MIDWEST
ADVANCED
BEHAVIORAL
HEALTH

Midwest Advanced Behavioral Health
16 Emerald Terrace
Swansea, IL 62226
Phone: (618) 558-9035

Client Information

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Client's First Name: _____ Client's Last Name: _____
Birthday: _____ Age: _____ Gender: _____
Marital Status: _____
Address: _____
State: _____ Zip code: _____
Phone: _____
E-mail: _____

○ I authorized Midwest Advanced Behavioral Health to leave a text or voice message
○ I authorized Midwest Advanced Behavioral Health to leave an email to the address above.

Please fill out if client is under 18 years of age

Guardian's First Name: _____ Last Name: _____
Address: _____
State: _____ Zip code: _____
Phone: _____
E-mail: _____
Relationship to Client: _____

Primary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Secondary Insurance Company: _____
Subscriber ID # (including letters): _____
Group Number: _____
Insurance Policyholder Full Name: _____
Insurance Policyholder Date of Birth: _____
Insurance Policyholder Address: _____
Insurance Policyholder Relationship: Self Spouse Child Other

Presenting Problem

THE REASONS FOR YOUR VISIT:

_____
_____
_____
_____

When did these problems start? What was going on in your life at that time?

_____
_____

Please list any psychiatric or “mental” problems you have been diagnosed with:

_____
_____
_____

Please list any medical or “physical” problems that you have been diagnosed with:

_____

Please list any medications you currently take, and what you take them for:

_____
_____

Pyschiatric Questionaire

Do you feel hopeless and or worthless at this moment?

- ○ Yes
- ○ No

How often in the last two weeks have you felt that you would be better off dead?

- ○ Never
- ○ Sometimes
- ○ Many times
- ○ All the time

Have you ever attempted suicide?

- ○ Yes
- ○ No

Do you have any current plans or desires to end your life?

- ○ Yes
- ○ No

Coordination of Treatment

- ○ You may inform my Physican or Psychatrist
- ○ I decline to inform my Physician or Psychatrist

Primary Care Physician Name: _____
Address:_____
Phone:_____

Psychiatrist Name: _____
Address: _____
Phone: _____

_____ _____
Client Signature (12 years and older) Date

_____ _____
Guardian Signature Date

Insurance Authorization

I understand that Midwest Advanced Behavioral Health does not contract with all health insurers and it is my responsibility to know if my health insurance provides coverage for Midwest Advanced Behavioral Health services or requires a referral or pre-approval for such services.

I understand that I am financially responsible to Midwest Advanced Behavioral Health for any co-pays, deductibles and/or co-insurance not covered by my health insurance.

I understand that I authorize Midwest Advanced Behavioral Health to release my health plan and any information related to my insurance to make insure all payment are rendured. Midwest Advanced Behavioral Health will be assigned the payment for all insurance benefits for charges that occur with services provided to me.

_____ _____
Client Signature (12 years and older) Date

_____ _____
Guardian Signature Date

Credit / Debit Card Payment Consent

Client name:_____
(Card holder) Name on card if different than client: _____
Card Number:_____
Card Code: _____
Expiration Date :_____

I authorize Midwest Advanced Behavioral Healthto charge my credit/debit/health account card for professional services for our scheduled appointment. If I do not cancel before 24 hours, or no show my appointment, I recognize that Midwest Advanced Behavioral Health will charge my card as a late cancel or no show if I do not show up for the appointment. I MAY be billed for $125.00.
I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials: _____

Card holder Initials (If different than client): _____

Date:_____

Signature: _____

Fees not covered by insurace.

The following may not be covered by insurance and would be "out of pocket" to the client

Clinical Phone Consultation:

60 Minutes. $125.00
45 Minutes $95.00
30 Minutes $65.00
15 Minutes. $35.00

Private Pay Therapy Sessions:

60 Minutes (Psychotherapy) $125.00
60 Minutes (Reunification Therapy) $250.00
60 Minutes (Sex Offender Evauluation) Please see additional paperwork

Court Apperance and Record Preparation

Medical Records Preparation: $30.00/15 min. increment of time
Report Preparation: $30.00/15 min increment of time
Court Appearance Retainer/Hourly Fee: $700.00 retainer $350.00 per hour (not incl. travel)

_____ _____
Client Signature (12 years and older) Date

_____ _____
Guardian Signature Date

Notice of Privacy Practices

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request

_____ _____

Client Signature (12 years and older) Date

_____ _____

Guardian Signature Date

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

_____ _____

Client Signature (12 years and older) Date

_____ _____

Guardian Signature Date

ABA Therapy:

Please see additional ABA Therapy Paperwork

ABA fees not covered by insurance

Clinical Phone Consultation:

60 Minutes	$125.00
45 Minutes	$95.00
30 Minutes	$65.00
15 Minutes	$35.00

Private Pay:

Initial Evaluation- 120 Minutes	$250
Treatment plan- 60 minutes	$150
Treatment -60 Minutes	$125
Family Adaptive Behaviors- 60 Minutes	$125
No Show/Late Cancel Fee	$125
IEP Meeting	$250