ALEXANDER J. PARET
& ASSOCIATES
EXPERTS IN BILINGUAL, CLINICAL,
CHILD & ADULT FORENSIC PSYCHOLOGY

5250 Old Orchard Road, Suite 300
Skokie, IL 60077

Telephone: (847) 904-2299
Facsimile: (847) 834-0087

Patient Registration Instructions — Please Read Before Completing Forms

We wish to take this opportunity to welcome you to our practice. We look forward to collaborating with you in achieving your goals for counseling. Please take a few minutes to carefully review and complete the attached forms. We ask that you complete this set of forms and bring them with you to your first appointment.

1) If the patient is not the guarantor, and you wish use health insurance, please be sure to provide all requested information regarding the guarantor, including the guarantor's social security number and date of birth.

2) Please review the *Consent for Treatment* form in its entirety. Fees for evaluation and counseling services are shown on the *Consent for Treatment* form; fees for other specialized services may be found at the Alexander J. Paret & Associates (AJP&A) fee schedule. If you are electing to use health insurance to offset the costs of counseling, it is recommended that you contact your health insurance company prior to the first appointment to determine: 1) if your policy has a restricted network of providers; 2) if your AJP&A clinician is in your network; 3) the amount of any deductible which must be met; 4) the amount of any copays once the deductible is satisfied; 5) any restrictions upon mental health benefits or the need for authorization of care. Please record this information in the spaces provided on the *Consent for Treatment* form.

3) If you wish AJP&A to bill your insurance company, please sign the written release to disclose information on the attached form. If you wish AJP&A to be the payee from your insurance company please also sign the assignment of benefits section of this same form.

4) Your HIPPA privacy rights are summarized on two sheets of information — these pages are yours to keep—and we ask that you sign the attached form indicating that you have been provided with this information.

5) All patients are to complete the attached *Payment Agreement*. Please provide credit card billing information. As explained on the form, you may use cash or check to pay for services provided however your credit card may be utilized for collection of unpaid balances resulting from deductibles, copays, late cancellation or failed appointment charges. Please be sure to check the appropriate boxes indicating how you wish to make payment for services, complete credit card information and sign the *Payment Agreement* at the bottom.

Please take special note of information found in both the *Consent for Treatment* and *Patient Rights & Responsibilities* forms regarding our policy concerning **late cancellations** or **failed appointments**:

1) You will benefit most from your course of counseling if you make it a scheduling priority. However, we know that juggling commitments can be difficult and we will work to accommodate your needs.

2) If you need to reschedule an appointment, AJP&A requires at least 24 hours notice—*a full business day in advance of the hour of your appointment*—giving notice of the intent to cancel a scheduled appointment. Also, please note: appointments scheduled on Mondays (or Tuesdays if following a holiday weekend) must be canceled by 5:00 pm the preceding Friday afternoon. If you have a scheduling conflict and must cancel an appointment, it is sufficient to leave a voicemail message by calling 847-904-2299. This notification must be provided a full 24 hours (or 1 business day) in advance of the hour of the scheduled appointment in order to avoid being billed for the appointment. We are unable to make allowances or exceptions to this policy, except in cases of sudden serious illness, family emergency or severe inclement weather. Be advised that business/work conflicts, scheduling of kids' athletic or school events, unexpected travel or other similar circumstances which might arise are not deemed as grounds for waiver of the late cancellation policy.

3) If you are the guarantor of your son or daughter and they are of age to make their own scheduling arrangements for ongoing counseling, you may wish to stay informed of appointments which have been scheduled, since you will ultimately be responsible for charges. We would be happy to coordinate scheduling information via email or phone—let us know your preference and provide the necessary contact information.

4) ***With regard to late cancellations or failed appointments, you will be charged the full, customary fee for the scheduled service. Your insurance company will not be billed for the late cancellation or failed appointment- you will be responsible for payment of the full usual and customary fee per the AJP&A fee schedule. In the event that you incur such a charge, we ask that you provide payment prior to or at time of the next scheduled appointment.***

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PATIENT REGISTRATION INFORMATION – *please print clearly & legibly*

Patient Information

Last Name	First Name	MI	Date of Birth / /	Age	Sex

Address	Apt. #	City	State	Zip

Patient Social Security Number	Home Phone	Work Phone	Cell Phone

Patient Employed By	Occupation

If contact by email for scheduling, billing or other matters is convenient, please provide email address:

Guarantor--Name of Person Financially Responsible for Patient's Care

(Provide this information only when guarantor is not the patient)

Last Name	First Name	MI	Date of Birth / /	Age	Sex

Address	Apt. #	City	State	Zip

Guarantor Social Security Number	Home Phone	Work Phone	Cell Phone

Guarantor Employed By	Occupation

If contact by email for scheduling, billing or other matters is convenient, please provide email address:

Health Insurance Information (may be left blank if a copy of insurance card—both front & back— is obtained)

Name of Insurance Company	Name of Subscriber	Relation to patient

Plan/Policy #	Group #	Effective Date, if known

Insurance Company Claims Billing Address	City	State	Zip

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CONSENT FOR TREATMENT

Patient Name: _____

1) I hereby consent to receive behavioral health services provided by the mental health professionals affiliated with Alexander J. Paret & Associates (AJP&A).
2) I authorize and request that AJP&A perform assessments and to administer those treatments as may be considered advisable in making a diagnosis and treating my condition.
3) I realize that no particular outcome or result can be guaranteed as a result of my consent to receive treatment by AJP&A.
4) I hereby release AJP&A from responsibility for any injury which may result from my declining services recommended by AJP&A or terminating services against clinical and/or medical advice.
5) I have read, understood and signed the *Patient Rights, Responsibilities and Statement on Confidentiality* and agree that I will follow the procedures described therein, specifically including the following:
   a) AJP&A requires notice by telephone no later than one business day—24 hours in advance of a scheduled appointment (or for Monday appointments and Tuesday appointments which follow holiday weekends, no later than 5:00 pm on the preceding Friday afternoon).
   b) If I do not give proper notification I understand that I am responsible for paying the full customary fee, per the AJP&A fee schedule in effect at the time the appointment was scheduled, for the missed appointment (not a reduced/contracted fee or the customary co-pay charge).
      i) Failed appointments will result in my being billed the full customary fee, per the AJP&A fee schedule in effect at the time the appointment was scheduled, and I understand that no claim will be submitted to my insurance company for this charge.
      ii) Late cancellations (e.g., cancellation without adequate advance notice specified above in par 5a) will result in being charged the full customary charge except as negotiated with the treating therapist due to instances of unforeseen events such as sudden illness, family emergency or severe inclement weather. Personal scheduling conflicts (e.g., due to employment or other circumstances) shall not be eligible grounds for waiver of the late cancellation charge.
   c) AJP&A kindly requests that payment for failed appointments and/or late cancellations be provided in full at the next scheduled appointment.
6) Non-urgent calls (e.g., scheduling or other non-urgent matters) are best managed by making use of the AJP&A voicemail system at (847) 904-2299, leaving a message for the specific provider.
7) In the event of an after hours emergency, it is recommended that patients contact the treating clinician as instructed on the AJP&A voicemail service or contact the nearest hospital emergency room.
8) I have been given the opportunity to review the AJP&A fee schedule and I understand that the fee structure for AJP&A services is as follows (*consult fee schedule and fill-in fees shown for your provider*):
   Fee for initial evaluation session is: $210 (psychologist)
   Fee for each individual/family/marital psychotherapy session is: $165 (psychologist)
   If using health insurance to offset costs of treatment, the deductible which must be met before accessing insurance benefits is anticipated or known to be: $_____.
   If using health insurance the anticipated co-payment per session is: $_____.
9) I understand that I am responsible for making payment for each session immediately following each appointment as set forth in the accompanying Payment Agreement.

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I certify that I have read the above Consent for Treatment information and signify my agreement with my signature below:

_____	_____
Signature of Patient	Date
_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Witness	Date

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PATIENT RIGHTS & RESPONSIBILITIES

Patient Name: _____

As a Consumer of Healthcare Services, Your Rights Include The Following

To individualized service, to participate in treatment planning and to see your clinical record.
To be advised at the time that treatment is initiated of the cost of the services to be provided.
To know the professional status, licensure, training and experience of the staff members responsible for your treatment.
To confidentiality of all records and communications, within the extent prescribed by law (see below), including the confidential handling of personal and medical records and to approve or refuse the release or records to any individual outside Alexander J. Paret & Associates (AJP&A).
Upon request, to know the risks, side effects, benefits and/or experimental nature of all treatment procedures and to be advised of known alternate treatment procedures available, their indications and foreseeable outcome.
Upon request, to a clear and concise explanation of the proposed treatment and procedures, the goals of treatment and anticipated outcome of treatment.
To refuse treatment. Should you choose to refuse recommended treatment, you shall be provided, upon request, a clear description of anticipated consequences of the decision to refuse treatment to the extent these consequences are foreseeable.
To request the opinion of a consultant at personal expense and to request a review of your treatment plan.

As a Consumer of Healthcare Services, Your Responsibilities Include The Following:

Missed appointments & late cancellation policy

You are responsible for scheduling and keeping appointments with the treating clinician. AJP&A requires notice by telephone no later than 24 hours in advance of a scheduled appointment (or for Monday appointments and Tuesday appointments which follow holiday weekends, no later than 5:00pm on the preceding Friday afternoon). It is sufficient to leave a voicemail message for your specific clinician when calling to cancel a scheduled appointment. Please note that patients are responsible for payment of the full usual & customary fee, per the AJP&A fee schedule in effect at the time the appointment was scheduled, for a failed appointment or late cancellation. Please note, too, that your insurance company will not be billed for the late cancellation or failed appointment. Other than circumstances such as sudden illness, family emergency or severe inclement weather, we are unable to make exceptions to this policy.

Fees

Fees are discussed and set at the time of the initial appointment, based upon the AJP&A fee schedule in effect at the time of service delivery, which is available for review upon request. Expected fees for some services are shown on the *Consent for Treatment* form. Payment arrangements are detailed on the *Payment Agreement* form. Collections procedures for AJP&A are described in policy, which is available for review upon request. In the case of prolonged nonpayment for services per the AJP&A fee schedule in effect at the time the appointment was scheduled reserves the right to implement its collections policy which could include the use of collections agencies, alternative dispute resolution procedures and/or small claims court filing.

Insurance reimbursement

Some services provided by AJP&A may be eligible for reimbursement by your health insurance. If you plan to use health insurance benefits, your AJP&A clinician will work with you to comply with the requirements of your insurance and/or managed care company. Your treating clinician will arrange to have claims filed with your insurance company if you so desire. However, you are ultimately responsible for payment for all services, including payment for denied services, within contractual limitations and in accordance with the terms set forth in the accompanying *Payment Agreement*. Additionally, you are responsible for participating in any appeals processes for denied claims.

Information Concerning Confidentiality

As a recipient of psychological services through AJP&A, your treatment is confidential within the limits prescribed by law. In general, no information about you or your treatment will be released to anyone without your written permission. However, relevant laws require that your therapist contact others about your safety if you present a danger to yourself and/or others, or if your therapist learns of child abuse/neglect or, under certain circumstances, if so ordered by a court. In addition, your therapist may consult with a clinical supervisor, or other qualified clinician, without your consent to improve the quality of care provided. If the recipient of services is under 12 years of age, your therapist may discuss the treatment with the recipient's parent or legal guardian without consent. If the recipient is 12 through 17 years of age, the therapist may discuss the treatment with a parent or legal guardian when the recipient is informed and does not object to sharing information with his/her parent or guardian, or if the therapist does not feel there are compelling reasons not to disclose information with the parent or guardian. Information may also be disclosed to the guardian of a recipient who is 18 years or older. Information may also be disclosed to outside agencies & organizations to support collections and billing procedures. Otherwise, except as provided by law, no information may be disclosed without the written consent of a recipient

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who is 18 years or older. Further information on confidentiality is provided in the related Privacy Notice, provided at time of intake.

I certify that I have read the above Patient's Rights and Responsibilities and signify my agreement with my signature below:

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Parent/Guardian **Date**

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Patient Name: _____

RELEASE OF INFORMATION FOR PROCESSING HEALTH INSURANCE CLAIMS/CHARGES & CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby authorize (AJP&A) to release any of the following information for the purpose of obtaining reimbursement for treatment services provided to me and/or my dependents. Information to be released may include:

1. Admitting diagnosis
2. Treatment summary/dates of service
3. Billing summary & charges
4. Verbal/written exchange of information
5. Progress notes
6. Treatment plan
7. Final diagnosis and/or termination summary

This information may be released to any or all of the following parties/organizations as needed:

1. Any third-party payor having responsibility for payment of charges incurred through rendering of psychological services by AJP&A.

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This consent is valid until such time that all claims have been settled to the satisfaction of AJP&A or up to three years from the date of discharge form AJP&A, whichever is longer. I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize AJP&A to contact the actual or additional insured (e.g., my spouse or other guarantor), and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate this consent at any time before the expiration date so long as I submit my revocation in writing to AJP&A. Finally, this consent does not permit any agency reviewing clinical information and/or records to redisclose my records to any other agency/person/organization without my written consent.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance carrier, as described in the accompanying Payment Agreement, and that if I refuse to sign this release of information form I will likely have to pay for any and all charged incurred, without utilizing health insurance benefits.

I certify that I am the client; if I am not the client I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

Signature: _____ Date: _____

Relation to Patient: _____ Witness: _____ Date _____

ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me or to my dependent I hearby assign, transfer and set over AJP&A all of my rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits as they pertain to charges incurred for services rendered by AJP&A. I understand that I am financially responsible to AJP&A for charges not covered by my insurance and/or managed care company by this assignment for any reason

Signature: _____

(Insured's or authorized agent's signature) **Date**

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PATIENT IS TO RETAIN THIS FORM FOR HIS/HER OWN RECORDS & SIGN ACKNOWLEGEMENT THAT THE FORM WAS RECEIVED

PRIVACY NOTICE Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Alexander J. Paret and Associates (hereafter referred to as "AJP&A") may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"

– Treatment is when AJP&A provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when AJP&A consults with another health care provider, such as your family physician or another psychologist.

– Payment is when AJP&A obtains reimbursement for your healthcare. Examples of payment are when AJP&A disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

– Health Care Operations are activities that relate to the performance and operation of AJP&A. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within AJP&A offices such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my AJP&A offices such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is the patient's written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

AJP&A may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when AJP&A is asked for information for purposes outside of treatment, payment, or health care operations, AJP&A will obtain an authorization from you before releasing this information. AJP&A will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes made about conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that AJP&A has already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage—law provides the insurer the right to contest the claim under the policy.

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III. Uses and Disclosures without Authorization

AJP&A may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If AJP&A has reasonable cause to believe a child known through a professional capacity may be an abused child or a neglected child, AJP&A must report this belief to the appropriate authorities. Adult and Domestic Abuse – If AJP&A has reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, AJP&A must report this belief to the appropriate authorities.
- *Health Oversight Activities* – AJP&A may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and AJP&A must not release such information without a court order. AJP&A can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to AJP&A a specific threat of imminent harm against another individual or if an AJP&A clinician believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, AJP&A may make disclosures believed necessary to protect that individual from harm. If AJP&A believes that you present an imminent, serious risk of physical or mental injury or death to yourself, AJP&A may make whatever disclosures consdiered necessary to protect you from harm.
- *Worker's Compensation* – AJP&A may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, AJP&A is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, AJP&A will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, AJP&A will discuss with you the details of the request for access process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. AJP&A may deny your request. On your request, AJP&A will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request,

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AJP&A will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

AJP&A clinicians are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

AJP&A reserves the right to change the privacy policies and practices described in this notice. Unless notified of such changes, however, AJP&A is required to abide by the terms currently in effect.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact AJP&A or contact the Illinois Guardianship & Advocacy Commission. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on February 1, 2013.

Patient Name: _____

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PRIVACY NOTICE ACKNOWLEGMENT

By signing below, I acknowledge that I have received a copy of *Notice of Polices and Practices to Protect the Privacy of Your Health Information* regarding the care I am receiving through Alexander J. Paret and Associates.

_____ _____
Signature of Patient **Date**

_____ _____
Parent/Guardian **Date**

_____ _____
Witness **Date**

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Acknowledgement of Patient Responsibilities

To accommodate the needs of our patients, we are enrolled in numerous insurance programs. Each plan has different guidelines regarding the level of care to which you are entitled and where you should obtain these services. Even within a single insurance company, there may be different plans and your particular coverage may differ depending on what type of contract your employer has negotiated. **Providing quality psychological care for our patients is our primary concern.** We are willing to provide that care within the guidelines of your insurance plan. It would, however, be impossible for us to monitor all of the individual requirements of every plan. **You are responsible for knowing and informing us exactly what your plan guidelines are.** We will work with you to attempt insurance reimbursement.

If we are contracted with your insurance carrier, we will bill you for your portion after your insurance company pays us. If through verification of benefits, a co-pay is indicated, you are expected to pay that co-pay at the time of service. You will be financially responsible for all deductibles, co-insurance, non-covered services, and all remaining balances after insurance pays.

If we are not contracted with your insurance company and are successful in receiving information from your insurance company confirming your insurance coverage for upcoming services, you will be required to prepay only the calculated out-of-pocket expense amount. We will bill your insurance for services rendered, but you will be financially responsible for deductibles, co-insurance, non-covered services, and all remaining balances after insurance pays.

If you are classified as a self-pay patient, payment in full is due at time of service.

I authorize payment of insurance benefits to Alexander J. Paret and Associates for claims submitted on my behalf. I authorize the release of any medical information necessary to process claims on my behalf. I also agree to be fully responsible for all patient charges to the extent that these charges are not satisfied by the assigned benefits.

Should you carry a balance exceeding 30 days, we will automatically charge your credit card on file to bring your account up-to-date.

I have read and understand the policy stated above, and agree to accept responsibility as described. I also authorize Dr. Paret to validate this card if I carry an outstanding balance greater than 30 days. These charges will be credited to my account.

Visa MasterCard Amex (circle one) # _____ Exp: _____

3 or 4 digit Card Security Code _____ Billing zip code for card: _____

I HAVE READ THE INFORMATION IN THIS DOCUMENT AND CONSENT TO ABIDE BY ITS TERMS.

_____ _____ _____

Patient Name (print) **Signature** **Date**