining our client's confidentiality. We will only release healthcare information about you according to Federal and State laws and ethics of the counseling profession. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

Associates in Behavioral Science collects health information about you and stores it in a chart, on a computer, and in electronic health records. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. For example, we may share your information with other health care providers who will provide services we do not provide or for consultation purposes.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, and business planning and management. We may also share medical information about you with other health care providers, health care clearinghouses and health plans that participate with us.

4. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

5. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm.

6. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process.

7. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

8. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

9. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws.

10. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law.

11. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Inspect and Copy. You have the right to inspect and copy your health information. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

3. Right to Amend or Supplement. You have a right to request that we amend your health information. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial.

4. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this practice.

5. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Anthony DeJoseph, PsyD 708-788-8808

I have read and understood the above information and I have received a copy of this Notice of Privacy Practices.

DATE:______________________________

SIGNATURE OF CLIENT:____

SIGNATURE OF PARENT/GUARDIAN:__________________________________

SIGNATURE OF THERAPIST:____

Quality Behavioral Healthcare

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RECIPROCAL RELEASE OF INFORMATION FORM
OUTPATIENT PSYCHOTHERAPY/DIAGNOSTIC SERVICES

I, ______________________________ ____________ do hereby authorize
(name of patient) (date of birth)

- ☐ Ralph Menezes, M.D.
- ☐ Anthony DeJoseph, Psy.D.
- ☐ My therapist at Associates in Behavioral Science and/or his or her administrative or clinical staff
- ☐ Other:____

to *release* and/or *exchange* confidential and protected information from my medical/clinical record as follows:

The name (title if possible), address and telephone number of the person or organization to which disclosure is to be made:

____

____

The type of information to be released/exchanged (summary of treatment, case notes, etc.):

____

____

The purpose or need for this information:

____

____

Only information relevant to this purpose shall be released:

____

____

The consequences, if any, of not signing this release are:______________________________

____

This consent is valid until ______________, 20__ and may be revoked in writing at any time except to the extent that action has been taken in reliance thereon. Information released prior to revocation shall not be affected. I understand the right to inspect and copy information to be disclosed, and this information will not be disclosed without my specific written consent.

______________________ ________ ______________________ ________
(patient signature, 12 and over) (date) (parent/guardian signature if patient under 18 or legally incompetent) (date)

I attest to the identity of the above signatures:______________________________________
(witness) (date)

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Confidentiality Agreement for Adolescents

This Confidentiality Agreement is an addendum to the Consent for Diagnosis & Treatment Form—in consideration of Illinois Law, which allows children ages 12 and older to have the legal right to make decisions about their treatment.

Therapy needs to be a safe place for all participants. When the identified client is an adolescent, it is especially important that we develop a trusting relationship in order to address concerns that brought him or her into therapy. At the same time, parents need to know information about their child(ren) that allows them to fulfill their responsibilities as parents. As parents, you are entitled to a diagnosis, attendance information, goals, and progress. In addition, when treatment is terminated, I can provide a summary, with some veto power given to your child. We will keep all information learned from and about your child confidential unless the child agrees that it will be shared. We will encourage and assist your adolescent in sharing information with you when appropriate.

As outlined in the Treatment Agreement, we can break confidentiality (for any client) for the following reasons:

- Risk of harm to self or an identified other
- Report/suspicion of child abuse or neglect
- Report/suspicion of elder abuse or neglect

We recognize that teenagers often engage in behavior that parents consider dangerous. In order to clarify what is considered to be a risk of harm (dangerous), we would like to take a few moments to come to an agreement about which behavior(s) could be disclosed without specific consent.

The following are behaviors that might come up in therapy:

- Alcohol use
- Driving under the influence of alcohol
- Drug use
- Eating concerns (e.g., starvation, purging)
- Self-mutilating behavior
- Sexual behavior
- Unprotected sex

When these behaviors come up in therapy, I will work with your child to assess the level of dangerousness, potential implications, and appropriate interventions. Those behaviors discussed and agreed upon by all parties, ***could be*** disclosed without consent. Thank you for choosing us to work with your son or daughter. Please feel free to contact us at any time to ask questions, discuss concerns and/or schedule an appointment to discuss ways you can assist your child.

I consent for Associates In Behavioral Science to treat my child. I understand and agree to the terms of this agreement.

______________________________	______________________________
Patient, Date	Therapist (Print Name)
______________________________	______________________________
Parent/Legal Guardian, Date	Therapist (Signature), Date