CHICAGO PSYCH SERVICES
TREATMENT FOR THE WHOLE PERSON

155 North Michigan Ave., Suite 622
Chicago, IL 60601
www.chicagopsychservices.com
312-912-3978

Intake Form

PLEASE PRINT CLEARLY

Today's Date _____

PERSONAL INFORMATION

PATIENT (S) _____

Date of Birth _____ Gender _____

Address _____

_____

City, State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

RESPONSIBLE PARTY _____

Responsible Party's SSN _____

Address (if different) _____

_____

City, State _____ Zip _____

Home Phone (if different) _____

Work Phone (if different) _____

Cell Phone (if different) _____

Email: _____

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____
Name Phone # Relationship

Source of referral _____ Reason for referral _____

How did you hear about Chicago Psychology Services? _____

FINANCIAL

_____ _____ _____

Signature of Responsible Party Printed Name Date

OVER

Office Use Only
Therapist Name _____
Dx _____
Special Instructions _____
_____

Location
☐ Chicago Loop

Billing
☐ Client Self Pay

☐ Insurance_____ _____
# of Approved Visits _____

FAMILY INFORMATION

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NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO PATIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Patient (s)						
1.						
2.						
Parent (s)						
1.						
2.						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
6.						
Others Living in Household						
1.						
2.						
3.						
4.						
5.						
6.						

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MEDICAL INFORMATION

1. **Patient Name** _____

Have you ever been treated for emotional difficulties before (When and Where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____ Medications? _____

Are you presently being treated by a physician for any physical condition? _____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

Current Medications and Dosages (List) _____

2. **Patient Name** _____

Have you ever been treated for emotional difficulties before (When and Where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____ Medications? _____

Are you presently being treated by a physician for any physical condition? _____

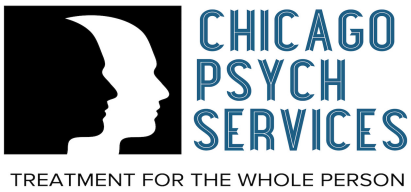
Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

***If more than two patients, please indicate above medical information on separate sheet for other patients.**

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Anger	___Grief	___Paranoia
___Anxiety	___Guilt	___Physical Aggression
___Behavior Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Somatic Complaints
___Delusions	___Interpersonal Conflicts	___Suicidal Thoughts/Attempt
___Depressed Mood	___Irritability	___Weight Gain
___Disruption of Thought Process/Content	___Manic	___Weight Loss
___Emotional/Physical/Sexual Trauma	___Mood Swings	___Worthlessness
___Excessive Crying	___Oppositional	___Other (Specify)
___Family Conflicts	___Panic Attacks	



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How could your life be better?

INSURANCE INFORMATION

Insurance Policy:_____

Member ID Number:_____

Group Number:_____

Policy Holder's Name (if not patient's):_____

Policy Holder's Date of Birth (if not patient's):_____

Policy Holder's Adress (if different than patient's):_____

City:_____ State:_____ Zip Code:_____

Office Use Only

Insurance Representative Spoken To: _____

Reference Number: _____

Preauthorization Needed: Y__ N__

Number of Sessions: _____

CPT Codes Supported:_____

ICD Codes Used:_____

Special Instructions: _____

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Privacy Practices Form

You, or a member of your family, are about to become involved in or psychology (psychotherapy, teletherapy, testing, hypnosis, biofeedback) with a trained and licensed psychologist. I wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   a) Type of therapy needed (individual, group, medication referral, hypnosis, biofeedback, etc.)
   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 50 minutes, intakes 90 minutes. At the end of each appointment you can discuss future appointments with your therapist.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You, and or your insurance will be personally charged for your appointment if not canceled at least 48 hours in advance other than for emergency reasons. Continued cancellations, or more than two cancellations over a month period could be grounds for terminations of services.

4. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment, oryou're your credit card number kept on file. Charges for services in addition to therapy may be levied (i.e., involvement in client litigation, document preparation, etc.). These fees will be negotiated individually with your therapist. We accept cash, credit, HAS, and check. Please make checks out to "Dr. Scott Hoye, Psy.D.," or provide us with your credit card information.

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We currently are in-network with Blue Cross/Blue Shield of Illinois PPO, Cigna PPO, Cigna Health Spring, Humana PPO, and Medicare. We will assist you in any way possible by providing receipts and documentation. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. Payments for services received through Chicago Psychology Services are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at Chicago Psychology Services and is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists at the office as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

   If more than one adult patient, each person should check and initial boxes.

   ☐ Yes ☐ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.
   ☐ Yes ☐ No I have received a copy of the Privacy Practices Form.
   ☐ Yes ☐ No I consent to the exchange of treatment information between CPS and my primary care physician.

Patient(s):
Physician's Name/Office and Phone Number _____

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Signed: _____ Date: _____

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7. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
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   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

8. APPOINTMENTS: Each intake is approximately 90 minutes. Therapy appointment is approximately 50 minutes. Some sessions may be longer, depending on the service provided (hypnosis, biofeedback, and psychological testing). At the end of each appointment you can discuss future appointments with Dr. Hoye.

9. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You, and or your insurance will be personally charged for your appointment if not canceled at least 48 hours in advance other than for emergency reasons. Continued cancellations, or more than two cancellations over a month period could be grounds for terminations of services.

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11. INSURANCE: Insurance is an agreement between you and your insurance company as to how mental health services will be paid for. We will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts for out-of-network payments. Payments for services received through Chicago Psychology Services are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

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Physician's Name/Office and Phone Number _____

CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS