REGISTRATION FORM

FULL NAME: _____ DATE:_____

ADDRESS: _____CITY, STATE, ZIP _____

HOME PHONE: (_____) _____CELL PHONE: ( ) _____OK TO TEXT? Y OR N

OK TO LEAVE A MESSAGE AT THIS NUMBER? Yes _____ No_____

GENDER _____ AGE _____ D.O.B. _____ EMPLOYER _____

REFERRED BY: _____

E-MAIL ADDRESS:_____ OK TO EMAIL? Y____ OR N____

NAME AND PHONE OF PRIMARY PHYSICIAN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

GROUP/POLICY NUMBER: _____MEMBER ID/SUBSCRIBER ID #_____

POLICYHOLDER NAME: _____ POLICYHOLDER EMPLOYER_____

IF INSURANCE REQUIRES PREAUTHORIZATION: Auth. #_____ Number of Visits _____ Dates of Auth._____

IS THIS IS AN EAP VISIT (Employee Assistance Program)? If yes: Auth. # _____ # of Visits _____Dates of Auth._____

Jefferson Park Office: 5015 W Lawrence Ave, Suite 102, Chicago, IL 60630 Portage Park Office: 4732 N Austin Ave, Unit A, Chicago, IL 60630 P: 847.340.9908 W: www.newinsightschicago.com E: newinsightsBHS@gmail.com

PATIENT'S RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____ CHILD _____ OTHER _____

IF CLIENT IS A MINOR, please complete the following sections:

MOTHER'S FULL NAME_____ PHONE _____

MOTHER'S ADDRESS: _____

FATHER'S FULL NAME:_____ PHONE: _____

FATHER'S ADDRESS:_____

WHO IS RESPONSIBLE FOR PAYMENT OF SERVICES? _____

INSURANCE AGREEMENT

Please note: Insurance companies typically require the release information to them regarding diagnosis, type and place of services rendered, dates of services, and other related confidential information (e.g., treatment plans, periodic review of services). New Insights Behavioral Health Service cannot control such information once it has been released to an insurance company. **I accept responsibility for payment the insurance company may not cover. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

Patient/Responsible Party: _____ Date:_____

INFORMED CONSENT FOR TREATMENT

I consent to have New Insights Behavioral Health Services and its professional staff perform psychotherapy and/or related mental health treatments when deemed necessary or advisable by appropriate members of the professional staff and/or consultants in consultation with New Insights Behavioral Health Services. This statement has been fully explained to me and I understand it.

Patient/Responsible Party: _____ Date:_____

PRIVACY POLICY

I acknowledge having been offered *by New Insights Behavioral Health Services*, "Notice of Privacy Policies" and their "Clients Rights Statement" My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, as explained in the Policy. My right to make a complaint and file a grievance under Illinois laws has also been explained. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that *New Insights Behavioral Health Services* has already made disclosures with my prior consent.

Patient/Responsible Party: _____ Date: _____

PRACTICE POLICIES AND PROCEDURES

Please acknowledge that you have read each section below by initialing.

FEES AND PAYMENTS

Payment is due in full at the time of the visit, unless the Therapist has a contract with your insurance company. In that case, any deductible and co-payments are due at the time of the visit. Therapists collect their fees in session. The office accepts cash, check and credit card payments. All checks are to be made out to *New Insights Behavioral Health Services*. The office charges $25.00 for any returned check. If fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. _____Initial

INSURANCE CLAIMS

For all therapists, New Insights Behavioral Health Services will file your insurance claim promptly. Insurance benefits are verified following the first session and therapists are notified of the quote of benefits and pre-certification requirements, if any. Because a quote of benefits is not a guarantee of coverage, claims are not always paid exactly how we would expect. ***We will do our best to work with your insurance company, but should your insurance company deny a claim, or pay at a different benefit level than anticipated, it is your responsibility to follow up with your insurance company. Any remaining balance is the client's responsibility.***
_____Initial

APPOINTMENTS AND CANCELLATIONS

Therapists schedule their own appointments and can be contacted directly to inquire about availability. There are often waiting lists for appointment times; therefore, your appointment is valuable to your Therapist and other clients. Please notify the office or therapist as soon as possible of any appointment cancellations. ***Appointments not canceled at least 24 hours in advance will be billed to the patient at the full session rate and cannot be billed to, nor reimbursed by insurance.*** _____Initial

NOTICE OF PRIVACY POLICIES AND CLIENT RIGHTS

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: November 1, 2014

We respect patient/client confidentiality and only release confidential 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 New Insights Behavioral Health Services.

If you have any question about this policy or your rights contact Dr. Amit Kakkar at 847.340.9908.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Communication between a therapist and their client is strictly confidential and protected under Illinois state law and professional ethics. Any communication regarding your personal information requires a written authorization for release of information. However, under certain circumstances, confidentiality is limited. These circumstances include the following:

Payment. With your written consent, 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.

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing. For example: a) situations in which a therapist believes the client poses a threat to him/herself or others; b) situations in which records are ordered to be released by a Judge of the Courts; c) When the information disclosed involves the transmission of contagious or transmittable diseases; d) when the information disclosed involves information regarding child abuse, or abuse of the elderly; e) when a client's account is turned over to a collection agency or attorney for non-payments

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. We will leave appointment information on your answering machine unless you tell us not to.

PATIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect the client record that New Insights Behavioral Health Services has generated about you. We may charge you a reasonable fee of $50.00 for copying and mailing your record.

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

Restriction on Record. You may ask us not to use or disclose part of the clinical information. This request must be in writing. New Insights Behavioral Health Services is not required to agree to your request if we believe it is not in your best interest to permit use and disclosure of the information.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

1. New Insights Behavioral Health Services 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.
2. No client shall be presumed legally disabled unless declared so by a court.
3. 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 the Agency being unable to provide services to you.
4. If you have a complaint about the services provided you may file a grievance by doing the following: Contact Dr. Amit Kakkar at 847.340.9908.

CONSENT TO EMAIL AND TEXT

Please note that emails and text are not secure forms of communication. If you choose to email or text with the therapist, please be aware of this risk. If you choose to email or text with the therapist, please limit communications to scheduling appointments. Please do not send or discuss any confidential information in order to protect your privacy.

Do you consent to the use of email? Yes _____ No _____ Do you consent to

the use of text? Yes _____ No _____

_____

Client Signature Date

_____

Parent Signature, if applicable Date

_____

Therapist Date

Credit Card Authorization

New Insights Behavioral Health Services wants to work with you to make sure that claims and statements are paid accurately and efficiently. We request that you provide credit card information to secure your account. In the event that your account becomes past due, we will charge your card any remaining balance due. All open balances will be billed on a monthly basis. Your account will become past due if payment is not received within 30 days of the statement billing date. You may also set up regular monthly payments on your credit card if you prefer not to receive statements.

Unpaid past due accounts may be turned over to a collection agency if no payment arrangements are made.

Client Name_____

Credit Card #_____ Exp_____ CVV_____

Cardholder Name_____ Billing Zip code_____

Please check one:

_____ Maximum amount to charge $_____

_____ Please charge my card $_____ on a weekly/monthly (circle one) basis until my balance is paid in full.

I authorize New Insights Behavioral Health Services to charge my credit card listed above and to keep my signature on file for future charges as authorized by me.

Cardholder Signature_____Date_____