SUMMIT CLINICAL SERVICES PC REGISTRATION

1761 S. Naperville Rd, Suite 200, Wheaton, IL 60189; Phone: (630) 260-0606

(03.23)

Welcome to Summit Clinical Services – We're glad you're here

Patient Information Today's Date: _____

Patient Full Legal Name: _____
(LAST Name) (FIRST Name) (Middle Initial)

Street Address: _____

City: _____ State: _____ Zip: _____

The following email address and cellular phone number may be used for communication from Summit Clinical Services PC for phone and electronic messages, courtesy appointment reminders, account and insurance matters, marketing, etc.

Best Email Address: _____

Best Contact Cellular Phone Number (_____) _____ - _____

Signature: _____ Date: _____ / _____ / _____

Alternate Phone Number: (_____) _____ - _____ ( )home ( )cellular ( )work ( )other_____

Patient Date of Birth: _____ / _____ / _____ Patient Age: _____ Gender: Male Female Non-Binary

Patient Social Security: _____- _____ - _____ **Marital Status: ( )Single ( )Married ( )Widowed**
( )Divorced ( )Legally Separated

Ethnicity (circle one): Hispanic Non-Hispanic Decline to Answer

Race (circle one): American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Other Decline Answer

Emergency Contact: Name _____ Relationship: _____ Best Phone: (____)_____-_____

Patient Employment Status: Not Employed Full Time Part Time Retired Occupation: _____

Employer Name: _____ Phone: (_____) _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Student Status: FT PT n/a Grade: _____ School: _____

Whom may we thank for referring you? _____

Reason for Visit: _____

Current Medications: _____

Known Medical Problems: _____

Allergies: _____

Primary Care Physician (Name/Address/Phone): _____

_____

SUMMIT CLINICAL SERVICES PC OFFICE POLICIES

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(03.23)

Welcome to Summit Clinical Services PC. We appreciate being your choice for mental health services. Please read the following closely as it explains pertinent information regarding our policies.

_____ (*initial***) **FINANCIAL POLICY**

- **Accepted insurances:** All providers accept Blue Cross/Blue Shield of Illinois PPO (and PPO CHOICE), NMPN HMO, and Aetna; some providers accept Medicare. We also accept other insurance plans with out-of-network benefits, but do not file claims for you. All patients will receive a Superbill that contains all of the information necessary to assist the patient in their own efforts to obtain insurance reimbursement for out-of-network insurance plans.
- **Insurance benefits:** It is your responsibility to contact your insurance company to learn about any qualifications, limitations and benefits available. Any referrals and authorizations are the responsibility of the patient/insured/guarantor.
- **Payment:** Payment for treatment, co-pays, or deductibles are due at the time services are rendered. Services may be terminated due to non-payment. Accounts with no payment activity or those with previous payment arrangements that are not being adhered to will be considered past due after 60 days, will be subject to $20 monthly rebill fee, and may be referred to an outside collection agency. All costs associated with this action will be the responsibility of the patient.
- **Care coordination services:** Your provider may need additional time outside of your scheduled visits to manage your care. These duties may include reviewing past treatment records, discussing care with other providers, communicating with family members involved in your care, completing disability/school forms or writing requested letters/reports/authorizations. Your provider may charge for care management services depending on your specific needs. These charges may be reimbursed by some, but not all, insurance companies. The patient will be responsible for payment if not covered by insurance company.
- **Returned payment:** Returned checks or credit card disputes will be subject to a $35 fee.

_____ (*initial***) **APPOINTMENTS**

- **Cancellation policy**: We require 24 business hours advance notice to avoid cancellation fees unless a separate arrangement was made with your provider. This means that Monday appointments need to be canceled on Friday. You may be charged up to the full fee for the service scheduled if not canceled as specified.
- **Frequent cancellations/missed visits**: Follow up treatment as advised by your provider is required on an ongoing basis to provide quality care. Please note that your treatment may be terminated due to multiple missed appointments/cancellations. Payment for a missed appointment/late cancellation is required prior to or at the beginning of the next appointment. Insurance companies do not provide reimbursement for cancellations or missed appointments; this will be the patient's/guarantor's responsibility.
- **Late arrivals**: For appointments with our providers, arrivals of more than 15 minutes late may need to be rescheduled and may be subject to the full missed appointment fee.
- **For minors**: At least one parent/legal guardian must be present with the patient at each psychiatric appointment. If at least one parent/legal guardian and/or patient is not present for an appointment, this would count as a missed appointment, with the potential of being charged the full missed appointment fee.
- **Behavior**: Disrespectful and/or inappropriate behavior and language towards staff, providers and/or other patients may be reason for the termination of services.
- **Termination**: If there is no patient communication with the provider for 60 days or more, the patient will be considered to be inactive and will be terminated from Summit Clinical Services (unless otherwise discussed with your provider(s)). In these cases, if interested, the patient may call the intake line to reengage in services if available and/or appropriate to reinstate treatment. Termination may also occur if the client no longer holds residence in the state of Illinois.

SUMMIT CLINICAL SERVICES PC OFFICE POLICIES, continued (page 2 of 2)

_____ (*initial***) **EMERGENCIES AND PHONE CALLS**

- Summit does not provide crisis or emergency appointments.

- **Emergency phone calls**: Please call the Suicide and Crisis Lifeline at 988 for mental health crisis support, call 911 or go to the closest emergency room.
- **Urgent phone calls**: You may call our office 24 hours a day. Please leave a message with the answering service or emergency voicemail on your provider's phone extension for phone calls after-hours. A charge may apply for frequent after-hours phone calls.
- **Routine phone calls**: To reach psychiatrists, please leave a detailed message with the office; to reach therapists, please leave a message on their direct voicemail by dialing the provider's extension.

_____ (*initial***) **MEDICATION REFILLS**

- Medication refills should be addressed at regularly scheduled appointments. Not following your doctor's recommended follow up plan may result in denial of a refill request. Please allow at least 72 hours for medication refills to be processed. Please have your pharmacy send an electronic request when possible. After hours or emergency requests may be subject to a $50 prescription fee.

_____ (*initial***) **CONFIDENTIALITY**

- We are committed to making this a safe place for you to get help. We adhere to all the legal protections of your confidentiality. Confidential information will only be disclosed with signed release of information authorization form unless authorized or required by law.

Guarantor Agreement/assignment and release

I certify that I have read and agree to the above policies of Summit Clinical Services PC. I also agree that I am personally and wholly financially responsible for all charges incurred, and I will assure that full, timely payment is made to Summit Clinical Services PC for all services.

I further hereby authorize the doctors/clinicians or office representatives to release to my insurance company or its affiliates all information necessary to process my service claim to secure the payment of benefits and assign those benefits directly to Summit Clinical Services PC, including authorized insurance and government benefits.

GUARANTOR** Information: *(normally the patient if 18 years or older -- financially responsible for this account; not necessarily the insured policy holder) ** Initials need to match the signed guarantor*

Patient Name: _____ Patient Date of Birth: _____

Guarantor Printed Full Legal Name: _____ Gender: M or F
(LAST Name) (FIRST Name) (MIDDLE Initial)

Social Security Number: _____-_____-_____ Relationship to Patient (circle): self spouse parent other:_____

Phone #: _____ Date of Birth: _____

Home Address/City/State/Zip:_____

Employer Name/Address/City/State/Zip:_____

*GUARANTOR** SIGNATURE*: _____ *Date*: _____

** Initials match the printed/signed guarantor, not necessarily the insured/policy holder

SUMMIT CLINICAL SERVICES PC HEALTH INSURANCE INFORMATION

Patient Insurance Information *(If Applicable)*

Our providers accept assignment for Blue Cross Blue Shield of Illinois PPO (and PPO CHOICE), NMPP HMO, and Aetna, with some providers accepting Standard Medicare

Patient Name: _____ Date of Birth: _____

PRIMARY INSURANCE : BLUE CROSS PPO BLUE CROSS CHOICE MEDICARE-standard NMPP-HMO Aetna Other

Policy Holder Legal Name: _____

Policy Holder Birth Date: _____ / _____ / _____ Social Security: _____ - ____ - _____

Address: _____ City: _____ State: ____ Zip: _____

Best Phone: (_____) _____ - _____ ( )home ( )cellular ( )work ( )other_____

Policy Holder Employer Name/Address: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Insurance Company Phone Number: _____

Relationship to Patient (circle one): Self Spouse Parent Other _____

SECONDARY INSURANCE : BLUE CROSS PPO BLUE CROSS CHOICE MEDICARE-standard NMPP-HMO Aetna Other

Policy Holder Legal Name: _____

Policy Holder Birth Date: _____ / _____ / _____ Social Security: _____ - ____ - _____

Address: _____ City: _____ State: ____ Zip: _____

Best Phone: (_____) _____ - _____ ( )home ( )cellular ( )work ( )other_____

Policy Holder Employer Name/Address: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Insurance Company Phone Number: _____

Relationship to Patient (circle one): Self Spouse Parent Other _____

I authorize the release of any medical or other information necessary to process all claims for services. I also request and authorize payment of government and insurance medical and mental health benefits to be issued directly to Summit Clinical Services PC.

Signature : _____ *Dated:* _____

Summit Clinical Services PC
1761 S Naperville Rd, Suite 200 - Wheaton, IL 60189
Phone: (630)260-0606
(03.23)
Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover
Cardholder Name (as shown on card): _____
Card Number: _____ - _____ - _____ - _____
Credit Card Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Summit Clinical Services PC to charge my credit card above for agreed upon purchases (which may include co-payments, co-insurances, deductibles, account balances, missed appointment/no show/late cancellations, phone calls/conversations, service fees, non-insurance-plan covered services, and other amounts owed), for the person/persons listed below**. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer/Cardholder Signature Date

Billing Email Address: _____

** Patient Name / Date of Birth : _____

** Patient Name / Date of Birth : _____

**Patient Name / Date of Birth : _____

SUMMIT CLINICAL SERVICES PC
Acknowledgement
Receipt of Notice of Privacy Practices
Consent of Treatment

(03.23)

Summit Clinical Services PC provides outpatient mental health services to adults, couples, adolescents, children, and families. These services may include individual, group, or family therapy, parent guidance, psychological evaluations, and/or psychiatric consultations, medication management, medical office services, etc. You and your clinician will decide together which services will meet your individual needs. It is important that a patient enters psychiatric treatment voluntarily and understands that some forms of treatment may lead to uncomfortable and/or difficult emotions and/or a change in experienced symptoms.

Although behavioral health communications with our clinicians are confidential in nature and cannot be disclosed without your permission, there are situations in which we are obligated by law to disclose confidential information. We must report any reasonable suspicion of child abuse and/or neglect to the appropriate authorities. We also need to make any necessary disclosures to protect against a clear risk of harm being inflicted by a client on himself/herself or on another person (examples can include, but are not limited to, concerns about suicide, homicide, significant drug use, or drinking and driving). In addition, confidential information can be released in response to a court subpoena. Confidential information will only be disclosed with signed authorization form unless authorized or required by law.

With regard to child and adolescent treatment services, in order to create a safe and positive therapeutic environment, effort will be made to honor patient confidentiality. However, in many cases it is desirable and necessary to share certain information with parents or legal guardians, as they are interested in and often play an important role in your treatment progress and emotional health. Parents will have input into the goals of treatment for therapy and/or medication management, and will be periodically informed of treatment progress. Effort will be made to keep the details of therapy/treatment sessions private whenever possible.

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"I understand the information above, and give my consent to engage in child/family/individual therapy and/or psychiatry evaluation and treatment services within the limits of confidentiality as described above."

"I acknowledge receipt of Summit Clinical Services PC (SCS) Notice of Privacy Practices as required by the federal government Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"), *which provides detailed information about how the practice may use and disclose my confidential information. I understand that SCS may use or disclose for the purpose of treatment, payment, or health care operations, information in the patient record. I understand that SCS has reserved a right to change the privacy practices that are described in the Notice, and that a copy of any Revised Notice will be posted in the patient waiting room."*

Patient Printed Name: _____ *Date of Birth:* _____

Patient Signature *(age 12 and older):* _____ *Date:* _____

*Parent/Legal Guardian 1 Signature (for patient under age of 18):*_____ *Date:*_____

*Parent/Legal Guardian 2 Signature (for patient under age of 18):*_____ *Date:*_____

SUMMIT CLINICAL SERVICES

Telehealth Consent Form for Phone or Videoconferencing Sessions During COVID-19

(03.23)

By signing this form, you are consenting to mental health services via telehealth and that you are aware of issues that might arise, as listed below. If you have any questions, please speak with your provider.

1. Potential telehealth issues and/or concerns:

a. No telehealth session is done over text or email. You and your provider will discuss the best method of communication for your sessions.

b. If you have Siri, Google Now, Alexa or any other digital assistant app on your phone, be sure they are turned off before your session, and unplug any smart speakers in the room before your session. If they are on, please be aware that they are always listening.

c. No method of technological communication can be completely confidential. With any technology, there is always a small risk of hacking and therefore loss of confidentiality. However, be assured that your mental health providers have made every effort to keep secure the technology they are using during your sessions.

d. Your mental health provider will not record your sessions, and you also agree not to record any treatment sessions.

e. All minors must have a parent/guardian present at the same physical location during an appointment.

f. You agree to maintain confidentiality on your end of the session by using secure Wi-Fi (not public) and having updated virus protection on any device used.

g. At the time of your phone or videoconferencing session, please be in a quiet place where you will not be distracted or interrupted, and your session will not be overheard.

h. With any technology, there is always the risk of being inadvertently disconnected. If the call or video session is disrupted at any time, your provider will call you back. If the calling technology appears to be dysfunctional, your provider will contact you about another time to call.

i. The patient must provide the physical address/location during telehealth sessions. All sessions must be conducted with the patient located within Illinois state lines (unless otherwise discussed with your provider).

j. As with any mental health session, you are ultimately responsible for payment. Although our office checks insurance benefits for telehealth, it is suggested that you check with your health insurance policy to see whether phone or videoconferencing telehealth sessions are covered at this time.

2. If you are having an urgent concern, call your provider or contact emergency services (911, 988, and/or safely travel to the nearest emergency room). Do not use the video platform.

I have read and understand the above information, and I consent to using phone or videoconferencing for telehealth. I understand that I can withdraw my consent to phone or video sessions at any time.

Patient Printed Name: _____ *Date of Birth:* _____

Patient Signature *(age 12 and older):* _____ *Date:* _____

Parent/Legal Guardian 1 Signature (for client under age of 18): _____ *Date:* _____

Parent/Legal Guardian 2 Signature (for client under age of 18): _____ *Date:* _____