Office Use Only:

Therapist:
Diagnosis Code(s):
W/S:
First Date of Service:

PATIENT REGISTRATION

PATIENT

Name_____**Date of Birth**_____
(Last) (First) (Middle Initial) Mo. Day Year

Male or Female (Please Circle) **Is the Patient a Minor? Yes or No (Please Circle)**

Address_____
(Street/Box No.) (City) (State/Zip)

Social Security Number_____**Home Phone**_____

Cell Phone_____**E-MAIL**_____
[ ] Yes please send my correspondence via email. [ ] No, please send via First Class Mail. [ ] DO NOT SEND ANY CORRESPONDENCE.

EMERGENCY CONTACT PERSON

Name_____**Phone**_____

OTHERS IN FAMILY

Name_____**DOB**_____**Relationship**_____

Name_____ **DOB**_____ **Relationship**_____

Name_____ **DOB**_____**Relationship**_____

Name_____**DOB**_____ **Relationship**_____

RESPONSIBLE PARTY

Name_____**Relationship**_____

Address_____
(Street/Box No.) (City) (State/Zip)
Work Phone_____

Social Security Number_____**Date of Birth:**_____ **Home Phone**_____

EMPLOYER(S)

Patient Employed By_____**How Long**_____

Address_____**Phone**_____

Spouse Employed By_____**How Long**_____

Address_____**Phone**_____

REFERRED BY (Please indicate if referred through your Employee Assistance Program and what the EAP company name is)
Name_____**Phone**_____

Address_____

INSURANCE **We will take a copy of your insurance.**

1. **Simply stated, what brings you to our office?**_____
_____
_____

2. **Is your condition related to:___Employment___Auto Accident___Other Accident? Please check appropriate box.**

3. **How is your general health? Please circle:**
Excellent **Good** **Fair** **Poor**

4. **Do you have or have you had any of the following. Please circle:**

Rheumatic Fever	**Diabetes**	**Anemia**	**Sinus Problems**
Any Heart Problems	**Hepatitis/Liver Disease**	**Arthritis**	**Asthma or Hay Fever**
High Blood Pressure	**Kidney Problems**	**Mouth Ulcers**	**Stomach Ulcer**
Low Blood Pressure	**Glaucoma**		
Circulatory Problems	**Allergies to Anesthetics**	**Hormone Disorder**	
Stroke	**Cancer/Tumor**	**Nervous Problems**	
Allergies to Medicine Or Drugs	**Epilepsy**	**Emphysema**	**Tuberculosis**
Radiation (x-ray) Treatments	**Psychiatric Care**	**Other**_____	
		Other_____	

5. **Please list any medications you are currently taking and for what purpose:**_____
_____
_____
_____
_____

6. **Do you have any known allergies? Please list:**_____

7. **Please list any hospitalizations or operations**_____
_____
_____

8. **Have you or are you using any illicit drugs?**_____**If so, please list:**_____
_____
_____

9. **Have you ever received psychological or counseling services before?**_____
If yes, please give dates and simple statement of problem_____
_____
_____

10. **Is there a history of medical or psychiatric illness in your family?**_____
If yes, give relationship or family member to you and type of illness or problem_____
_____

Patient Name:_____ **Date of Birth**_____

Patrick J. Kennelly & Associates, P.C./Primary Care Physician Consent Form for Coordinating Care

I, _____, authorize/do not authorize_____,
(Circle One)

My mental health provider and _____,_____
(Primary Care Physician Name) (PCP Address and Phone Number)

to exchange information regarding my treatment and my medical healthcare for coordination of care purposes as may be necessary. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above noted provider. I also understand it is my responsibility to notify my provider if I choose to change my Primary Care Physician.

_____ _____
I Authorize Communication between my Provider and my PCP (Patient Signature) **Date**

_____ _____
I DO NOT Authorization Communication Between my Provider and my PCP (Patient Signature) **Date**

11. Name of Primary Care Physician:_____

Address_____

Phone_____**Fax**_____

12. Are you being treated by a physician now?_____
If yes, please give reason for treatment_____
_____
_____

I CERTIFY THAT THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

_____ _____
Signature of patient, or parent/guardian if a minor **Date**

CANCELLATION POLICY

I understand that should I, at any time during the course of my treatment, need to cancel or change an appointment time, I will need to do it 24 hours in advance of the appointment time or be charged for the hour, since it has been reserved for me and without sufficient notice is unavailable to another client.

Please note: This is not a charge which can be submitted to insurance.

Signature of patient or parent/guardian if a minor:

_____

Date_____

I understand that although my insurance may pay a portion of the cost of the professional services received in this office, I am ultimately responsible for complete payment of the charges. Because of my responsibility and because I realize that prompt payment allows the office to keep its fees as low as possible, I will pay by the session or follow another payment plan negotiated with the therapist.

Responsible Party_____
(Signature)

Date_____

PATRICK J. KENNELLY PH.D. & ASSOCIATES P.C.---------OFFICE POLICY AND INFORMATION

The psychiatric services provided by Patrick J. Kennelly, Ph.D. & Associates, P.C. are strictly on a consultation basis and are not to be considered supervision of another therapist's work.

The undersigned hereby employs Patrick J. Kennelly, Ph.D. & Associates, P.C. to render psychological and/or psychiatric counseling services and agreed to the following terms in connection with said employment.

1. To pay the balance due indicated on the monthly statement of my account in full within 30 days following the date of the initial billing.
2. In the event suit is necessary to enforce payment of a delinquent account, the undersigned agrees to pay for attorney's fees and all court costs incurred therein. Venue for said suit shall be in Cook County, Illinois.
3. In the event that an outside Collections Agency is necessary to enforce payment of a delinquent account, there will be a 9% interest annually charged to said account.
4. There will be a $25 service charge for all returned checks.
5. To examine each monthly statement within 30 days of the billing date and advise Patrick J. Kennelly, Ph.D. & Associates, P.C. of any billing errors.

FEES:	**Initial Diagnostic Assessment**	**(45-50 minutes)**	**90791**	**$204.00**
	Individual Therapy 45 min	**(38-52 minutes)**	**90834**	**$126.00**
	Individual Therapy 60 min	**(53+ minutes)**	**90837**	**$183.00**
	Conjoint/Family Therapy	**(45-50 minutes)**	**90847**	**$153.00**
	Individual Therapy 30 min	**(16-37 min.)**	**90834**	**$ 83.00**
	Telephone Consultations			**$ 40 per 15 minutes***
	Correspondence, letters, reports (i.e. FMLA paperwork, psychological reports, disability reports, letters to attorneys, school, etc.)			**fee determined by therapist at conclusion of report****

***This can include any phone calls made for the purpose of exchanging information and coordinating a client's care. (i.e. child's teachers, school counselor, social worker, medical doctor, attorney etc.) Health care companies do not usually consider this a reimbursable expense.**

Signature of responsible party_____

Date_____

All court cases are billed per court ordered fees

MUST BE COMPLETED AT TIME OF INTAKE:

Please provide the following credit card information. It is understood that despite your means of payment, your credit card account will be charged for any outstanding balance.

THIS INFORMATION MUST BE COMPLETED. ALL INFORMATION IS KEPT CONFIDENTIAL AND WILL ONLY BE USED TO CLEAR UP ANY OUSTANDING BALANCE.

Visa_____ **Mastercard**_____ **Discover**_____

Account Number_____**Expiration Date**_____

V-Code_____**(3 digit ID on back of card)**

Name as it appears on credit card_____**Signature**_____

Your credit card will only be charged if there has been no activity on your account for two months and no response to statements sent monthly.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Introduction

At Patrick J. Kennelly, Ph.D. and Associates, P.C. we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your rights as they relate to your protected health information. This notice is effective 9/23/2013, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Patrick J. Kennelly, Ph.D. and Associates, P.C., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your health or medical record or PHI (Patient Health Information).

Our Privacy Practices

Use and Disclosure: We may use or disclose your PHI for treatment, payment or health care operations. For example:

- **Treatment:** Your PHI may be used or disclosed to any physicians or other health care providers involved with the medical services provided to you.
- **Payment:** Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
- **Health Care Operations:** Your PHI may be used or disclosed as part of our internal health care operation. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, managed care peer review or Medicaid or Medicare peer review, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorization: We will not use or disclose your medical information for any reason except those described in this Notice unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

I will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice.
- Psychotherapy notes.

Patient Access: We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice.

Locating Responsible Parties: Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative or other person that is responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Disasters: We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts or to avert a serious threat to public health or safety.

Required by Law: We may use or disclose your medical information when we are required to do so by law. This might include information for judicial and administrative proceedings in response to an order of the court or an administrative tribunal; or a subpoena, discovery request or other lawful process, not accompanied by a court order or an ordered administrative tribunal.

Deceased Persons: After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research: Your PHI may also be used or disclosed for research purposes only in the limited circumstance not requiring your written authorization, such as those that have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security: We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence and other national security activities.

Uses and Disclosure in Emergency Situations: We will use and disclose PHI as appropriate to provide treatment in emergency situations such as suicide, homicide, child and elder abuse. In thos instances where we have not previously provided our NPP to a patient who receives direct treatment in an emergency situation, we will provide the Notice as soon as practicable following the provision of the emergency treatment.

When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the 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 corner 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.

Marketing Purposes: We will not use or disclose any PHI for marketing purposes unless we have your written permission to do so. We may engage in communications about products and services that encourages recipients of the communication to purchase or use the product or service for treatment, to direct or recommend alternative treatments, therapies, healthcare providers or settings of care to the individuals. We may contact the individual with appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual. We may e-mail the above information if we have your permission to do so.

Your Individual Rights

Access and Copies: In most cases, you have the right to review or to purchase copies of your PHI (excluding psychotherapy notes) by requesting access or copies in writing to our Privacy Office. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting: You have the right to receive an accounting of the instance, if any, in which your PHI was disclosed for purposes other than those described above for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Requests must be made in writing to our Privacy Officer.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make this request in writing to our Privacy

Officer. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Right to Restrict Disclosures When You Have Paid for Your Care Out of Pocket: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to be Notified if There is a Breach of Your 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 PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. Under certain circumstances we may deny your request but will provide you with a written explanation of the denial. You have a right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending you medical record.

We reserve the right to change our practices at any time and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will e-mail the revised notice to you.

For More Information or to Report a Problem or

If you have questions and would like additional information, you may contact our Privacy Officer at (847) 310-8578. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer of the Office for Civil Rights. The address for the OCR is listed below:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Patrick J. Kennelly, Ph.D. and Associates, P.C.