11520 W. 183rd Pl. Suite 100
Orland Park, IL 60467
Office: 708-478-7080
Fax: 708-478-7086

REGISTRATION PACKET

Patient's Full Name: _____ SS#_____

Patient's D.O.B.: _____ Sex: _____ Age: _____

Parent Full Name (if patient is a minor): _____

Home Address: _____

City: _____ State:_____ Zip Code: _____

Home Telephone: _____ Cellular Phone: _____

Work Phone: _____ Email: _____

Preferred Cell Number for Appointment Reminders: _____

School/Employer Name: _____

School/Employer Address: _____

City: _____ State:_____ Zip Code: _____

Occupation/Grade: _____

Name of Primary Care Physician: _____

Physician Address: _____

City: _____ State:_____ Zip Code: _____

Physician Telephone: _____ Physician Fax: _____

Emergency Contact Person:_____ Relationship: _____

Emergency Contact Phone Number: _____

Patient referred by: _____

INSURANCE AND HEALTH CARE INFORMATION

Full Name of Insured: _____ Relationship: _____

Insured D.O.B.: _____ Insured SS# _____

Insured Driver's License # _____ State: _____

Insured Home Address: _____

City: _____ State:_____ Zip Code: _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State:_____ Zip Code: _____

Insured Home Phone: _____ Insured Work Phone: _____

Primary Insurance Co. Name: _____

Primary ID# _____ Primary Group # _____

Secondary Insurance Co. Name: _____

Secondary ID# _____ Secondary Group # _____

Job Related/Workman's Compensation Injury: Yes No Company: _____

Please list any medical conditions, injuries, hospitalizations, etc. below: _____

_____

_____

_____

_____

Current medications and dosage: _____

_____

_____

What brings you to our office today? _____

_____

_____

_____

_____

I am interested in:	diagnosis/evaluation	psychiatric medication management
(please circle)	individual therapy services	family therapy services
	crisis intervention	couples counseling
	addictions services	educational/IEP assistance

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OFFICE POLICIES AND BILLING INFORMATION

PLEASE RETAIN THIS NOTICE FOR YOUR RECORDS

Scheduling and Cancellations - Please note that psychotherapy sessions are typically 45-50 minutes long, and psychiatric medication management visits are typically 15-30 minutes long. New patient appointments/evaluations for both psychiatric/psychotherapy services are 1 hour. While our office does make every effort to assist patients with scheduling and appointment reminders, please keep in mind that the patient is ultimately responsible. Appointments not cancelled within 24 hour notice in non-emergency circumstances will be subject to a $80 no show fee, which cannot be billed to the patient's insurance company and will be the patient's sole responsibility.

Payments – Payments for all services are required at the time of service. This includes insurance co-pays, debuctibles, no show fees, and any additional patient balance responsibility not covered by your insurance policy.

Emergencies - In the event of a clinical emergency, patients may contact their provider via phone. If a provider is not available in case of emergency, please call your local crisis line, contact your primary care physician, your local health department, or proceed to your local emergency room. Call 911 in immediate matters of personal safety. Non-emergency patient requests/communication are typically handled via email or our office staff; please speak to your provider regarding communication preferences.

Prescriptions – If your treatment plan includes psychotropic medication, we request that all patients speak to their psychiatrist regarding their upcoming prescription needs in person during your appointment, and be sure that they have the necessary prescriptions to last them until their next scheduled appointment. Also, if the patient has not been seen by a Full Service Alliance provider within the past six months, we will be unable to process your prescription refill request until the patient is seen in office for an appointment.

Confidentiality – We are committed to making this a safe place for you to get help. To that end, we adhere to all legal protections of your confidentiality. Limitations include staff consultation, life-threatening behavior, child abuse, elder abuse, and judge's orders to release information.

Authorizations – Patients seeking services at the Full Circle Alliance authorize the following:
1..I authorize the release of information to my insurance company(s).
2. I authorize direct payment to my service provider.
3. I understand that it is my responsibility to pay any deductible, co-insurance amount or any other balance not paid by my insurance, for services provided. This payment is expected no later than 30 days after receipt of billing information from this office.
4. I understand that it is my responsibility to pay any co-pay the day and time services are provided.
5. I understand that there will be a service charge on all returned checks.
6. I understand that if my account is sent to collection a collection fee of 33% will be added to the total owed when sent to collection. All attorney fees and court costs incurred by the creditor will be the responsibility of the debtor.

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NOTICE OF PRIVACY PRACTICES

PLEASE RETAIN THIS NOTICE FOR YOUR RECORDS

Effective April 14, 2003

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I am required to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment: I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, licensing and conducting

or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard, the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. I may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

• Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the social work licensing board or the health department)

• Required by Court Order

• Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submityour request in writing to me at 11520 W. 183rd Pl. Suite 100, Orland Park, IL 60467.

• **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right toinspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.

• **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.

• **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

• **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

• **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me at 11520 W. 183rd Pl., Suite 100, Orland Park, IL 60467

Please retain this copy for your records and provide your signature on the signature page to acknowledge receipt

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RECEIPT AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient/Client Name: _____
DOB: _____ /_____ /_____ SSN: _____-_____-_____
I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Full Circle Alliance's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Full Circle Alliance at (708) 478-7080.

Signature of Client(s): _____ _____
Date: _____/_____/_____

Signature of Parent, Guardian or Personal Representative*: _____
Date: _____/_____/_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)
_____ Patient/Client Refuses to Acknowledge Receipt
Signature of Witness: _____ Date_____/_____/_____

RECEIPT AND ACKNOWLEDGEMENT OF OFFICE AND BILLING POLICIES

Patient/Client Name: _____
DOB: _____ /_____ /_____ SSN: _____-_____-_____
I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Full Circle Alliance's Office and Billing Policies. I understand that if I have any questions regarding these policies, I can contact the Full Circle Alliance at (708) 478-7080.

Signature of Client(s): _____ _____
Date: _____/_____/_____

Signature of Parent, Guardian or Personal Representative*: _____
Date: _____/_____/_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)
_____ Patient/Client Refuses to Acknowledge Receipt
Signature of Witness: _____ Date_____/_____/_____

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AUTHORIZATION FORM FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I, _____, the Full Circle Alliance Inc.
(Name of Patient or Authorized Agent)
to release to/or secure from

_____
(Name of Health Care Facility, Physician, Agency etc.)

_____
(Street Address, City, State and Zip Code)

the following information contained in the patient record of _____
(Patient's Name)

born: _____/_____/_____.

To be disclosed, the following items must specifically be checked:
☐ Account Information ☐ Treatment Summary
☐ Office Psychotherapy Notes ☐ Verbal Discussion of Case
☐ Psychological Testing Report ☐ Other (specify): _____

The purpose(s) of the authorization is (are):
☐ At the request of the individual ☐ Coordination of Mental Health Treatment
☐ Payment of Account ☐ Other (specify): _____

I understand that the practice may not condition treatment on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the the provider has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on_____.
(Date)

Date: _____/_____/_____ _____
(*Signature of Client)*

_____ _____
(Signature of Witness) *(Signature of Parent or Guardian)*
**Client signature is required in addition to the parent or guardian signature for clients ages 12-17

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ELECTRONIC AND SOCIAL MEDIA POLICIES AND CONSENT

We the staff of the Full Circle Alliance acknowledge the importance and value of the use of social and electronic media to supplement and enhance mental health treatment. For our patients' benefit, we have developed the Full Circle Alliance website (found at www.thefullcirclealliance.com) to provide helpful information regarding our office, providers, intake and payment procedures, as well as psychoeducational articles and videos regarding common mental health conditions and questions. Additionally, the Full Circle Alliance is now on both Facebook and Twitter, where patients can get up to date information regarding office closings, new services and providers, and basic mental health information as requested. However, please note that providers and office staff of the Full Circle Alliance are not able to interact with patient via their personal webpages, blogs, Facebook, or Twitter accounts due to confidentiality clauses and professional boundaries.

Additionally, social and electronic media is a useful tool to communicate with your provider regarding treatment questions, emotional/behavioral updates, and medication concerns. In some cases, when appropriate, face to face treatment can now be conducted through telepsychiatry electronic mediums such as Skype, allowing face to face interaction between patient and provider when circumstances make an office visit difficult.

We here at the Full Circle Alliance hold your privacy and confidentiality in highest regards, and thus hold true to all legal and ethical principles of confidentiality while utilizing social and electronic media. However, we do recognize that the nature of internet based communications may carry some degree of risk in terms of third party interception of communication, and ask that our patients remain aware of this potential when making the decision to communicate electronically. Also, please note that all communications via social and electronic media are subject to become part of the patient's clinical record, at the discretion of the provider.

I understand these risks and hereby consent to the use of the following forms of social media for treatment and/or communication purposes:

☐ FCA Website ☐ FCA Facebook page
☐ FCA Twitter account ☐ Email ☐ Text messaging
☐ Skype ☐ Other (specify): _____ OR

☐ I decline the use of social and electronic media for communication/treatment purposes at this time. I understand that declining this policy means that staff/providers of the Full Circle Alliance will solely communicate with me through face to face or telephone contact, and attempts to contact staff via social or electronic means (website, email, etc.) will receive no response.

Date: _____/_____/_____ _____
(*Signature of Client)*

_____ _____
(Signature of Witness) *(Signature of Parent or Guardian)*

**Client signature is required in addition to the parent or guardian signature for clients ages 12-17