JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

NEW PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone # _____ Work Phone #: _____

Email: _____

Place of Employment: _____ Job Title: _____

Marital Status (Circle One): Single Married Divorced Separated Widowed

Parent/Guardian's Name (if minor): _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Coordination of Care with Primary Care Physician and/or Psychiatrist

Who is your medical doctor? _____ Phone # _____

May we contact your doctor? Yes /No OR I do not have a medical doctor __

*****IMPORTANT: If you answer YES, please complete the Release of Information sheet.*****

Who is your psychiatrist? _____ Phone # _____

May we contact your psychiatrist? Yes/No OR I do not have a psychiatrist ___

***** IMPORTANT: If you answer YES, please complete the Release of Information sheet.*****

Are you allergic to any meds? If YES, please list: _____

_____

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

RELEASE OF INFORMATION

Patient Name _____ Date of Birth: _____

I, the above-named patient, authorize John R Day & Associates, Ltd to *obtain from* or *release to*:

Name: _____ Phone #: _____

Check one or more of the following:

1) Discharge summary of hospitalization (s): _____ Date of Admission (s): _____
2) Summary of outpatient psychotherapy treatment: _____
3) School records, including IEP if applicable: _____
4) Reports of psychological testing results: _____
5) Summary or copies of relevant medical information: _____
6) Summary or copies of relevant legal information: _____
7) Other information (list here): _____

I understand that the information above are deemed necessary for my treatment. I understand that I may revoke this consent at any time in writing. This Release is effective for one year from the signature date. Please check the box(es) below to indicate your preference. If no boxes are checked, you consent for us to choose the best method for releasing your records in accordance with privacy standards.

___ I consent for this office to ***email*** my records to the above person or entity identified above.

___ I do not consent for this office to email my records, but to send them by mail instead. Printing and handling costs may apply depending on the volume of records to be sent.

___ I consent for this office to ***Fax*** my records to the above person or entity identified above.

___ I do not consent for this office to Fax my records, but to send them by mail instead. Printing and handling costs may apply depending on the volume of records to be sent.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Witness Signature **Date**

Notice to Recipient of Information

This information has been disclosed to you from records whose confidentiality may be protected by federal and/or state law. If the records are so to protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2 A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

3716 W Brighton Ave, Peoria, IL 61615 309-692-7755 Fax 309-692-2262

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy. We require you to read and sign this policy prior to any treatment.

All patients must complete and sign our New Patient Information Sheet before seeing the therapist.

PAYMENT FOR YOUR SESSION IS DUE AT THE TIME OF SERVICE. ANY DEDUCTIBLE AND/OR CO-PAY IS ALSO DUE AT THE TIME OF SERVICE. WE RESERVE THE RIGHT TO RESCHEDULE ANY APPOINTMENT FOR WHICH PAYMENT HAS NOT BEEN MADE. WE ACCEPT CASH, CHECKS, DEBIT AND CREDIT CARDS. WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.

Regarding Insurance:
If you have health insurance, as a courtesy, Christian Psychological Associates will verify your benefits before your first visit. You will be informed of your payment responsibilities verbally and in writing at your first visit. You are ultimately responsible for knowing your own insurance benefits.

At your first visit, we will need to make a copy (front and back) of your current insurance card. You will also need to sign the "Informed Consent" form, which allows us to bill your insurance carrier using a universal insurance form. Christian Psychological Associates will bill your insurance carrier for each session. We may accept assignment of insurance benefits. However, we do require that your deductible/co-pay/coinsurance be paid at the time of service or we reserve the right to reschedule your appointment. If your Insurance Company has not paid your account in full within 45 days, the balance will become your personal responsibility. We will require that you pay us the balance in full and you must check with your insurance company to find out why payment was not made, and/or pursue reimbursement yourself. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. **In addition, if your account becomes past due and is placed with an agency for collection purposes, you will be responsible for all collection agency fees (which are typically 33-50%), reasonable attorney's fees, and court costs.**

Usual & Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Attention Parents/Guardian of Minor patients:
The adult accompanying a minor (the parent or guardian of a minor) is responsible for payment. If there is a court order indicating the parent not present is responsible for medical bills, Christian Psychological Associates will forward the bill(s) to the said parent if we receive a copy of the court order. **However, the court order is between both parents of the minor, not Christian Psychological Associates and the parents**. We do not "split bills." The parents must arrange payments themselves. Therefore, if full payment is not received within 30 days, **the parent initiating treatment and/or bringing the child to the appointment** is responsible for full payment regardless of signature or lack of signature below.

Billing:
Statements will be mailed to all accounts showing the balance owed. You will receive a statement even if there is a balance outstanding to the insurance company, which may include the balance owed by the insurance company. **Note: patient balances over 90 days will be sent to a collection agency. Patient or Responsible Party will be responsible for all costs of collections, including collection agency fees, attorney fees, and court costs.**

Late Cancellation/No Show Policy:
Office hours are Monday through Thursday, 7 AM to 8 PM and Friday 7 AM to 5 PM. We are closed on all major holidays. There is an answering service 24 hours a day, 7 days a week. **If an appointment needs to be rescheduled and/or cancelled, please call (309) 692-7755 24 hours before the appointment to avoid a late cancellation or no-show charge of $80.00**.

I have read and understand the financial policy of Christian Psychological Associates.

_____	_____	_____
Patient/Guardian/ Responsible Party Signature	**Printed Patient Name**	**Date**

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

INFORMED CONSENT

I understand that John R Day & Associates provides psychological services, such as psychological testing, psychotherapy (also referred to as counseling), and follow up visits as needed. I understand that each psychologist or therapist has different specialties and will utilize these skills for treatment. By signing below, I am giving consent for psychological services provided by John R Day & Associates.

I understand that I am responsible for my bill for services provided and that payment is due upon completion of service. If I expect any portion of my bill be reimbursed or paid by insurance or prepaid health plan, it is my responsibility to ensure that my therapist has met my carrier's requirements.

I authorize payment directly to John R. Day & Associates, Christian Psychological Associates Ltd., on all my insurance admissions. I authorize the release of information of my care to my insurance companies to help obtain payment from them. I authorize my insurance company and my therapist to obtain any information they require to fulfill this function. This authorization will remain in effect until revoked by me in writing.

I understand my rights and responsibilities as a client at John R. Day & Associates, Ltd., also known as Christian Psychological Associates. I understand the nature of my rights to confidentiality, as well as the financial policies of the practice as contained in the Financial Policy that I have received.

_____ _____

Patient/Guardian/Responsible Party Signature **Date**

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

LIMITS OF CONFIDENTIALITY

Under certain legally defined situations, therapists are required to report information revealed during the course of therapy to other agencies or persons without your written consent. Every effort would be made to discuss with you, should a situation arise. In emergency situations this cannot be guaranteed, however:

1. If you reveal information to your therapist about child abuse or neglect or elder adult physical abuse, therapists are required by law to report this to the appropriate authority.

2. If you threaten suicide, therapists are required by law to report this to the appropriate individuals.

3. If you threaten bodily harm or death to another person, therapists are required by law to warn the intended victim and notify the appropriate law enforcement agencies.

4. If you are in therapy or being tested by order of a court of law, the results of treatment or tests ordered must be revealed to that court.

5. If a court of law issues a legitimate subpoena, therapists are required by law to provide the information specifically described in the subpoena.

I have read the above limits of confidentiality. I have a full understanding of their meaning and consequences. I agree to these limits of confidentiality.

_____ _____

Signature of Patient/Guardian **Date**

_____

Printed Name of Patient

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

NO SHOW / CANCELLATION POLICY

1. The first time you **NO SHOW** or **CANCEL** an appointment in less than 24 hours of your scheduled appointment, there will not be a charge to you.

2. All subsequent times, you will be charged **$80.00.** A No Show or Late Cancellation charge will be applied to your account.

_____ _____

Patient/Guardian/Responsible Party Signature **Date**

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

HIPAA PRIVACY ACT

JOHN R. DAY & ASSOCIATES' Commitment to Privacy of Patient Information: John R. Day & Associates supports an ethical and moral vision for the delivery of health care. We believe that the patients receiving our care are multi-dimensional beings, functioning on a physical, emotional, and spiritual level. In order to fully meet the patient's needs, we believe we have an obligation to safeguard the information shared with us during the provision of care. We are committed to meeting the full extent of the law in order to conduct the business of health care in a moral and ethical way.

Employee Commitment to Maintaining Privacy: Each employee, or work force member is responsible for protecting the privacy of patient information. The protection of patient information is an active role with every job or position. Each employee, or work force member is required to sign a confidentiality statement, indicating his or her commitment to maintaining the privacy of patient information.

Patient Rights: The patients have several new rights under the Privacy Rule: The right to access and view their record, the right to request an amendment, the right to request an accounting of disclosures, the right to request a restriction, the right to request confidential communications, the right to designate a patient representative, and the right to receive Notice of our privacy practices. All rights, except Notice should be required in writing. To exercise these rights, the local privacy officer/local contact should be contacted.

Use of Information in the Provision of Patient Care: During the provision of care, Protected Health Information may be exchanged with other providers of care for the treatment of patients, for the payment of a provider, and for the provision of health care operations of the provider.

Securing the Environment: John R. Day & Associates has the responsibility to reasonably protect patient information. This protection includes the physical environment. Employees who work with patient information of the computer should be aware of the direction of their computer screen, and make sure that the public cannot view it. A computer screen should not be left on while unattended. Emails should not contain Protected Health Information unless absolutely necessary. The destination of the email should also be considered. Protected Health Information should not be emailed to someone's home, unless absolutely necessary to provide patient care. Machines receiving faxes should not be located in a public area. If there is a common fax, staff that take the fax should be limited, rather than open to any staff walking by. The number for faxing should be verified, and automatically programmed, if possible.

Incidental Disclosure: During the provision of care, information is exchanged between caregivers. During that exchange, the information may be overheard. When information is overheard during the course of treatment, it is considered an incidental disclosure. Incidental disclosure is not an excuse for negligent disclosure of Protected Health Information. An example if incidental disclosure is when a repairman, such as the telephone repairman, comes into contact with PHI while repairing the telephone system. Since we did not provide the PHI to the repairman, and access to the PHI was not necessary for the repair, the disclosure was incidental.

Reporting of Suspected Violation: Any patient or employee may report a suspected violation of the protection of the privacy of patient information. A suspected violation should be reported to the immediate supervisor.

I acknowledge that I have received the Privacy Practices of John R. Day & Associates, LTD. I understand the uses and disclosure of protected health information by John R. Day & Associates, LTD.

_____	_____	_____
Patient/Guardian/ Responsible Party Signature	**Printed Patient Name**	**Date**

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following policy. Many of these common modes of electronic communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. If you have questions about this policy, please speak with our Risk Management Officer: Jessica Le.

Social Media

John R Day & Associates participates in various social media as a matter of business and information. You may view our posts, participate in discussion, or ask questions. However, please do not reveal more identifying information about yourself than you feel comfortable. **The Illinois Legal and Ethical guidelines do not allow therapists to have personal contact with clients through social media while you are in treatment as it may compromise your treatment.** Please understand if your therapist does not accept your friend requests on social media.

Web Searches

There is an incredible amount of information on the internet about individuals, whether it is correct or not. If you encounter information about us that you would like to clarify, please speak to your therapist about it or contact our office to speak with the Risk Management Officer. It has become common to review providers on the internet. We cannot respond to these. If you do please be aware that it might have a significant potential damage to your therapist's ability to work with you whether the review is positive or negative. We encourage you to speak with your therapist about your thoughts instead.

Text Messaging

Text messaging is a fast and efficient way to communicate. However, text messaging is unsecure. Text messaging does not replace time in therapy. We only send texts as an appointment reminder, which does not have any protected health information. The practice does not respond to text messaging. Text messaging with your therapist must be arranged between you and your therapist ahead of time. If you initiate text messaging, it is automatically understood that you consent to text messaging with your therapist.

Email

John R Day & Associates uses email and text messaging to remind clients of their appointments. Our system generates an email with a link for Patient Ally, your Patient Portal. We use email for administrative purposes such as billing and related activities, such as sending reports, etc. We also use email within our practice. However, email is highly unsecure. We do not use encryption technology. However, we have procedures that provide reasonable safeguards to protect health information. Whenever possible, we request that you sign a Release of Information to authorize us to email your records to other providers, individuals, or offices.

If you request documents from us for yourself via email, you are consenting for us to send potentially private information. If you initiate email to the office or your therapist, you are automatically consenting to email between you and our office and/or your therapist. It is up to your own discretion whether to communicate highly sensitive or personal information via email. We will not do so in the body of the email. You may revoke this consent in writing at any time. Please understand that email communication between you and our office or you and your therapist may become a part of your permanent records if we deem it relevant.

Faxing

As with email, our fax is not encrypted. In some instances, we use fax to send billing to your insurance. This is allowed. Whenever possible, we will request a Release of Information from you to fax your records to other providers, individuals, or offices which you consent. We use reasonable safeguards to ensure that the fax goes to the correct place. You may also request your records or bills be faxed to yourself as long as you understand that faxing is unsecure.

I acknowledge that I have received the Electronic Communication Policy of John R. Day & Associates, LTD.

_____ _____

Patient/Guardian Signature **Date**