JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

NEW PATIENT REQUEST
INSTRUCTIONS:

Please read, complete, and sign ALL 8 PAGES. Incomplete forms will delay the intake process. You may print or use a PDF app such as Adobe Reader or Foxit Reader. Mail, email, or fax the entire document to us. Email PDFs only. NO PHOTOS.
To expedite the process, you may also send us a copy of the front and back of your insurance card.
3716 W Brighton Ave, Peoria, IL 61615 * Main: 309-692-7755 * Fax: 309-692-2262 * home@christianpsychological.org

INSURANCE INFORMATION

Patient Name: _____ Date of Birth: _____

PRIMARY INSURANCE: _____ Plan: PPO/HMO _____ Employer: _____

Policy Holder/Subscriber: _____ DOB: _____ Relationship to Patient: _____

ID#: _____ Group#: _____ Customer Service #: _____

Subscriber Address: _____ City: _____ Zip: _____

SECONDARY INSURANCE: _____ Plan: PPO/HMO _____ Employer: _____
If Medicare is Primary, has Crossover been set up? Yes ☐ No ☐

Policy Holder/Subscriber: _____ DOB: _____ Relationship to Patient: _____

ID#: _____ Group#: _____ Customer Service #: _____

Subscriber Address: _____ City: _____ Zip: _____

EAP: _____ Authorization #: _____ # of Sessions: _____

Start Date: _____ End Date: _____ Customer Service #: _____

Policy Holder/Subscriber: _____ DOB: _____ Employer: _____

Additional Information:

JOHN R DAY & ASSSOCIATES, LTD
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NEW PATIENT INFORMATION

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

Address: _____City: _____ State: _____ Zip Code: _____

County: _____ Cell Phone #: _____ Other Phone #: _____

Email (for billing and documents): _____

Reminder Preference: Voicemail ☐ Text ☐ Email ☐ Marital Status: _____ Gender: _____

Reason for seeking services: _____

Referred by: _____ Provider Requested: _____ Location: _____

RESPONSIBLE PARTY NAME: _____ Relationship to Patient: _____
(If patient is under 18 years old)

Address: _____City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ Other Phone #: _____

Email (for billing and documents): _____

Emergency Contact:

Name: _____ Relationship to Patient: _____

Address: _____City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ Other Phone #: _____

Coordination of Care with Primary Care Physician and/or Psychiatrist

Who is your medical doctor? _____ Phone # _____

May we contact your doctor? Yes ☐ No ☐ I do not have a medical doctor ☐

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

Who is your psychiatrist? _____ Phone # _____

May we contact your psychiatrist? Yes ☐ No ☐ I do not have a psychiatrist ☐

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

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

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

☐ I do not consent for this office to email or 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.

_____ _____

Patients (12 and older)/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.

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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.

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. **However, you are ultimately responsible for knowing your own insurance benefits.** If your Insurance Company has not paid your account within 45 days, the balance will become your personal responsibility.

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.

Responsible Party:
If you are 18 years old, you are fully responsible for your account. If someone else is responsible, you must provide us with their name, address, number, and email on page 1.

If the patient is a minor, the responsible party is the individual who brings the child regardless of relationship.

Billing:
In our effort to go paperless, statements will be emailed. You will receive a statement when there is a balance 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 (typically 30-50%).**

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**.

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

_____	_____	_____
Patient/Responsible Party Signature (18 years and older)	**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). I understand that each psychologist or therapist has different specialties and will utilize these skills for treatment.

I understand that these services may include **TELEHEALTH**, depending upon what my insurance allows.

> *[Telehealth are therapy sessions through real time video. We use Doxy.me, which is a HIPAA compliant video program. In some instances, Telehealth may be conducted over the phone (audio) where video may not be available, or the patient does not know how to use video. Telehealth may be recommended by insurance or the therapist when a patient cannot come into the office for any reason. Telehealth may also be requested by the patient. Telehealth sessions are not recorded. Telehealth sessions are billed to your insurance if it covers the service.]*

By signing below, I am giving consent for psychological services provided by John R Day & Associates.

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 Christian Psychological Associates 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 patient at John R. Day & Associates, Ltd./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 Signature (18 years and older)	**Printed Patient Name**	**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.

_____	_____	_____
Patient/Guardian Signature (Patients 12 and older must sign)	**Printed Patient Name**	**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 on 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. Machines receiving faxes should not be located in a public area. The number for faxing should be verified, and automatically programmed, if possible. Patients and employees should be informed regarding electronic communication policy at the practice.

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 of incidental disclosure is when a repairman, such as an electrician, comes into contact with PHI while in the office area. 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 Signature (18 years and older)	**Printed Patient Name**	**Date**

JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

ELECTRONIC COMMUNICATION POLICY FOR YOUR RECORDS

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.