Psychiatric Services of
Southern Illinois


**Psychiatric Services of Southern Illinois**
2900 Frank Scott Parkway W., Suite 990, Belleville, IL 62223
Office Phone: 618-236-6501
Office Fax: 618-236-6551


# New Client Packet

Welcome to Psychiatric Services of Southern Illinois (PSSI). **Full completion** of this packet will enable us to provide you with the best possible service.

**Please bring the following to your first appointment.**

- ☐ Insurance Card(s)
- ☐ Driver's License or Photo ID
- ☐ Copay or other payment.

**Please note the following:**

Client Registration (next page) must be filled out completely. The date of birth of the insurance policy holder is required to submit insurance claims. If you do not have this information, we cannot bill your insurance. You would then be held responsible for charges that your insurance would otherwise cover.

Completion of this packet in its entirety is necessary.

**Please Review** - Check that each page has been **signed and initialed.**

**Thank you for your cooperation and patience in filling out these forms to help us better understand your needs and bill your insurance correctly.**
**We look forward to working with you.**

Client Initials _____

# CLIENT REGISTRATION

The information below is pertaining to the Client being seen

Today's Date: Month_____Day_____Year_____

Client Name: _____

Client Birthdate: Month_____Day_____Year_____

## Contact Information

Home Address: _____

_____

_____

*Authorization for PSSI to send mail to the address listed above: Yes or No (Circle One)

Phone(s): _____

*Authorization for PSSI to leave voice messages on Phone(s) listed above: Yes or No (Circle One).

Email Address: _____

*Authorization for PSSI to email the address listed above: Yes or No (Circle One).

Demographics :

Sex: M / F (Please circle one)

Identified gender: M / F / Other (please circle one)

Please indicate pronouns used: He/him She/her They/them Other: _____

Highest level of education: _____

Occupation: _____

Referred By: _____

Marital Status: Single / Married / Separated / Divorced / Widowed / Other: _____

(Please Circle One)

Emergency Contact:

Name/Phone: _____

The person listed above may be contacted by PSSI staff in case of emergency.

Client Initials _____

## Insured/Responsible Party Information

All items in this section must be completed to bill your insurance.

If using **Private Pay** Please Circle N/A and skip to the Next Page

Policy Holder Information:

Policy Holder's Full Name: _____

Policy Holder's Phone #: _____

Policy Holder's DOB: _____

Relationship to the Client: _____

Policy Holder's Address: _____

Insurance Provider's Information:

Primary Insurance Company: _____

Insurance I.D. #: _____

Insurance Group #: _____

Mental/Behavioral Health Phone: _____

(Located on Back of Ins. Card)

Secondary Insurance Company: _____

Insurance I.D. #: _____

Insurance Group #: _____

Mental/Behavioral Health Phone: _____

(Located on Back of Ins. Card)

If applicable, please provide information on tertiary insurance company on the back of this sheet and check here if done. _____

Client Initials _____

# Appointment Information

Today's initial appointment will take approximately 45-60 minutes. Starting counseling is a major decision, so you may have many questions. This document is intended to inform you of what to expect, our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

## OFFICE HOURS

Office hours are Monday – Thursday, 9am – 5pm, Friday, 9am – 2pm. You may reach the office by phone at (618) 236-6501 to schedule an appointment. If office staff is unavailable, you may leave a message on our office voice mail box and a staff member will return your call as soon as possible during normal business hours. **Do not** leave messages if you have a psychiatric emergency; please dial 911 or go to the nearest Emergency Room.

## COMMUNICATION

It is our normal practice to communicate with you at your home address and daytime phone number that you gave us when you scheduled your appointment about health matters, such as appointment reminders, etc. You have the right to request that our office communicate with you in a different way. Please DO NOT provide phone numbers if you do not wish for us to leave messages. If a phone number is provided as a form of contact, the front office will leave a message at that number.

## FINANCIAL/INSURANCE

As a general practice, we will bill your insurance company. However, you are responsible to be aware of your coverage and benefits. You will be held financially responsible for any remaining balance or sessions that are not covered by insurance. All payments and/or co-payments are due at the time of each appointment. If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If we receive more than one returned check from an individual we may refuse future payment by check.

## NO-SHOW/LATE CANCELLATION POLICY

We ask that you contact our office within 24 hours if you are not able to make your appointment. If you do not show up for a scheduled appointment or if you cancel with less than 24 hours' notice, a NO SHOW/LATE CANCELLATION FEE of **$50.00** may be charged for the missed appointment. This cost is not covered by insurance. It is your responsibility and must be paid in full before your next appointment. It is at the therapist's discretion to bill for No-Show/Late-Cancel, as well as to terminate treatment if multiple appointments have been missed without appropriate cancellation.

However, we understand that life throws us curve balls and not all appointments can be cancelled within 24 hours. We ask that you do your best to respect our time and give us as much notice as you can. If you are sick, PLEASE CALL US TO RESCHEDULE. IF YOU SHOW UP NOTICEABLY SICK OR UNDER THE INFLUENCE OF ILLICIT SUBSTANCES (FEVER/VOMITTING), YOUR THERAPIST HAS THE RIGHT TO RESCHEDULE. Your therapist may also reschedule in the event he/she is sick with the goal to keep you healthy.

## Minors and Parents

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining trust. While privacy in psychotherapy is very important, parental involvement is also essential to successful treatment. Therefore, it is our policy that any client over the age of 12 and under 18 and his/her parents or guardians understand that only general information will be shared with parents/guardians, including the child's diagnosis, progress in treatment, and the child's attendance at scheduled sessions. Parents will be informed if a disclosure is required by law. All other information the child provides will remain confidential unless authorized to be released by the child. By signing this agreement, you will be protecting your child's privacy by waiving your right of access to your child's treatment records. Please be aware that your child is unlikely to utilize therapy to discuss his/her decisions in areas that will be reported to you. If we ever believe that your child is at serious risk of being harmed or of harming him/herself or another person, we will inform you.

You agree that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding between the two of you using your therapist's involvement with your child. In particular, you agree to instruct attorneys not to subpoena your therapist or the client's records to refer in any court filing to anything that I have said or done. You additionally agree not to ask your therapist to testify in court.

## Disclosure Regarding Litigation

By signing this Disclosure statement, you express understanding that it is not the role of the therapist to be involved in litigation of any kind or to testify in court. YOU AGREE NOT TO SUBPEONA your therapist or another employee at PSSI to court for testimony or for disclosure of treatment information in such litigation; and YOU AGREE NOT TO REQUEST that the therapist write any reports to the court or to your attorney, making recommendations regarding custody, workman's compensation, or other legal issues. The court can appoint professionals, who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court. If this is your reason for seeking counseling, please be honest and we will provide you with a referral. By signing this you understand and acknowledge that **YOU DO NOT DO COURT RELATED COUNSELING.**

**Client Signature is required**: _____

Parent/Guardian signature if client is a minor: _____

DATE:_____

## Parent Understanding and Consent

Children under age 12 entering therapy must have consent from their legal guardian(s). If there is a joint custody agreement, both parents must be aware of treatment and provide consent to PSSI for their child to be receiving counseling services. A copy of the custody agreement must be provided to therapist to have on file.

**CHILD'S NAME:**_____ **DOB:** __/__/__

**PARENTS: (Name all parents/step-parents/legal guardians. CUSTODIAL parent(s) must sign form)**

**Mother:**

**Name:** _____

**Address:**_____,_____,____,_____
(City) (State) (Zip)

**DOB:**__/__/__ **Age:**____ **Home or Cell Phone:**_____

**Occupation:**_____ **Work Phone:**_____

**Father:**

**Name:** _____

**Address:**_____,_____,____,_____
(City) (State) (Zip)

**DOB:**__/__/__ **Age:**____ **Home or Cell Phone:**_____

**Occupation:**_____ **Work Phone:**_____

**Legal Guardian**

**Name:** _____

**Address:**_____,_____,____,_____
(City) (State) (Zip)

**DOB:**__/__/__ **Age:**____ **Home or Cell Phone:**_____

**Occupation:**_____ **Work Phone:**_____

**I, (*Print Name*)_____ attest that I am the custodial parent of above named minor, and I authorize child to participate in psychotherapy with this office. I agree and understand that while insurance may be billed for psychotherapy services, I am legally responsible for any and all charges incurred in providing this and/or other services by this office. Copies of documentation of legal custody of child, and any other legal issues pertaining to child must be provided on, or before date of first visit. Copies of these documents will be kept in child's record.**

_____ _____

**CUSTODIAL PARENT (Mother/Father/Guardian - Circle One)** **DATE**

## UNDERSTANDING PSYCHOTHERAPY INFORMED CONSENT

It is important for you to understand what counseling is about and what you may expect during therapy. Please read this material carefully and ask your therapist or the front desk staff to explain anything that is unclear to you.

**What are Counseling and Psychotherapy?**

"Counseling" and "Psychotherapy", or simply "therapy", are words for the same process which is: using proven methods to assist people in changing how they think, feel and behave. Legitimate therapy is practiced by licensed professionals in their field of expertise (i.e. social work, counseling, psychology, psychiatry).

**How does therapy work?**

Therapy will involve several steps. Therapy sessions are usually 45 to 50 minutes in length, and frequency depends on each individual's needs.

The counseling process is different for every person and each therapist has his/her own unique style and approach. Generally, your counselor will first listen to the concerns that you brought to counseling. He/she will get to know you and how you view your life and yourself. You may come to understand your situation better as you and your counselor talk. After you and your counselor explore your concerns, you will choose specific goals and objectives for therapy. Next, you and your counselor will work together to develop a plan for meeting those goals. You and your counselor will define and work toward accomplishing your goals using research-proven methods. These methods include, for example, accessing your inner strengths and resources, changing thoughts that affect how you feel and what you do, or homework assignments in which you try on new behaviors to see how they fit. You and your counselor may decide to involve other family members in your sessions. Please know that any work in the sessions will occur only with your permission. It is very important to your counselor to see that your limits are respected. Your specific needs and concerns will determine what is done.

Your counselor will frequently take time to examine your progress toward your goals to make sure you both are on the right track. You and your counselor will decide together when your therapeutic goals are met and when to move toward completing therapy.

Your therapy may be terminated if you fail to maintain regular attendance or if your therapist feels you are not making progress. You will be notified in advance of any possible termination of services.

## CONFIDENTIALITY AND EMERGENCY SITUATIONS:

If an emergency situation occurs for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact emergency services (911), or proceed to the nearest Emergency Room for assistance. **Your therapist is not on-call** outside of their office hours. However, your therapist can follow up on emergency services with standard counseling and support to the client or the client's family.

Your verbal communication and clinical records are strictly confidential except for situations covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communications with practitioners or office staff. This includes e-mail, instant messaging, social media and text.

We understand the ever growing popularity and convenience of social media and instant messaging; however, please do not contact your therapist through social media sites or instant messaging services, as these are not confidential and are not a reliable way to contact providers.

Therapists are required to keep the identity of their clients confidential. Consequently, therapists will not acknowledge you first in a public setting to ensure your confidentiality is protected. Therapists also will not accept any social media invitations/friend requests. Our duty as therapists is to care for clients in a professional role of therapist.
In general, communications between a client and a therapist, as well as records pertaining to those communications, are confidential and may not be released without written authorization by the client or the client's legal guardian. However, there are a few exceptions:

- **Administrative Personnel:** You should be aware that PSSI employs administrative personnel. In most cases, we need to share protected information with these persons for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. Office staff members are bound by the same rules of confidentiality as therapists. Office staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice.
- **Consultation:** Therapists regularly consult with other professionals about cases in order to provide clients with high quality care. During a consultation, every effort is made to avoid revealing the identity of clients. The consultant is also legally bound to keep information confidential.
- **Other Privacy practice restrictions:** Please read and sign the Notice of Privacy Practices attached to this document for an understanding of when it is required by law for therapists to disclose information.

If you have any questions, feel free to discuss the limitations of confidentiality with your therapist or the office staff members.

Client Initials _____

**As a client with PSSI, you have the responsibility:**

To be honest in providing information.

To keep your appointments, to be on time, and to give at least 24-hour notice, or as much notice as possible, if you should need to cancel your appointment.

To be free of alcohol/drugs during your therapy session and abstain from using alcohol/drugs on PSSI premises

To abstain from displaying or utilizing weapons during your appointment or on PSSI premises

To respect the therapists, staff, and facility.

To respect the privacy and rights of others.

To know your insurance requirements, deductibles, and co-pays.

To pay your co-pay, deductible, or full charge before each appointment.

_____ _____

Client Signature (Informed Consent) Date

**COORDINATION OF TREAMENT:** It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for the duration of your treatment at PSSI. If you prefer to decline consent, no information will be shared; **however we do need your physicians name and demographic information for insurance billing**.

**____You may inform my physician(s)** **____I decline to inform my physician**

Physician's Name: _____

Physician's Phone #: _____

Clinic Name: _____

Physician's Address: _____

_____ _____

Client Signature (Communication with physician) Date

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** I/We have reviewed and received a copy of the Notice of Privacy Practices, if requested. Signing this acknowledgement does not mean you have agreed to any uses or disclosures of your protected health information outside the purposes outlined in the Notice of Privacy Practices.

_____ _____

Client Signature (Notice of Privacy Practices) Date

## Presenting Problem and Treatment History

Please briefly describe why you are seeking counseling:

Medical History:
Please Describe significant medical history:

Please list all prescription, non-prescription medications, and supplements below:

Do you take all your medications regularly, as prescribed? Y/N. If no, please explain:

**Please be aware that outpatient therapy may not be the appropriate level of care for you at this time based on the severity of what you are struggling with. We ask that you be completely honest with us about your symptoms so that we can either provide the best care or refer to a more appropriate level of care.**

## SYMPTOMS

Please check any symptoms you are currently experiencing:

- ☐ Change in appetite (more or less)
- ☐ Feeling sad Crying spells
- ☐ Too little sleep (falling or staying asleep)
- ☐ Sleep more than usual
- ☐ Fatigue Loss of interest &/or pleasure
- ☐ Avoiding friends or family
- ☐ Expect failure
- ☐ Decreased concentration
- ☐ Thoughts of death
- ☐ Cutting or burning oneself (or other self-injury)
- ☐ Suicide plan or attempt
- ☐ Depression
- ☐ Often sick
- ☐ Loneliness
- ☐ Slow moving
- ☐ Hopelessness
- ☐ Confusion
- ☐ Worthlessness
- ☐ Lack of confidence/Low self-esteem
- ☐ Guilt

- ☐ Reckless or dangerous behavior
- ☐ Racing thoughts
- ☐ Pressured speech
- ☐ Inflated self-esteem

- ☐ Marital/Family problems
- ☐ Sexual Problems
- ☐ Relationship problems
- ☐ Gender/sexuality issues/confusion

- ☐ Long term memory problems
- ☐ Short term memory problems
- ☐ Wound up or tense more days than not
- ☐ Obsessive thoughts Compulsive or repetitive behavior
- ☐ Panic attacks
- ☐ Irritable
- ☐ Anxiety
- ☐ Muscle tension
- ☐ Irrational fear of something or someone

- ☐ Talking/acting w/out thinking
- ☐ Fidgety, restless, overactive
- ☐ Difficulty paying attention
- ☐ Frequent day dreams
- ☐ Bored easily
- ☐ Learning difficulties
- ☐ Often lose things

- ☐ Excessive dieting/exercise
- ☐ Obsessed with losing weight
- ☐ Use of laxatives
- ☐ Engage in self-induced vomiting
- ☐ Eating things that are not food

- ☐ Vandalism
- ☐ Fire-setting
- ☐ Lack of remorse for wrong-doing
- ☐ Selfish
- ☐ Bullies/gets in fights
- ☐ Lying
- ☐ Truancy
- ☐ Theft
- ☐ Argumentative/sudden anger
- ☐ Defiant of authority
- ☐ Temper tantrums
- ☐ Stubborn

- ☐ Avoiding adults
- ☐ Afraid to leave a loved one

- ☐ Upset by minor changes
- ☐ Easily embarrassed

- ☐ Feeling detached from one's body
- ☐ Feelings of unreality
- ☐ See or hear things others don't
- ☐ Believe things others tell you aren't true

- ☐ Fear of strangers
- ☐ Difficulty trusting
- ☐ Believe others are out to get you
- ☐ Intrusive thoughts
- ☐ Avoid things related to traumatic event
- ☐ Startle easily
- ☐ Flashbacks
- ☐ Nightmares

Other symptoms not mentioned above:

How do your symptoms hinder your life?

Have you experienced any of the above mentioned symptoms in the past? If so, Please describe:

Any history of substance abuse?: Y/N If yes, please describe:

Are you currently suicidal? (circle one) Yes No

If yes, do you have a plan? Yes / No (circle one; if yes, please describe plan here)

_____

Have you ever had suicidal thoughts? Yes No

If yes, when?_____

Are you currently homicidal? (circle one) Yes No

If yes, do you have a target and/or plan? Yes / No (circle one; if yes, please describe plan here)

_____

Have you ever had homicidal thoughts? Yes No

If yes, when?

_____

Have you ever attempted to seriously harm another person or animal? Yes No
If yes, when? (Please list all attempts)_____

Have you ever been diagnosed with a psychiatric disorder? Yes No

Provide diagnosis and explain: _____

Have you ever been hospitalized for psychiatric purposes? Yes No

If yes, when? (please list all hospitalizations)_____

_____

Have you ever received therapy? Yes No

If yes, when and where?_____

Has/Does any of your immediate family suffer from mental health issues? Yes No

If yes, please describe:_____

_____

## Psychiatric History

**COORDINATION OF TREAMENT:** It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared, **however we do need your physicians name and demographic information for insurance billing**.

**____You may inform my physician(s)** **____I decline to inform my physician**

Psychiatrist's Name: _____

Phone #: _____

Clinic Name: _____

Address: _____

_____ _____

Client Signature (Communication with PSYCHIATRIST) Date

## AUTHORIZATION

I authorize treatment deemed necessary by PSSI. I authorize PSSI to release to my health plan provider any and all information which is deemed necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to PSSI for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay PSSI for all charges not paid by either my insurance companies and/or employer. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement. I understand and authorize that if payment is not received by PSSI within this time frame, my credit card on File will be charged.

_____ _____

Client Signature Date

## Contractual Agreement between Client(s) and Psychiatric Services of Southern Illinois

**Signature on File**

My Signature(s) hereon authorizes PSSI to submit insurance claims to applicable insurance/EAP companies on my behalf and authorizes the release of any information necessary to process this claim to include release of medical records and payment authorization applicable to any current future treatment.

_____ _____

Client Signature Date

_____ _____

Guardian Signature Date

# Psychiatric Services *of* Southern Illinois

## Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the physician's
(Patient's Name)

Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____.

# Psychiatric Services *of* Southern Illinois

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

1. Psychiatric Services of Southern Illinois, LLC is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
    a. For treatment – The collection and sharing of protected health information by and among health professionals involved in the treatment and care of our patient.
    b. For payment – The use of protected health information in billing the patient's insurance carrier or their business partners to include personal identification, medical symptoms, and treatments for which Psychiatric Services of Southern Illinois, LLC seeks payment for services or in response to queries from the insurer or their business partners in adjudicating the claim.
2. Psychiatric Services of Southern Illinois, LLC intends to engage in one or more of the following activities:
    a. Psychiatric Services of Southern Illinois, LLC may contact the individual to provide appointment reminders.
    b. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
3. Psychiatric Services of Southern Illinois, LLC reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
4. Psychiatric Services of Southern Illinois, LLC will provide individuals or Patients with a revised Notice by mail if requested, otherwise a new notice may be obtained at the offices.