

Dx # _____

Site _____

Dr. _____

Gersten & Assoc., P.C.
REGISTRATION FORM

Patient Information

Name First _____ Initial _____ Last _____ Sex _____ Marital Status _____
Social Security No. _____ - _____ - _____ D/O/B ____/____/____ Who referred you _____
Street Address _____ Apt. No. _____
City _____ State _____ Zip _____ Home Phone () _____ - _____
Cell Phone () _____ - _____ Business Phone () _____ - _____ Email Address _____
Currently Employed YES () NO () Full Time Student YES () NO () Part Time Student YES () NO ()
Would you be interested in receiving practice updates? YES () NO ()

Employer Information

Employer Name _____ Employer Phone () _____ - _____
Street Address _____ City _____ State _____ Zip _____

Guarantor Information (Person Insured or Responsible for Payment of Your Bill)

Name First _____ Initial _____ Last _____ Relationship _____
Social Security No. _____ - _____ - _____ D/O/B ____/____/____
Street Address _____ Apt. No. _____
City _____ State _____ Zip _____ Home Phone () _____ - _____
Cell Phone () _____ - _____ Business Phone () _____ - _____ Other () _____ - _____

Emergency Contact

Name _____ Relationship _____
Home Phone () _____ - _____ Cell Phone () _____ - _____ Business Phone () _____ - _____
Physician Name _____ Phone () _____ - _____ Other () _____ - _____

Insurance Information

Primary Insurance Co. _____ Group # _____ ID # _____
Secondary Insurance Co. _____ Group # _____ ID # _____

ASSIGNMENT OF BENEFITS/GUARANTEE OF PAYMENT: I authorize and instruct my insurance company, if any, to pay any and all relevant benefits directly to the psychologist. I understand, and guarantee, that I am responsible to the psychologist for all the charges not covered by my group or individual insurance plans.

Signature Date Relationship Witness

CONSENT FOR TREATMENT: I authorize the psychologist to administer treatment as deemed necessary or advisable by the psychologist.

Signature Date Relationship Witness

Gersten & Assoc., P.C.

PSYCHOLOGIST & PATIENT AGREEMENT

Welcome to Gersten & Assoc., P.C. The following included some essential information about psychotherapy. Please read and sign at the bottom to indicate that you accept this agreement.

Length and Frequency of Treatment: Psychotherapy typically involves regularly scheduled forty-five minute sessions. Treatment length and session frequency vary depending on your individual needs and our mutually established therapy goals.

Confidentiality: Information you share with me is kept strictly confidential and will not be disclosed without your written consent. I will use confidential information for the purpose of treatment, payment and operations. Confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situations in which children are at risk, such as abuse or neglect. Refer to the document(s) titled "Notice of Privacy Practices" for a thorough explanation of different types of confidentiality associated with health care information and the regulations in place protecting this information.

Patient Rights: There are specific rights that as my patient you retain. These include the opportunity to object to the use or disclosure of protected health information, request alternative communication channels, access your protected health information, amend your protected health information, view a record of all disclosures by my practice, and complain and/or file reports of privacy violations.

<u>Fee Policy:</u> Initial Diagnostic Evaluation	\$225	Extended Therapy Session	\$175
Individual Therapy Session	\$150	Late Cancellation/Missed Session	\$75
Family Therapy Session	\$165	Returned Check Fee	\$25

If you need to cancel an appointment, please notify me at least twenty-four hours in advance; otherwise, I will charge you for the missed session. When you make an appointment you are reserving professional time set-aside specifically for you. If you do not attend or provide sufficient cancellation notice, the time is simply lost. Please be aware that insurance companies will not cover cancellation charges.

If you have mental health insurance coverage, I will assist you with insurance reimbursement through my administrative office. In some circumstances insurance may pay only part of my fee. For example, although my fee is \$225 an insurance carrier may allow for a \$90 fee. You will be charged for the difference between my ordinary fee and the limit placed by insurance unless otherwise determined by my contractual agreement with your insurance company. This issue is typically clarified on or before our first two sessions. Fees or co-payments are paid at the time of the office visit, and balance payments are paid within 30 business days from receipt of invoice.

Phone and Emergency Contact: If you need to contact me by phone, do not hesitate. I am usually able to return calls within the day. You will not be charged for phone calls unless we have a scheduled conversation or a problem-solving call that lasts more than fifteen minutes. In case of an emergency, I can be paged.

Physician Contact: Physical and psychological symptoms often interact. Please inform me of your medical conditions and treatment along with the physician(s) involved. In addition, medication is sometimes helpful for psychological problems. I will provide a referral for medication evaluation, when appropriate, or will consult with your primary care physician if (s)he prescribes medication for such issues.

Freedom To Withdraw: You have the right to end therapy at any time. I will provide you with the names of other qualified psychotherapists upon request.

Informed Consent: I have read and understand the above statements. I have had an opportunity to ask questions and I agree to enter into a professional psychotherapy relationship with Gersten & Assoc., P.C.

PATIENT _____

DATE _____

Gersten & Assoc., P.C.

Notice of Privacy Practices — Short Version

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. Although these laws are complicated, you must be provided with important information. This document is a shorter version of the full, legally required NPP, which is available for you to view in our waiting room. We would be happy to provide you with your own copy upon request. Please refer to the full version for more information. Also, since these documents can't cover all possible situations, please talk with us directly about any questions or concerns.

We will use the information about your health, which we receive from you or from others, mainly to provide you with treatment, to arrange payment for our services, or for other business activities that are called health care operations. After you have read this NPP, you will be asked to sign a consent form to let us use and share your information. If you do not consent and sign this form, we will be unable to provide you with treatment.

If we want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private; however there are times when the laws require us to use or share it such as:

1. when there is a serious threat to your health and safety, to the health and safety of another individual, or to the public. In such an event, we will only share information with a person or organization that is able to help prevent or reduce the threat.
2. in some lawsuits, and legal or court proceedings.
3. if a law enforcement official requires us to do so.
4. for Workers Compensation and similar benefit programs.

There are other situations that don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask to be called at home, and not at work, in order to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or in the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement unless it is against the law, in case of an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records for a minimal administrative fee. Please contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must explain the reasons you want to make the changes.
5. You have the right to a copy of the NPP. If we make changes, we will notify you and post them in our waiting room. You can also obtain a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Gersten & Assoc., P.C.

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and Gersten & Assoc., P.C. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you, who need it to arrange payment for your treatment, or for other business or government functions.

By signing this form you are agreeing to let us use and send your information to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and may therefore change our Notice of Privacy Practices. If we do change it, you can get a copy in our office or from our Privacy Officer.

You have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; however, if we do agree, we promise to comply with your wish.

After you have signed this consent form, you have the right to revoke it by writing a letter telling us you no longer consent. We will comply with your wishes about using or sharing your information from that time on, although we cannot change the fact that some information may have been sent or shared before that date.

Signature of Patient	Printed Name of Patient	Date
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Signature of Personal Representative	Printed Name of Personal Representative	Date
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Description of Personal Representative’s Authority	Relationship to the Patient
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NPP copy given to the patient/parent/personal representative.
Date _____

Gersten & Assoc., P.C.

Office: 847.329.9210

Gottlieb Professional Building

675 W. North Avenue, Ste 306
Melrose Park, Illinois 60160
Fax: 708.681.9280

Westmoreland Building

9933 Lawler Avenue, Ste 338A
Skokie, Illinois 60077
Fax: 847.329.9280

St. Francis Professional Building

800 Austin St, East Tower, Ste 352
Evanston, Illinois 60202
Fax: 847.328.9210

External Authorization Form

Authorization to use and disclose protected health information

I am completing this form to allow the use and sharing of protected health information about

Printed name: _____ Date of Birth: _____

I hereby authorize: _____

(Insert name, address & phone number of individual to disclose records)

To disclose protected health information and/or records to:

(Insert name, address & phone number of individual to receive records)

- Check here if authorization is given for the parties listed above to mutually exchange the information described below.

DESCRIPTION:

- Inpatient or outpatient treatment records for physical, psychological, psychiatric or emotional illness, or drug and/or alcohol abuse.
- Admission and discharge summaries.
- Psychological or psychiatric evaluations, testing records, reports, assessments, treatment notes, summaries or other documents with diagnoses, prognoses and recommendations, and behavioral observations or checklists completed by any staff member or by the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans and other similar plans.
- Social, family, educational, and vocational histories.
- Social work assessments and plans.
- Progress, nursing, case or similar notes.
- Evaluations and reports of consultants.
- Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- Vocational evaluations and reports.
- Billing records.
- Academic and educational records, including achievement and other tests results, reports of teachers' observations, and all other school or special education documents.
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: I do not release these.
- Complete copy of the medical record.
- Other: _____

The information will be used/disclosed for the following purposes:_____

I understand and agree that this Authorization will be valid and in effect until_____upon which this Authorization expires. I understand that after that date or event, information cannot be used or released to the person or organization unless I sign a new Authorization like this one.

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above, who is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signature of Patient Printed Name of Patient Date

Signature of Personal Representative Printed Name of Personal Representative Date

Description of Personal Representative's Authority Relationship to the Patient

I acknowledge that I received a copy of this completed form.

I, a mental health professional, have discussed the issues above with the patient and/or his personal representative. My observations of his or her behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent.

Signature of Professional Printed Name of Professional Date