

**Behavioral Health Patient Registration Packet – Child & Adolescent
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: (_____) _____

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:** ____ / ____ / ____

REFERRAL SOURCE

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Friend/Patient | <input type="checkbox"/> External Referral | <input type="checkbox"/> Website |
| <input type="checkbox"/> Event/Health Fair | <input type="checkbox"/> Staff/Student | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Physician/Specialist | <input type="checkbox"/> RFU Student | <input type="checkbox"/> Other: _____ |

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PATIENT PROFILE**

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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:

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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: <i>(such as Synthroid, Vitamin D, etc.)</i>	Strength: <i>(88mcg, etc.)</i>	Directions: <i>(such as 1 tab twice a day, as needed, etc.)</i>
<input type="checkbox"/> <i>Check if none</i>		

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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
<input type="checkbox"/> <i>Check if none</i>					

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.

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

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Have you used any of the following illegally or excessively either in the past or recently? Yes No

Please check all that apply.

<input type="checkbox"/> Alcohol	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Marijuana	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Cocaine	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Heroin or Opium	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Barbiturates	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Valium or Librium	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> PCP	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> LSD	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Mushrooms	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Inhalants	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Pain Medication(s)	# of Years Used _____	Amount Used _____	Date of Last Use _____
<input type="checkbox"/> Other _____	# of Years Used _____	Amount Used _____	Date of Last Use _____

Do you smoke or chew tobacco? Yes No If yes, what kind, daily use and how long ago did you start?

DEVELOPMENT

Compared to other children, was this child slow in any of the following?

- | | |
|--|--|
| Sitting without support <input type="checkbox"/> Yes <input type="checkbox"/> No | Walking without support <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Speaking words <input type="checkbox"/> Yes <input type="checkbox"/> No | Talking in sentences <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Toilet training <input type="checkbox"/> Yes <input type="checkbox"/> No | Being dry at night <input type="checkbox"/> Yes <input type="checkbox"/> No |

Does the child have any history of physical or sexual abuse? Yes No

Has the child had any involvement with the court system? Yes No

Does the child exhibit any of the following problems? If yes, please explain.

Externalizing Problems

- Yes No Hyperactive/Fidgety _____
- Yes No Temper Outbursts/Tantrums _____
- Yes No Argumentative at Home _____
- Yes No Oppositional with Authority Figures _____
- Yes No Does Not Accept Responsibility for Behavior _____
- Yes No Alcohol Abuse or Other Substance Abuse _____
- Yes No Inappropriate Sexual Behavior _____
- Yes No Absenteeism from School _____
- Yes No Lies/Cheats _____
- Yes No Steals from Family _____
- Yes No Steals from Non-Family _____
- Yes No Vandalism _____
- Yes No Arson _____
- Yes No Away Overnight without Permission _____
- Yes No Threatens People _____
- Yes No Gets into Fights or Seriously Hurts People _____
- Yes No Animal Cruelty _____
- Yes No Curfew Violations _____
- Yes No Carries a Weapon _____
- Yes No Probation or Detention _____
- Yes No Other Disruptive Behaviors _____

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Other Problems

- Yes No Wets the Bed Past Age 5 _____
- Yes No Wets or Soils with BM in Daytime _____
- Yes No Cries Often or Seems Sad _____
- Yes No Socially Withdrawn _____
- Yes No Sleep Disturbance _____
- Yes No Recent Weight Loss or Gain _____
- Yes No Sleeps Excessively _____
- Yes No Suicidal Thoughts or Attempts _____
- Yes No Hears Voices that are Not Present _____
- Yes No Sees Things that are Not Present _____
- Yes No Smells Things that are Not Present _____
- Yes No Intentional Self-Injury _____
- Yes No Talks about Strange Things _____
- Yes No Strange Movements _____
- Yes No Fear or Anxiety Spells _____
- Yes No Perfectionistic _____
- Yes No Repetitive Thoughts _____
- Yes No Compulsive Hand-Washing or Other Compulsions _____
- Yes No Separation Anxiety _____
- Yes No Speech Problems _____
- Yes No Lacks Age Appropriate Relationships _____
- Yes No Too Happy or Energetic at Times _____
- Yes No Unpredictable Mood Swings _____
- Yes No Forgets Too Much _____
- Yes No Slow Academically _____
- Yes No Other _____

FAMILY INFORMATION

Do the child's father and mother live together? Yes No Does anybody in the family have a nervous or emotional problem?
 Yes No If yes, please explain. _____

Please check the level of the child's father's education. 8th Grade or Less Some High School Graduated High School or GED
 2 Years or More of College Graduated College

What is the child's father's occupation? _____ What is the child's father's age? _____

Please check the level of the child's mother's education. 8th Grade or Less Some High School Graduated High School or GED
 2 Years or More of College Graduated College

What is the child's mother's occupation? _____ What is the child's mother's age? _____

Signature of Patient _____ Date ____/____/____

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

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): _____



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: _____

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