Hinsdale Psychological Resources

Introduction Packet

Welcome to Hinsdale Psychological Resources. This document contains important information about the professional services and business policies. Additionally, enclosed is a notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA), a federal law providing patient rights regarding clinical records and disclosures of Protected Health Information (PHI). This summary explains the use of your personal information for treatment, billing, and healthcare operations.

Please read the information carefully and complete the responses as requested. Pages 1-6 are yours to keep; please feel free to note any questions so that we can discuss them at our next meeting. When you sign this document, it will represent an acknowledgment that you received and agree to this HIPAA document. It will also act as an agreement between us for the provision of services with informed consent. You may revoke this agreement in writing at any time.

For your first appointment, please ensure to bring your Driver's License or State ID, Insurance Card (including Medicare Card or Secondary Insurance), and reading glasses or hearing devices (if applicable).

At Hinsdale Psychological Resources, we are dedicated to meeting patient goals and providing thorough and timely services. We look forward to working with you.

Hinsdale Psychological Resources

107 S. Vine Street, Hinsdale, Illinois 60521

Phone: (630) 850 - 9650

Fax: (630) 850 - 9607

INFORMED CONSENT FOR OUTPATIENT PSYCHOLOGICAL SERVICES

Psychological services are not easily described in general statements. It is an individualized experience which varies depending on the patient's needs and concerns being addressed. Psychological services are not like a medical doctor visit. Often there are multiple options for treatment, which you and your provider may explore together and find the best matched services for your needs. It is important to be aware that the treatments utilized are referred to as *evidence-based* practices, meaning that the services provided are founded in up-to-date scientific research on psychological treatment. Additionally, psychological services differ from medical services regarding your role in the process. Unlike most medical treatments, psychological treatment encourages a very *active participation* on your part. In order for the treatment to be most successful, you and your provider will identify treatment goals and strategies together which are intended to be practiced in your everyday life outside of session.

Psychological services can have benefits and risks. Since most clients are seeking treatment to address a concern or problem, our sessions often involve discussing unpleasant aspects of your life. At times, you may experience uncomfortable feelings like sadness, frustration, loneliness, stress, or hopelessness. On the other hand, psychological services have also been shown to have benefits for people who complete treatment. This may include stronger relationships, solutions to specific problems, improved ability to deal with health problems or life stressors, and significant reductions in feelings of distress. The results of therapy are highly individualized depending on many factors and goals for treatment.

The initial meeting will involve an evaluation of your needs; for some, this may require additional sessions. By the end of the evaluation, your provider will be able to offer you some first impressions and an initial treatment plan if you decide to continue with services. You should evaluate this information along with your own opinions, treatment goals, and comfort level of working with the provider. Therapy involves a commitment of time, finances, and energy, so you should be thoughtful about your treatment plan. If you have questions, please ask your provider whenever they arise, and make your provider aware of any way to clarify your expectations or increase your comfort with this process.

TYPES OF SERVICES

Depending on your goals, there are different types of psychological services provided. You may have been referred for a specific service, or perhaps you are unsure of what would be most appropriate. The following are the primary types of services provided:

Neuropsychological Assessment: This service involves an initial intake, assessment, and feedback with the purpose of evaluating cognition typically impacted by neurological or psychiatric disorder. On the initial meeting, your provider will gather background information and identify your concerns as well as the concerns of your referral source if applicable (e.g., your

physician or other third-party). If appropriate to proceed, you will engage in a thorough assessment process which may include paper and pencil forms, computer evaluations, or hands-on tasks or puzzles. These are typically lengthier appointments. Once completed, you will have a feedback session with your provider to review the results, better understand functioning, and discuss helpful recommendations. This entire process may range from two to five meetings which are often spread across several weeks.

Psychotherapy Treatment: This service involves initial intake followed by a course of psychological treatment. These services may be conducted individually with the client or can accommodate the attendance of participating family members as warranted. You will usually be scheduled for one 40-45 minute appointment per week, although some sessions may be longer or more frequent. Psychotherapy can be brief (4-6 sessions) or long-term; however, a typical course of therapy is 16-20 sessions.

CANCELLATION POLICY

Once an appointment is scheduled it is being held specifically for you, and you must be aware that you are responsible for full payment unless a cancellation is made *48 hours in advance*. Any missed session fees cannot be billed to your insurance company and will be paid out of pocket. Additionally, you are financially responsible for all fees not paid by your insurance company or workers' compensation carrier.

BILLING/INSURANCE

Hinsdale Psychological Resources *does not accept any commercial insurance*. For patients with commercial insurance, they will be required to pay in full at time of service and will be provided with documentation to submit for payment on their own. For those patients covered by Medicare with a secondary insurance or covered by the Department of Labor, your bills will be submitted by this office and provider will accept assignment. For those patients covered by Medicare with Medicaid/Illinois medical insurance card, you are not held responsible for the co-pay or any fees. If for any reason your secondary insurance company does not pay, you will be responsible for that amount. For those patients who do not have secondary insurance to supplement Medicare benefits, you will be required to submit the co-pay at the time of service.

For those patients receiving services through a Workman's Compensation carrier, bills will be submitted directly to the insurance company for payment. These fees will require pre-approval prior to services being rendered. If for any reason the insurance carrier does not approve or discontinues approval, services will be discontinued, although we will make every attempt to help you transfer to another provider. Please be aware that all fees not collected will be your responsibility at the time of settlement.

COMMUNICATIONS

The phone number for Hinsdale Psychological Resources is (630) 850-9650. During office hours, your provider is typically with patients and not immediately available by telephone. This number will reach the front desk. If unavailable or after hours, you can leave a voicemail for business needs (e.g., scheduling or messages for your provider). We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. For more sensitive or timely psychological concerns, you can select to be transferred to the answering service to page your provider. We may be unable to immediately respond to the page; therefore, if you cannot wait for a return call, please contact 911 or go to the nearest emergency room.

PROFESSIONAL RECORDS

The professional laws and standards require that treatment records include Protected Health Information (PHI). You may submit a written request for a copy of your records. These records are written in a professional manner specific to the field and may include psychological language and interpretations which can be misunderstood or perceived as concerning to untrained readers. If you request records, it is recommended to review them with your psychological provider so that we can discuss the contents or address any questions. The law does permit providers to withhold records due to their opinion that the contents may be harmful to the patient. In this case, a detailed explanation will be provided and we will reach a resolution together. Patients may be charged an appropriate fee for professional time spent in responding to information requests. Additionally, any individual that has an outstanding balance on their account will be charged for records.

CONFIDENTIALITY

The law generally protects the privacy of communications between a patient and a psychologist, which is considered confidential information. In most situations, your provider can only release information about your treatment if you sign a written consent form. However, there are exceptions to confidentiality and in the following situations no authorization is required:

The provider may occasionally find it helpful to consult other healthcare or mental healthcare professionals. The other professionals are also legally bound to keep the information confidential. Unless you provide objection, your provider will not necessarily inform you about these consultations.

If you are involved in a court proceeding, your provider may be required to disclose information. If you are involved in or contemplating litigation, you should consult with your attorney regarding the potential role of our services. If a patient files a complaint or lawsuit against an employee of Hinsdale Psychological Resources, relevant information may be disclosed regarding that patient in these proceedings.

A disclosure of your records may be required by health insurers for payment. If a government agency is requesting the information for health oversight activities, it may be required to provide them your information. As required by HIPAA, any formal business associates (i.e., a billing service) would maintain the confidentiality of data except as specifically allowed in the contract or otherwise required by law.

If you are receiving evaluation or treatment through a third-party request, the third-party may also have rights to your records. If you are a minor or have a guardian, parents/guardians have the right to examine your treatment records (although ideally your assent is first obtained).

There are some situations in which your providers are legally obligated to take action to attempt to protect the patient or others from harm. Protective actions may include notifying the potential victim, contacting your family members or others who can assist, contacting the police or other emergency services, or seeking hospitalization for the patient. Filing reports with additional appropriate agencies may also be warranted, such as the Department of Children and Family Service, Department of Aging, or Firearm Owners Identification database. Disclosure will be limited to what is necessary, however revealing some information about a patient's treatment may be required for protective actions in the following situations:

- If there is threat or behavior of violence towards identifiable victim
- If there is imminent risk of serious harm or mental injury to oneself
- If there is reasonable suspicion of abuse or neglect of a minor under the age of 18
- If there is reasonable suspicion of abuse, neglect, or exploitation of an adult with a disability
- If there is reasonable suspicion of abuse, neglect, or exploitation of an adult over the age of 60

MINORS & PARENTS

If you are under eighteen years of age, please be aware that the law may provide your parents/guardians the right to examine your treatment records. In order to protect the sensitive nature of our work together, it is our policy to request an informal agreement from parents that they do not obtain your records for their examination. Instead, they will be verbally provided with general information about our work together, ideally with you present or with our prior discussion of such information. However, if the provider has concern for your safety or the safety of others, including high risk situations, your parent/guardian may be notified of these concerns if needed.

PRIVACY PRACTICES AND PATIENT RIGHTS (effective date April 14, 2003)
The Health Insurance Portability and Accountability Act (HIPAA) provides patient rights regarding clinical records and disclosures of Protected Health Information (PHI).
These rights include:

- Obtaining a copy of your paper or electronic medical record
- Correcting your paper or electronic medical record
- Requesting confidential communication
- Requesting to limit the information we share
- Obtaining a list of those with whom we've shared your information
- Receiving a copy of this privacy notice
- Choosing someone to act for you
- Filing a complaint if you believe your privacy rights have been violated

As a provider under HIPAA, we are required by law to maintain the privacy and security of your PHI. Additionally, patients should understand that their information may be shared as appropriate for treatment, billing, research, help with public health and safety issues, compliance with the law, response to organ and tissue donation requests, work with a medical examiner or funeral director, address workers' compensation, law enforcement, and other government requests, or in respond to lawsuits and legal actions. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. If you believe your privacy rights have been violated, you may file a complaint with our Compliance Director by calling (630) 850-9650 for further information. All complaints must be submitted in writing.

THE FOLLOWING PAGES ARE TO BE COMPLETED AND PROVIDED TO HINSDALE PSYCHOLOGICAL RESOURCES. YOU MAY REQUEST A COPY.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge receipt of the Notice of Privacy Practices for Hinsdale Psychological Resources.

ACKNOWLEDGMENT AND CONSENT
I acknowledge receipt and have read the policies outlined. I accept the conditions set forth and consent to treatment as provided by Hinsdale Psychological Resources. I authorize Hinsdale Psychological Resources to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claims. Additionally, I assign any medical reimbursement to Hinsdale Psychological Resources.
Please note requirement of assent from minors in addition to consent from parents/guardians.

_____
Print Patient Name

_____ _____
Signature of Patient Date

_____
Print Name(s) of Legal Guardian(s), if applicable

_____ _____

_____ _____
Signature(s) of Legal Guardian(s), if applicable Date

CONSENT FOR MESSAGES
I give consent to Hinsdale Psychological Resources to contact me at:

CIRCLE PREFERRED NUMBER	*MAY LEAVE VOICEMAIL*
Cell phone: _____	☐
Home phone: _____	☐
Other phone: _____	☐

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Print Patient Name Print Name of Legal Guardian

Release of Information

I, _____, authorize Hinsdale Psychological Resources to:

_____ release records to/communicate with:

_____ obtain records from/communicate with:

_____ My physician, Dr. _____

_____ My other medical provider _____

_____ My family member(s) _____

_____ My attorney_____

_____ Other _____

Address: _____

Phone: _____

Fax: _____

The records include:

___ All
___ Diagnosis
___ Social History
___ School Data
___ Admission
___ Neuropsychological Testing Report
___ Psychological Testing Report
___ Treatment Progress
___ Medication
___ Other_____

This is for treatment from (date)_____ to _____

I understand this authorization expires in three years and I may revoke authorization in writing at any time.

_____ _____
Signature of Patient or Legal Guardian Date

OFFICE USE ONLY:

Witness_____ Date_____

INITIAL INTAKE FORM

Name: _____ Today's Date: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Emergency Contact:_____

Relationship: _____ Phone:_____

Referral Source: _____

Brief description of concerns/goals:_____

PERSONAL INFORMATION

Age: Date of Birth: Gender: Race:

Primary Language: Other Languages:

Writing Hand: Right Left Both

CHILDHOOD HISTORY

Born premature? NO / YES, *describe*:

Problems with birth/delivery? NO / YES, *describe*:

Difficulties with childhood developmental milestones? NO / YES, *describe*:

Who primarily raised you?

Number of siblings:

Please endorse any of the following which apply in childhood/adolescence:

❍ Depressed/anxious	❍ Parent with substance/alcohol abuse
❍ Arguing with parents often	❍ Teased/bullied often by others
❍ Social difficulties	❍ Took care of self or siblings (beyond typical)
❍ Pregnancy (pregnant or pregnant partner)	❍ Engaged in substance use (alcohol, marijuana, illicit drugs)
❍ Issues with adult authority figures	❍ Behavioral problems in home/school

EDUCATION HISTORY

Highest grade or degree achieved:

What kind of grades did you get in school?

Did you repeat a grade?	YES / NO	Skip a grade?	YES / NO
Receive Special Education?	YES / NO	Skip out of school often?	YES / NO
Learning issues in reading?	YES / NO	Suspended from school?	YES / NO
Learning issues in arithmetic?	YES / NO	Expelled from school?	YES / NO

VOCATIONAL HISTORY

Were you in the military? YES / NO Which branch? _____ How long? _____

What type of discharge did you receive?

Current employment status: Employed_____hours per week On restrictions
Unemployed Retired Medical Leave Disabled

Primary profession:

Current (or most recent) employer:

How long have/had you been there?

LEGAL HISTORY

Do you have a criminal record? NO / YES, *describe*:

Spent time in jail or prison? NO / YES, *describe*:

Had driver's license suspended or revoked? NO / YES, *describe*:

SOCIAL HISTORY

Current Marital Status: Single Married Divorced Separated Widowed

If partnered (past or present), how long?

Any additional previous marriages? If so, when and how long?

Children? YES / NO
Ages of biological children:
Ages of step-children:
Ages of adopted children:

Who currently lives in your home:

MEDICAL HISTORY

Do you have history of the following (please circle):

Asthma/Respiratory Problems Back Problems Heart Problems Blackout Spells

Broken Bones Chronic Pain Digestive Problems (stomach/bladder/bowel) Ulcers

Joint Pain Obesity Fainting Dizziness Headaches Migraines Concussion

HIV Insomnia Fatigue Seizures Stroke Traumatic Brain Injury

Cancer Diabetes High Cholesterol High Blood Pressure Thyroid Problems

Other pertinent medical history:

MENTAL HEALTH HISTORY

Diagnoses, if known:

Treatment with a psychiatrist (doctor who prescribes medications)? NO / YES, *describe dates, how long, frequency of visits:*

Treatment with a psychologist or counselor? NO / YES, *describe dates, how long, frequency of visits:*

Psychiatric hospitalization? NO / YES, *describe dates, how long:*

Take medications for mood or nerves? NO / YES, *describe medication, dates, how long:*

Please endorse any of the following which apply throughout the lifespan:

❍ Depressed/anxious	❍ Attempt suicide
❍ Abuse (sexual, physical, verbal)	❍ Self-harm behaviors
❍ Domestic violence	❍ Homelessness
❍ Auditory/visual hallucinations	❍ Grief, death, loss of loved one
❍ Eating and weight problems	❍ Trauma

FAMILY MEDICAL AND MENTAL HEALTH HISTORY

Do any of your family members have history of the following (please circle):

Cancer Diabetes Migraine Headaches Heart Disease Seizures Stroke

Hypertension/High Blood Pressure Obesity Dementia ADHD Chronic Pain

Heavy Alcohol Use Drug Use Depression/Anxiety Bipolar Disorder Suicide

Schizophrenia Learning Difficulties Developmental Delay Intellectual Disability

Other significant family medical history:

_____

HEALTH HABITS

In the past month, have you been:

Having issues with appetite or eating (over or undereating)? YES / NO

Having issues with sleep (falling/staying asleep or early awakening)? YES / NO

Having issues with sexuality/sexual function(relations, interest, performance)? YES / NO

Using tobacco products (cigarettes, cigars, vape, chew)? YES / NO

Type of product: _____ Frequency: _____ per day

Have you used tobacco in the past? YES / NO When did you quit?

Consuming alcoholic beverages? YES / NO If yes,_____ per week

Have you drank in the past? YES / NO When did you quit?_____

Did you ever attend AA meetings? YES / NO

Do you ever feel a need to cut down or stop your drinking? YES / NO

Has anyone ever told you that you have a drinking problem? YES / NO

Did drinking ever get you into trouble with family or work? YES / NO

Ever arrested for drunk driving? YES / NO

Using marijuana, medical marijuana, CBD, or THC products? YES / NO

Type of product: _____ Frequency: _____ per week

Have you used these in the past? YES / NO When did you quit?_____

HEALTH HABITS ***(continued)***
In the past month, have you been:

Using illegal drugs (cocaine, opioids, meth, MDMA, hallucinogenics)? YES / NO

Type of product: _____ Frequency: _____ per week

Have you used these in the past? YES / NO When did you quit?

Drinking caffeinated beverages (coffee, tea, soda pop, energy drinks)? YES / NO

Type of product: Frequency: per day

ACTIVITIES OF DAILY LIVING		
In the past month, have you been:		
Exercising?	YES / NO	_____days/week, _____minutes per day
Driving?	YES / NO	
Doing household chores?	YES / NO	
Dressing and washing self?	YES / NO	
Managing money?	YES / NO	

CURRENT MEDICATIONS

List the medications you are <u>currently</u> taking:

Medicine	**Amount/Dose**	**What for?**	**Taken Today?**	**Does it help?**
			YES / NO	YES / NO
			YES / NO	YES / NO
			YES / NO	YES / NO
			YES / NO	YES / NO
			YES / NO	YES / NO
			YES / NO	YES / NO
			YES / NO	YES / NO