CONNECTIONS THERAPY CENTER

Registration Form

Dr. Cindy Stear, PsyD and Associates
815-957-0115
drcindystear@connectionstherapycenter.com

DATE: _____ REFERRED BY: _____ DIAGNOSIS: _____

PATIENT NAME: _____BIRTHDATE: _____

SOCIAL SECURITY #: _____ MARITAL STATUS: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME #: _____ WORK #: _____ CELL #: _____

EMAIL ADDRESS: _____

BEST WAY TO CONTACT YOU: TELEPHONE: home, work, or cell TEXT or EMAIL

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE: _____ RELATIONSHIP TO YOU: _____

INSURANCE CARRIER: _____ ID #: _____

GROUP #: _____ INSURANCE CO. PHONE #: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S DOB: _____POLICYHOLDER'S SS #: _____

RESPONSIBLE PARTY FOR CHILD/MINOR: _____

RESPONSIBLE PARTY'S ADDRESS: _____

RESPONSIBLE PARTY'S PHONE #: _____ AND/OR CELL #: _____

I authorize Connections Therapy Center to verify the employment and insurance coverage provided on this form. I hereby assign and transfer to Connections Therapy Center all rights in the benefits payable for the service rendered by my insurance company. I authorize all insurance companies under which I am insured, to pay directly to Connections Therapy Center and I will pay for all charges incurred, for all charges in excess of the sums actually paid by the insurance company. I also understand that I am personally and fully responsible for payment of all charges for professional services rendered by Connections Therapy Center. If charges are not paid within a reasonable period of time, the balance will go to a collection agency. I understand all costs due to this process will be added to the account balance (35% fee). I hereby certify the information provided is correct to the best of my knowledge. My signature on this page further certifies that I opt out of any and all insurance audit risk reviews. Please note: Staff are not available for court work. Staff reserves the right to withdraw from your treatment if court involvement occurs, as this is considered legal, not medical, in nature.

I have read and fully understand the information listed above.

_____ _____
PATIENT OR LEGAL REPRESENTATIVE SIGNATURE DATE

CONNECTIONS THERAPY CENTER

Consent to Treatment

Dr. Cindy Stear, PsyD and Associates
815-957-0115
drcindystear@connectionstherapycenter.com

I voluntarily present for treatment and consent to the therapist to provide psychotherapeutic treatment to myself and/or (name)_____, who is my (dependent)_____. While I expect benefits from treatment, I fully understand that benefits and particular outcomes cannot be guaranteed. I understand that because of the counseling/therapy, we may experience uncomfortable emotions, and/or physical discomfort. I understand that regular attendance will produce the maximum benefits but that we are free to discontinue treatment at any time. If we decide to do so, I will notify the therapist at least two weeks in advance so that effective planning for continued care can be implemented. I know of no reason I/he/she/we should not undertake this therapy and participate fully and voluntarily.

AGENCY INFORMATION

This agency is not a crisis center. While we are available for brief consultations by telephone, regular telephone contact is not a provided service. However, you can leave a confidential message on their voice mail at any time. In the event of an emergency when a therapist is not available, you are encouraged to go to the emergency room at any local hospital for an evaluation where medical and psychiatric staff are always available or call 911 for assistance. Texts are for brief scheduling purposes and reminders during regular business hours only, not for clinical exhanges.

PRIVACY/CONFIDENTIALITY

We are ethically and legally bound to keep the nature of our contacts with you confidential unless you give written permission to share information with others. There are some exceptions to this standard:

- *If you are in danger or harming yourself, we will take measure to protect you;*
- *If you are threatening to harm someone else, we have a legal duty to warn them;*
- *If we have reason to suspect child abuse, DCFS or the appropriate child welfare body, by law, must be contacted;*
- *If we have reason to suspect elder abuse, by law, we will contact the proper agency;*
- *If you are involved in a legal proceeding and the court orders case records, we will make efforts to protect your confidentiality, however we cannot guarantee it in that situation;*
- *Patient information may be discussed in clinical staff meetings at Connections Therapy Center for the purpose of supervision, required by some insurance companies;*
- *We may be required to provide information to Insurance/managed care;*
- *I understand this information concerning treatment may include history and diagnosis-specific information concerning alcohol abuse/mental health/drug abuse/HIV/AIDS; and*
- *I understand I have the right to revoke this authorization, I am aware that my revocation may prevent payment or reduce payment for services received, and I become responsible for payments.*

I have read and fully understand the information listed above.

_____ _____

Client/Legal Representative *Date*

CONNECTIONS THERAPY CENTER

Payment Policy

Dr. Cindy Stear, PsyD and Associates
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drcindystear@connectionstherapycenter.com

YOUR FIRST APPOINTMENT: *The 1st session with our staff at Connections Therapy Center will allow you to gain an understanding of your concerns, problems and symptoms. It is scheduled 60 minutes and the fee is $350.00. During this time your therapist will work with you to develop a plan of treatment, including frequency of sessions needed, issues to focus on and referral to an M.D. for a medical consult (if indicated). Sessions after that are usually scheduled for 37-45 minutes ($300.00) or 53 minutes ($325.00). There may be an add-on charge if additional services are required ($25.00). Crisis sessions are rare. They can be scheduled for 60 minutes ($475.00) with additional 30 minute add ons if needed for $175.00 per 30 minute block. Private pay clients are seen for 60 minutes, and payment is requested at time of service.*

DAY OF SERVICE: *Connections Therapy Center would appreciate payment at the time of service. If you are covered by insurance, we expect your co-pay amounts or any percentages, including deductible, not covered, to be paid at the time of your session. We accept cash, checks and credit cards. A 4% service fee will be charged on all credit/debit/HSA/FLEX card payments.*

PAYMENT POLICY: *All balances 60 days and over are due in full. Any other arrangement would require **prior** approval by your therapist or the office staff.*

INSURANCE: ***IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFIT LIMITS (SESSIONS PER YEAR, DEDUCTABLE, COPAY, COINSURANCE) AND IF YOU ARE REQUIRED TO HAVE PRE-AUTHORIZATION FOR MENTAL HEALTH SESSIONS. ***
When complete insurance information is supplied, our office will file insurance as a courtesy and are glad to do so. If, however, there is a significant delay with insurance, we will ask you for the money and will reimburse you once insurance has paid us. It is understood that we are NOT responsible for collecting insurance benefits or negotiating the settlement of a disputed claim. Any insurance you have is a contract between you and your insurance company.

AGREEMENT FOR PAYMENT: *In consideration for services rendered to the client, by your therapist at Connections Therapy Center, the undersigned patient and/or guardian agrees and guarantees to payment in full, any and all charges. (This excludes negotiated discounts between your insurance company and your therapist.) The undersigned also agrees to pay any additional charges related to the cost of collection of this account including, but not limited to, collection agency fees (35%), and reasonable attorney fees which are incurred by Connections Therapy Center in enforcing payment in the event the undersigned fails to pay. Note that any payment made once the account goes to collection will be applied to the cost of collections first, then to the principle. Federal law does not allow us to negotiate your account after it has been submitted to collections. You are responsible for notifying us of any change of address during and after your treatment if you have an account balance.*

PHONE/LETTER/REPORT CHARGES: *Phone sessions are not covered by insurance and will appear on your monthly statement. Please limit your phone calls to fifteen minutes. You will be charged appropriately based on our current rate $325.00 per hour, prorated, for all calls over 5 minutes. Charges will be applied for reports or letters written outside of the therapy session, at a prorated hourly fee. These are not typically covered by insurance, and you will be responsible for these charges.*

BILLING POLICY:
Questions about billing and payment should be directed to the billing office: PBO 800-690-7792. Please add this number to your phone.
CANCELLATIONS: *All cancellations must be made 24 hours in advance between the hours of 8:30 am- 4:30 pm M-F. If you fail to call ahead of time you will be billed $100.00. Insurance does not cover this expense. If you call ahead to reschedule it helps us to try to fill that spot, and if we can do so you will not be charged.*
NO SHOWS: *If you fail to show for a scheduled appointment, you will be billed $100.00. Insurance does not pay this fee.*

I have read and fully understand the information listed above.

DATE: _____ *SIGNATURE:* _____

CONNECTIONS THERAPY CENTER

Notice of Privacy Practices

Dr. Cindy Stear, PsyD and Associates
815-957-0115
drcindystear@connectionstherapycenter.com

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it very carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed above.

USES & DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

TREATMENT: We may use or disclose your health information to a physician or other healthcare providers providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY & FRIENDS: We must disclose your health information to you as described in the Patient Rights Section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal official health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, email, postcards, or letter).

***PATIENT RIGHTS*/ACCESS:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information above for a full explanation of our fee structure.)

DISCLOSURE ACCOUNTING: You have the right to receive a list of instance in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before April 14, 2003. If you request this accounting more than once in a twelve month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend our health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS & COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

CONNECTIONS THERAPY CENTER

Acknowledgement of Receipt of Notice of Privacy Practices

*** You May Refuse to Sign This Acknowledgement ***

Dr. Cindy Stear, PsyD and Associates
815-957-0115
drcindystear@connectionstherapycenter.com

I , _____ have been offered a copy of this office's

Notice of Privacy Practices.

PRINT FULL NAME: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining this acknowledgement
- ☐ An emergency situation prevented us from obtaining this acknowledgement
- ☐ Other (Please Specify) _____

Staff initials: _____

CONNECTIONS THERAPY CENTER

Release of Information

Dr. Cindy Stear, PsyD and Associates
815-957-0115
drcindystear@connectionstherapycenter.com

PATIENT: _____

_____ _____
ADDRESS *CITY/STATE/ZIP CODE*

DATE OF BIRTH: _____ *HOME PHONE #:* _____ *CELL #* _____

I, _____

AUTHORIZE _____ *to release/receive information about my care from:*

_____
NAME OF FACILITY/AGENCY/INDIVIDUAL

_____
ADDRESS

_____
CITY/STATE/ZIP CODE

_____
OFFICE PHONE *FAX NUMBER*

_____
INFORMATION TO BE RELEASED/DATES OF SERVICE NEEDED

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE *DATE*

_____ _____
WITNESS *DATE*

I understand that the records disclosed may contain information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or Human Immunodeficiency Virus (HIV). They may also include information regarding Behavioral or Mental Health Services, Developmental Disabilities, or Treatment for Alcohol and/or Substance Abuse. _____ *patient or guardian signature*

I have the right to inspect and obtain a copy of the records that are to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that my refusal to consent to the release of the above mentioned information will prevent disclosure of the necessary information. I understand this authorizes two-way exchange of information, unless specifically restricted in writing.

I further understand that if this authorization is for the purpose of third party payment that medical information as may be necessary to process benefits will be disclosed to my insurance company and/or the insurance company's review agency. If I refuse to authorize release of information for this purpose, it may adversely affect my entitlement to insurance benefits.

I understand that I may revoke this authorization at any time (except to the extent of any action already taken) and that if I do revoke this authorization I must do so in writing. In lieu of this revocation, this release expires on _____, or one year from the original signature date.

Connections Therapy Center Office Policies

Session lengths will be in accordance with your insurance company directives. Sessions will be 53 minutes long for our Meridian, BCBS, Anthem, Alliance, Aetna, Medicare, and most private insurance covered-services. Sessions will be 37 minutes long for our Illinois Public Aid, and Beacon/ Value Options clients. Sessions will be 60 minutes long for our private pay clients.

For any clients who are covered by private insurance or private pay, you will be charged a fee of **$100.00** for any late cancellations or no shows, unless your therapist waives this due to illness or emergency. *Cancellations need 24 hours notice.*

For any clients who are covered by Medicaid or Medicare insurance, you will be discontinued from our services if you cancel late or are a no show 2 times, unless your therapist waives this due to illness or emergency. *Cancellations need 24 hours notice.*

For any client whose treatment becomes court-involved, please remember we are a medical service, not a legal service. If your case is court-involved we ask you to seek services with experts in this area outside of our office. Insurance does not cover any services that are not based on medical need. This includes requests for emotional support animal letters. Our insurance carrier and ethical guidelines do not permit us to write such letters if we are your clinical provider. We can refer you to a forensic evaluator for such needs.

Due to HIPPA laws, please do not email or text us anything clinical in nature. Email or text is offered during routine business hours for quick scheduling questions. Please do not email or text reports, school notes, lab results, etc. Please provide us a hard copy in order to have us review them, rather than asking us to copy these. We do not keep electronic records, for your added protection.

As always, please contact your insurance provider prior to January 1 of each year, to ask if you will owe a deductible, copay, coinsurance, or will need a pre-authorization or physician referral for your services here in the upcoming year. Insurance company requirements can change each year. Please pay all aging balances as soon as possible, or contact the billing office for any questions or payment schedules: PBO: Jolene or Kristi, 800-690-7792. Please add this number to your phone.

Thank you for your cooperation.

_____ _____

Signature Date