NEUROPSYCH

Vernon Hills:

977 Lakeview Parkway, Suite 170
Vernon Hills, IL 60061
(847) 367-1611

Northbrook:

Berkson Medical Building
333 Skokie Blvd, Suite 107
Northbrook, IL 60062
Phone: (847) 367-1611
Fax: (847) 367-4079
(Note: GPS does not work for this address)

Directions: Please complete all forms as thoroughly as possible, prior to the first visit. If you are unsure about something, feel free to contact us or we will clarify for you prior to the first visit.

Completing this paperwork helps us to focus on our first priority; helping you to resolve your problem.

(This cover page may be omitted.)

Patient History and Insurance Information

Last Name *Middle Initial* *First Name*

Street

City *State* *Zip*

Date of Birth Age Social Security Number

Home Phone *Cell Phone* *Work Phone*

Education

__High School __College __Other

Marital

__Single __Married__Partner__Separated__Divorced __Widowed

Employer *Employer Address* *Employer Phone*

Insurance

Insurance Co. *Policy number* *Group Number* *Insurance Phone*

Name of Person Insured *Date of Birth* *Address* *Phone*

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Neuropsych all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information neccessary to secure payment of benefits I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

_____Date_____

Patient Signature

_____ Date_____

Emergency Contact

Name

Phone Number Relationship

Neuropsych Financial Policy

- Full Payment is due at time of services unless Neuropsych participates in your insurance plan. If we participate in your health care plan, Neuropsych will be responsible for billing your insurance company.

- We will only bill insurance companies with whom we have in-network status. For all other plans it is the patient's responsibility to submit bills to the insurance company after paying the balance in full at Neuropsych.

- Missed appointments will be billed in full to the patient unless canceled by 3:00 pm the prior business day. We are unable to bill your insurance company for charges incurred by missed appointments. The credit card that we have on file may be billed for the entire cost of the session missed.

- Patients receiving medication must be seen for regular appointments at intervals agreed upon with their physician. The physician will provide you with the correct amount of medication to last until your next designated appointment. If circumstances arise that you miss this appointment or lose your prescription, and refills are required, you may be charged a fee for a phone refill.

- There will be a $30 fee on all returned checks.

I understand and agree to this financial policy.

_____ _____

Signature of Responsible Party Date:

Notice of Privacy Practices for Protected Health Information

Neuropsych is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operation.

A copy of the Privacy Practices is available for your review in our front office.

Neuropsych requires your authorization to use an automated telephone system and/or email in order to notify you of a pending appointment or related health care communication. The information that may be included is the name of your scheduled treating provider and the time and place of your appointment.

Neuropsych requires your authorization to disclose to third parties who may answer your phone(s), limited protected health information regarding pending appointments and to leave a reminder message on your voicemail or answering machine.

Your signature below indicates that you have reviewed this information and authorized us to contact you at the number indicated below:

_____ ____/____/_____

Print Name Date

_____

Authorized Telephone Number

_____

Signature of Patient/Patient Representative

_____

Relationship to Patient

Psychiatric History

Current Therapist/Counselor:		Telephone:	( ) -
Please list any other therapists, either current or past:			
Please list any other psychiatrists, either current or past:			
Do you have any previous psychiatric hospitalizations?		☐ Yes ☐ No	
If yes, please indicate when you were hospitalized and where: ☐ N/A			
Please list all <u>past</u> psychiatric medications:			
Please list all <u>current</u> psychiatric medications: (Include dose and prescriber)			

Medical History

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:
Please list all medical conditions:
Please list all hospitalizations and surgeries:
Current Medications (Include dose and prescriber)

Primary Care Physician

Name:		Telephone:	( ) -

Specialty Care Physicians

Name:		Telephone:	( ) -
Name:		Telephone:	( ) -
Name:		Telephone:	( ) -

Family History

Please indicate if any of the following family members have a history of psychiatric illness:	
☐ Father:	☐ Mother:
☐ Siblings:	☐ Other Family:
If you have children, please list their names, date of birth and any relevant medical or psychiatric history:	
Please indicate any other information that you feel might be important to your care:	

Who referred you to us?		
☐ Physician	☐ Therapist:	☐ Friend
☐ Ins Co:	☐ Other:	

Patient Health Questionaire (PHQ-9)

Over the **last 2 weeks,** how often have you been bothered by any of the following problems? Check the box that corresponds to your answer.		Not at all	Several Days	More than Half the Days	Nearly Every Day
1.	Little interest or pleasure in doing things	☐	☐	☐	☐
2.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
3.	Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
4.	Feeling tired or having little energy.	☐	☐	☐	☐
5.	Poor appetite or overeating	☐	☐	☐	☐
6.	Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7.	Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so figedty or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9.	Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
		0	1	2	3

If you checked off ***any*** problems, how ***difficult*** have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

For office coding only:	0			
			Total Score:	

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.

Neuropsych (two locations) phone 847-367-1611 fax 847-367-4079

Authorization for Release of Information

To be completed only when patient requests Neuropsych receive, send or contact a therapist, primary care doctor, former MD, or Institution

I, _____, authorize:

Neuropsych, _____ Staff Person Name 977 Lakeview Parkway, Suite 170 Vernon Hills, IL 60061 Telephone: (847) 367-1611 Fax: (847) 367-4079	***To Release To:***	_____ Name _____ Organization _____ Address

The Following Specific Information:

☐Medical History/Hospitalizations	☐Social History
☐Summary of Psychiatric Treatment	☐All Progress Notes
☐ Summary of Medical Treatment	☐Alcohol/Drug Assessment
☐Psychiatric Evaluation Results	☐HIV/AIDS Related Information
☐Psychological Evaluation Results	☐Lab/Diagnostic Results
☐Mental Disorder/Diagnoses	☐Nature and Outcome of Treatment
☐Other:	☐Dates of Treatment
☐ Telephone Contact to Facilitate:	
☐Family Evaluation	☐Psychological Evaluation
☐Treatment Planning	☐Other:

Regarding: _____ _____/_____/_____ _____
Client Name Birthdate Address

For the purposes of:
☐Continuity of Care ☐Psychological/Psychiatric Evaluation ☐3rd Party Reimbursement ☐Other:_____

By signing this form, I understand the following provisions:

- I am under no obligation to sign
- Neither my health care nor payment for my health care will be affected if I do not sign this form, except for health care related to employment physicals, injuries or illnesses sustained on the job, and research.
- I have the right to revoke this authorization at any time by written request. (Except for information previously disclosed.)
- This consent is valid for 3 months (90 days) unless otherwise indicated.
- Failure to sign will mean that information will not be requested or released. One consequence for refusing to release the information includes, but may not be limited to, a failure on the part of the receiving party to fully appreciate, or be aware of, the client's pertinent history.
- I have the right to inspect and copy the information disclosed.

Expiration Date: _____/_____/_____

Signature of Adult or Guardian of Minor Date

Signature of Minor (12-18 years of age) Date

Witness Date

Witness 2 Date

If client is present but physically unable to sign authorization and oral agreement is given, a second witness is required.