HOME PSYCH SERVICES, P.C.
Quality Behavioral Healthcare
in the Comfort of Your Home™

DEMOGRAPHIC FORM

TODAY'S DATE: enter date.

FULL NAME OF CLIENT: name
ADDRESS: address
CITY: city **STATE:** state **ZIP CODE:** zcode
CELL PHONE: phone **WORK PHONE:** phone
E-MAIL ADDRESS: email
CLIENT'S BIRTHDATE: mm/dd/yy **AGE:** age **MARITAL STATUS:** Please select. **GENDER:** Please select If other, add here
CLIENT'S SOCIAL SECURITY NUMBER: SS#
CLIENT'S OCCUPATION: occupation **EMPLOYER:** employer
SPOUSE'S NAME: name **WORK PHONE:** phone

If client is a MINOR or DEPENDENT, please complete the following section:

FATHER'S FULL NAME: name **DOB:** mm/dd/yy

FATHER'S PLACE OF EMPLOYMENT: employment.

FATHER'S E-MAIL: email. **PHONE:**select. number

MOTHER'S FULL NAME: name. **DOB:** mm/dd/yy

MOTHER'S PLACE OF EMPLOYMENT: employment.

MOTHER'S E-MAIL: enter email. **PHONE:** select. number

If client is a student, what is his/her grade level? grade level. **School?** school.

Guarantor Name, if different from above: name.

Guarantor Address, if different from above: address.

Guarantor Phone number, if different from above: number

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OFFICE POLICIES

Effective communication is the cornerstone of a good working relationship. To answer questions that clients frequently ask about fees, confidentiality, and other services offered, Home Psych Services, P.C. (hereinafter, HPS) has carefully developed the following policy statements for your information and discussion. Please feel free to talk with anyone affiliated with HPS about any questions you might have regarding the practice policies. You are encouraged to take this "Office Policies" form home with you and to take the time to read it thoroughly and completely.

Confidentiality

Communications between a provider and client are strictly confidential and protected under Illinois state law and by professional ethics. To communicate with others about your case, we must first have your permission in writing. However, certain communications may be made, or certain situations may occur, for which confidentiality is limited, these include:

1) Situations in which a provider believes the client poses a threat to him/herself or others; or
2) Situations in which records are ordered to be released by a Judge of the Courts; or
3) When the communications involve the transmission of contagious or transmittable diseases; or
4) When the communications involve information regarding child abuse, neglect or abuse of the elderly;
5) When a client's account is turned over to a collection agency or attorney for non-payment;
6) When there is a matter of law enforcement or National Security concerns;
7) When you are involved in a Workers' Compensation claim where your treatment may be relevant;
8) When you are a registered Organ Donor or member of the Military.

Your HIPAA Rights

HPS will only disclose your Protected Health Information (PHI) to someone you designate with your expressed oral and / or written permission. The limits of confidential are explained in the above paragraph. It is understood that you have the right to request restrictions on what PHI will be disclosed to others, the right to receive confidential communications, the right to inspect and copy (if desired) your medical information, the right to request amendments to your medical information, and the right to an accounting of any disclosures made of your PHI. You also have the right to obtain a copy of our full HIPAA Rights Notification (effective date April 14, 2003).

Treatment by Fully Licensed Providers

HPS is a special type of group behavioral healthcare private practice which employs Psychiatric Nurse Practitioners, Clinical Psychologists, Professional Counselors, and Social Workers who are fully licensed in the State of Illinois. HPS provides both insurance-based and low-cost cash-based behavioral healthcare to best serve our clients' needs. This approach allows us to offer quality behavioral healthcare to clients who might be uninsured, under-insured or simply prefer not to use their health insurance.

Fees and Payment

HPS has designed its fee structure with two (2) tiers of pricing. Tier 1 is our usual and customary rates that are billable to insurance companies. Tier 2 is our discounted, low-cost cash rates designed to encourage its clients to confidently pay for services out of pocket realizing the value and discount they are getting on the pricing of the services compared to using traditional insurance pricing. HPS's fee schedule typically offers a discount of anywhere between 50% - 75% off compared to traditional insurance rates. For example, HPS's insurance rate for a one-hour diagnostic evaluation with medical examination (90792) is $350. This same procedure on our cash-rate scale is only $200. The insurance rate for a medication management office visit (99213) is $200. This same procedure on our discounted cash scale is just $100. The same discounted pricing applies to counseling services which are offered through telehealth for your convenience. Our insurance rates for a one-hour diagnostic evaluation without medical examination (90792) is $200. The discounted cash rate is just $80 for this same service. The insurance pricing for an outpatient psychotherapy visit, 38-52 minutes (90834) is $140. The discounted cash rate is just $80. We also offer 20-30-minute psychotherapy visits (90832) for half the price of our published insurance and discounted cash rates.

Our fee schedule is clearly and transparently published on our website and printed on our office paperwork. You will always be fully informed of treatment costs upfront and prices will not deviate from what is posted / advertised. Payment is kindly requested for all services at the time they are rendered or when they are booked online. We will provide a copy of your Superbill which includes your name, date of service, place of service type of service, provider name, and diagnosis. We accept payment by check and accept most major credit cards including VISA, Mastercard, Discover, and American Express. Checks should be made out to "Home Psych Services" or, simply, "HPS." You will be invoiced for services rendered through PayPal and can pay the invoice conveniently and securely on-line. There is a $35 service charge for each returned check. There will be an interest charge of 1.5% on all charges that are over thirty (30) days past-due or an annual percentage rate of 18%. The finance charge on your account is computed by applying the periodic rate to charges owed by the client or their responsible parties that are over thirty (30) days old at the end of each billing cycle after payments or credits have been applied. Delinquent accounts may be turned over to a professional agency for collection. If your account is placed with a collection agency, all costs, including court costs and attorneys' fees, will be your responsibility.

Psychotropic Medication Management

HPS employs a team of Advanced Practice Registered Nurses (often called "Nurse Practitioners") to offer psychotropic medication management and health education. Nurse practitioners are specifically credentialed by the State of Illinois to diagnose and treat medical and psychiatric illnesses. The following clinic policies are observed when you are receiving psychotropic medication management by HPS's team of nurse practitioners:

- ❑ You must receive regular counseling (typically defined as no less than often than once monthly) by a licensed therapist either within HPS or on the outside by another practice;
- ❑ If you are prescribed medication(s), it is your responsibility to take your medication(s) as prescribed and follow up with HPS's nurse practitioners as recommended;
- ❑ If you are prescribed medication(s), you agree not to give or share any of your medication(s) with others; and that, if you do, you may be subject to disciplinary / legal action in accordance with relevant laws;

- If you are prescribed medication(s), you agree that, if you have questions about your medications that cannot wait until your next regularly scheduled appointment, you may contact HPS's nurse practitioners at the telephone numbers provided to you by them or by calling the general number. You also understand that HPS reserves the right to charge you for all such telephone consultations which last longer than five (5) minutes in duration at the concierge rates for psychiatric consultation outlined elsewhere in this form;
- If you are prescribed medication(s), it is your responsibility to ensure that you have enough medication(s) to cover such things as school breaks, holidays, summer vacation, etc. either through arrangements with HPS's nurse practitioners or through a medical provider at home.
- Ordinarily, you will be expected to return to the clinic for a follow-up appointment with your nurse practitioner no less often than every ninety (90) days. We usually will prescribe no more than a ninety (90) supply of any medication. We are always mindful of prescription drug costs and will always attempt to prescribe the most cost-effective medications to treat your conditions and will authorize generic prescriptions whenever possible.

Credit Card Authorization Form

Each client is requested to complete the Credit Card Authorization Form which is part of this New Client Registration Packet. The purpose of this form is for HPS to have a copy of each client's credit card on file for payment of outstanding account balances that are greater than ninety (90) days past due. By signature of this form, you are authorizing HPS to charge any outstanding account balances greater than ninety (90) days past-due to the credit card on file.

Office Hours and Emergencies

HPS is open Monday – Sunday. Daytime and evening appointments are available for your convenience. We see client by appointment only and, usually, walk-in appointments are not accepted. However, because we are a concierge practice, we often can accommodate same day appointments. If you are experiencing a crisis (defined here as needing to urgently contact your provider about a matter but where there is no risk of harm to yourself or others), you are encouraged to first attempt to contact your provider directly by telephone or via text message. Next, you may also call or text the main HPS office telephone number. For emergencies (defined here as there being a threat of harm to yourself or somebody else), you are encouraged to contact emergency services directly (dial 9-1-1) or to proceed to your nearest emergency room.

Cancellation Policy

Appointments are individually reserved. We kindly request that cancellations are made at least twenty-four (24) hours in advance. You may be charged the full amount of your visit for missed appointments or late cancellations made with less than 24 hours' notice.

Benefits and Risks of Behavioral Healthcare Treatment

Although many clients who seek relief from emotional and behavioral problems utilizing psychotherapy and psychiatric medication management experience significant improvement in their lives, HPS offers no guarantees or promises that you will experience a positive outcome from seeking help within its clinic. There are many, many factors that contribute to success or failure when seeking help through psychotherapy and psychiatric medication

management. Your provider will attempt to identify factors that might help or hinder your progress in treatment. Ultimately, though, you proceed with treatment under your own choice and at your own risk.

STATEMENT OF UNDERSTANDING OF OFFICE POLICIES

Instructions. Read each question and check Yes or No.

Do you have any questions about anything that was explained to you?

☐Yes ☐No

Do you agree with the conditions and provisions explained to you in the Office Policies form?

☐Yes ☐No

Do you acknowledge that the HIPAA Rights Notification Form was explained to you and made available for copy if so desired?

☐Yes ☐No

*By signature below, you are acknowledging that you have been given a copy of the **Office Policies Form** and understand and agree to the office policies of HPS.*

signature. today's date.
(e-Signature of Client / Responsible Party) Today's Date

name.
(Printed Name)

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CREDIT CARD AUTHORIZATION FORM

This form authorizes HPS to automatically charge any unpaid account balances that are greater than ninety (90) days past due. I understand that, by my signature below, I am authorizing HPS to charge the credit card listed below for any and all unpaid balances on my account that are greater than ninety (90) days past due. I also understand that any inaccurately disputed charge-backs to this credit card will be assessed a fifty ($50.00) fee which will be added to any amounts owed to my account and that my account may be turned over to a Collection Agency for further collections efforts on my delinquent account. This form will be securely stored in your client file and may, at your request, be updated at any time.

I, enter name., hereby authorize HPS to bill my the credit card listed below for any and all unpaid balances on my account that are greater than ninety (90) days past due.

Credit Card Type (check one):

☐VISA ☐MASTERCARD ☐DISCOVER ☐AMERICAN EXPRESS

CREDIT CARD NO.: CC num.

CREDIT CARD EXPIRATION DATE: exp date

VERIFICATION / SECURITY CODE (3 DIGIT CODE ON BACK OF CARD BY SIGNATURE LINE): code.

NAME AS PRINTED ON CREDIT CARD: name.

CREDIT CARD BILLING ADDRESS: address.

CITY: city. STATE: state. ZIP: zcode.

YOUR SIGNATURE: signature.

PRINTED NAME: name.

TODAY'S DATE: date.