Provider Name:	Appt. Date & Time:
Front Desk Initial:	Pages to Review:

NEW CLIENT PAPERWORK

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	Email
Policy Holder				

INSURANCE INFORMATION

Please present your insurance card upon first visit.

Disclaimer: Edgewood Clinical Services is not a participating provider with Medicaid or Medicare.

Is insurance being used? Yes ☐ No ☐ **If no, please fill out Self-Pay Agreement Form**

PRIMARY INSURANCE

Are you covered under Medicaid or Medicare as primary or secondary insurance? Yes ☐ No ☐

If yes, please fill out Medicaid/Medicare Opt-Out Agreement Form

Name of Primary Insurance: _____ Member ID: _____

Group Number: _____ Policy Holder Name: _____ Policy Holder DOB: _____

SECONDARY INSURANCE

Are you covered under any other insurance plans: Yes ☐ No ☐

If yes, please fill out the below secondary insurance information

Name of Secondary Insurance: _____ Member ID: _____

Group Number: _____ Policy Holder Name: _____ Policy Holder DOB: _____

ADDITIONAL INFORMATION

Do you the client 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?

Name: _____ Organization: _____ Phone Number: _____

Edgewood

CONSENTS AND NOTIFICATIONS

Please initial each box to acknowledge your consent

☐ **CONSENT FOR TREATMENT**

By signing the below, I consent to the evaluation and treatment process with Edgewood Clinical Services, and the client understands that this process may include the identified client, spouse, children, and/or other family members. I understand that the client has 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 put forth by following suggested recommendations.

☐ **RED FLAGS RULE**

The **Red Flags Rule**, a rule the Federal Trade Commission (FTC) began enforcing on December 31, 2010 requires certain businesses and organizations, including many doctors' offices, hospitals, and other **health care** providers, to establish a written procedure to help avoid identify theft. In order to stay in compliance with this rule, as well as to spot any warning signs of identity theft or insurance fraud, Edgewood collects a Driver's License or State ID from all clients or guardians being seen. For more information on this rule, please visit www.ftc.gov.

☐ **APPOINTMENTS**

Appointments will be scheduled at a time mutually acceptable to both the client and the provider. Twenty-four-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-hour notice will result in a charge of $100 for every missed counseling appointment, $300 for initial psychiatric sessions, and $150 for follow-up psychiatric appointments. There is $25 returned check fee.

☐ **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	Psychological Testing: $175/hr.	Documentation/Written Correspondence: $225 per hr.
Interactive Complexity: $25-$50	Group Therapy: $70	Professional Consultation Services (Attorney meeting, etc.): $500/hr
Diagnostic Assessment: $235-$300	Extended Crisis: $250-$400	Copying of Records: $25-$50
Psychiatric Follow-Up Visits: $300-$350	Phone Consultation: $50-$80	Refill of Prescription due to No Show/Late Cancel appointment - $50
No Show/Late Cancel Fees: Initial Psychiatric Appt: $300 Follow-Up Psychiatric Appt: $150 Counseling Appt: $100 Group: $50 Psychological Testing: $150	Attendance at school/off-site meetings: $150/hr. (includes travel)	Returned Check Fee: $25

Additional fees may be assessed and may or may not be covered by your insurance. These charges may result in a client responsibility for services such as the following: *Return to Work documentation, school communications and 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 pre-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 client responsibility indicated by my insurance carrier.

Edgewood

ELECTRONIC COMMUNICATION

☐ I consent to sending and receiving 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.

☐ **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. All Clinical Providers 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 to themselves or others. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that all communication with other non-Edgewood Clinical Services 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 as well as patient rights and grievance policy at any time. I am also aware that the notice is available on the agency website at EdgewoodClinicalServices.com.

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

Client Signature *(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. Two-way communication through this service is NOT activated. *If you wish to discontinue this notification please contact Billing@EdgewoodClinicalSerivces.com.*

Client Name: _____ Cell Phone: _____

Authorized Signature *(Client 12 & over or Parent/Guardian)*: _____ Date: _____

CONSENT TO RELEASE INFORMATON TO OTHER MEDICAL PROFESSIONALS

Edgewood Clinical Services values your overall health and believes coordination of care with your healthcare providers is important.

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

Name: _____ Address: _____

Phone: _____ Email: _____ Specialty: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature *(if client is 18 and under):* _____ Date: _____

OR

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

Clinician Initial: _____

Edgewood

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. Any personal financial arrangements resulting from divorce agreements should be managed privately and Edgewood Clinical Services will invoice only the Financially Responsible Party below.

Accounts with overdue balances of 45 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 Information:

Printed Name: _____ Signature: _____ Date: _____

Phone Number: _____ Billing Address: _____

CREDIT CARD ON FILE POLICY

All clients are required to keep a credit card on file with Edgewood in order to receive services. All copays will be collected or ran with the credit card on file at the time of service. 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 EdgewoodClinicalServices.com or by credit card on file. Your credit card will be securely stored on file to be used only for the selection of your choice below, and will be valid for the duration of your treatment unless cancelled with written notice.

Per our policy, please select ONE option of your choice:

_____ ***(initial)*** **Option 1:** Please charge my card after each session for all copays and for all non-covered service charges, co-insurances, deductibles, monthly balances, formal Payment Plan Agreements (PPA), Special Fee Agreements (SFA), no show/late cancel fees, 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 45 days past due if no formal payment plan agreement has been made.

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 & HSA 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.

Edgewood

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 Edgewood Provider to be able to exchange information on your behalf. Please note that completion of this form is not a requirement for treatment.

I, _____ (Relationship to client: _____) 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:

	Diagnostic Assessment/ITP Information		Psychiatric Records
	Clinical Summary		Psychological Assessment
	Financial		
	Other:		

It is our policy to not release clinical session notes unless required by Insurance or court order.

Purpose of Disclosure:

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

Client Signature (12 and over): _____ Date: _____

Parent/Guardian Signature (if client under 18 or disabled): _____ Date: _____

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 Administrative 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 and over): _____ Date: _____

Parent/Guardian Signature (if client under 18 or disabled) _____ Date: _____

Edgewood

SYMPTOM CHECKLIST

Client Name: _____ DOB: _____ Date: _____

Reason for seeking assessment/treatment: _____

Please check off any of the concerns or symptoms listed below that the client is currently experiencing

	difficulty adjusting to a recent change		loss of interest in previous activities
	experience of a traumatic event		recurrent flashbacks
	unstable relationships		episodes of lost time, unexplainable actions
	difficulty learning		trouble with memory or concentration
	sensory problems (hyper- or hypo-)		confusion
	developmental delays		daydreaming
	problems with social skills		hyperactivity/attention problems
	language delays/communication prob.		headaches/stomach aches
	fatigue/low energy		sexual problems
	tearfulness		gender identity concerns
	anxiety/worry/nervousness		identity concerns
	panic attacks		feelings of unreality
	reluctant to leave home or familiar neighborhood		obsessive thoughts/excessive fears
	perfectionism		unusual thoughts or perceptions
	guilt/shame feelings		excessive energy
	trouble sleeping (too much or too little)		impulsive decisions or actions
	depressed mood/sadness		difficulty trusting others
	self-injury		low self-esteem
	eating problems (too much or too little)		avoidance of conflict
	spending habits		withdrawn, isolating
	Repetitive behaviors/habits/compulsions		shy/uneasy around others
	concern about alcohol/drug use		fear of failure
	concern about lying or dishonesty with others		fear of disapproval
	anger/irritability		need to please others and be liked
	mood swings		difficulty saying “no” to others or asserting self
	loss of temper/anger outbursts		difficulty making independent decisions
	aggressive/violent behaviors		feelings of futility/loss of hope
	physical abuse (current or past)		loss of joy in living
	verbal/emotional abuse (current or past)		lack of sense of a future
			Other:

Please list any medications you are taking:

_____

Pharmacy Information

If we need to contact your preferred pharmacy we will have the information on file.

Preferred Pharmacy Name: _____Address _____

Preferred Pharmacy Phone #: _____Fax: _____