Decatur Psychological Associates, P.C.
3040 N. University Ave. Suite 2
Decatur, IL 62526
phone: 217.872.1700
fax: 217.872.1366
www.decaturpsych.com

REGISTRATION

Today's Date _____

Patient Information

Name: _____ Preferred name: _____

Address: _____City: _____ST: _____ Zip Code: _____

Date of Birth: _____ Social Security Number: _____

Phones: Home:_____ Cell:_____ Work:_____

Appointment reminder calls? _____

Email address:_____

If Employed:

Name of Employer: _____ Occupation: _____

If Patient is under the age of 18 who is the legal guardian?

Name: _____ Relationship: _____

Address: _____ ST: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Date of Birth: _____ Social Security Number: _____

Additional Information:

Primary Care Physician _____ Address _____ Phone _____

May we contact your Physician if necessary? _____

Please list all medications that you are currently taking:

Please list any allergies:

FINANCIAL POLICY

- Patients are responsible for providing all demographic and insurance information at the time of service. Billing your insurance company is a courtesy and all balances not covered by insurance are your responsibility.

- All charges for co-pay, co-insurance and self-pay are due on the day of the appointment. Payment may be made using cash, check or credit/debit card. Until your insurance and deductible/co-pay amount can be verified, you are responsible for the total payment of each office visit.

- You are responsible to check with your insurance company to verify coverage and verify provider participation.

- There is a $20 fee for checks returned for insufficient funds.

- If your account is past due with no payment for 90 days, it may be turned over to a collection agency. You would be responsible for your balance plus collection fees.

- **If an appointment is made and is not cancelled 24 hours prior to the appointment time, a $50 No Show charge will be applied to your account.**

Please sign below if you have read and agree to the above policy.

Name (please print) _____

Signature _____ Initials: _____

Date _____

Decatur Psychological Associates, P.C.
3040 N. University Ave. Suite 2
Decatur, IL 62526
phone: 217.872.1700
fax: 217.872.1366
www.decaturpsych.com

Insurance Information

Method of Payment ☐ Self Pay ☐ EAP ☐ Insurance ☐ Other

If payment is by insurance please complete the section below:

Name of Insurance Company _____

Insurance ID Number_____ Group Name and Number _____

Phone Number of Company _____

Is Preauthorization required? ☐ No ☐ Yes Is Physician Referral required? ☐ No ☐ Yes

Who is the Insured Member if not the Patient

Name: _____ Relationship: _____

Address: _____ City _____ ST: _____Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Date of Birth __ __ / __ __ / __ __ __ Social Security Number __ __ __ - __ __ - __ __ __

Employer: _____

Employer Address: _____

☐ **I DO** give my permission for Decatur Psychological Associates, to bill my **insurance or E**mployee **A**ssistance **P**rogram for services rendered.

☐ **I DO NOT** give my permission for Decatur Psychological Associates, P.C., to bill my insurance or **E**mployees **A**ssistance **P**rogram for services rendered.

Name (please print) _____

Signature: _____ Initials:_____

Date: _____

Decatur Psychological Associates, P.C.
3040 N. University Ave. Suite 2
Decatur, IL 62526
phone: 217.872.1700
fax: 217.872.1366
www.decaturpsych.com

Consents

*Patient's Full Name*_____ *Date of Birth*_____

CONSENT OF TREATMENT: I authorize and consent to the performance of psychiatric treatment and/or testing considered necessary or advisable by staff associated with Decatur Psychological Associates, P.C.

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of mental health benefits to Decatur Psychological Associates, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I also understand that if this bill goes to collection and/or an attorney, I am fully responsible for all reasonable costs for collection and/or attorney fees that are incurred, as well as court costs.

RELEASE OF INFORMATION: I authorize Decatur Psychological Associates, P.C. to release information including but not limited to; Medical History, Diagnosis, Mental Health Assessments and **Progress Notes** to any physician that may have referred me to this practice or to any physician that I may be referred to by this practice.

× _____ _____ _____ × _____ _____ _____

Signature of Patient (or Guardian) Initials Date Signature of Guarantor Initials Date

CONSENT FOR USE OF PROTECTED HEALTH INFORMTION (PHI) FOR TREATMENT, AND PAYMENT AND HEALTHCARE OPERATIONS: My "PHI" means health information, including my demographic information, collected from me and created or received by my health care provider, another health care provider, a health plan, my employer or a health care clearinghouse. This "PHI" relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use of disclosure of my "PHI" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my "PHI" is used or disclosed to carry out treatment, payment or healthcare operations of the practice. My Provider is not required to agree to the restrictions that I may request. However, if she/he agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that my provider has taken action in reliance on this consent. I understand I have the right to review my provider's Notice of Privacy Practices prior to signing this document.

× _____ _____ _____

Signature of Patient (or Guardian) Initials Date

Decatur Psychological Associates, P.C.
3040 N. University Ave. Suite 2
Decatur, IL 62526
phone: 217.872.1700
fax: 217.872.1366
www.decaturpsych.com

CONTACT INFORMATION FORM

I authorize Decatur Psychological Associates, P.C. to communicate with the following people (for example: parents, guardians, spouses, partners, friends) to confirm ***insurance or appointment information.***

Name	Phone	Relationship	Emergency contact Y / N

I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____ _____
Signature of Patient (or Guardian) *Initials* *Date*

_____ _____ _____
Signature of Patient (age 12-17) *Initials* *Date*

Decatur Psychological Associates, P.C.
3040 N. University, Suite 2
Decatur, Illinois 62526
217 872-1700

I acknowledge that I have received a copy of the **HIPAA NOTICE OF PRIVACY AND SECURITY POLICY.**

Signature_____ Date_____

Print Name_____

Decatur Psychological Associates, P.C.
3040 N. University Ave., Ste 2
Decatur, IL 62526
217-872-1700 Phone
217-872-1366 Fax

Name _____ Date of Birth _____ SS# _____

Address _____

Hereby REQUEST and AUTHORIZE Decatur Psychological Associates, P.C. to release/obtain the following information pertaining to my Substance Abuse and/or Mental Illness:

Release to / obtain from:

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

_____

(Address) (State) (Zip)

_____ _____

(Phone) (Fax)

The above information for the following period of time shall be released: From:_____ To: _____.

Purpose of Disclosure: **Continuum of Care**

This information is being disclosed from records whose confidentiality is protected by one of the following state or federal laws. State law and federal regulation (42 CFR part 2) and mental health and developmental disabilities confidentiality act (ILL. Rev Sate 1991. ch91 1/2 Par 801 ct seq.) which prohibits the redisclosure of any general authorization for the release of medical or other information is not sufficient for this purpose. I understand that I have the right to inspect and receive copy of the information that is disclosed.

I understand that I can revoke this consent in writing at any time except as to disclosures already made. Unless revoked, this consent to release will expire on year from the date signed on _____. This is a continuing disclosure which covers the entire treatment episode and until all claims are filed and processed.

I attest to the Identity of Signatory (is) below:

_____ _____ _____

Guardian Signature Date Date Sent/Initial

_____ _____ _____

Patient Signature Witness Signature Therapist/Doctor Signature

*** If the Patient is 13 years or older they MUST also sign the consent***