Oak Park Behavioral Medicine LLC

101 N. Marion St. Suite 313 ✤ Oak Park, IL 60301
Dr. Taft: 312-725-6175 ✤ Dr. Edlynn: 708-986-1750 ✤ Ms. Cohen: 708-730-2852 ✤ Dr. Burda: 708-762-3171

Welcome to our practice! Please take a few moments to complete the following information.

Today's Date: _____

Personal Background

Full Name:		Date of Birth:	
Gender:	❑ Male ❑ Female ❑ Transgender	Age:	
Race:	❑ White ❑ Black/African American ❑ Latino/a ❑ Asian ❑ Native American/Pacific Islander ❑ Other _____	Ethnicity:	❑ Non-Hispanic ❑ Hispanic
Married:	❑ Yes ❑ No	Children:	❑ Yes ❑ No
Employed:	❑ Yes ❑ No		
Phone:	( ) ❑ Home ❑ Cell ❑ Work	Ok to leave message?	❑ Yes ❑ No
Address:			
City:		ZIP:	
Email:		Ok to email?	❑ Yes ❑ No
Emergency Contact	❑ Spouse ❑ Parent ❑ Other Family ❑ Friend	Phone:	

Health Background

Referred by:	❑ Self ❑ Primary Care MD ❑ Specialist ❑ Mental Health Provider ❑ Other		
Referring Physician:		Phone:	
Medical Diagnoses:	❑ Irritable Bowel Syndrome ❑ Inflammatory Bowel Disease ❑ GERD ❑ EGID ❑ Other Digestive Condition ❑ MACS ❑ Cancer ❑ Allergies ❑ Fibromyalgia ❑ Migraine/Chronic Headache ❑ Insomnia ❑ Chronic Pain ❑ Other (Please list) _____ _____		
Mental Health Diagnoses:	❑ Anxiety ❑ Depression ❑ Panic Attacks ❑ PTSD ❑ Bipolar Disorder ❑ Other (Please list) _____		

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Current Medications:	_____ _____ _____ _____ _____	Troublesome Side Effects?	❑ Yes ❑ No
My Illness(es) impact me	❑ Emotionally ❑ Socially ❑ Financially ❑ At Work ❑ At Home ❑ As a parent ❑ As a spouse ❑ Other _____		
Stress impacts my illness	❑ Not at all ❑ Minimally ❑ Moderately ❑ Severely		
How well do you sleep?	❑ Well ❑ OK ❑ Poorly Average hours of sleep per night		

Do you exercise regularly (2-3 times / week for 30 minutes or more)?	❑ Yes ❑ No	What types of exercise do you do?	
Have you changed your diet/eating habits because of your illness?	❑ Yes ❑ No	Please briefly describe:	
Have you ever used any regular relaxation techniques?	❑ Yes ❑ No	Check all that apply?	❑ Yoga ❑ Meditation ❑ Hypnosis ❑ Mindfulness ❑ Guided imagery ❑ Other
What are your goals for treatment with us?	❑ Treat the symptoms of my disease ❑ Cope with my disease better ❑ Manage my stress ❑ Help navigate my health care ❑ Treat anxiety, depression or other mental health symptoms ❑ Improve my daily functioning ❑ Improve my relationships ❑ Other: _____ _____		

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Today's Date: _____

Please think about **how your chronic illness** impacts your as you answer the following questions. Over the **last 2 weeks**, how often have you been bothered by the following problems:

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, like reading a book or watching TV				
Moving or speaking so slowly that other people could or have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❏ Not difficult at all ❏ Somewhat difficult ❏ Very difficult ❏ Extremely difficult

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Primary Insurance Information

We are only in-network providers for the following plans. If your plan is not listed, please discuss coverage with our office prior to your first appointment.

Insurance Plan:	❑ Aetna ❑ Blue Cross Blue Shield (Non-HMO Plans Only) ❑ Cigna ❑ Humana ❑ Magellan ❑ Medicare ❑ United Healthcare		
Member ID:		Group #	
Office Co-Pay:	$	Co-Insurance	%
Deductible:	$	Met?	❑ Yes ❑ No
Policy Holder:	❑ Self ❑ Spouse		
Spouse's Name:		Date of Birth:	
Address If not, please provide	❑ Same _____		

Secondary Insurance (If Applicable)

Insurance Plan:	❑ Aetna ❑ Blue Cross Blue Shield (Non-HMO Plans Only) ❑ Cigna ❑ Humana ❑ Magellan ❑ Medicare ❑ United Healthcare		
Member ID:		Group #	
Office Co-Pay:	$	Co-Insurance	%
Deductible:	$	Met?	❑ Yes ❑ No
Policy Holder:	❑ Self ❑ Spouse		
Spouse's Name:		Date of Birth:	
Address If not, please provide	❑ Same _____		

Payment Information

We ask all patients to keep a credit card/HSA on file should any out-of-pocket expenses be applied after insurance payments are made. 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. A receipt will be emailed to you via Square Credit Card Services.

Card Type:	❑ HSA ❑ VISA ❑ MC ❑ AMEX ❑ Discover		
Card Number:		Security/CID:	
Expiration Date:		Billing ZIP:	

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Guidelines and Informed Consent to Treatment

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 you require ongoing emergency support we will refer you to an outside agency that can provide this service.

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 his/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. We 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 you 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 you should be careful in sending any information that you would not want someone else to see. Email should never be used, for any reason, in situations where you are in immediate danger of harming yourself or others. If you send an email with a threat to harm yourself or someone else, your therapist is obligated by law to contact police to do a safety check if she is unable to reach you by phone to ensure safety.

Use of Telepsychology: Video Conferencing (VC) is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. We utilize FaceTime. This VC platform is encrypted to the federal standard, is HIPAA compatible, but does not have a HIPAA Business Associate Agreement (BAA). Apple has confirmed that all communications through FaceTime are protected by end to end encryption. Access controls are in place, via Apple IDs, to ensure the service can only be used by authorized individuals. Apple also does not store any information sent via FaceTime. FaceTime is a peer-to-peer communication channel, and voice and audio communications are transmitted between the individuals involved in the session. Apple also cannot decrypt sessions. We strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). Most insurance covers VC sessions in full. We will verify with your insurance provider prior to initiating VC visits. Like email, we cannot fully guarantee that VC is an entirely secure way to send information.

Payment and Cancellation Policy: Payment is expected at the time of services unless otherwise arranged. Cash, check or major credit card is acceptable. You hereby authorize treatment and accept responsibility for charges incurred, regardless of any other arrangements with third parties, including insurers. You understand a **$50 cancellation fee** will be charged if you do not give **24-hours' notice** when cancelling an appointment.

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

_____ _____

Patient Signature Date

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Release of Information and Communication Authorization

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 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, _____ (❏ Patient ❏ Parent/Guardian) authorize Oak Park Behavioral Medicine LLC Provider ❏ Dr. Tiffany Taft ❏ Dr. Emily Edlynn ❏ Robin Cohen, LCPC ❏ Dr. Lori Burda to release (Check all that apply):

❏	Complete health record, including records related to mental healthcare (excludes psychotherapy notes), communicable diseases, HIV/AIDS, and the treatment of alcohol or drug abuse.
❏	Complete health record with the exception of the following information:
	❏ Mental health records (including psychotherapy notes) ❏ Communicable diseases (including HIV/AIDS) ❏ Alcohol/drug abuse treatment ❏ Other (Specify): _____
Send to:	
Address:	
Fax:	
Dates to include:	❏ Entire Treatment ❏ From _____ to _____

I authorize ❏ Dr. Tiffany Taft ❏ Dr. Emily Edlynn ❏ Robin Cohen, LCPC ❏ Dr. Lori Burda to communicate with the following people about my treatment (Check all that apply):

❏ Medical provider (MD, RN, etc.)	Name:	
❏ Mental health provider	Name:	
❏ Family member	Name:	
❏ Other	Name:	

_____ _____

Signature of Person Providing Consent Date