| Clinician Name: | Appt. Time & Date: | Still Review Pages: |
|---|---|---|
| Front Desk Sign Off: | Clinician Sign Off: | For Office Use Only: |

## NEW CLIENT INFORMATION

Client's Full Name: _______________________________________________Gender: ______Date of Birth: ___________

Social Security # (required):_______________________Emergency Contact:___________________________________

Emergency Contact Phone #:_____________________Relationship:__________________________________________

Client Address:_________________________________City:_______________________State:______Zip:____________

Cell Phone:_______________ Home or Secondary Phone: _______________ Email:__________________________

| Family Member Name | Date of Birth (mm/dd/yyyy) | Relationship | Phone Number and/or Email |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## INSURANCE INFORMATION

***Please present your card upon first visit**

If insurance is not being used, please check here ☐

Name of Insurance Plan*: ________________________________ ID Number: ___________________________________

Group Number: ______________________________________ Single or Family Coverage: ________________________

If Family coverage, please list all covered members: ________________________________________________________

_____________________________________________________________________________________________________

Policy Holder Name: _____________________________________ Policy Holder DOB: ______________________

Policy Holder Social Security #__________________ Policy Holder Employer: ___________________________________

Policy Holder Home Address and Phone (if different from client's contact information):_________________________________

_____________________________________________________________________________________________________

### SECONDARY INSURANCE

If you are covered under any other medical plan in addition to the coverage listed above, please complete the following:

| Health Plan Name | Name of Person Covered | Policy Number | Policy Holder Name |
|---|---|---|---|
| | | | |

Do you require handicap accessibility or will you require assistance due to a disability? **Yes/No**

**If yes**, please describe so that we can be sure to be prepared to provide the assistance needed. In the event that we cannot make an accommodation, we will speak with you directly about how we may best help or if you would prefer to be referred out to another agency more adequately equipped to support your needs.

_____________________________________________________________________________________________________

Who can we thank for referring you to Edgewood Clinical Services? ___________________________________________

Clinician Initial: _________

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# CONSENTS AND NOTIFICATIONS

## CONSENT FOR TREATMENT

I consent to the evaluation and treatment process with Edgewood Clinical Services, and I understand that this process may include myself, my spouse, my children, and/or other family members. I understand that I have the right to withdraw from treatment at any time. I understand that if I am a divorced parent of a child, my ex-spouse may be informed of our child's treatment at Edgewood. I understand that the number of visits I receive will depend on the type(s) of issues that exist, the recommendations made, and the effort that I (client) puts forth by following suggested recommendations.

## APPOINTMENTS

Appointments will be scheduled at a time mutually acceptable to both the client and the therapist or doctor. 24-hour advance notice of cancellation is required, except in cases of extreme emergency. Please be advised that we DO NOT offer 24 hour emergency crisis coverage. If there is an emergency, please visit your nearest emergency room, or call 911. Appointments missed or canceled with less than 24 hours' notice will result in a charge of $40.00 for clinical sessions, $40 per hour for psychological testing sessions, $235 for initial psychiatric sessions and $75-100 for follow up psychiatric sessions. There is a $25 returned check fee.

## HOURS OF OPERATION

**Clinical Hours:** Monday-Friday 8:30am to 9:30pm, Saturday 8am to 7pm, Sunday 8am to 4pm
**Intake Dept. Hours:** Monday – Thursday 8am-6:30pm, Friday 8am-5pm
**Billing Dept. Hours:** Monday – Friday 8am to 4:30pm

## POTENTIAL EXPENSES

When possible, Edgewood will bill your health insurance for services rendered. Below are fees that may be charged to the client directly because your insurance company may not cover them:

Individual/Family Therapy: $165-$185
Group Therapy: $50
Written Correspondence: $80
Interactive Complexity: $25-$50
Extended Crisis: $250-$400
Psychological Testing: $175/hr
Diagnostic Assessment: $235
Phone Consultation: $50 - $80
Copying of Records: $25-$50
Professional Consultation Services (Attorney meeting, etc.): $500/hr
Attendance at IEP/off-site meetings: $150/hr (includes travel)
Late Payment Fee: $25 (may be assessed for delinquent/past due accounts)

Additional fees may be billed to your insurance that may result in a client responsibility for services such as the following: *Return to Work documentation, school excuse letters, reports to court, consultation with other medical and/or treatment providers, medication prescription changes and/or phone & email consultation between scheduled appointments, and clinical preauthorization reviews with insurances*.

## INSURANCE

I understand that Edgewood will verify my insurance benefits and coverage. I am responsible for out of pocket costs that may be incurred and the benefit information that Edgewood may relay to me is not a guarantee of coverage or benefits. I authorize the release of any medical or other information necessary to process my insurance claim and payment to Edgewood for services provided to myself, child, or family. Billing will be submitted to insurance under the provider with whom I see, or the supervisor of that provider depending on contract requirements. I am ultimately responsible for all payment obligations arising out of treatment and guarantee payment for these services. I am responsible for deductibles, co-payments, coinsurances or any other non-covered or denied charges, which become patient responsibility indicated by my insurance carrier.

## ELECTRONIC COMMUNICATION

I agree to send and receive email and newsletter communications with Edgewood. I understand the risks of compromised confidentiality with electronic communications such as email, texting, social media sites, or other modes of electronic communication and I assume responsibility.

## EQUAL ACCESS TO TREATMENT

No client shall be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence, disability, genetic information or source of payment.

Clinician Initial: _________

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**CONFIDENTIALITY**

All personal client information is kept strictly confidential. No clinical information will be released without your written authorization and consent unless required by your insurance provider. Physicians, Licensed Psychologists, Clinical Social Workers, and Counselors in the state of Illinois are required by law to report any suspected child abuse or neglect. They are also required to make a report if a client is a lethal danger. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that all communication with other providers or individuals can be made by Edgewood Clinical Services only by my written consent. I have received a summary of the Notice of Privacy Practices for Edgewood Clinical Services. I have been made aware that I may request a copy of the complete notice at any time. I am also aware that the notice is available on the practice website at www.edgewoodclinicalservices.com.

My signature below reflects my understanding and acknowledgment of the aforementioned Edgewood Clinical Services consents and notifications.

Client Signature *(Client 12 & over)*:______________________________________ Date: ____________________

Parent/guardian Signature:_____________________________________________ Date:___________________

**CONSENT FOR SMS TEXT NOTIFICATIONS**

Edgewood offers appointment reminders through SMS texts which will arrive from 847.973.5686; your normal cell charges will apply. An individual consent must be completed in order to receive automatic notifications via text.

Client Name: ______________________________ Cell Phone Number:____________________________________

Authorized Signature *(Client 12 & over)*:_____________________________ Date:_______________

*If you wish to discontinue this notification at any time please contact info@edgewoodclinicalserivces.com.*

**CONSENT TO RELEASE INFORMATON TO OTHER MEDICAL PROFESSIONALS**

☐ I hereby give my consent to communicate with my own or my child's Primary Care Physician (PCP) or other relevant health care provider about treatment.

**OR**

☐ I choose to refuse permission and do not prefer to have any other medical providers contacted regarding my care at Edgewood Clinical Services.

If consent is provided, please complete below.

***Primary Care Physician or other Health Care Provider:***

Name: _________________________Address: __________________________________________

Phone: ________________Email: _______________________________Specialty: _________________

**Client Signature:** ________________________________________ Date: _____________________

*(Client 12 & over)*

**Parent/Guardian Signature**: _________________________________ Date: ________________________

Clinician Initial: _________

# FINANCIAL STATEMENT AGREEMENT

Edgewood Clinical Services is committed to providing the highest quality of mental health services to all of our clients. In order to do so, Edgewood and our clients must understand the benefits provided to a client by an insurance provider. Many insurance plans have deductibles, co-insurance, and co-pay amounts that are the client's responsibility; deductibles must be met before insurance will begin to cover the cost of our services. These deductibles apply to ALL medical providers; they are not isolated to mental health. A credit card is required to be placed on file to receive services at Edgewood in order to ensure prompt payment and minimize delinquent accounts.

In cases where a client does not have insurance, Edgewood and the client must have a clearly outlined fee for services rendered which is due at the time of service. It is understood that all client fees will be paid in full by the designated *Financially Responsible Party*. We accept checks, cash, FSA/HSA accounts, all major credit cards or PayPal. If there are circumstances that prevent the Financially Responsible Party from meeting the financial obligations of the client obtaining services, they should contact our Billing Department to explore payment options.

Accounts with overdue balances of 60 days or greater, which do not have a formal payment plan agreement arranged, will have the credit card on file charged accordingly. All unpaid balances shall accrue interest at the rate of 5% per annum, or the maximum amount as allowed by law, until paid If the card on file declines for any reason, the overdue balances without formal payment plan agreements may be forwarded to a collections agency without notice to the designated Financially Responsible Party. I also agree that if Edgewood Clinical Services refers my account to a collection agency or to an attorney who files a civil action against me, then I shall be liable to Edgewood Clinical Services for all reasonable attorney's fees, litigation expenses and court costs.

Client Name: ____________________________________________ Client DOB: _________________________________

**Financially Responsible Party**: ____________________________/____________________________/_________
*(Must be 18 years or older)* *(Printed Name)* *(Signature)* *(Date)*

## CREDIT CARD ON FILE POLICY

**All clients are required to keep a credit card on file with Edgewood in order to receive services**. Clients are required to pay any fees due at the time of service and are welcome to pay balances due from monthly statements in person, by mail, by phone, online at www.edgewoodclinicalservices.com, or by credit card on file by selecting OPTION 1 below. Your credit card will be securely stored on file to be used only for the selection of your choice below.

***Per our policy, please select the option of your choice:***

______ **Option 1:** Please charge my card after each session for all copays, and monthly for all non-covered service charges, co-insurances, deductibles, monthly balances, formal Payment Plan Agreements (PPA), Special Fee Agreements (SFA), and any other accrued charges.
***(initial)***

______ **Option 2:** Please charge my card approximately the first week of the month for all outstanding balances greater than 60 days past due if no formal payment plan agreement has been made.
***(initial)***

**Credit Card Information**

Card Holder's Name:__________________________Phone number:______________Email:________________________

Credit Card Number:___________________________________________________Expiration Date:_________________

Security Code (3 digits on back of card, 4 digits on front if AmEx):________Billing Zip Code of Credit Card:____________

Visa, MasterCard, AmEx, or Discover (circle one, flex spending accepted)

Card Holder Signature:__________________________________________________Date:________________________

*I understand that by signing above, I am authorizing Edgewood Clinical Services to charge my card for the option selected above. These balances may include co-pays, co-insurance amounts, deductibles, no show fees, late charges, payment plan agreements and other accrued fees. I understand that Edgewood Clinical Services will send a receipt from my credit card as proof of payment. Edgewood will contact me if my card is declined or expired. If a new card is not provided and payment is not received, services will be suspended. Credit card information is securely stored with our Merchant Services Vendor. Once entered, your credit card number is redacted from the original document (for your privacy) and only the last four digits of your card number are kept on file for reference.*

Clinician Initial: _________

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## CONSENT FOR RELEASE OF INFORMATION

In certain cases clients may want Edgewood Clinical Services to be able to discuss files with school personnel, ex-spouses, legal guardians or other healthcare practitioners. Please complete if you would like your clinician to be able to exchange information on your behalf. Please note that completion of this form is not a requirement for treatment.

I, ________________________________________________Relationship: ___________________ authorize to:

☐ give information to: ☐ release information from:

Name/Organization: ______________________________________________________________________________

Address: _______________________________________City: ________________________State: ____Zip: ________

Phone: ____________________Fax: _______________Email: ____________________________________________

Regarding (Client name): ____________________________________________________Birthdate: _______________

This information to be exchanged from__________to__________ or for 12 months from signature date.

**Disclosure Information Needed:**

☐ Mental Health Assessment/ITP ☐ Psychiatric Records ☐ Financial Information

☐ Clinical Summary ☐ Psychological Assessment ☐ Other: ___________________

**Purpose of Disclosure:**

☐ Continuity of Care ☐ Personal use ☐ Attorney/Court ☐ Financial/Benefits

Client Signature (12 years old and over): ____________________________________________________________

Guardian Signature (if client under 12 or disabled) ____________________________________________________

OPTIONAL: Co-Custodial Guardian (if divorced with co-custody of under 12) ________________________________

Date: _____________________________ ECS Initials: __________________

I understand that I may revoke this authorization at any time; however, the revocation must be in writing either mailed or emailed to Edgewood Clinical Services Practice Director. As pursuant to Illinois law, information used or disclosed through this authorization may not be further disclosed to a third party without an additional signed consent form.

**By signing below, I revoke the consent to release information to the party above:**

Client Signature (12 years old and over): ____________________________________________________________

Guardian Signature (if client under 12 or disabled): ____________________________________________________

OPTIONAL Co-Custodial Guardian (if divorced with co-custody of under 12): ________________________________

Date: _____________________________ ECS Initials: __________________

Clinician Initial: _________

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# SYMPTOM CHECKLIST

Name: ______________________________________ Date: _________________________________

Reason for seeking assessment/treatment: ____________________________________________________________

______________________________________________________________________________________________

Please check any of the concerns or symptoms listed below that you are currently experiencing:

___ difficulty adjusting to a recent change
___ experience of a traumatic event
___ unstable relationships
___ difficulty learning
___ sensory problems (hyper- or hypo-)
___ developmental delays
___ problems with social skills
___ language delays/communication prob.
___ fatigue/low energy
___ tearfulness
___ anxiety/worry/nervousness
___ panic attacks
___ reluctant to leave home or familiar neighborhood
___ perfectionism
___ guilt/shame feelings
___ trouble sleeping (too much or too little)
___ depressed mood/sadness
___ suicidal thoughts
___ self-injury
___ eating problems (too much or too little)
___ spending habits
___ Repetitive behaviors/habits/compulsions
___ concern about alcohol/drug use
___ concern about lying or dishonesty with others
___ anger/irritability
___ mood swings
___ loss of temper/anger outbursts
___ aggressive/violent behaviors
___ physical abuse (current or past)
___ verbal/emotional abuse (current or past)

___ loss of interest in previous activities
___ recurrent flashbacks
___ episodes of lost time, unexplainable actions
___ trouble with memory or concentration
___ confusion
___ daydreaming
___ hyperactivity/attention problems
___ headaches/stomach aches
___ sexual problems
___ gender identity concerns
___ identity concerns
___ feelings of unreality
___ obsessive thoughts/excessive fears
___ unusual thoughts or perceptions
___ excessive energy
___ impulsive decisions or actions
___ difficulty trusting others
___ low self-esteem
___ avoidance of conflict
___ withdrawn, isolating
___ shy/uneasy around others
___ fear of failure
___ fear of disapproval
___ need to please others and be liked
___ difficulty saying "no" to others or asserting self
___ difficulty making independent decisions
___ feelings of futility/loss of hope
___ loss of joy in living
___ lack of sense of a future
___ other _________________________________

Clinician Initial: _________