CENTER FOR
EMOTIONAL WELLNESS
of the Northwest Suburbs

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Welcome to our practice. This notice describes policies related to the use of the records of your care as well as your rights as a client seeking services. If you have questions about this policy or your rights, don't hesitate to ask. By my signature below I _____ acknowledge that I received a copy of the Notice of Privacy Practices for Center for Emotional Wellness

_____ _____

Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name _____

Relationship to Client _____

.....

For Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other

This form will be retained in your medical record

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

INFORMATION DISCLOSED WITH YOUR CONSENT. In order to provide effective care, there are times when confidential information will need to be shared with others.

Treatment. Treatment information about you may be disclosed to provide, coordinate, or manage your care or any related services, including sharing information with others who are being consulted or to whom you are being referred.

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.

INFORMATION DISCLOSED WITHOUT YOUR CONSENT. Under Illinois and federal law, information about you may be disclosed without your consent for the following circumstances:

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

Follow Up Appointments/Care. You may be contacted to remind you of future appointments, information about treatment alternatives or other health related benefits and services that may be needed.

Accounting for Disclosures. You may request an accounting of disclosures your clinician has made related to your medical information, except for information used for treatment, payment, or healthcare operations purposes, or that was shared with you or your family. This also excludes information that your clinician has been required to release or information for which specific consent to release has been given. To receive information regarding disclosure made for a specific time period no longer than six years after your initial date of service, please submit your request in writing to your clinician. You are charged a fee for the time involved in preparing this list.

Questions and Complaints. If you have any questions, complaints, or wish for a copy of this policy, you may contact your clinician for further information. You may also contact the Secretary of Health and Human Services if you believe your clinician has violated your privacy rights. You will not be retaliated against for filing a complaint.

Changes in Policy. Your clinician reserves the right to change the Privacy Policy based on the needs of the practice and changes in state and federal law.

CENTER FOR
EMOTIONAL WELLNESS
of the Northwest Suburbs

POLICY ADDENDUM

Please be advised that "No shows" and sessions canceled with less than twenty-four hours' notice will be charged the full session rate. This charge is the responsibility of the client as insurance does not reimburse for missed sessions.

Your signature below affirms that the responsible party has read, understood, and agrees to abide by this policy addendum.

SIGNATURE _____ DATE _____
(12 YEARS OR OLDER)

Consent for Treatment

I, _____hereby request psychological services from the Center for Emotional Wellness of the Northwest Suburbs.

SIGNATURE _____ DATE _____

PARENT/GUARDIAN _____ DATE _____

WITNESS _____ DATE _____

CENTER FOR
EMOTIONAL WELLNESS
of the Northwest Suburbs

INTAKE SUMMARY SHEET

Patient Name _____
Address _____
City _____ State _____ Zip Code _____
Gender (M) (F) Date of Birth _____ Age _____ Soc. Sec. Number _____
Phone _____ (Home) Phone _____ Ext _____ (Work)
Phone _____ (Mobile) Phone _____ (Other)

Responsible Party (Statements will be sent here)
Name _____
Address _____
City _____ State _____ Zip Code _____
Gender (M) (F) Date of Birth _____ Age _____ Soc. Sec. Number _____
Phone _____ (Home) Phone _____ Ext _____ (Work)
Phone _____ (Mobile) Phone _____ (Other)

Other Responsible Party (if more than one person)
Name _____
Address _____
City _____ State _____ Zip Code _____
Gender (M) (F) Date of Birth _____ Age _____ Soc. Sec. Number _____
Phone _____ (Home) Phone _____ Ext _____ (Work)
Phone _____ (Mobile) Phone _____ (Other)

Insurance Information
Insured's Name: _____
Employer: _____
Insured's DOB: _____
Insurance Co: _____
Address: _____
Phone: _____
Social Security #: _____
Group #: _____
Relationship to Client: _____

I authorize this office to release any information obtained during assessment or treatment of this client which is necessary to expedite and support any insurance claims on this account. I understand I am responsible for all charges regardless of insurance coverage. I authorize the payment of benefits otherwise payable directly to me, directly to the provider. I authorize the use of this signature on all insurance submissions. I authorize release and use of information required to collect outstanding charges on this account.

_____

Client's/Parent's/Guardian's Signature **Date**