GRAND OAKS
BEHAVIORAL HEALTH

Libertyville Office:
1800 Hollister Drive, Suite 201
Libertyville, IL 60048-5263

Northbrook Office:
3000 Dundee Road, Suite 111
Northbrook, IL 60062

Please fill out entire document

Patient Information

Patient Name _____ Date of Birth _____
Last First MI *Month Day Year*

Address _____ Home Phone _____

_____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

☐ Female ☐ Male E-Mail _____

Patient Social Security Number: _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Under 18, Mother's name: _____ Father's Name: _____

Parent contact information: Name: _____ Phone Number/Email: _____

Insurance*

Insured Name _____ Date of Birth _____
Last First MI *Month Day Year*

Address _____ Home Phone _____

_____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

☐ Female ☐ Male E-Mail _____

Insured Social Security Number: _____

Place of Employment: _____

Secondary Insurance: ☐ Yes ☐ No

**** Please provide your insurance card(s) to the Receptionist.***

Primary Care Physician

Primary Care Physician Name: _____ Practice Name: _____

Address: _____

Who referred you to Grand Oaks Behavioral Health?

☐ Doctor *(please provide name)* _____ Practice Name: _____

Address: _____

☐ Insurance Company ☐ Internet ☐ Website ☐ Advertisement ☐ Friend/Acquaintance

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Please read and initial the following information:

_____ I authorize the release of information necessary to process my insurance claim

_____ I authorize payment of insurance benefits to my Psychologist/LCSW/LCPC/Physician

_____ I authorize my Psychologist/LCSW/LCPC/Physician to release information to my primary care physician and/or referring physician.

_____ I understand that payment is to be made at the time of the session unless prior financial arrangements have been made.

_____ I understand that I am financially responsible for all scheduled appointments unless a minimum of 24 hours notice is given

_____ I agree to pay a No Show or Late Cancellation Fee of $100 if I do not cancel within 24 hours before a scheduled appointment

_____ I have received, read, and understand the Psychologist/LCSW/LCPC/Physician-Patient agreement provided to me which includes a Notice of Privacy Practices.

_____ I permit my Psychologist/LCSW/LCPC to consult with other Grand Oaks Behavioral Health Clinical staff in order to provide the best possible care for me.

Patient or Parent Signature: _____ Date: _____

Phone: (847) 549-1189 • Fax: (847) 932-4066 • Website: www.grandoaksbh.com

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

I, _____ hereby authorize _____
Patient Name *Grand Oaks Behavioral Health Clinician*

to disclose to my Primary Care Physician, _____
Name of Primary Care Physician/Medical Practice

_____
Practice Address

All clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of my health status.

This authorization becomes effective _____, and may be revoked by me in writing
Today's date

at any time, with the exception of any actions already taken to coordinate my care. Unless previously revoked by me, this authorization automatically terminates twelve (12) months from the effective date. I understand that this authorization does not extend to the release of any AIDS/ HIV information unless I also placed my initials here_____. I further understand that the information authorized by this release will be released to the authorized representative only, for purposes noted above. I understand I (or my legal representative) am entitled to a copy of this authorization form for my records.

_____ _____
Legal Signature of Patient or Legal Guardian *Date*

_____ _____
Name of Patient Witness *Date*

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and State law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

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Authorization for Automatic Credit Card Payment

For your convenience, and to guarantee payment for services rendered, we request documentation of a major credit card.

I authorize Grand Oaks Behavioral Health, LLC to keep my signature on file and to charge my credit card account listed below for Co- pays, Coinsurance, and Deductible amount not collected at time of service. In addition, I authorize Grand Oaks Behavioral Health, LLC to charge my credit card for any outstanding account balances following insurance determination, including fees due to late cancellation or non-attendance of scheduled appointments.

I understand that credit card charges may not coincide with scheduled appointment dates.

I understand that this authorization is valid until I cancel the authorization through written notice to the health care provider or unless otherwise indicated.

_____ _____

Card Member Signature (authorization for automatic credit card payment) *Date*

Credit Card Information:

Card Type: ☐ Master Card ☐ Visa ☐ Discover ☐ American Express

Account Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration Date: _____ 3 Digit Security Code: _____

Card Member Name (as it appears on Card): _____

Card Billing Address:

_____

Street City State Zip

Patient Name: _____

You will be responsible at the time of service for payment of the annual deductible, co-payments and co-insurance.

****Please Note:** *If the patient is under 18 and the parent is going to drop them off for appointments, we strongly encourage you to leave a credit card for copayments. Copayments/Coinsurance is expected at each visit.*

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Scheduled Appointment Reminder Authorization

I authorize Grand Oaks Behavioral Health to send me appointment reminders.
Please specify how you would like us to contact you:

CHOOSE ONE:

☐ Phone Call: Preferred Phone Number: _____

☐ Text Message: Cell Phone Number: _____

☐ Email: Email Address: _____

____ **Please initial if you do not wish to receive appointment reminders. I am aware that missed appointments result in a $100 fee.**

Electronic Statement Delivery

By providing your information below you are consenting to receiving statements electronically. When electronic statements are available, an email will be sent to the email address you provided above (or on file at time of statement). The email will contain a link to our secure website where you will need to login to view your electronic statement. Paper statements may also be provided at your request.

☐ Yes, opt me into electronic statements delivery

☐ No, I prefer to receive paper statements

Patient or Parent Signature: _____ Date: _____

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Patient Financial Policy & Advance Notice of Possible Payment Denial

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations / referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible at the time of service.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- Your insurance may not cover the necessary amount of hours required to complete psychological testing, CPT code 96101. I accept liability for those services not paid by the insurance.
- I have been notified by my provider that, in my case, the insurance is likely to deny payment for the services identified above. I have read and understand the above statement. I accept liability for those services not paid by the insurance.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.

Signature of Beneficiary/Responsible Party: Date of Birth

Printed Name of Beneficiary/Responsible Party: Date