Provider Name ____________________

Dirksen Center for Neurobehavioral Health

______ **Arlington Heights**
______ **Fox River Grove**

PATIENT INFORMATION

Last Name______________________________ First____________________MI____________

Street Address______________________________City____________State__________Zip__________

Home Phone____________________ Cell Phone__________________ Ok to leave message? Yes ☐ No ☐

Marital Status______________Date of Birth____________________Age__________Sex__________

Soc Sec Num____________________Language Preference ______________________________

Race: __Asian ___ American/Alaskan Indian ___ Black/African American ___ Hawaiian ___Other/Unk ___White ___Declined

Ethnicity: _____Hispanic / Latino _____Non Hispanic /Non Latino ____Declined

Email Address__________________________ Emergency Contact Name____________________

Emergency Contact Phone:____________________ Relationship______________________________

GUARANTOR INFORMATION

WHOMEVER BRINGS IN MINOR CHILD MUST COMPLETE THIS SECTION

Last Name____________________ First__________________MI______Marital Status__________

Street Address______________________________City____________State__________Zip__________

Home Phone____________________ Cell Phone__________________ Ok to leave message? Yes ☐ No ☐

Date of Birth__________________Age________Sex__________Soc Sec Num____________________

Email Address____

POLICYHOLDER INFORMATION

Last Name____________________ First__________________MI______Marital Status__________

Street Address______________________________City____________State__________Zip__________

Home Phone____________________ Cell Phone__________________ Ok to leave message? Yes ☐ No ☐

Date of Birth__________________Age________Sex__________Soc Sec Num____________________

	PRIMARY	**SECONDARY**	**OTHER**
INS COMPANY NAME			
POLICY HOLDER NAME			
POLICY NUMBER			
RELATIONSHIP TO PT			
EMPLOYER OF INSURED			

All signatures contained herein apply to services rendered at:

Dirksen Center for Neurobehavioral Health

Informed Consent for Treatment:
I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature____Date__________________________

Relationship to patient (if applicable)____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient Name____ Date______________________________

Patient OR Guarantor Signature (if patient is a minor)____

Medicare Authorization and Assignment of Benefits:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature_____________________________________ Date___________________________________

HIPAA Privacy Notice Acknowledgement:

I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

Signature_____________________________________ Date___________________________________