ROSALIND FRANKLIN UNIVERSITY
HealthClinics

# Behavioral Health Patient Registration Packet – Adult
## PATIENT INFORMATION

Patient's Name: Last_____ First_____ MI_____

Date of Birth: _____ Social Security#: _____

Address: _____ Apt./Suite#:_____

City: _____ State: _____ Zip: _____ Home Telephone: (_____) _____ Cell Phone: (_____) _____

Name of Employment:_____ Work Address: _____

City/State/Zip:_____ Work Phone: _____

Preferred Method of Contact: ❒ Home ❒ Cell ❒ Work ❒ Email: _____

Ethnicity: ❒ African American ❒Hispanic/Latino ❒ Caucasian ❒ Asian ❒ Other_____

Preferred Language: ❒ English ❒ Spanish ❒ Other:_____ Do you need an Interpreter? ❒ Yes ❒ No

Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Preferred Pharmacy: _____
(Name) (Address) (Phone)

Emergency Contact Name: _____ Phone: (_____)_____

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## RESPONSIBLE PARTY (Please complete if different from patient or patient is a minor)

Last Name:_____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security#: _____

Address: _____ Apt./Suite#:_____

City: _____ State: _____ Zip: _____ Telephone: (_____) _____ E-mail: _____

Relation to Patient: ❒ Spouse ❒ Parent ❒ Grandparent ❒ Legal Guardian ❒ Other: _____

**I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I have received and I am subject to all the terms on the Financial Responsibility Agreement form.**

**Patient Signature (18 and older): _____Date: _____ / _____ / _____**

**Parent/Guardian Signature: _____ Date: _____ / _____ / _____**

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## REFERRAL SOURCE

❒ Friend/Patient
❒ Event/Health Fair
❒ Physician/Specialist
❒External Referral
❒Staff/Student
❒RFU Student
❒ Website
❒ Social Media
❒ Other: _____

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## PATIENT PROFILE

Patient's Name: Last_____ First_____ MI__ _____ _____

Date of Birth: _____ Social Security#: _____

**A note to our patients:** Please complete this questionnaire as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.

### TYPE OF SERVICE REQUESTED (please check one)

□ Therapy/Counseling □Psychological Testing □ Psychiatric Assessment/Medication Management □ Not Sure

**Briefly explain why you are seeking behavioral health services:**

### PRIMARY CARE PHYSICIAN

Primary Care Physician Name: _____ Phone: _____ Last PCP Visit Date:_____

Address: _____City: _____ State: _____ Zip: _____

### SOCIAL HISTORY

Current or past tobacco use: Amount/packs per day: _____ How long: _____Quit date: _____

### MEDICAL HISTORY

Do you have children? ❒ Yes ❒ No If yes, what are their ages: _____

Do you exercise regularly? ❒ Yes ❒ No If yes, please describe type of exercise and how often below:

_____

Do you have any **medication allergies or any allergic reactions** to anything? ❒ Yes ❒ No If yes, please explain below:

_____

Do you have an EPI Pen for severe allergic reactions? ❒ Yes ❒ No ❒ N/A

Do you have any history of head injury with or without loss of consciousness? ❒ Yes ❒ No ❒ N/A If yes, Please explain below:

_____

**FOR WOMEN ONLY:**

Date of your last menstrual period? _____

Do you use any form of birth control? ❒ Yes ❒ No If yes, please specify: _____

Are you currently Pregnant? ❒ Yes ❒ No

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Date of Birth: _____ Social Security#: _____

**Please list all medications and supplements you are taking** including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. ***Attach another page if needed.***

| **Name of medication/supplements:** *(such as Synthroid, Vitamin D, etc.)* | **Strength:** *(88mcg, etc.)* | **Directions:** *(such as 1 tab twice a day, as needed, etc.)* |
|---|---|---|
| ❒ ***Check if none*** | | |
| | | |
| | | |

Patient's Name: Last_____ First_____ MI__ _____ _____

Date of Birth: _____ Social Security#: _____

**Please list any surgeries or hospital stays (including psychiatric illness in the past six months) you have had and their approximate date/year:**

**Type of surgery/reason for hospitalization:** Date:

_____ _____ / _____ / _____
_____ _____ / _____ / _____
_____ _____ / _____ / _____

**If you have received counseling or psychiatric treatment in the past, please complete the following table:**

| **Facility or Course of Treatment** | **Inpatient or Outpatient** | **Illness or Symptoms Treated** | **Dates of Treatment** | **Name of Medication/ Dosage/Frequency** | **Response to Medication** |
|---|---|---|---|---|---|
| ❒ ***Check if none*** | | | | | |
| | | | | | |
| | | | | | |

**Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank.** Please indicate which relative has the condition.

| **Condition** | **Self** | **Mother** | **Father** | **Sibling** |
|---|---|---|---|---|
| Allergies | | | | |
| Anemia | | | | |
| Anxiety | | | | |
| Arthritis | | | | |
| Asthma | | | | |
| Cancer | | | | |
| Cataracts | | | | |
| Congestive heart failure | | | | |
| Depression | | | | |
| Diabetes | | | | |
| Fibromyalgia/chronic fatigue | | | | |
| Nervous or Emotional Problem | | | | |

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Patient's Name: Last_____ First_____ MI__ _____

Date of Birth: _____ Social Security#: _____

Have you used any of the following illegally or excessively either in the past or recently? □ Yes □ No
**Please check all that apply.**

| | | | |
|---|---|---|---|
| □ Alcohol | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Marijuana | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Cocaine | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Heroin or Opium | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Barbiturates | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Valium or Librium | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ PCP | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ LSD | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Mushrooms | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Inhalants | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Pain Medication(s) | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |
| □ Other _____ | # of Years Used _____ | Amount Used _____ | Date of Last Use_____ |

Did you have treatment for any of the above alcohol or drug use? □ Yes □ No
If yes, please indicate type of treatment and dates of treatment. _____
_____
Have you been involved with self-help groups such as AA, NA, or etc? □ Yes □ No
If yes, please list. _____

## DEVELOPMENT

During your childhood/adolescence did you exhibit any of the following problems?

□ Yes □ No Fear of School_____
□ Yes □ No Tics_____
□ Yes □ No Frequent Falls_____
□ Yes □ No Truancy_____
□ Yes □ No Ran Away from Home_____
□ Yes □ No Lied to Family or Others_____
□ Yes □ No Moved Often_____
□ Yes □ No Sleep Disturbances_____
□ Yes □ No Awkward at Games_____
□ Yes □ No Speech Problems_____
□ Yes □ No Wet the Bed Past Age 5_____
□ Yes □ No Animal Cruelty_____
□ Yes □ No Arson_____
□ Yes □ No Were (Are) Left Handed_____
□ Yes □ No Sexually Promiscuous_____
□ Yes □ No Other _____

During your childhood, were you ever abused? □ Sexually □ Verbally □ Physically □ Neglected □ Other
Are there any special, unusual, or traumatic circumstances you experienced growing up? □ Yes □ No
If yes, please explain. _____

When your mother was pregnant with you, did she have any problems with the pregnancy? □ Yes □ No
If yes, please explain. _____

When your mother was pregnant with you, did she have any problems during labor? □ Yes □ No
If yes, please explain. _____

Did you have any developmental milestone delays in sitting, walking, talking, or etc.? □ Yes □ No
If yes, please explain. _____

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## FAMILY INFORMATION

Does anybody in the family have a nervous or emotional problem? □ Yes □ No
If yes, please explain. _____
_____

Signature of Patient_____ Date ____/____/____

Signature of Legal Guardian (if applicable) _____ Date ____/____/____

**Note: This form is not an "advance directive" and does not give authority to any person to consent or refuse consent to any health care treatment or procedure on your behalf.** Please ask our staff if you desire further information about advance directives.

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## Authorization for Treatment

Name of Patient: _____ Date of Birth: _____/_____/_____

I, as the patient or responsible party (for patient named above), authorize Rosalind Franklin University Health System (Health System) to administer medications, immunizations, and to perform such diagnostics and medical procedures as deemed medically necessary for my care based on the judgment of the physician(s) and other health care provider(s) of the Health System. I understand that I have the opportunity to discuss treatment options with the physician(s) and other health care provider(s).

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party: _____

## Acknowledgement of Receipt of Notice of Privacy Practices

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their patients at their first visit. It also requires that we seek a written acknowledgement from our patients that we did, in fact, deliver that notice. Accordingly, the Rosalind Franklin University Health System asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" by signing this form. I acknowledge receipt of the Rosalind Franklin University Health System Notice of Privacy Practices on the date indicated below.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party (print): _____

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**Financial Responsibility Agreement**

Rosalind Franklin University Health System (Health System) is committed to your care, and we thank you for choosing us to serve you today. As part of the treatment, you will incur costs for the services and supplies rendered to treat you. As the patient, or guarantor for the patient, you will be responsible for payment in full. Because we value you as our customer, we attempt to work with you to resolve these costs. If you have any questions related to your financial situation, please contact the Patient Financial Services Department at (847) 247-6932.

We accept most insurance plans; however, you are responsible for verifying that we are a participating member with your insurance. If you have a HMO, you have responsibility for obtaining the necessary referral(s). All co-payments will be taken at the time of registration. As a courtesy, we will bill your insurance directly for payment. If there is a dispute with your insurance, we have the right to bill you prior to resolution. It is important, at each visit, you provide us with the most current information regarding your insurance.

If you do not have insurance, we are committed to providing you ways to make payment in full for services received. We accept cash, personal checks, and credit cards as forms of payment. We offer a 15% discount for payment in full at the time of service. In order to be eligible for this discount, you must have no outstanding balance due. If you are unable to make payment in full at the time of service, we will bill you for the balance due. A Financial Hardship Program is offered to qualifying individuals based on income level, as well. Discounts are based upon your level of income relative to Federal Poverty Guidelines. If you believe you may qualify, please ask for an application.

As a final alternative, we use a collection agency to collect on past due balances. If you fail to make payment on your account, you will be responsible for the costs incurred by the collection agency. This includes, but is not limited to, the fee assessed by the agency to the Health System for their services and legal fees, if necessary.

By signing this acknowledgement, you (or guarantor for the patient) accept responsibility for payment of the services and supplies rendered by the Health System. You certify that you have read and understand your responsibilities and provided accurate and complete information.

Signature of Patient or Responsible Party: _____ Date: _____

Name of Patient or Responsible Party: _____

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# 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.

### INTRODUCTION

Rosalind Franklin University Health System is required by law (the federal HIPAA Privacy Rule) to maintain the privacy of protected health information (PHI) and to provide you with this notice of our legal duties and privacy practices regarding PHI. We are required to abide to the terms of this notice. We may change at any time the terms of this notice for all PHI we maintain. If we do so, we will revise this notice to reflect the new terms and have it available for you upon request.

### PERMITTED USES AND DISCLOSURES

At times, other federal laws and the laws of the State of Illinois impose stricter limits on the use and disclosure of PHI than the HIPAA Privacy Rule. In those cases, the HIPAA Privacy Rule states that we must follow the laws that provide you with the greater amount protection over your PHI. Subject to those stricter limits, we may use and disclose your PHI as follows:

**Treatment**. We may use or disclose your PHI for treatment activities of a health care provider. For example, we may use your PHI to provide medical care to you and we may disclose PHI to another physician who is providing medical care to you.

**Payment**. We may use or disclose your PHI for activities relating to obtaining reimbursement for the health care services you received. In addition, we may disclose your PHI for similar activities of another health care provider or a group health plan that relates to you. For example, we may use your PHI to bill you or your insurance company, as appropriate, for services rendered.

**Health Care Operations**. We may use or disclose your PHI for certain activities relating to the operation of the Health System as a health care provider. In addition, we may disclose your PHI for those activities relating to the operation of another health care provider or a group health plan with which you have a relationship. For example, we may use and disclose your PHI for activities relating to quality assessment, training of health care professionals, fraud and abuse detection, and compliance programs.

**Other Permitted Uses and Disclosures**.

We may use and disclose your PHI so long as certain conditions that relate to your privacy and public necessity are met:

* to **Persons Involved in Your Care or Payment of Your Care**, but you will have the opportunity to object and, if you do object, we will abide by your wishes.
* to **Business Associates** who perform functions for us and who have promised in a written agreement to safeguard your PHI.
* as **Required by Law**, so long as the specifics of the use or disclosure is no more than that required by the law.
* for **Public Health Activities**, such as reporting disease, injury, and vital statistics.
* to **Report Adult Abuse, Neglect, and Domestic Violence**, under certain conditions.
* to a **Health Care Oversight Agency** that oversees the health care system.
* for **Judicial and Administrative Proceedings**, so long as there is a lawful court order or other legal demand.
* for certain **Law Enforcement Purposes**, such limited PHI relating to fugitives, crime victims, suspicious deaths, crimes on our premises, and crimes in emergencies.
* certain information about **Decedents** to coroners, medical examiners, funeral directors, and organ/tissue donation entities.
* for **Research Purposes**, so long as an oversight board approves the request under strict guidelines, is preparatory work that does not leave the Health System, or is about decedents.
* to **Avert a Serious Threat to Health or Safety**, as necessary under the circumstances.

* for certain **Specialized Government Functions**, such as Armed Forces personnel, national security activities, correctional facilities, and government health benefit programs.
* for **Workers' Compensation** programs.
* to contact you and provide information **Useful Information**, such as appointment reminders and health-related benefits and services that may be of interest to you.
* to contact you about the Health System's efforts to **Raise Funds**, but you have the right to opt out of receiving these fundraising communications.
* a **Limited Data Set**, which deletes certain information about you, so long as the PHI is only used for research, public health, or health care operations purposes and the recipient agrees in writing to safeguard your PHI.

**Your Written Authorization**. Other than the uses and disclosures discussed above, we will not use or disclose your PHI without your written authorization. This includes uses or disclosures made for marketing purposes, that constitute a sale of your PHI, and of most psychotherapy notes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure that occurred prior to this Health System receiving your revocation.

## YOUR RIGHTS

A brief summary of your rights are as follows. For additional information regarding these rights, you may contact the office listed at the end of this notice.

**Access**. You have the right to inspect and obtain a copy of your PHI records. To do so, you must seek access in writing. A reasonable fee may be charged for copying and postage, if applicable.

**Amendment**. You have the right to seek an amendment to your PHI records. To do so, you must make your request in writing. Even if the PHI record is determined to be accurate and complete, you have the right to submit a statement of disagreement.

**Accounting**. You have the right to obtain a list of certain disclosures that occurred regarding your PHI. To do so, you must seek your accounting in writing. Some disclosures would not be mentioned on that list, such as those associated with treatment, payment, and health care operations and disclosures you personally authorized in writing.

**Further Restrictions**. You have the right to seek further restrictions on how we use or disclose your PHI. To do so, you must make your request in writing. Although we are not required to agree to most of those requests, we will review them and, if we do agree, we will document it and abide by it. We are required to agree to a request to restrict a disclosure of your PHI to a health plan for payment or health care operations purposes when the PHI relates to a health care item or service for which we have been paid in full by you or by other alternative means.

**Confidential Communications.** You have the right to request that we communicate with you using alternative means or at alternative locations. To do so, you must make your request in writing. If the request is reasonable, we will accommodate it.

**Copy of this Notice**. You have the right to receive a paper copy of this notice upon request, even if you previously agreed to receive this notice electronically.

**File a Complaint**. You may file a complaint with us and to the U.S. Department of Health and Human Services if you believe we have violated your privacy rights and we will not retaliate against you in any way. To file a complaint with us, you should contact the office listed at the end of this notice.

**Notice of Breach.** You have the right to receive notifications of breaches of your unsecured PHI.

## FURTHER INFORMATION

If you have any questions, desire to file a complaint, or seek further information about matters contained in this notice, you may contact:

Paulette Zolicoffer
Privacy Officer
Rosalind Franklin University Health System
3471 Green Bay Road
North Chicago, IL 60064
Tel: (847) 578-8767