Sholtes and Associates, LTD

Welcome to our office. Please complete all 5 pages of this registration form.

PATIENT INFORMATION

Gender Listed on Insurance:
Female ☐ Male ☐

LEGAL NAME

Female ☐ Male ☐ Other ☐

PREFERRED NAME AND GENDER (if different from above)

SSN BIRTHDATE AGE

ADDRESS

CITY STATE ZIP

Ok to leave a voicemail? Yes ☐ No ☐

HOME PHONE WORK PHONE MOBILE PHONE

EMAIL

RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Employer Information

EMPLOYER NAME OCCUPATION

Referred by:

NAME EMAIL

Medical Information

Major Illness(es) & Date of Last Physical

Primary Care Physician Name & Phone #

Medication Allergies (If none check here ☐)

Medication(s) currently used

Responsible Party

NAME PHONE EMAIL

ADDRESS CITY STATE ZIP

Insurance Information - If you want us to file claims for you, please have your card out for photocopying. We are in-network with BCBS PPO and Aetna for Northwestern Students only!

Client Relationship to Primary Insured (check one) ☐ Self ☐ Spouse ☐ Child ☐ Other

NAME DATE OF BIRTH PHONE

ADDRESS CITY STATE ZIP

ID AND GROUP NUMBER NAME OF INSURANCE COMPANY

INSURANCE:

If you are covered by either a Blue Cross/Blue Shield PPO, or Northwestern Student Insurance plan: We will bill at an in-network level for those plans. It is your responsibility to contact your insurance carrier to discuss your plan's mental health benefits, including any deductibles, co-payments, annual and lifetime limits, and if authorizationis required. We will file claims for in network plans.

If you are covered by an Out of Network Provider Plan: The out of pocket payment is due at the time of service. After payment has been made and applied towards the billed services, we will provide you with an Insurance Invoice to submit to your insurance plan.

If we file, your insurance company may pay us directly. You are responsible to contact your insurance company for information about your out-patient mental health benefits. Benefits vary widely even within the same insurance plan. If your plan does not pay us within 32 days, you will be billed. All claims filed with insurance companies are subject to benefit and eligibility limitations at the time the claims are filed. **NON-COVERED SERVICES:** Any care not paid for by your existing insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. This may include fees for prior authorizations, prescription refills, telephone consultations and letter writing.

PLEASE CALL YOUR INSURANCE TO OBTAIN:

1. REFERRALS AND AUTHORIZATIONS: You are responsible for obtaining any authorization or precertification required by your insurance company for your initial visit. Failure to obtain authorization for services may result in increased cost to you for services provided. Please check with your insurance carrier to find out what if any authorization is needed.

2. The name and address of your mental health insurance company - This may NOT be the same company that is on your insurance card for your other medical claims. For your own financial planning, you will want to specifically verify whether Robert or Susan Sholtes are in network with your mental health insurance company. **Payment Method:** We accept cash, checks, credit cards, and FSA/HSA.

Signature below indicates understanding and agreement with policies stated above. A separate release of information will be needed before contacting your doctor.

Signature of Responsible Party	**Date**	**Signature of Responsible Party**	**Date**
Signature of Parent (if client is minor)	**Date**	**Signature of Parent (if client is minor)**	**Date**

SHOLTES & ASSOCIATES, LTD., CREDIT CARD AUTHORIZATION

I, _____. hereby authorize Sholtes and Associates, LTD., to charge my credit/debit card for any account balance that is more than 60 days past due. I understand my card will be charged on a regular basis for these amounts.

I authorize my card to be charged for fees as indicated above.

_____ **PATIENT INITIALS**

Credit Card Number: _____
Exp. Date: _____ **CVV Code:** _____

Billing Address for the Credit/Debit Card listed above:

_____

_____

_____

Patient Name:_____

Signature:_____**Date:**_____

AUTOMATIC BILLING

Additionally, for your convenience, if you wish to have your balance changed to your credit/debit card for any patient responsibility from services rendered (deductible, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointment) after each visit, please check auto-charge and initial below

_____ **Auto-charge**

_____ **Initials**

STATEMENT INFORMATION

You will receive statements from Sholtes and Associates, LTD., electronically.

Signature:_____ **Date:**_____

Policies:

1. **MEDICAL RECORDS:** The confidentiality of your medical record is our number one priority at S&A. All medical record requests must be submitted in writing on our medical record release form.

2. **FORMS, AND LETTERS:** Fee for completion of forms or composing letters will be billed in at the rate of $50 for each 15 minute increment

3. **PRESCRIPTION REFILLS:** Please see PRESCRIPTION DRUG POLICY AND PROCEDURES on page 5 (this is only for persons seeing Dr. Bob Sholtes)

4. **APPOINTMENTS:** Appointments are held especially for you and they are a valuable resource at our practice. If you are unable to keep your scheduled appointment, please provide a minimum of 1 working day advance notice. Dr Sholtes' is in the office on Monday, Tuesday, Friday and Saturday. We charge for missed appointments or cancellations made less than one working day in advance of the appointment. Fees for missed appointments are due at or prior to your next appointment. Appointment reminder calls or emails are attempted as a courtesy for you, but it is your responsibility to keep track of appointment dates and times.

5. Emergency coverage is not provided by our practice. We provide outpatient, non emergency services. You are instructed to utilize emergency services available in the community for all life threatening emergencies. We will attempt to be available if you are experiencing any urgent need for treatment during our working week (Monday-Saturday), but we may not be able to respond during a busy work day until the end of that day or the next work day. We are not available after hours. Any messages left after hours may not be heard until the next scheduled workday. If you do not receive a timely response to any messages left on the secure portal or by voicemail, please try contacting us again.

Signature below indicates understanding and agreement with policies stated above.

A separate release of information will be needed before contacting your doctor.

_____ _____

Signature of Client Date Signature of Responsible Party Date

_____ _____

Signature of Insured (if different) Date Signature of Parent (if client is minor) Date

PLEASE ALSO READ AND SIGN THE CLIENT AGREEMENTS AND AUTHORIZATIONS ON PAGE 4.
A copy of our privacy policies is attached to the end of this document for your review.

Sholtes and Associates, LTD Registration

CLIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby consent to the treatment provided by Sholtes and Associates, its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment for me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Sholtes and Associates. I authorize Sholtes and Associates to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Sholtes and Associates may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE

I authorize payment to be made directly to Sholtes and Associates for insurance benefits payable to me.
I understand that I am financially responsible to Sholtes and Associates for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

PRIVACY POLICY I acknowledge having received Sholtes and Associates, "Notice of Privacy Policies and Practices." My rights, including the right to see a copy of my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Sholtes and Associates has already made disclosures with my prior consent.

FOLLOW-UP SERVICES I agree ☐ or do not agree ☐ to be contacted for follow up services by phone, mail, or e-mail after services at Sholtes and Associates. Failure to agree prevents us from leaving reminders about appointments on your voice mail.

_____ _____
Client Signature (ages 18+) **Date**

If the client is unable to sign, verbal consent given _____.
Reason for inability to sign: _____

FOR MINORS ONLY: I (we) represent that we are the parent(s) or legal guardian(s) of the above named person, a minor. I (we) authorize and consent that our son/daughter receive treatment at Sholtes and Associates for his/her emotional difficulties.

_____ _____ _____
Parent/Guardian Signature(s) **Relationship(s)** **Date**

_____ _____ _____
Parent/Guardian Signature(s) **Relationship(s)** **Date**

_____ _____
Minor's Signature (ages 12 - 17) **Date**

Sholtes and Associates, LTD Registration

PRESCRIPTION DRUG POLICY AND PROCEDURES

- **Please use your medication management appointment to discuss your medication.**

- **If you have questions about your medications or if you need to report side-effects, please message your provider in the secure portal**

- **If you need your medication adjusted or would like to be started on a new medication, we request that you request an appointment with enough time to discuss your experiences and the risks/ benefits of any change.**

- **We expect that you keep scheduled appointments and if canceled you will reschedule in a timely manner. If you do not schedule within the time frame as outlined by your provider, you may be billed for refill requests at the rate of $25 for each refill as well as be expected to make a follow up appointment within 2 weeks.**

- **If a controlled substance/narcotic prescription is prescribed to you, it is understood that we are the only doctor providing this medication to you. If you obtain this medication (or similar medication) from another physician, without our knowledge, we will no longer provide prescriptions for this medication, and we may be forced to terminate the doctor patient relationship.**

PRESCRIPTION REFILLS

- **All prescription refill requests should be handled during scheduled office appointments or by sending a message to your provider in the secure portal. Please keep up with your supply of medication to avoid running out.**

- **Our office may not provide refills for medications after hours or on weekends. For your convenience, you may leave a message in the portal 24 hours a day, but requests are handled during administrative office hours only.**

- **Prescriptions refills for ADHD, must be written individually monthly by the doctor. Some pharmacies permit predating ADHD medications for up to 3 months, but most do not.**

PRIOR AUTORIZATION FEES

- **Prior Authorization for prescriptions (if required by patient's insurance) $25.00**

Fees for letter writing, form completion, prior authorization and prescription refills due to missed or canceled appointment are not reimbursed by your insurance company.

Sholtes and Assocaites, LTD.
500 Davis Ave., Suite 1006 Evanston, IL. 60201
847-328-1920 Ph/ 847-328-1925 Fax

Email & Text Messaging Registration Form

You may give permission to Sholtes and Associates, LTD., to communicate with you by email and text message (SMS). This form provides information about the risks of these forms of communication, guidelines for communication, and how we use this form of communication. It will also record your consent or refusal for these forms of communication.

How We Will Use Email & Text Messaging: Sholtes and Associates, LTD., uses these methods of communication only about non-sensitive and non-urgent issues. All communications to or from you may be part of your dental record. Please refer to our Notice of Privacy Policy for information permitting uses regarding privacy matters.

Risks of Using Email & Text Messages: Risks include, but not limited to, the following:

- **Emails & texts can be circulated, forwarded, stored electronically and on paper and broadcast to unintended recipients.**
- **Senders can easily misaddress and send the information to unintended recipients.**
- **Backup copies may exist even after the sender and/or other recipient has deleted his/her copy.**
- **They can be intercepted, altered, forwarded or used without authorization or detection.**
- **They can be used as evidence in court.**
- **They may not be secure, and it is possible that a third party may breach the confidentiality of such communication.**
- **Data charges may apply.**
- **Sholtes and Associates, LTD., is not liable for breaches of confidentiality caused by you or any third party.**

Sholtes and Associates, LTD., primarily uses email and text to confirm upcoming appointments. Please provide us with a valid cell phone number and email address that you want these confirmation sent too.

Name _____Cell Phone #_____
Email Address _____

☐ **Yes, please sign me up to receive e-mail AND text messages**

☐ **I do not wish to be contacted via text messaging. (Email only).**

☐ **I do NOT wish to be contacted via text messaging OR email.**

Signature_____ Date_____

Sholtes and Associates, Ltd
500 Davis St Suite 1006 Evanston, IL., 60201
P (847) 328-1920 F (847) 328-1925

NOTICE OF PRIVACY POLICIES AND PRACTICES

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.

Effective Date: February 1, 2005

We respect patient confidentiality and only release medical information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by this practice "Sholtes and Associates".

Privacy Contact

If you have any questions about this policy or your rights contact the Office Manager at extension 311.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, ***there are times when may share your information*** with others beyond our practice, ***only with your written permission.*** For example:

Treatment We may use or disclose medical information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our practice that we are consulting with or referring you to.

Payment Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes. If you choose not to use your insurance, be sure to let our Office Manager know at extension 311.

Healthcare Operations We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.

Follow-Up Appointments/Care We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Under Illinois and federal law, ***information about you may be disclosed without your consent*** in the following circumstances:

Emergencies Sufficient information may be shared to address the immediate emergency you are facing.

As Required by Law this would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse or institutional abuse.

Serious Threat to Health or Safety If you communicate with us a specific threat of immediate harm against another specific individual, or if you pose a clear risk of inflicting physical or mental injury against an individual, we are expected to warn that individual even without your consent. Also, if you appear to pose an immediate, serious risk of self inflicted physical or mental injury or death, we may make disclosures considered necessary to protect you from harm.

Governmental Requirements Notes taken during your sessions are privileged under state law. Any request for information by any party about your evaluation, diagnosis and treatment and the records thereof, will not be released without your written permission or a court order. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure.
If your are sent for an evaluation at the specific request of a third party, you will be asked to sign a release of information in advance of the requested evaluation.
We may be expected to disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws related to worker's compensation or other similar programs, established by state law, that provide benefits for work-related injuries or illness without regard to fault.
There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects.

Criminal Activity or Danger to Others If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

PATIENT RIGHTS

You have the following rights under Illinois and federal law:

1. ***Copy of Record*** You are entitled to inspect the health record our practice has generated about you. We may charge you a reasonable fee for copying and mailing your record.

2. ***Right to Request Restrictions*** You have the right to request restrictions on certain uses and disclosures of protected health information. We are not always required to agree to the restrictions requested. Please notify our Office Manager at extension 311.

3. ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** You have the right to request and receive confidential communications of your private health information when and how you prefer. For example, you may not want your family members to know you are treated here. You may request bills to be sent to an alternative address.

4. ***Release of Records*** You may consent in writing to the release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent that no action has been taken in reliance on your prior authorization.

5. ***Amending Record*** If you believe that something in your record is incorrect or incomplete, you may request that we amend it. To do this contact the Office Manager at extension 311 and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a written statement indicating that you disagree with us. We will then file our response and your statement and our response will be added to your record.

6. ***Accounting for Disclosures*** You may request an accounting of any disclosures we have made related to your private health information, except for information we were required to release by law. To receive information regarding disclosure made for a specific time period no longer then six years and after, please submit your request in writing to the Office Manager. We will notify you of the cost involved in preparing this list.

Questions and complaints If you have any questions, or wish a copy of this Policy or have any complaints you may contact the Office Manager in writing at our office for further information. You also may complain to the Secretary of Health and Human Services if you believe our Practice has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy Sholtes and Associates reserves the right to change its Privacy Policy based on the needs of Sholtes and Associates as well as changes in state and federal law.

CLIENT RIGHTS STATEMENT

As a client of Sholtes and Associates, you have the following rights:

To not be denied services on the basis of age, sex, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record.

To have services provided in the least restrictive environment available for your needs pursuant to an individualized treatment plan.

You will have nondiscriminatory access to services in accordance with the Americans With Disabilities Act. Confidentiality of your status and records, including HIV status and testing as provided for under Illinois law.

Sholtes and Associates has the right to limit services based on the funding we receive. This may require us to prioritize services based on the severity of your service needs. Services not covered by governmental grants are charged based on the cost of providing those services.

No client shall be presumed legally disabled unless declared to by a court.

You have the right to give an informed consent to treatment. You also have a right to refuse treatment and be told the consequences of such refusal. This could include Sholtes and Associates being able to provide services to you.

If you believe your rights have been violated, you have a right to contact any of the following groups:

Guardianship and Advocacy Commission
28 North Clark, Suite 450, Chicago, Il 60602
(312)3457000

Equip for Equity
11 East Adams, Suite 1200, Chicago, IL 60603
(312) 341-0022

Department of Mental Health
100 W. Randolph, Suite 6-400, Chicago, IL 60601
(312) 814-2735

Department of Children and Family Services
406 East Monroe, Springfield, IL 62701
(800) 252-2873 (Hotline)

Office of Inspector General (OIG)
Stratton Building, Springfield, IL 62765
(800) 368-1463

Additional referrals for accessing guardians, conservators, self-help groups, advocacy services, outside providers, and legal advocacy serves can be obtained through your therapist.
You are encouraged to speak to your provider (therapist, psychiatrist, etc.) regarding grievances, complaints or concerns to attempt to resolve the issue informally.

If the grievance cannot be resolved to your satisfaction, you may put your complaint in writing and submit it to the Sholtes and Associates Office Manager. You may submit your written complaint to the office manager through your therapist, through our reception desk or by mail. The office manager has 21 days from receipt of the complaint to investigate and respond to your grievance in writing.

If you are not satisfied with our response, you may contact the Illinois Psychiatric Association at 312-263-7391, the National Association of Social Workers, Illinois Chapter at (312) 236-8308 or the Illinois Psychological Association at (312)371-7610 for further information and assistance with your grievance.

We reserve the right to change the terms of this notice in the future. If we do, we will provide you with a revised notice by hand delivery at the next billing or scheduled appointment.

Bob Sholtes, MD

Susan Sholtes, LCSW