Welcome! Thank you for choosing Glen Manor Counseling.

Patient Information		
Patient's Name: (First, MI, Last)		Marital Status: Single/Mar./Div./Other
Street Address:		DOB: / /
City, State, Zip Code:		Male or Female
Phone (Best # to reach you at):	Email Address:	S.S.#:
Employed: Y or N Employer Name: _____ Full Time Student: _____ Part Time Student: _____		
Presenting Problem:	Medications:	
Whom may we Thank for referring you?		

Parent or Guardian Information for Children.		
Mother/Guardian's Name:	Work Phone:	Cell Phone:
Address (if different):		
Father / Guardian's Name:	Work Phone:	Cell Phone:
Address (if different):		

Insurance Information (Please Give Us Your Insurance Card To Copy)		
Name of Primary Insurance and Policy Holder:	Name of Employer:	Policy holder Date of Birth:
ID or Subscriber #:	Group #:	Deductible or Co-Pay:
Relationship to patient if not self:		
Name of Secondary Insurance and Policy Holder:	Name of Employer:	Policy holder Date of Birth:
ID or Subscriber #:	Group#:	
Relationship to patient if not self:		

In Case of Emergency		
Name of relative or friend:	Relationship to Patient:	Home and/or Cell #:

Cash Pay Policy: Patients without medical insurance are required to pay $150.00 at the time of service for the initial evaluation, and $110.00 at the time of service for all follow up sessions. Patients paying at the time of service without billing insurance are receiving a discounted rate.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Glen Manor Counseling to release any information to my insurance company to process my claims.

_____ _____

Patient/Guardian Signature Date

Glen Manor Counseling
Informed Consent

Clinical Billing and Expectations

Please sign below to indicate you have read and understand the following:

1. Responsibility for payment of your account remains with you at all times: billing your insurance company is a courtesy to you. Please contact us immediately if there is a problem with your claim.

2. Copays and other estimated out of pocket amount(s) due are to be collected at the time of service.

3. You will receive a monthly statement showing itemized charges and the total amount due on your account. We ask that no balance ever exceed $300.00 at one time.

4. A $25.00 to $100.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. The amount will reflect the amount of times you have cancelled same day or no showed for an appointment. Please note that after 2 or more no show appointments, you will be subject to termination from Glen Manor Counseling.

5. There is a $35.00 fee for all returned checks for insufficient funds.

6. We do use a medical collection agency for all non-paid balances after 90 days without payment arrangements. In the event that an account is overdue and turned over to the agency, the client or guarantor will be held responsible for any collection fees/court costs. If your account has been referred to the collection agency, you will be discharged from Glen Manor Counseling.

Signature(s): _____ Date: ____/____/_____

Confidentiality and Emergency Situations:

Your verbal communication and clinical records are strictly confidential except for:

1. Information (diagnosis and dates of service) shared with your insurance company to process your claims/verity treatment or information necessary to collect payment.
2. Information you and /or your child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services.
3. Where you sign a release of information to have specific information shared.
4. If you provide information that informs me that you are in danger of harming yourself or others.
5. If any emergency situation for which the client or guardian feels immediate attention is necessary, the client or guardian understands they are to contact emergency services in the community. Glen Manor Counseling will follow those emergency services with standard counseling and support of the client or the client's family.

Signature(s): _____ Date: ___/___/_____

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

There is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Signature(s): _____Date: ___/___/_____

HIPAA ACKNOWLEDGEMENT/CONSENT FORM: I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment form third party payers (e.g. my insurance company):
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of you Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is no affected.

Signature: _____ Date: ___/___/_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ maybe treated as a client by Glen Manor Counseling, Ltd.

Signature: _____ Date: ___/___/_____