Behavioral Health Center of Illinois

CLIENT INFORMATION FORM

Reset Form

PATIENT INFORMATION

(Please fill out all required and applicable fields and write legibly)

Patient's Demographic Information

First (Required) | Middle Initial | Last (Required)

Address Information

Street | City | State | Zip code

Contact Information

Home Phone | Cell Phone | Work Phone

Birthdate (Required)	Marital Status	Sex	Gender What gender do you identify as?
	Single ☐ Married ☐ Divorced ☐ Widowed ☐	Male ☐ Female ☐	

INSURED INFORMATION

(If different than patient information)

(Insured's Demographic Information)

First (Required) | Middle Initial | Last (Required)

Relation To Patient	Social Security Number (If Tri-Care Insurance)	Birthdate (Required)	Phone Number

Insured's Address Information

Street | City | State | Zip code

Insured's Employer Information

Employer | Address

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Company Name: _____	Company Name: _____
Group/Plan No: _____	Group/Plan No: _____
Member Id: (Required) _____	Member Id: (Required) _____

Office Use Only

Dr Sara Bahn

CLIENT INTAKE FORM

Referred By

EMERGENCY CONTACT INFORMATION

Name			
First	Last		
Relationship to you?		**Phone**	
Address			
Street	City	State	Zip code
Family Physician			

PLACE OF EMPLOYMENT INFORMATION

Employer Name		
Occupation	**Years Worked**	**Household Income**

FAMILY/HOMELIFE INFORMATION

Immediate Family Information
(Spouse/Partner, Children & Other)

Spouse/Partner Name	Years Together	Spouse/Partner Occupation

Children			Other persons who you live with you and their relationship to you.	
Name	Age	Lives with me	Name	Relationship
Child :		☐		
Child:		☐		
Child:		☐		
Child:		☐		

HEALTH HISTORY INFORMATION

Outpatient Medical Record

Please check all those that have occurred at any time.

Alcoholism ☐	Anemia ☐	Appendicitis ☐	Asthma ☐	Bulimia/ Anorexia ☐	Cancer ☐	Diabetes ☐	Epilepsy ☐
Food Tolerance ☐	Fibromyalgia ☐	Head injury ☐	Hearing Problems ☐	Hypertension ☐	Learning Problems ☐	Measles ☐	Mumps ☐
Neurological disease ☐	Pneumonia ☐	Pregnancies ☐	STD ☐	Scarlet Fever ☐	Speech Problems ☐	Special Diets ☐	Stroke ☐
Substance Abuse ☐	Thyroid Problems ☐						

Gastrointestinal problems? _____ Significant weight loss/gain? _____

List all allergies _____ HIV Positive? ☐ Yes ☐ No If yes how long? _____

Others not listed _____

Do you experience any of the following?

Please check all those that have occurred at any time.

Abdominal Pain ☐	Bed Wetting ☐	Breathing Problems ☐	Changes in Appetite ☐	Colds ☐	Constipation ☐	Coughs ☐	Diarrhea ☐
Dizziness ☐	Ear Infection ☐	Eye/Vision Problems ☐	Fainting Spells ☐	Chest Pain ☐	Fatigue ☐	Frequent Urination ☐	Headaches ☐
Memory Problems ☐	Menstrual Problems ☐	Nausea ☐	Nose bleeds ☐	Sore throat ☐	Toothache ☐	Vomiting ☐	

List any of the operations, Medical Procedures or Hospitalizations for medical, psychiatric/emotional, drug or alcohol problems.

(Please include Dates)

Occurance	Date	Occurance	Date

Prescription drugs you currently take or have taken in the past six months.

Prescription Drug Name	Frequency/Dosage	Reason Prescribed

Note any of the side effects of adverse reactions to medications listed above.

LEGAL STATUS

Are you currently involved with the criminal justice system? No ☐ Yes ☐ (If yes please explain below)

	How long used?	How often used?	How much used?
Alcohol			
Tobacco			
Cannabis			
Non-prescription Drugs			

Please help me understand what problems brought you to this office.
Check all that apply

Marital ☐ Job ☐ School ☐ Alcohol ☐ Substance Abuse ☐ Depression ☐ Moodiness ☐ Self Confidence ☐

Illness ☐ Psychological ☐ Children ☐ Family ☐ Fatigue ☐ Sexual Problems ☐ Traumatic Experience ☐ Loneliness ☐

Describe other reason or elaborate on above.

Are you currently having any suicidal or homicidal thoughts? No ☐ Yes ☐ (If yes please explain below)

Previous contact with psychiatrist for medication, or psychologist for psychological evaluation.

Name	City	Year(s)	Age	Couples	Court Ordered
				☐	☐
				☐	☐
				☐	☐
				☐	☐

CLIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM

I authorize **Dr Sara Bahn** to use and/or disclose certain protected health information (PHI) about me to (list names and phone numbers)

Primary Insurance	**Secondary Insurance**
Company Name: _____	Company Name: _____
Employee Assistance Program	**Other**
Company Name: _____	Name: _____

This authorization permits **Dr Sara Bahn** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the purpose of appropriate **Psychological Evaluation, Treatment Recommendations and Treatment Plan.**

This authorization will renew every year for the next ten (10) years, from the signed date on this form, unless explicitly canceled by Dr Sara Bahn or Client.

I do not have to sign this authorization in order to receive treatment from **Dr Sara Bahn**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to **Dr Sara Bahn** by e-mail at **DrSaraBahn@BehavioralHealth.Center** or mailed to our office address at: 1220 South 7Th Street, Springfield, IL. 62703.

CONSENT FOR TREATMENT AND OFFICE POLICIES

Welcome to our practice. This document contains important information about my professional services and business policies. Please read it carefully, and write down any questions that you may have so that we can discuss them at our next meeting

SERVICES

Psychotherapy provides you with an opportunity to examine thoroughly the problems with which you are struggling, and it may lead to important changes. Although most people who engage in psychotherapy benefit from the process, there are no guarantees. Psychotherapy often leads to improved relationships, solutions to specific problems, significant reductions in feelings of distress, and an improved ability to enjoy life. Progress in psychotherapy may vary depending on the particular problems being addressed, number of different approaches that can be utilized to address the problems you hope to address. It can depend on such factors as your motivation and effort, as well as life circumstances. To be successful, psychotherapy requires a collaboration between the patient and the therapist.

During the course of psychotherapy and as part of the process of change, you may also experience uncomfortable feelings. These feelings are an important part of the psychotherapy process and often serve as a catalyst for further understanding and growth. It is important for you to bring up with me any concerns you have about the process as it unfolds. If at any time you would like to have the opinion of another professional or seek treatment elsewhere, I will refer you to another qualified mental health professional. You may discontinue psychotherapy at any time.

I normally conduct an initial evaluation that may last one to three sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. During this period, you should evaluate whether you feel comfortable working with me. Therapy involves a large commitment of time, energy, and money, so you should make an informed choice about the therapist you select. If psychotherapy is begun, I will schedule one or more 50-minute sessions per week at a time we agree.

CONFIDENTIALITY AND ITS LIMITS

Meetings between a client and his/her psychotherapist are confidential and legally privileged, and the psychotherapist will not release information discussed to anyone without the client's written permission. However, in the following important situations a therapist is legally and ethically required to go outside the context of the therapeutic relationship and release necessary information about the patient in order to preserve his/her safety or that of another:

1. If there is an emergency situation in which the psychotherapist believes that the client may be a danger to her/himself or that s/he is gravely disabled;
2. If the client communicates a serious threat of harm to another person or against someone to the psychotherapist;
3. If the psychotherapist has reasonable suspicion that a child or an elder/dependent adult is being abused; or if the client's records are subpoenaed as evidence during a legal proceeding.

These situations have rarely arisen in our practice. If any such situation arises, I will attempt to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Additionally, disclosure of confidential information may be required by your insurance carrier in order to process a claim. In this circumstance, only the minimum amount of information will be communicated to the carrier. Please also note that if there is a breach or refusal to pay a balance, information can be given to a collection agency or small claims court.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions and concerns that you may have. The laws governing these issues are quite complex, and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

PAYMENT FOR SERVICES

Patients are expected to pay for services by check, cash, credit card or money order at the time that services are rendered, except when other arrangements have been made. Checks are payable to **Behavioral Health Center of Illinois**.

All Co-Pays/Co-Insurance and any other amount owed is due at time of service.

Our office provides as a courtesy, a quote of benefits for clients and cannot guarantee payment by your insurance company. It is ultimately your responsibility to confirm with your insurance company the cost for services. Please contact your insurance company directly to confirm your benefit for services.

In addition to psychotherapy appointments, I charge this amount for other professional services you may need on a prorated basis for time periods of less than one hour, such as telephone conversations lasting longer than I0 minutes, consulting with other professionals with your pe1mission, preparation of records or treatment summaries and the time spent performing any other service you may request of me.

If you become involved in litigation that requires my participation, you will be expected to pay for the professional time required, even if l am compelled to testify for the other party. Because of the complexity and difficulty of legal involvement, **Behavioral Health Center of Illinois** charges $500/per hour for preparation and attendance, at any legal proceeding.

Please notify me as soon as possible if any problems arise during the course of therapy regarding your ability to make timely payments.

CANCELLATION POLICY

Once a regular appointment time is reserved for you on mutual agreement, you are responsible for payment of all reserved sessions. **Cancellations must be made at least 24 hours before your appointment and may be rescheduled within two weeks**; this allows us to contact clients on our wait list for an appointment availability. Cancelled sessions made at least 24 hours before will not be billed for that session.

Cancelations made without a 24-hour notice will be billed at the rate of $100 for therapy sessions and $250 for Psychological Testing and Evaluation sessions.

CONTACTING ME

My telephone is answered by a confidential voicemail at **(217) 679-5379**. I monitor my voice mail regularly and will make every effort to return your call within 24 hours, with the exception of weekends and holidays. When I am unavailable for an extended period of time, the name of a colleague whom you can contact in my absence will be provided to you, if necessary. If at any time you feel that you need immediate assistance or are experiencing a psychiatric emergency, contact your physician or the nearest emergency room and ask for the mental health professional on call.

PROFESSIONAL RECORDS

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records if you ask for them. Because these are professional records, they can be misinterpreted and/or can be upsetting to lay readers. If you wish to see your records, I recommend that you review them in my presence so we can discuss the contents. Clients will be charged an appropriate fee for a preparation time that is to comply with an information request.

Notes:

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. This authorization will remain in effect until cancelled, you may cancel this authorization at any time by contacting us at **(217) 679-5379**.

Credit Card Information

Credit Card Type:

MasterCard ☐ VISA ☐ Discover ☐ American Express ☐

Other Card Name

Cardholder's Name: (As shown on card)

Card Number: ____ - ____ - ____ - ____

Expiration Date: __ / __ (mm/yy)

CVV Number: ___ (Found On Back Of Card)

Zip Code: (Credit Card Billing Address)

CANCELLATION POLICY/CO-PAY & CO-INSURANCE RESPONSIBITY

********** ATTENTION **********

All Co-Pays/Co-Insurance payments and any other amounts owed are due at time of service.

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Office Policy for all testing and therapy services

Our office and our billing management company, Psychiatric Billing, provide only as a courtesy, quotes of benefits for clients**. It is ultimately the client's responsibility to confirm with their own insurance company their cost for services.** Our quote is a courtesy and cannot guarantee payment by your insurance company. Please contact your insurance company directly to confirm your benefit for services.

Cancellation Policy

Our office policy charges a 24-hour cancellation fee of $100.00 for a therapy session and $250.00 for psychological testing and evaluation appointment if you do not notify the office 24 hours prior to appointment so that the client wait list for appointment availability can be called.

Sincerely,

Behavioral Health Center of Illinois

Forms Checklist and Signature Page

Write your initial's in the table below next to each form to verify that you have received it. Your signature on this page will apply to each form listed below. Please use the appropriate signature line, you do not need to fill out both.

Initials	Form Name
_____	Client Registration Form
_____	Client Intake Form
_____	Client Authorization for Use and Disclosure of Protected Health Information Form
_____	Consent for Treatment/Office Policies Form
_____	Credit Card Authorization Form
_____	Cancellation Policy/Co-Pay Co-Insurance Responsibility Form

_____ _____

Client Signature **Date**

_____

Client Name (printed)

_____ _____

Parent or Legal Guardian Signature **Date**

_____

Parent or Legal Guardian Name (printed)

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