



Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

● www.hawthorncounseling.com

Evaluation Services Patient Registration Packet

Welcome to Hawthorn Counseling Group. Completing the registration packet is the first step towards getting the help you are seeking and we look forward to working with you to achieve your goals for counseling. Please note the following about the attached forms:

- ✓ If the patient is not the *guarantor*, and you wish use health insurance, please be sure to provide all requested information regarding the *guarantor*, especially the guarantor's date of birth.
- ✓ Please review the *Consent for Treatment* form in its entirety. If you are electing to use health insurance to offset the costs of counseling, it is recommended that you contact your health insurance company prior to the first appointment to determine: 1) if your policy has a restricted network of providers; 2) if your HCG clinician is in your network; 3) the amount of any deductible which must be met; 4) the amount of any copays once the deductible is satisfied.
- ✓ All patients are asked to complete the attached *Payment Agreement*. Please provide credit card billing information. As explained on the form, you may use cash or check to pay for services provided however your credit card may be utilized for collection of unpaid balances resulting from deductibles, copays, late cancellation or failed appointment charges.

Please pay special attention to our policies regarding late cancellations or failed appointments:

- You will benefit most from your course of counseling if you make it a scheduling priority. However, we know that juggling commitments can be difficult and we will work to accommodate your needs.
- If you need to reschedule an appointment, Hawthorn Counseling Group requires at least 24 hours' notice—a full business day in advance of the hour of your appointment—giving notice of the intent to cancel a scheduled appointment. Also, please note: appointments scheduled on Mondays (or Tuesdays if following a holiday weekend) must be canceled by 5:00pm the preceding Friday afternoon. If you have a scheduling conflict and must cancel an appointment it is sufficient to leave a voicemail message in your specific clinician's voicemail box by calling 847-680-0755, then entering the mailbox extension for your HCG clinician. This notification must be provided a full 24 hours (or one business day) in advance of the hour of the scheduled appointment in order to avoid being billed for the appointment. We are unable to make allowances or exceptions to this policy, except in cases of sudden serious illness, family emergency or severe inclement weather. Be advised that business/work conflicts, scheduling of kids' athletic or school events, unexpected travel or other similar circumstances which might arise are not deemed as grounds for waiver of the late cancellation policy.
- If you are the guarantor of your son or daughter, and they are of age to make their own scheduling arrangements for ongoing counseling, you may wish to stay informed of appointments which have been scheduled since you will ultimately be responsible for charges.
- With regard to late cancellations or failed appointments, you will be charged the full usual and customary fee for the scheduled service. Your insurance company will not be billed for the late cancellation or failed appointment—you will be responsible for payment of the full usual and customary fee per the HCG fee schedule.
- If using health insurance, please provide a copy of your health insurance card and submit with the forms



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PATIENT REGISTRATION INFORMATION

PLEASE PRINT

<i>Patient Information</i>					
Last Name	First Name	MI	Date of Birth / /	Age	Sex
Address	Apt. #	City	State	Zip	
Home Phone	Work Phone		Cell Phone		
Patient Employed By			Occupation		
<i>Guarantor--Name of Person Financially Responsible for Patient's Care (Provide this information only when guarantor is not the patient)</i>					
Last Name	First Name	MI	Date of Birth / /	Age	Sex
Address	Apt. #	City	State	Zip	
Home Phone	Work Phone		Cell Phone		
Guarantor Employed By			Occupation		
<i>Health Insurance Information (may be left blank if a copy of insurance card--both front & back-- is obtained)</i>					
Name of Insurance Company		Name of Subscriber & Date of Birth		Relation to patient	
Plan/Policy #		Group #		Effective Date, if known	
Insurance Company Claims Billing Address			City	State	Zip



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CONSENT FOR EVALUATION

Patient Name: _____

- 1) I hereby consent to receive behavioral health services provided by the mental health professionals affiliated with Hawthorn Counseling Group (HCG).
- 2) I authorize and request that HCG perform assessments as may be considered advisable in making a diagnosis and providing treatment recommendations.
- 3) If I am receiving services from HCG in connection with an independent medical examination, fitness for duty evaluation, presurgical assessment or school fitness evaluation, and arrangements have been made for the referring organization (e.g., employer, disability management company or school) to pay for services provided by HCG :
 - a) I understand that HCG has been retained by the referring organization to provide assessment services.
 - b) I understand that HCG is acting as an agent of the referring organization for the purpose of this evaluation and that any written report generated from the evaluation will become the property of the referring organization.
 - c) I understand that I must provide written consent for verbal and written exchange of information between HCG and the referring organization in order to receive evaluation services.
 - d) I understand that HCG may request consent to consult with other providers familiar with my history, or may request collateral contact with family members, in order to conduct the requested evaluation.
 - e) I understand that HCG provides independent medical examination or fitness evaluations only in a consultative capacity and that employment, fitness, disability or academic placement decisions remain the sole responsibility and discretion of the referring organization.
 - f) I understand that if the evaluation is for a presurgical assessment, HCG bears no responsibility for the decision to proceed with the medical procedure, has no opinion regarding the medical indications for the procedure under consideration and cannot guarantee or have any control over the outcome of the medical procedure.
 - g) I understand that independent medical examination or fitness for duty evaluations consist only of assessment services and do not constitute a treatment relationship between myself and HCG.
- 4) I realize that no particular outcome or result can be guaranteed as a result of my consent to receive evaluation by HCG. I understand that any recommendations provided represent the evaluator's best professional judgement. I hereby release HCG from responsibility for any injury which may result from accepting a recommended plan of care, declining services recommended by HCG or terminating services against clinical and/or medical advice.
- 5) I have read, understood and signed the *Patient Rights, Responsibilities and Statement on Confidentiality* and agree that I will follow the procedures described therein, specifically including the following:
 - a) HCG requires notice by telephone no later than one business day—24 hours in advance of a scheduled appointment (or for Monday appointments and Tuesday appointments which follow holiday weekends, no later than 5:00pm on the preceding Friday afternoon).
 - b) If I do not give proper notification of cancellation of an evaluation appointment, or fail to attend a scheduled appointment, I understand that I may responsible for paying the full customary fee, per the HCG fee schedule in effect at the time the appointment was scheduled, for the missed appointment.

I certify that I have read the above information and signify my agreement with my signature below:

X _____
Signature of Patient

Date

X _____
Signature of Parent/Guardian

Date



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Patient Name: _____

RELEASE OF INFORMATION FOR PROCESSING HEALTH INSURANCE CLAIMS & CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby authorize Hawthorn Counseling Group (HCG) to release any of the following information for the purpose of obtaining reimbursement for treatment services provided to me and/or my dependents. Information to be released may include:

- | | |
|---|---|
| 1. Admitting diagnosis | 5. Progress notes |
| 2. Treatment summary/dates of service | 6. Treatment plan |
| 3. Billing summary & charges | 7. Final diagnosis and/or termination summary |
| 4. Verbal/written exchange of information | |

This information may be released to any or all of the following parties/organizations as needed:

- | | |
|--|---|
| 1. Any third-party payor having responsibility for payment of charges incurred through rendering of psychological services by HCG. | 4. Collection agencies utilized by HCG. |
| 2. Review agents or auditors of third party payors | 5. Legal representatives related to small claims court processing (e.g., court representatives, judges, attorneys). |
| 3. Managed care utilization review agents | |

This consent is valid until such time that all claims have been settled to the satisfaction of HCG or up to three years from the date of discharge from HCG, whichever is longer. I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured, or for which there is more than one insured. In this case, I authorize HCG to contact the actual or additional insured (e.g., my spouse or other guarantor), and to obtain or provide such information necessary to submit claims for reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate this consent at any time before the expiration date so long as I submit my revocation in writing to HCG. Finally, this consent does not permit any agency reviewing clinical information and/or records to redisclose my records to any other agency/person/organization without my written consent. I understand that HCG has no power to prevent such redisclosure.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance carrier, as described in the accompanying Payment Agreement. Additionally, I understand that failure to grant this authorization would prevent HCG from filing claims on my behalf, resulting in being billed-in-full for services.

I certify that I am the client; if I am not the client I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

X _____
Signature of Patient Date

X _____
Signature of Parent/Guardian Date

ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me, or to my dependent, I hereby assign, transfer and set over to HCG all of my rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits as they pertain to charges incurred for services rendered by HCG. I understand that I am financially responsible to HCG for charges not covered by my insurance and/or managed care company by this assignment for any reason

X _____
Signature of Patient Date

X _____
Signature of Parent/Guardian Date



PRIVACY NOTICE

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Hawthorn Counseling Group (hereafter referred to as “HCG”) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment, and Health Care Operations”
 - Treatment is when HCG provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when HCG consults with another health care provider, such as your family physician or another psychologist.
 - Payment is when HCG obtains reimbursement for your healthcare. Examples of payment are when HCG disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - Health Care Operations are activities that relate to the performance and operation of HCG. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Use” applies only to activities within HCG offices such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of my HGC offices such as releasing, transferring, or providing access to information about you to other parties.
- “Authorization” is the patient’s written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

HCG may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when HCG is asked for information for purposes outside of treatment, payment, or health care operations, HCG will obtain an authorization from you before releasing this information. HCG will also need to obtain an authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes made about conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that HCG has already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage—law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

HCG may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If HCG has reasonable cause to believe a child known through a professional capacity may be an abused child or a neglected child, HCG must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If HCG has reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, HCG must report this belief to the appropriate authorities.
- Health Oversight Activities – HCG may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and HCG must not release such information without a court order. HCG can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to HCG a specific threat of imminent harm against another individual or if an HCG clinician believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, HCG may make disclosures believed necessary to protect that individual from harm. If HCG believes that you present an imminent, serious risk of physical or mental injury or death to yourself, HCG may make whatever disclosures considered necessary to protect you from harm.
- Worker's Compensation – HCG may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, HCG is not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, HCG will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, HCG will discuss with you the details of the request for access process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. HCG may deny your request. On your request, HCG will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, HCG will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- HCG clinicians are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- HCG reserves the right to change the privacy policies and practices described in this notice. Unless notified of such changes, however, HCG is required to abide by the terms currently in effect.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact HCG or John D. Jochem, Psy.D., or contact the Illinois Guardianship & Advocacy Commission. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 1, 2003.



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PRIVACY NOTICE ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of *Notice of Policies and Practices to Protect the Privacy of Your Health Information* regarding the care I am receiving through Hawthorn Counseling Group.

X _____
Signature of Patient Date

X _____
Parent/Guardian Date



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PAYMENT AGREEMENT

Patient Name: _____

In consideration of the services to be rendered by the clinicians of Hawthorn Counseling Group (HCG), I agree to pay HCG for all services provided to the patient, at the established rates listed in the HCG fee schedule in effect at the time services are received, or as otherwise negotiated with HCG.

I also understand that I am financially responsible for any deductibles, co-payments and/or other charges not covered by third-party payors, including failed appointment & late cancellation charges.

I certify that the information provided to HCG is, to the best of my knowledge, complete and accurate. I will make arrangements for prompt and regular payment of fees to HCG for services. I understand that payment is due either in-full or in-part at the time services are provided, as arranged when services are initiated.

I understand that I may pay by cash or check. I grant permission to HCG to bill my credit card account or flex spending account noted below for payment of any charges. This includes payment of any unpaid balances which are 30 days or more past due, including co-payments, deductibles, failed appointment & late cancellation charges.

In understand that credit card charges will show on billing statements as "Hawthorn Counseling Group".

All patients are asked to provide credit card billing information below:

TYPE OF CREDIT CARD: VISA M/C FLEX SPENDING ACCOUNT DEBIT CARD

NAME OF CARD HOLDER:

PRINT

ACCOUNT NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

EXPIRATION DATE:

--	--	--	--

AGREEMENT AND AUTHORIZING SIGNATURE:

Patient Parent/Guardian _____ Date