PERSONAL GROWTH ASSOCIATES
Schaumburg ▪ Crystal Lake ▪ Glen Ellyn

FIRST NAME: ________________________________ MIDDLE INITIAL ________ LAST NAME: __________________________________

ADDRESS: ____CITY, STATE, ZIP ____

HOME PHONE: (_____) _____________________CELL PHONE: (_____) __________________ PATIENT SS# _____________________

GENDER ________ AGE _________ D.O.B. _______________ EMPLOYER ____

WORK PHONE: (_____) _____________________________ E-MAIL ADDRESS: ____

WOULD YOU LIKE TO RECEIVE OUR E-MAIL NEWSLETTER? YES NO

WHAT IS YOUR PREFERRED METHOD OF CONTACT? __________________ IF BY PHONE, MAY WE LEAVE A MESSAGE? YES NO

INSURANCE INFORMATION

PATIENT'S RELATIONSHIP TO INSURED: SELF ______ SPOUSE ______ CHILD ______ OTHER _______

POLICYHOLDER NAME: ____

POLICYHOLDER EMPLOYER: ____

POLICYHOLDER SS#: _____________________________________GENDER____________ D.O.B. ____________________________

NAME, PHONE #, AND BILLING ADDRESS OF RESPONSIBLE PARTY (**IF DIFFERENT THAN ABOVE)**: _________________________

____

IF INSURANCE REQUIRES PREAUTHORIZATION: Auth. #_________________ Number of Visits _______ Dates of Auth._____________

IS THIS IS AN EAP VISIT (Employee Assistance Program)? If yes:

Auth. # ___________________________# of Visits _______________Dates of Auth.______________________________________

SECONDARY INSURANCE INFORMATION

POLICYHOLDER NAME: ____ _____________________________

POLICYHOLDER EMPLOYER: ____

POLICYHOLDER SS#: ________________________________GENDER ____________ D.O.B. _________________________________

PATIENT'S RELATIONSHIP TO INSURED: SELF ______ SPOUSE ______ CHILD ______ OTHER _______

INFORMED CONSENT FOR TREATMENT

I consent to have Personal Growth Associates and its professional staff perform evaluation, psychotherapy, medication management and/or related mental health treatments when deemed necessary or advisable by appropriate members of the professional staff and/or consultants in consultation with Personal Growth Associates. This statement has been fully explained to me and I understand it.

Patient 12 years and older: ____Date:___________________________

Legal Guardian/Responsible Party: ________________________________ Date: __________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

I authorize the release of any medical information acquired in the course of my/patient examination or treatment to expedite insurance benefit payments to Personal Growth Associates. **I accept responsibility for payment the insurance company may not cover. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

Patient/Responsible Party: ____ Date: __________________________

Rev 1/20

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HOW WERE YOU REFERRED TO OUR PRACTICE?

- ☐ Physician – What is doctor's name? ____________________________________
- ☐ Therapist- What is therapist's name? ____________________________________
- ☐ Another patient/client
- ☐ Your insurance provider
- ☐ School – What is the name of the school? ______________________________
- ☐ Hospital – What hospital? ____
- ☐ Internet/website – Which one?
  - ☐ Personal Growth Associates website
  - ☐ Psychology Today website
  - ☐ Your insurance provider website
  - ☐ Other (please specify)_____________________
- ☐ Other (specify) ____

PHYSICIAN INFORMATION

NAME AND PHONE OF PRIMARY PHYSICIAN:

____

MAY WE CONTACT YOUR PRIMARY PHYSICIAN TO LET THEM KNOW YOU ATTENDED TODAY'S SESSION?
☐ YES ☐ NO

MAY WE CONTACT YOUR PRIMARY PHYSICIAN TO DISCUSS YOUR CASE?
☐ YES ☐ NO

CONTACT INFORMATION

NAME OF PERSON(S) YOU AUTHORIZE PERSONAL GROWTH ASSOCIATES TO SPEAK WITH:

____

WHOM CAN WE CONTACT IN CASE OF EMERGENCY:____PHONE:___________________

WHAT INFORMATION ARE WE PERMITTED TO SHARE WITH PERSON(S) LISTED ABOVE?

☐ APPOINTMENT INFORMATION ☐ BILLING INFORMATION ☐ INFORMATION REGARDING TREATMENT

PRIVACY POLICY

I acknowledge having been offered *Personal Growth Associates*, "Notice of Privacy Policies" and their "Clients Rights Statement" My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, as explained in the Policy. My right to make a complaint and file a grievance under Illinois laws has also been explained. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that *Personal Growth Associates* has already made disclosures with my prior consent.

Patient 12 years and older: ____Date: __________________

Legal Guardian/Responsible Party: _______________________________________ Date: __________________

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POLICIES AND PROCEDURES

Please acknowledge that you have read each section below by initialing.

CONTACTING YOUR DOCTOR/THERAPIST

The office phone number is (847) 413-9700 for both our Schaumburg and Crystal Lake offices. Each Doctor and Therapist has his/her own voice mail box. When you reach the Doctor's/Therapist's mailbox, leave your message and he/she will return your call as soon as possible. If you do not know the extension, follow the instructions on the voice mail message menu. All of the Doctors/Therapists carry pagers 24 hours for emergencies, and there is always a psychiatrist on call. Once your Doctor/Therapist receives the page and retrieves your message, he/she will return your call. ________Initial

FEES AND PAYMENTS

Payment is due in full at the time of the visit, unless the Doctor/Therapist has a contract with your insurance company. In that case, any deductible and co-payments are due at the time of the visit. Therapists collect their fees in session. Fees for psychiatric services are collected at the front desk. The office accepts cash, check and credit card payments. All checks are to be made out to PERSONAL GROWTH ASSOCIATES. The office charges $25.00 for any returned check. If fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. _______Initial

ELECTRONIC HEALTH RECORD

The Electronic Health Record, or EHR, is the system used by our clinicians and other staff to improve access to your medical history. The EHR replaces the paper or hard copy medical chart with computerized records, adding many new capabilities to improve the care you receive, including electronic prescribing and remote access to your medical information. Now your clinician can view your secure records anytime, anywhere to safely provide after-hours or emergency care.

How Is my Health Information Protected? Privacy and security safeguards are in place to protect your personal health information. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, a federal law, requires your health care providers to give you a Notice of Privacy Practices to inform you how your information may be used and shared, as well as how you can exercise your rights under the HIPAA Privacy Rule. The same privacy rules that protect your paper records also protect your EHR. Additionally, the HIPAA Security Rule, also a federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. Standards include access controls, like tracking who can access your health information and password protections.

Personal Growth has entered into a Business Agreement with Psych Select Software, LLC (Business Associate) to provide web-based access to software that handles patient scheduling, messaging, and records management. Health Information is stored according to the HIPAA Security Rule, is backed up, and Business Associate will not use or disclose PHI except as permitted or required by this agreement or as Required by Law, and will comply with any limitations on uses and disclosures to which Covered Entity has agreed and communicated to Business Associate.

_______Initial

PATIENT PORTAL

Personal Growth Associates also utilizes a HIPAA compliant Patient Portal which can be used to contact your clinician regarding scheduling, reading and signing documents, getting reminders and confirming appointments, and making payments to your account. This is completely optional and if you consent to exchange information via this portal, you will be asked to fill out and sign the Patient Portal consent form.

_____Initial

INSURANCE CLAIMS

For all therapists, Personal Growth Associates will file your insurance claim promptly. Insurance benefits are verified following the first session and therapists are notified of the quote of benefits and pre-certification requirements, if any. Because a quote a benefits is not a guarantee of coverage, claims are not always paid exactly how we would expect. ***We will do our best to work with your insurance company, but should your insurance company deny a claim, or pay at a different benefit level than anticipated, it is your responsibility to follow up with your insurance company. Any remaining balance is the client's responsibility.*** ________Initial

APPOINTMENTS AND CANCELLATIONS

Appointments for psychiatric visits are made through our office appointment line (847) 413-9700. Therapists schedule their own appointments and can be contacted directly to inquire about availability. There are often waiting lists for appointment times; therefore, your appointment is valuable to your Doctor/Therapist and other clients. Please notify the office or therapist as soon as possible of any appointment cancellations. ***Appointments not canceled at least 24 hours in advance will be billed to the patient at the session rate and cannot be billed to, nor reimbursed by, insurance.*** ______Initial

MISCELLANEOUS POLICIES

Appropriate behavior in and around Personal Growth Associates offices and grounds is expected. Parents are responsible for their children, and need to supervise their behavior and/or instruct them regarding these policies. Patients and/or families will be held financially responsible for property damage and/or vandalism, if such damage occurs. I acknowledge having been offered Personal Growth Associates, "Notice of Privacy Policies" and their "Clients Rights Statement."

_______Initial

PERSONAL GROWTH ASSOCIATES
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Credit Card Authorization

Personal Growth Associates wants to work with you to make sure that claims and statements are paid accurately and efficiently. We require that you provide credit card information to secure your account. This information is stored within out Electronic Record system which is secure and password protected. Credit numbers will not be stored on paper. Depending on the arrangement you make with your clinician, you may elect to have your credit card charged for the amount due at each time of service, or to authorize payment once a month for the outstanding balance due at that time. There is also the option to pay your balance through our Patient Portal. **In the event that your account becomes past due, we will charge your card any remaining balance due.** All open balances will be billed on a monthly basis. Your account will become past due if payment is not received within 30 days of the statement billing date. **Missed appointment charges will automatically be charged to your card unless other arrangements are made.**

Unpaid past due accounts may be turned over to a collection agency if no payment arrangements are made.

Client Name____

Credit Card #____ Exp_________
(Visa, Mastercard or Discover)

Cardholder Name____ Billing Zipcode___________

CID (code on the back of your card) _________

I authorize Personal Growth Associates to save my credit card information within their Electronic Health Record Program. I authorize Personal Growth Associates to charge my credit card listed above for copays, deductible amounts due, co-insurance, past due balances, and missed appointment fees, as discussed with my clinician. I authorize Personal Growth Associates to keep my signature on file for future charges as authorized by me.

Cardholder Signature_____________________________________Date____________

REQUIRED

PERSONAL GROWTH ASSOCIATES
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CONSENT FOR RELEASE OF INFORMATION

Patient's Name____Date of birth_________
I authorize Personal Growth Associates to release information to and/or receive information from:

1. Person or agency____
Address____
Phone/fax____
To exchange the following information:

___ Medical History ____ Outpatient care ___ Appointment Scheduling
___ Psychiatric Evaluation ____ Laboratory Tests ___ Billing/Financial Info.
___ Psychological Tests ____ Substance Abuse Eval. ___ Other _______________
___ Inpatient Care ____ Discharge Summary

2. Person or agency____
Address____
Phone/fax____
To exchange the following information:

___ Medical History ____ Outpatient care ___ Appointment Scheduling
___ Psychiatric Evaluation ____ Laboratory Tests ___ Billing/Financial Info.
___ Psychological Tests ____ Substance Abuse Eval. ___ Other _______________
___ Inpatient Care ____ Discharge Summary

3. Person or agency____
Address____
Phone/fax____
To exchange the following information:

___ Medical History ____ Outpatient care ___ Appointment Scheduling
___ Psychiatric Evaluation ____ Laboratory Tests ___ Billing/Financial Info.
___ Psychological Tests ____ Substance Abuse Eval. ___ Other _______________
___ Inpatient Care ____ Discharge Summary

The information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. The person or agency to whom information is disclosed may not re-disclose this information unless I specifically consent to such redisclosures. I understand I have the right to revoke this consent at any time. Otherwise, this consent will expire one year from the date of my signature.

Patient Signature (12 years and older)_________________________ Date ___________

Parent/Guardian Signature ________________________________Date _____________

Witness ____ Date _____________

Personal Growth Associates
919 N. Plum Grove Rd., Suite C, Schaumburg, IL 60173 phone 847-413-9700 fax 847-413-1701

Communication Policies for Personal Growth Associates

The following are general guidelines regarding communication with our providers:

24 hour notice is required for cancellation of a session/appointment. Missed appointments not cancelled within 24 hours will be charged at the full session fee and will be your responsibility; insurance cannot be billed for missed appointments.

E-mail communication is limited to discussion of scheduling and billing, not medical or therapeutic treatment issues.

In certain circumstances, communication outside of session may be billed as a phone consultation. Scheduling an appointment in the office is recommended – phone contact is not payable by your insurance company.

Phone consultations need to be scheduled with your clinician and can typically occur within 24 hours or the following business day, depending on the availability of your provider.

Rates for phone consultation:

10 minutes or less- $30
15 minutes - $45
20 minutes - $60
30 minutes - $90

I have read, understand, and agree to these policies.

____

Signature Date

Patient Name ________________________________Date of Birth _________

Patient Portal/Appointment Reminder Form

Patient Portal

Personal Growth associates offers secure communication as a service to patients who wish to view parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works: Secure messages and information can only be read by someone who knows the right password to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks: This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: 1) the secure message must reach the correct email address, and 2) only the correct individual (or someone authorized by that individual) must be able to have access to the message. Only you can make sure these two factors are present.

It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging: Online communications should never be used for emergency communications or therapeutic issues. If you have an emergency or an urgent issue, you should contact your clinician via telephone.

If there is information that you don't want transmitted via online communication, please inform your clinician.

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal. I understand the risks associated with online communications between my clinician and me, and consent to the conditions outlined. I agree to follow the instructions set forth herein, as well as any other instructions that my clinician may impose to communicate with patients via online communications.

Patient Signature (12 years and older)______________________________ Date __________

Parent/Guardian Signature ____________________________________Date ___________

E-mail to be used for Patient Portal: _______________________________________

Appointment Reminders

Personal Growth Associates can text or e-mail you appointment reminders

PATIENT NAME: ________________________________DOB:__________

Please indicate below which way you would like to be reminded:

- **EMAIL** I, ____, authorize Personal Growth Associates to send appointment reminders electronically via Email to the following email address:

  Please print clearly)____

- **TEXT MESSAGE** I, ____, authorize Personal Growth Associates to send appointment reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number:

  (Please print clearly)____

PERSONAL GROWTH ASSOCIATES
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NOTICE OF PRIVACY POLICIES AND CLIENT RIGHTS

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

Effective Date: April 14, 2003.

We respect patient/client confidentiality and only release confidential information about you in accordance with Illinois and federal law. This notice describes our policies related to the use of the records of your care generated by Personal Growth Associates.

Privacy Contact. If you have any question about this policy or your rights contact Steve Wodka, Privacy Officer, at (847) 413-9700 ext. 313.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your confidential information with others beyond Personal Growth Associates. This includes for:

Treatment. We may use or disclose treatment information about you to provide, coordinate, or manage your care of any related services, including sharing information with others outside Personal Growth Associates that we are consulting with or referring you to.

Payment. With your written consent, 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.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.

Information Disclosed without your consent. Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

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

Follow-Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information on your answering machine unless you tell us not to.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this, contact the Privacy Officer and ask for the *Request to Amend Health* Information form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 13, 2003, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints, you may contact our Privacy Officer in writing at our office for further information. You also may complain to the Secretary of U.S. Department of Health and Human Services if you believe Personal Growth Associates has violated your privacy rights. We will not retaliate against you for filing a complaint.
Changes in Policy. Personal Growth Associates reserves the right to change its Privacy Policy based on the needs of Personal Growth Associates and changes in stated and federal law.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners. We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. We are also required to share information, if requested with the U.S. Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

CLIENT RIGHTS STATEMENT

As a client of Personal Growth Associates you have the following rights:

1. To not be denied services on the basis of age, sex, gender identification, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record.
2. To services provided in the least restrictive environment available for your needs pursuant to an individualized treatment plan. You will have nondiscriminatory access to services in accordance with the American's With Disabilities Act.
3. Confidentiality of your status and records, including HIV status and testing as provided for under Illinois law.

PATIENT RIGHTS

You have the following rights under Illinois and federal law:

Copy of Record. You are entitled to inspect the client record that Personal Growth Associates has generated about you. We may charge you a reasonable fee of $25.00 for copying and mailing your record.

Release of Records. You may consent in writing to release your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the clinical information. This request must be in writing. Personal Growth Associates is not required to agree to your request if we believe it is not in your best interest to permit use and disclosure of the information. The request should be given to the Privacy Officer.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.

4. Personal Growth Associates has the right to limit services based on the funding we receive. This may require us to prioritize services based on the severity of your service needs. Services not covered by governmental grants are charged based on the cost of providing those services.
5. No client shall be presumed legally disabled unless declared so by a court.
6. You have the right to give an informed consent to treatment. You also have a right to refuse treatment and be told the consequences of such refusal. This could include the agency being unable to provide services to you.
7. If you believe your rights have been violated you have a right to contact the following group: Office for Civil Rights & Department of Health & Human Services
8. If you have a complaint about the services provided you may file a grievance by doing the following: Contact the Privacy Officer, Steve Wodka at (847) 413-9700 ext. 313.

Social Media Policy

This document outlines our office policies related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, we encourage you to bring them up when you meet with your clinician.

Friending

We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Personal Growth Associates does not have a **Facebook Page**. Individual clinicians may have a personal Facebook Page. Clinicians will not accept patients as Facebook fans, as above, because doing so could create a greater likelihood of compromised client confidentiality. In addition, the American Psychological Association's Ethics Code prohibits us from soliciting testimonials from clients. We feel that the term "Fan" comes too close to an implied request for a public endorsement of our practice.

Following

You can follow our website and sign up for our monthly newsletter by supplying your clinician with your email. Personal Growth Associates is also eliminating using Twitter at this time. As professionals, we will not view your online activities without your consent and without an explicit arrangement towards a specific purpose. We do not want to have information that could have a negative influence on our working relationship. If there are things from your online life that you wish to share with your clinician, please bring them into your session with the therapist where they can be viewed and explored together, during the therapy hour.

Business Review Sites

Business review sites such as Yelp, Healthgrades, and Bing may review our psychology practice. If you happen to find our practice or a clinician listed, please know that the listing is not a request for a testimonial, rating or endorsement from you as our patient. The APA Ethics Code states that under Principle 5.05 that it is unethical for clinicians to solicit testimonials. You have the right to express yourself on any site you wish, but due to confidentiality, we cannot respond to any review. We may not see these reviews, and you should be aware that if you are using these sites to communicate indirectly with us about

your feelings about therapy, there is a good possibility that the clinicians may never see it. If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process.

Location Based Services

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. Our practice has not been placed as a check-in location on sites such as Foursquare, Gowalia, etc. If you have GPS enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis.

Thank you for familiarizing yourself with our social media policy. If you have any questions or concerns about any of these policies/procedures, please bring them to the attention of the clinician you see for direct discussion.