x

Uptown Psych

4753 N. Broadway St.
Suite 900/925
Chicago, IL. 60640
Phone: 773-989-2780
Fax: 773-989-2781
info@uptownpsych.com
www.uptownpsych.com

Intake Form

Patient name: _____ Date of Birth: _____

SSN: _____Sex: _____Ethnicity: _____

Marital Status: Married Single Divorced Widowed Separated

Address: _____

City: _____State: _____Zip Code: _____

Telephone: _____Email: _____

Insurance Information

Insurance Provider: _____ Identification #: _____

Group #: _____

From whom or where do you receive your primary medical care?

Clinic/Doctors Name: _____

Phone: _____Address: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? **Yes** **No**

If Yes, by whom: _____

Emergency Contact

Name: _____Relationship: _____

Telephone Number: _____

Pharmacy Information

Pharmacy Name: _____

Address: _____ Telephone Number: _____

How did you hear about us: _____

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Office Financial Policy

Initial

_____ Self-Pay Services:	**Discounted Rate Fees**	**Out of Network Fees**
Initial psychiatric evaluation -- up to 60 minutes	$350	$350
Follow up psychiatry appointment -- 15-30 minutes	$165	$265
Therapy service -- 1 hour	$135	$200

_____ Miscellaneous Fees:	
Initial visit no show fee	$150
Follow-up no show fee	$100
Lost controlled substances prescriptions	$25
Refill (Future appointment must be scheduled)	$15
Letters	$20
Medical Records	$25

_____ Self-Pay Discounted Policy:

- I understand that because I am being offered a discounted price for services, I will not be provided claim information to submit to my insurance for reimbursement.

_____ Out of Network Reimbursement Policy:

- I understand that it is my responsibility to submit any claims to my insurance company for reimbursement.
- I understand that it can take up to a week to be provided an itemized receipt for my visit.
- I understand that I am being charged $265 upfront for psychiatry follow ups. Depending on the services provided that can range from $100-$300. If any differences in charges are found, the office will notify me.

Signed_____ **Date**_____
Patient/Guarantor

_____ By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above.

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Office Financial Policy

_____ Cancellation/No Show Policy:

- Failure to show up to an appointment without 24 hours' notice will be subject to a $150.00 (initial) or $100.00 (follow up) charge.
- Cancellations made at the time or after a scheduled appointment will be considered as a missed appointment.
- These fees will be charged on the date of the appointment with the card on file.

_____ Individual Financial Responsibility:

- Uptown Psych will verify benefits prior to an appointment but a quote of benefits is not a guarantee of payment.
- I understand that it is my responsibility to provide the office with any changes of insurance coverage prior or at the time of my visit.
- I understand that in the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- I understand that copays/deductible/coinsurance are due at time of service and any outstanding balances need to be paid prior to being seen.
- I understand that if payment cannot be made, my current/future appointments will be cancelled until full payment is received.
- I understand that I am financially responsible for any copay, deductible, coinsurance or non-covered service and may be contacted by email, fax or phone call.
- I understand that I may be billed under a supervised physician during the time my provider is being credentialed .
- I understand that if I am seeing a therapist, I may be billed under a supervised physician and can't see both of them on the same day.
- I understand that Providers may access records for administrative reasons.
- I consent to electronic signature with credit card swiped.

_____ I authorize Uptown Psych to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays, deductibles and/or coinsurance after all attempts Uptown Psych has made in collecting the balance.

Signed_____ **Date**_____

Patient/Guarantor

_____ By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above.

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Phone Consultation & Documentation Requests Policy

As a reminder, phone calls to your provider should be for emergency purposes only. All other matters are best discussed in session. In order to provide you with the best care, with your permission, our clinicians may communicate with other providers or collect outside information. At times, this information may be beneficial and inform your treatment.

Scheduling an appointment with one of our psychotherapists to complete any ancillary paperwork or discuss collateral information is highly recommended. For our Psychiatrists, appointments for these purposes are absolutely required. Please note, phone contact that our psychotherapists have with outside providers and paperwork completion time are not payable by your insurance company. These services may be billed directly to you from the fee schedule below.

Requests for documentation are granted on a case by case basis at the sole discretion of your provider. Typically, several sessions and consistent engagement in treatment is required for a provider to feel comfortable providing documentation of any kind.

Beneficial information sources by phone include, but are not limited to:

Outside providers such as past individual therapists or Psychiatrists, group therapy counselors, social workers, and psychological testing specialists. For minors, teachers, school psychologists or social workers, and Individualized Education Plan or 504 involved specialists can also be helpful.

Documentation requests can include, but are not limited to:

Clinical summaries of diagnostic impressions or treatment plans, FMLA (Family Medical Leave Act) paperwork completion, background check documents for employment, bariatric surgery candidate requirements, letters to verify work absences for mental health reasons, documentation to show attendance of mental health appointments (sometimes required for court ordered treatment and minors involved with Department of Child and Family Services), disability paperwork, and summaries of clinical recommendations or impressions as requested by outside medical professionals.

Rates for phone consultation: $75.00
Rates for documentation completion: $60.00

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Credit Card On File Form

We require keeping your credit/ debit/HSA card on file as a convenient method of payment when authorized.

_____ I authorize Uptown Psych to charge my credit/debit/HSA card for any late fees as outlined in the 'office financial policy' form.

_____ I authorize Uptown Psych to charge my credit/debit/HSA card for services not paid by my insurance company after 90 days from services rendered, including copays, deductibles and/or coinsurance after all attempts Uptown Psych has made in collecting the balance.

____ I will inform Uptown Psych if my credit card information or expiration date changes.

Visa MasterCard Amex Discover

Card Number _____

Expiration Date _____

CVV Code _____

Name on Card _____

Address _____

Zip Code _____

I understand that this form is valid without expiration unless I cancel in writing.

Signed_____ **Date**_____
Patient/Guarantor

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HIPAA Consent Form

This form is an agreement between you and Uptown Psych. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____

When we examine, test, 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 in our office to decide on what treatment is best for you and provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carryout certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use your information, how we share your information, and may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.uptownpsych.com, or by calling us at (773) 989-2780. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing and have it submitted to us. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of Patient: _____ Date: _____
Printed Name of Patient: _____

If Patient is under 18 years of age:

Signature of Parent/Guardian: _____
Printed Name of Parent/Guardian**:** Relationship to Patient**:** _____

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Email Policy

To better serve our patients, this office has established an email address for some form of communication. For routine matters that do not require response, please feel free to contact us at info@uptownpsych.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 12 hours. The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

_____ I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.
_____ I understand and agree that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____ _____
Patient signature Witness (optional)

_____
Date

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Email Policy

When requested this office will communicate some forms of information via email. This medium will be used with an eye towards medical and legal prudence.

- Email communications will only be used with established patients.
- Patients who elect to use email must be advised of this office's email policy and sign an informed consent (see attached).
- A copy of the consent will be given to the patient, if requested and another copy will be filed in the patient medical record.
- Email communications are restricted to conditions and situations which do not require immediate attention (see consent).
- Protected health information [PHI] will be transmitted in a secure format to render the information unusable, unreadable or indecipherable to unauthorized individuals. http://csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf
- Email communications are a permanent part of the patient medical record. They should be retained in the paper record and/or electronically consistent with the Illinois medical records retention rules http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021000850K6.17
- When a patient request has been completed, the staff member responsible for completing that task will be responsible for sending a confirmation message to the patient.
- As with any form of medical record documentation, unprofessional remarks or comments in email communications are prohibited.
- Confidentiality of patient information will be maintained at all times to protect the integrity of patient-identifiable information.
- When sending patient information via email, the sender is expected to double check all "To" fields before transmitting.
- Maintaining a master list of patients email addresses is discouraged.
- Outgoing messages will contain discreet subject headers and a banner of the top of each message stating "This is confidential medical communication."
- Each desktop workstation will have a password protected screen saver.

_____ _____

Patient signature Witness (optional)

_____

Date