COMPREHENSIVE PSYCHOLOGICAL SERVICES, P.C.
PATIENT INFORMATION FORM
(PLEASE PRINT)

_____ _____
Psychologist Date

PATIENT INFORMATION

Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Male____ Female____

Date of Birth ____/____/____ Age _____ Grade _____

Name of School _____

Patient's Pediatrician or Physician _____

Physician's Address _____

Physician's Phone # _____

Patient Referred by _____

RESPONSIBLE PARTY INFORMATION

Name_____ Relationship to Patient_____

Address_____
Street City State Zip

Home Phone _____ Work _____Cell _____

Email Address _____

Employer _____ Address _____

City _____ State _____ Zip _____

COMPREHENSIVE PSYCHOLOGICAL SERVICES, P.C.
INSURANCE INFORMATION FORM

PRIMARY INSURANCE

Policy Holder's Name_____

Address _____

City_____ State_____ Zip_____

Phone _____ Relationship to Patient _____

Policy Holder's Date of Birth ___/___/____

Employer of Policy Holder _____

INSURANCE COMPANY NAME _____

INSURANCE ID# _____ **GROUP #** _____

Claim Mailing Address _____

City/State _____ Zip _____

Phone # _____

I authorize the release of any information necessary for treatment/claims.

INSURED and/or **PATIENT SIGNATURE** _____

DATE SIGNED _____/_____/_____

8/2016

Comprehensive Psychological Services, P.C.

Michael J. Frey, Ph.D. **Kelly Grandt-Dudle, Psy.D.**

3233 N. Arlington Heights Road
Suite 300
Arlington Heights, Illinois 60004
(847)632-0334
Fax (847)632-1621

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and Comprehensive Psychological Services, P.C. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, 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 to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 847-632-0334, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on. We may have already used or shared some of your information and that cannot be changed.

_____ _____
Signature of Parent/Guardian Relationship to client

_____ _____
Signature of client (age 12 or older) Date

Comprehensive Psychological Services, P.C.

Michael J. Frey, Ph.D. Kelly Grandt-Dudle, Psy.D.

3233 N. Arlington Heights Road
Suite 300
Arlington Heights, Illinois 60004
(847)632-0334
Fax (847)632-1621

NOTICE OF PRIVACY PRACTICES
SHORT VERSION

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. These laws are complicated, but we must provide you with important information. This document is a shorter version of the full, legally required NPP which you have also received. Please refer to full document for more information. Because we are unable to cover all possible situations, you are encouraged to talk to our Privacy Officer (see end of document) about any questions you might have.

We will use the information about your health, which we obtain from you or others, to provide you with **treatment,** to arrange **payment** for our services or for some other business activities which are called, in the law, health care **operations.** After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If either party (you or us) want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Release of Information Authorization form to allow this.

Of course we will keep your health information private but there may be times when the law requires us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

For other examples of less frequent situations where we are required to disclose information, see full version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. You can obtain a copy of these records (fee may be charged for this service). Contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or incomplete, you can request us to make some changes (called amending) to your health information. This request must be made in writing and sent it to our Privacy Officer. You must inform us of the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP, we will post it in our waiting room and you can obtain a copy of the new NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Dr. Michael Frey and can be reached by phone at 847-632-0334, ext. 222.

The effective date of this notice is April 14, 2003.

COMPREHENSIVE PSYCHOLOGICAL SERVICES, P.C.
TREATMENT CONTRACT

PATIENT NAME: _____

You have requested professional services from a member of our clinical staff and this letter sets forth the agreement concerning our understanding of such services. This agreement shall become effective upon our receipt of a signed copy of this letter.

1. You understand that these services involve evaluation and therapy and may include: Individual and/or Family Therapy, Psychological or Neuropsychological Testing.

2. If you participate in whatever services are recommended by your therapist, you agree to pay for these professional services according to the fee schedule discussed with you. Payment is expected in the form of personal check, cash or credit card. A $25.00 fee will be charged for any check returned due to non-sufficient funds.

3. We will charge you on the basis of the time expended and we reserve the right to terminate the doctor-patient relationship for non-payment.

4. At the discretion of the therapist, you may be charged **$25.00** for missed appointments or cancellations **made less than 24 hours in advance**.

5. Please be advised that the business office will arrange a fee payment schedule upon your request if the need for such arrangements is necessary.

6. We reserve the right to designate the performance of professional services to our associate(s) if it becomes necessary in order to provide appropriate care.

7. In the event that it becomes necessary to utilize the courts to collect any unpaid balance, you agree to pay reasonable attorney's fees and any and all court costs which may be incurred by us in connection therewith.

8. The initial Diagnostic Interview fee is $250.00. Standard fees for Individual and/or Family Therapy are $175.00 per 45 minute session. Fees for psychological testing are determined by the specific assessment instruments being utilized and will be presented to you before testing occurs. Testing fees must be paid in full before the final written report will be distributed. All fees are expected at time of service unless other arrangements have been made.

9. Payments received from your insurance company will be credited to your account, however, if an insurance company has not settled a claim within **60 days of submission**, the patient will be notified and responsibility for the balance will transfer to the patient.

Please sign this agreement and return it to your therapist so that we will have a mutual memorandum of our understanding. Thank you.

_____ _____

Responsible Party (Parent or patient) Therapist Date