# Oak Park Behavioral Medicine, LLC

101 N. Marion St. #313
Oak Park, IL 60301

2530 Crawford St. #115
Evanston, IL 60201

Welcome to Oak Park Behavioral Medicine. Please take a moment to complete the following forms before your first appointment with us. If you have any questions, please contact your provider that you are scheduled to meet with, or our main office number (312-725-6175). We look forward to meeting with you!

**Personal Background**

Child's Full name:_____ Date of Birth: _____

Sex: □ Male □ Female Age:_____ Grade in school: _____

Race: □ White □ Black/African American □ Latino/a □ Asian □ Pacific Islander □ Native American
□ Other _____

Ethnicity: □ Hispanic □ Non-Hispanic

Your Name:_____ Relationship to child: _____

Marital Status: □ Married □ Not Married Number of Children: _____

Preferred Phone:_____Home/Cell/Work (Circle One) □ OK to leave a message?

Alternative Phone:_____Home/Cell/Work (Circle One) □ OK to leave a message?

Emergency Contact:_____Phone #:_____Relationship: _____

Your Email: _____

Your Home address: _____

**Primary Insurance Information**

*We are only in-network providers for the following plans. If you have other insurance, please discuss with us prior to your first appointment.*

□ Aetna □ Blue Cross Blue Shield PPO □ Cigna □ Humana □ Magellan □ Medicare

Member ID#:_____Group #: _____

Co-Payment:_____ (Specialist or mental health) Coinsurance: _____%

Individual Deductible:_____ Amount Met to Date: _____

Family Deductible: _____ Amount Met to Date: _____

Max out of pocket per year Individual: _____ Family: _____

Is there a limit for number of mental health claims? If so, maximum allowable number of visits? _____

Are you the policy holder? Yes No

If no, name of policy holder:_____ Relationship to patient: _____

Address:_____ Policy holder Date of Birth: _____

**Secondary Insurance Information**

□ Aetna □ Blue Cross Blue Shield PPO □ Cigna □ Humana □ Magellan □ Medicare

□ Other _____

Member ID#:_____Group #: _____

Co-Payment:_____(specialist or mental health) Coinsurance: _____%

Individual Deductible: _____ Amount Met to Date: _____

Family Deductible: _____ Amount Met to Date: _____

Max out of pocket per year Individual: _____ Family: _____

Is there a limit for number of mental health claims? If so, maximum allowable number of visits? _____

Are you the policy holder? □ Yes □ No If no, name of policy holder: _____

Relationship to patient: _____ Policy holder Date of Birth: _____

Address:_____ Phone Number: _____

**Health Background**

Primary pediatrician:_____ Referring physician (if different): _____

Medical or mental health diagnosis: _____
(If your child has more than one illness, please circle the one that gives him/her the most difficulty)

How long has your child had this condition?_____Months/Years (circle one)

How long did your child have symptoms before diagnosed?_____Months/Years (circle one)

On a scale of 1 to 10, 1 being very mild and 10 most severe, please rate your child's most recent or current experience of symptoms: _____

**Reason for Referral**

What are your main concerns about your child that bring you in for help today?

_____
_____
_____
_____
_____

When did you first notice you had these concerns?

_____
_____
_____

What have you tried to help with these concerns?

_____
_____
_____

What did you tell your child about coming to our office today?

_____
_____
_____

In the past 6 months, has your child been bothered by any of the following issues (check all that apply)?

- □ School problems
- □ Peer relationship problems
- □ Family relationship problems
- □ Difficulty managing stress
- □ Loss of interested in things he/she usually enjoys
- □ Loss of a loved one
- □ Excessive worry or anxiety
- □ Panic attacks
- □ Fear of leaving the house
- □ Sleep problems
- □ Chronic pain
- □ Mood swings
- □ Feeling sad or blue most days
- □ Social withdrawal
- □ Abuse (physical, emotional, sexual)
- □ Risky behaviors
- □ Problems with eating (too much, too little)
- □ Weight loss

Please list your child's current medications. Including prescription, over-the-counter, and supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Does your child have difficulties taking his/her medications as prescribed?

□ No □ Yes (Describe) _____

Has your child ever seen a therapist in the past?

□ No □ Yes (Describe) _____

Was the treatment helpful?

□ Yes □ No (Describe) _____

Is your child currently taking any medications for his/her mental health (e.g. Prozac, Wellbutrin, Abilify)?

□ No □ Yes (Please list) _____

Name of prescribing physician: _____

Phone Number: _____

Has your child ever been hospitalized for a psychiatric condition

□ No □ Yes (Describe) _____

To what extent do you think stress impacts the course and/or treatment of your child's condition?

□ Does not impact it
□ Minimally impacts it
□ Moderately impacts it
□ Severely impacts it

Please provide any additional information that you think would be helpful for us to know about your child:

**Treatment Guidelines and Consent:**

Emergency Management: Therapists are not available on an emergency or "on call" basis. Patients may leave a message, but there may be an extended period of time before the therapist receives the message and is able to respond. Patients requiring immediate assistance must call 911 or go to the nearest emergency room. If patients require this type of support, the therapist will provide a referral to an outside agency that can provide emergency staff.

Termination of Treatment: There are rare instances where a therapist may be obligated to make a unilateral decision to terminate therapy. These include, but are not limited to: the current treatment is ineffective; threats are made against the therapist or her family; the therapist does not have the necessary training to address the client's specific problem(s); there is a significant therapeutic impasse (e.g. repeated missed appointments). In the event the therapist determines that therapy will no longer continue, a suitable referral will be identified and relayed to the patient. The therapist is not responsible for this referral to be acted upon.

Use of Email: Patients may use email to communicate with their provider. Therapists will make every effort to reply to emails within 1 business day. However, emails should be limited to matters of business such as cancelling or changing an appointment, questions about something they should be working on at home, or other issues that are not considered sensitive topics. Email is never an entirely secure way to send information, so patients should be careful in sending any information that they would not want someone else to see. Email should never be used, for any reason, in situations where the patient is in immediate danger of harming him or herself or others. If a patient sends an email with a threat to harm themselves or someone else, the therapist is obligated by law to contact the police to do a safety check if the therapist is unable to get in contact with the patient by telephone to ensure safety.

**Payment:**

Payment is expected at the time of services unless otherwise arranged. Cash, check or major credit card is acceptable. I hereby authorize treatment for the patient listed above and accept the responsibility for charges incurred, regardless of any other arrangements with third parties, including insurers. I understand that I will be charged a **$50 cancellation fee** if I do not give **24-hours notice** when cancelling an appointment. In the unlikely event that I fail to remit payment for services with Oak Park Behavioral Medicine, LLC, my account will be sent to collections and/or legal action will be taken. I will be held responsible for all associated fees, including but not limited to the cost of collection services, attorneys, and therapists' time.

I have read and understand the above guidelines and consent to treatment.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Client (12 years & older) Date

**PERMISSION TO COMMUNICATE WITH FAMILY MEMBERS OR SCHOOL PERSONNEL**

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health care providers are prohibited from releasing or discussing any personal health information to anyone without appropriate permission. Therefore, we need your written authorization if you would like us to communicate with family members or others involved in your care (or your child's care, if applicable). Please let us know with whom we may communicate regarding any aspects of your health care (or that of your child, if applicable).

I,_____authorize Oak Park Behavioral Medicine LLC Providers (Circle all that apply) Dr. Tiffany Taft / Stephanie Horgan LCSW / Dr. Anjali Pandit / Dr. Devin Lincenberg to release or discuss

□my child's health information

Child's Name:_____(DOB / /____)

To:

Name:_____Phone Number:_____

Relationship: (check one; person must be at least 18 years old)

□Spouse / Partner
□Mother/Father
□Son/Daughter
□Grandparent
□Step-parent
□Aunt/Uncle
□Cousin
□Sibling
□Foster Parent
□Niece/Nephew
□Social or DCF Worker
□In-law
□Friend
□Nanny, babysitter or au pair
□Teacher
□School social worker, counselor, or psychologist
□Other: _____

_____ _____

PERSON PROVIDING CONSENT SIGNATURE DATE

**Client Consent to Communicate with Your Child's Physician**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and prohibits any further disclosure by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted. I also understand that I may revoke this consent at any time by notifying the provider in writing (except to the extent that action has already been taken in reliance on it). This release will automatically expire twelve months from the date signed below or upon the date specified here.

I,_____authorize Oak Park Behavioral Medicine LLC Providers (Circle all that apply) Dr. Tiffany Taft / Stephanie Horgan LCSW / Dr. Anjali Pandit / Dr. Devin Lincenberg to release or discuss

□my child's health information

Child's Name:_____(DOB / /____)

With:

Physician Name: _____

□ Primary Care / Internist □ Specialist (List specialty here:_____)

Phone Number: _____

_____ _____

PERSON PROVIDING CONSENT SIGNATURE DATE

**Financial Agreement & Credit Card on File**

We have implemented a required policy at Oak Park Behavioral Medicine that enables you to maintain your credit card/HSA information securely on file. In providing us with your credit card/HSA information, you are giving Oak Park Behavioral Medicine LLC permission to automatically charge your credit card on file for your co-pays, outstanding balances, or services. Payment arrangements are made with your individual provider and may be done as follows:

**Co-payment:** Per insurance contractual obligations, co-pays are made at each office visit. Co-pays may be paid with the credit card on file or other means at the end of your session.

**Co-insurance:** Per insurance contractual obligations, co-insurance payments are made after insurance claims have been processed and paid. Co-insurance may be paid on a weekly or monthly basis at your visit or by the credit card on file.

**Self-payment:** Self-payments may be made at each session (recommended) or at an agreed upon schedule between you and your provider. Self-payments may be paid with the credit card on file or other means at the end of your session.

If your insurance provider has paid their portion of your bill or you are self-pay and there is still an outstanding balance owed, Oak Park Behavioral Medicine LLC will notify you at your visit or via phone or email to arrange payment. You may instruct us to use the card on file or any other means of payment. If we do not receive your payment in full, any balance owed will be charged to your card on file. We use Square for credit card payments. A copy of the charge will be sent to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. We also request that if the card on file expires, that you provide us with updated card information at your next office visit.

This card will only be authorized for use of the credit card holder. You may revoke this consent at any time in writing.

I have read the above and agree to the financial stipulations for my care at Oak Park Behavioral Medicine LLC.

_____ _____

Signature Date

☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Health Savings Account

Credit Card/HSA Number: _____

Expiration Date: _____ Security/CID Code: _____

Billing ZIP Code: _____

**How did you hear about us?**

□ My physician or other healthcare provider
□ Word of mouth from friend, family, colleague, etc.
□ Psychology Today listing
□ Web search
□ Your website (www.opbmed.com)
□ Social media (e.g. Facebook, Twitter)
□ The OPBMed Blog (opbmed.blogspot.com)
□ Patient organization
□ Other: _____

**Do you use social media?**

□ Yes □ No

If Yes, please check which you regularly use:

□ Facebook □ Google+
□ Twitter □ LiveJournal
□ Blogs □ Meetup
□ Tumblr □ LinkedIn
□ YouTube □ Other:_____

**Do you use the internet for health information?**

□ Yes □ No

If Yes, please check which you regularly use:

□ WebMD □ Drugs.com
□ NIH □ Health Grades
□ Mayo Clinic □ Everyday Health
□ Yahoo! Health □ Rx List
□ MedicineNet □ Other: _____

**Thank You!**