Lakeshore Psychology Group
Registration and Insurance Information

601 Skokie Blvd., Suite 104
Northbrook, Illinois 60062
Phone: 847-564-1800

CLIENT REGISTRATION INFORMATION

First Name_____________________________Last Name______________________________
Street Address ____
City, State, Zip ____
Birth Date ____________________ Age _______ SS# _________________________________
Employer/School ____
Home Phone __________________________ Work Phone ____________________________
Cell Phone __________________________ Ok to leave a message? Yes or No (circle one)
Email ____
Parent/Guardian Name (if patient under the age of 18)_________________________________
Parent/Guardian Home Phone ____________________ Mobile ________________________
Emergency Contact __________________ Relationship _____________ Phone _____________
Primary Care Physician ________________________________ Phone __________________
How did you hear about our practice?____
Employment Status: __ Employed __ Full-time __ Part-time __ Student
Marital Status: __ Single __ Married

INSURANCE INFORMATION

Insurance Company ________________________________ Phone # ____________________
ID# ____
Group/Policy # ____
Policyholder's First Name _____________________Last Name ________________________
Street Address ____
City, State, Zip ____
Birth Date ____________________ Age _______ SS# _________________________________
Patient Relationship to the insured: __ Self __ Spouse __ Child __ Other
Employer ____
Home Phone __________________________ Work Phone ____________________________
Copay or Coinsurance Amount (may be different than your medical amount) _______________
Deductible (may be separate from your medical deductible) ____________________________
(For Office Use Only) Diagnosis Code______________________ CPT Code _____________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign, transfer, and set over to Lakeshore Psychology Group all of my rights to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments made by my Insurance Company.

Client or Authorized Person Signature___________________________ Date______________

Lakeshore Psychology Group
Credit Card Information
601 Skokie Blvd.
Suite 104
Northbrook, Illinois 60062
Phone: 847-564-1800

Credit Card Account Number ____
(Visa or MasterCard)

Expiration Date______________

CVV Code___________________

Cardholder's Signature____

Date_______________________

Lakeshore Psychology Group
Financial Policy

601 Skokie Blvd., Suite 104
Northbrook, Illinois 60062
Phone: 847-564-1800

We require all clients to read and sign this Financial Policy. By signing the policy, you are agreeing to the terms and conditions set out in it.

1) Full payment is due at the time of service for out of network clinicians. We accept checks made out to Lakeshore Psychology Group and cash. You will be charged for canceling less then 24 hours in advance and for missed appointments (no show).

2) The session fee will be discussed with your clinician.

3) The only insurance some of our clinicians accept is Blue Cross Blue Shield PPO (BCBS). For BCBS in network clinicians the following will apply:

-The client is responsible at the time of service for any deductibles and co- payments not covered by BCBS.

-We strongly recommend that you call your insurance company before your first appointment to determine if you need an authorization for mental health services and to find out what your mental health benefits are. Sessions that have not been authorized will not be covered by your insurance company and you will have to pay the full fee for these sessions.

-The following are important questions to ask your insurance company:

-How many sessions have been authorized?
-What is my authorization number?
-What is the maximum number of sessions I can use per year?
-What is my copay for each session?
-What is my deductible?
-Has my deductible been met to date?

-At the end of each month we will submit all BCBS claims. You are responsible for anything BCBS does not cover.

-You need to notify us if your insurance coverage changes. If you fail to do so, you will be responsible for any charges that your insurance company denies.

-Late cancellations (less than 24 hours in advance) and missed appointments (no show) can't be billed to your insurance company. You will be charged the full fee and the entire amount will be charged to your credit card.

4) We reserve the right to stop treatment for non payment

5) There is an additional $35.00 charge for returned checks.

Client Signature______________________________ **Date**__________________

Lakeshore Psychology Group
Late Cancellation/Missed Appointment Payment Policy

601 Skokie Boulevard
Northbrook, Illinois 60062
Phone: 847-564-1800

Any session cancelled less than 24 hours before the scheduled appointment time (LATE CANCEL) or any session missed altogether (NO SHOW) cannot be billed to your insurance company.

By signing this form, you acknowledge responsibility for full payment of any LATE CANCEL or NO SHOW appointments. Full payment is defined as your therapist's full fee with no insurance company discounts.

Client or AuthorizedSignature______________________________

Date____________________________

Lakeshore Psychology Group
Confidentiality Form
601 Skokie Blvd.
Suite 104
Northbrook, Illinois 60062
Phone: 847-564-1800

Confidentiality

The confidentiality of all communications between a client and his/her psychologist is protected by law and we can only release information about our work to others with your written permission. There are some situations, in which, we are legally required to take action to protect a client or others from harm, even if this may require revealing information about a client's treatment.

- If we believe that a client is a threat to cause serious bodily harm to another person, we may be required to take protective action that may include notifying the police, notifying the potential victim, or seeking appropriate hospitalization.

- If a client threatens to harm himself/herself, we may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.

- If we believe that a child, an elderly person or a disabled person is being abused, we are legally required to file a report with the appropriate state agency.

Clients may want to communicate electronically (for brief communication such as scheduling but not for therapy itself), whether via text or email. Be aware that we are unable to guarantee that these forms of communication are fully confidential.

Minors

If a client is under the age of 18, he or she is considered a minor. Before giving parents any information, we will discuss the matter with you. There may be situations, however, when we feel there is a high risk that you may seriously harm yourself or another person. In this case, we will notify either your parents or the appropriate authorities.

Lakeshore Psychology Group
Notice of Privacy Practices and Client Rights Statement
601 Skokie Blvd.
Suite 104
Northbrook, Illinois 60062
Phone: 847-564-1800

Welcome to Lakeshore Psychology Group. This notice describes policies related to the use of records of your care as well as your rights as a client seeking treatment services. If you have any questions about this policy or your rights, do not hesitate to ask. We respect patient confidentiality and only release medical information about you in accordance with Illinois and federal laws. This notice describes our policies related to the use of the records of your care generated by this practice.

Privacy contact: If you have any questions about this policy or your rights, please contact your clinician.

NOTICE OF PRIVACY PRACTICES

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: January 1, 2015

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information Disclosed With Your Consent. In order to provide effective care, there are times when confidential information will need to be shared with others.

Treatment: Treatment information about you may be disclosed to provide, coordinate, or manage your care or any related services, including sharing information with others who are being consulted or to whom you are being referred.

Payment: Information will be used to obtain payment for treatment and services provided. This might include contacting your insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations: Information about you may be used to coordinate business activities. This may include setting up your appointments or reviewing your care.

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 emergency you are facing.
- Follow-up Appointments/Care: You may be contacted 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. Unless instructed not to do so, information may be left on voice mail or an answering machine

- As Required By Law: This would include situations where there is a subpoena, court order, or a mandate to provide public health information. This would also include situations of suspected child abuse, elder abuse, or institutional abuse.
- Governmental Requirements: Information may be disclosed to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. There might also be a need to share information with the Food and Drug Administration related to adverse events or product defects. We might also, if requested, be required to share information with the U.S. Department of Health and Human Services to determine compliance with federal and state 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.

Information disclosed without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and that state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

CLIENT RIGHTS

Under Illinois and federal law, you have the right to not be denied services on the basis of age, gender, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record. You are entitled to receive services in the least restrictive environment and in accordance with the Americans with Disabilities Act. You have the right to confidentiality of your records provided under Illinois Law, and you have the right to refuse treatment and be informed of any consequences of such refusal. In accordance with Illinois and federal law, and under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you also have the following rights:

Copy of Record: You are entitled to inspect information in your record that your clinician has generated about you. You may be charged a reasonable fee for copying and mailing your record if this is requested.

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.

Right to Restrict Disclosures: You have the right to restrict certain disclosures of Personal Health Information (PHI) to a health plan when you pay out-of-pocket in full for our services.

Restriction on Record: You may request that part of your medical information not be disclosed. This request must be in writing and given directly to your clinician. Your clinician is not required to agree to your request if he/she believes it is in your best interest to permit use and disclosure of the information.

Contacting You: You may request that information be sent to another address or by alternative means. Your request will be honored as long as it is reasonable and your clinician is assured it is correct. Your clinician has the right to verify that the payment information is correct.

Amending Record: If you believe that something in your record is incorrect or incomplete, you may request that your clinician amend it. To do this, ask your clinician for the *Request to Amend Health Information* form. In certain cases, your request may be denied. If your request for an amendment is denied, you have the right to file a statement that you disagree with your clinician. Your clinician's response and your statement will be added to your record.

Accounting for Disclosures: You may request an accounting of any disclosures which your clinician has made related to your medical information, except for information used for treatment, payment, or health care operations purposes that was shared with you or your family. It also excludes information that your clinician has been required to release or information for which specific consent to release has been given. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to your clinician. You may be charged a fee for the time involved in preparing this list.

Breach of Unsecured PHI: You have a right to be notified if: a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule involving your PHI; b) that your PHI has not been encrypted to government standards; or c) your clinician's risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Questions and Complaints: If you have any questions, want a copy of this Policy, or have any complaints, you may contact your clinician for further information. You may also contact the Secretary of Health and Human Services if you believe your clinician has violated your privacy rights. You will not be retaliated against for filing a complaint.

Changes in Policy: Your clinician reserves the right to change the Privacy Policy based on the needs of the Practice and changes in state and federal law.

CLIENT AGREEMENTS AND AUTHORIZATIONS

PRIVACY POLICY: I acknowledge having received the "Notice of Privacy Practices" and "Client Rights" statement. My rights, including the right to see and copy my record, to limit disclosure of information and to request an amendment to my record, is explained in the Policy. I understand that I may revoke, in writing, my consent for release of my health care information, except to the extent that disclosure has already occurred with my prior consent

____________________	_______________	__________
Client or Authorized Person Signature	Relationship	Date

____________________	__________
Witness Signature	Date