



Welcome to Perspectives! In order to provide you with the best assistance possible, we would appreciate your filling out the enclosed forms prior to your first visit. When completed, please fax only the Application For Service form to 312/558-1570, Attn: Practice Manager. Bring all originals and your insurance card with you to your first appointment.

Included in this packet are:

- ❖ Application For Services
- ❖ Consent and Agreement For Mental Health Services
- ❖ Notification of Desirability of Conferring with Primary Care Physician Form
- ❖ Notice of Privacy Practices (Two copies will print. One copy is for your records the other is for your therapist's records.)

Thank you!



APPLICATION FOR SERVICES

OFFICE USE ONLY
DATE TX
LOCATION
CPT CODE
DIAG
FEE
CO-PAY
DEDUCTIBLE
SESSIONS/YR
AUTH
REFER BY
VERIFY INS Y N

CLIENT INFORMATION:

Name: Last First MI Social Security #
Sex: M F Date of Birth: Marital Status: S M D Sep W
Address:
City: ST: Zip:
Home Phone: Work Phone: Ext: Cell Phone:
E-Mail Address: May we send correspondence to this email? Yes No
Preferred method of correspondence: Email Paper Both

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

Name: Live with client? Yes No
Address: City ST Zip
Home Phone: Work Phone: Social Security #

WILL YOU BE USING: INSURANCE OR PAYING YOURSELF
IF USING INSURANCE, PLEASE FILL IN THE INFORMATION BELOW.

PRIMARY INSURANCE:

Name of Insurance Carrier: Phone:
Address of Insurance: City: ST Zip:
Is there a special number to call for Mental Health or Substance Abuse? Yes No
Have you called for precertification? Yes No N/A Date of Birth:
Name of Insured: Insured Employer:
Address: City: ST Zip:
Social Security #: Group Number: ID Number:
Relationship to Client: Self Spouse Parent Step-Parent Other

SECONDARY INSURANCE:

Name of Insurance Carrier: Phone:
Address of Insurance: City: ST Zip:
Is there a special number to call for Mental Health or Substance Abuse? Yes No
Have you called for precertification? Yes No N/A Date of Birth:
Name of Insured: Insured Employer:
Address: City: ST Zip:
Social Security #: Group Number: ID Number:
Relationship to Client: Self Spouse Parent Step-Parent Other

I/We authorize Perspectives, Ltd. to release any information necessary to process this claim.

Signed: Date:

I/We authorize the payment of benefits directly to Perspectives, Ltd. who accepts assignment. It is understood that the undersigned has the responsibility for payment of services. Assignment of Benefits does not release the undersigned from responsibility of payment.

Signed: Date:

Witness: Date:



## CONSENT AND AGREEMENT FOR MENTAL HEALTH SERVICES

**Appointments:** Each appointment, whether in the office or on the telephone, represents a specific amount of time reserved for you. If a problem arises and you are unable to keep this time, we require 24-hour notice of cancellation. You will be charged for late cancellations or failed appointments unless there is a clear emergency. Based upon the contractual requirements of your insurance company, charges for late cancellations or failed appointments may be entirely your responsibility.

**Insurance and Payments:** To avoid misunderstandings, we wish the person(s) responsible to know that all professional services rendered are charged directly to them and that they are responsible for payment of the fees. All fees are due at the time that services are rendered unless other specific arrangements have been made with the therapist. We will be happy to promptly complete necessary forms for your insurance company so that you may be reimbursed.

**Consent:** I/We hereby consent to treatment at Perspectives, Ltd. for myself/ourselves and/or our children. I/We understand that we may choose to terminate treatment at any time, and we understand that our communications are protected by relevant state and federal laws and by Perspectives' firm commitment to ethical standards.

Signatures: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



### NOTIFICATION TO PATIENT OF DESIRABILITY OF CONFERRING WITH PRIMARY CARE PHYSICIAN

Pursuant to Illinois law, you are hereby informed that it is desirable that you confer with your primary care physician, if you have one. If you have a primary care physician, I am required to notify him/her that you are seeking or receiving mental health treatment unless you waive such notification.

*Please indicate your wishes:*

My primary care physician is: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ I **AGREE** to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing the attached Authorization to Release Information permitting you to communicate with my said physician.

\_\_\_\_\_ I **WAIVE NOTIFICATION** of my primary care physician that I am seeking or receiving mental health services, and I direct you **NOT** to so notify him/her.

\_\_\_\_\_ I do not have a primary care physician and do not wish to see or confer with one. I therefore **WAIVE NOTIFICATION** of a primary care physician that I am seeking or receiving mental health services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Parent or guardian of minor patient or ward

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### NOTIFICATION TO PRIMARY CARE PHYSICIAN OF PATIENT RECEIVING MENTAL HEALTH SERVICES

Pursuant to Illinois law requiring that Licensed Clinical Social Workers inform their patients' primary care physician that a patient is seeking or receiving mental health services, you are hereby notified that \_\_\_\_\_ is seeking or receiving such services from me. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your records. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist



## NOTICE OF PRIVACY PRACTICES

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: April 14, 2003.

Perspectives, and its affiliated network providers located in and outside of the United States, respect patient confidentiality and only release medical information about you in accordance with federal and state laws. This notice describes our policies related to the use of the records of your care generated by Perspectives, Ltd.

Privacy Contact. If you have any questions about this policy or your rights contact Perspectives' Privacy Officer.

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your medical information with others beyond our practice. This includes for:

Treatment. We may use or disclose medical information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside our practice that we are consulting with or referring you to.

Payment. 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.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

**Information Disclosed Without Your Consent.** Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

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.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

## **PATIENT RIGHTS**

You have the following rights under state and federal law:

Copy of Record. You are entitled to inspect the medical record our practice has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, 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 medical information. This request must be in writing. The Practice is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Perspectives' Privacy Officer.

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. We also will be glad to provide you information by email if you request it. If you wish us to communicate by email you are also entitled to a paper copy of this privacy notice.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact Perspectives' Privacy Officer and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement that you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your medical information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to Perspectives' Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact Perspectives' Privacy Officer in writing at our office for further information. You also may complain to the Secretary of Health and Human Services if you believe our Practice has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. The Practice reserves the right to change its Privacy Policy based on the needs of the Practice and changes in state and federal law.

I have read and understand the Perspectives Notice of Privacy Practices statement, the Use and Disclosure of Patient Health and Information statement, and the Patient Rights statement.

Signatures: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_



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Witness: \_\_\_\_\_

Date: \_\_\_\_\_