Hawthorn Counseling Group
977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061 (847) 680-0755 • www.hawthorncounseling.com

Patient Registration Packet

Welcome to Hawthorn Counseling Group. Completing the registration packet is the first step towards getting the help you are seeking and we look forward to working with you to achieve your goals for counseling. Please note the following about the attached forms:

- ✓ If the patient is not the *guarantor*, and you wish use health insurance, please be sure to provide all requested information regarding the *guarantor*, especially the guarantor's date of birth.
- ✓ Please review the *Consent for Treatment* form in its entirety. If you are electing to use health insurance to offset the costs of counseling, it is recommended that you contact your health insurance company prior to the first appointment to determine: 1) if your policy has a restricted network of providers; 2) if your HCG clinician is in your network; 3) the amount of any deductible which must be met; 4) the amount of any copays once the deductible is satisfied.
- ✓ All patients are asked to complete the attached *Payment Agreement*. Please provide credit card billing information. As explained on the form, you may use cash or check to pay for services provided however your credit card may be utilized for collection of unpaid balances resulting from deductibles, copays, late cancellation or failed appointment charges.

Please pay special attention to our policies regarding late cancellations or failed appointments:

- You will benefit most from your course of counseling if you make it a scheduling priority. However, we know that juggling commitments can be difficult and we will work to accommodate your needs.
- If you need to reschedule an appointment, Hawthorn Counseling Group requires at least 24 hours' notice—a full business day in advance of the hour of your appointment—giving notice of the intent to cancel a scheduled appointment. Also, please note: appointments scheduled on Mondays (or Tuesdays if following a holiday weekend) must be canceled by 5:00pm the preceding Friday afternoon. If you have a scheduling conflict and must cancel an appointment it is sufficient to leave a voicemail message in your specific clinician's voicemail box by calling 847-680-0755, then entering the mailbox extension for your HCG clinician. This notification must be provided a full 24 hours (or one business day) in advance of the hour of the scheduled appointment in order to avoid being billed for the appointment. We are unable to make allowances or exceptions to this policy, except in cases of sudden serious illness, family emergency or severe inclement weather. Be advised that business/work conflicts, scheduling of kids' athletic or school events, unexpected travel or other similar circumstances which might arise are not deemed as grounds for waiver of the late cancellation policy.
- If you are the guarantor of your son or daughter, and they are of age to make their own scheduling arrangements for ongoing counseling, you may wish to stay informed of appointments which have been scheduled since you will ultimately be responsible for charges.
- With regard to late cancellations or failed appointments, you will be charged the full usual and customary fee for the scheduled service. Your insurance company will not be billed for the late cancellation or failed appointment—you will be responsible for payment of the full usual and customary fee per the HCG fee schedule.
- If using health insurance, please provide a copy of your health insurance card and submit with the forms

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PATIENT REGISTRATION INFORMATION

PLEASE PRINT

Patient Information

Last Name	First Name	MI	Date of Birth / /	Age	Sex

Address	Apt. #	City	State	Zip

Home Phone	Work Phone	Cell Phone

Patient Employed By	Occupation

Guarantor--Name of Person Financially Responsible for Patient's Care

(Provide this information only when guarantor is not the patient)

Last Name	First Name	MI	Date of Birth / /	Age	Sex

Address	Apt. #	City	State	Zip

Home Phone	Work Phone	Cell Phone

Guarantor Employed By	Occupation

Health Insurance Information (may be left blank if a copy of insurance card—both front & back— is obtained)

Name of Insurance Company	Name of Subscriber & Date of Birth	Relation to patient

Plan/Policy #	Group #	Effective Date, if known

Insurance Company Claims Billing Address	City	State	Zip

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CONSENT FOR TREATMENT **Patient Name:** _____

1) I hereby consent to receive behavioral health services provided by the mental health professionals affiliated with Hawthorn Counseling Group (HCG).
2) I authorize and request that HCG perform assessments and also to administer those treatments as may be considered advisable in making a diagnosis and also treating my condition.
3) Services will be provided and billed per the HCG fee schedule in effect at the time of service delivery. I understand that psychotherapy sessions are typically of 45-55 minutes duration and will be billed accordingly, depending upon the length of the appointment, as determined either at my request or at the clinician's discretion.
4) I realize that no particular outcome or result can be guaranteed as a result of my consent to receive evaluation or treatment services by HCG.
5) I hereby release HCG from responsibility for any injury which may result from my declining services recommended by HCG or terminating services against clinical and/or medical advice.
6) I have read, understood and signed the *Patient Rights, Responsibilities and Statement on Confidentiality* and agree that I will follow the procedures described therein, specifically including the following:
   a) HCG requires notice by telephone no later than one business day—24 hours in advance of a scheduled appointment (or for Monday appointments and Tuesday appointments which follow holiday weekends, no later than 5:00pm on the preceding Friday afternoon).
   b) If I do not give proper notification I understand that I am responsible for paying the full customary fee, per the HCG fee schedule in effect at the time the appointment was scheduled, for the missed appointment (not a reduced/contracted fee or the customary co-pay charge).
      i) Failed appointments will result in my being billed the full customary fee for a 45 minute session, per the HCG fee schedule in effect at the time the appointment was scheduled, and I understand that no claim will be submitted to my insurance company for this charge.
      ii) Late cancellations will result in being charged the full customary charge for a 45 minute session, except due to instances of unforeseen events such as sudden illness, family emergency or severe inclement weather. Personal scheduling conflicts (e.g., due to employment or other circumstances) shall not be eligible grounds for waiver of the late cancellation charge.
   c) HCG kindly requests that payment for failed appointments and/or late cancellations be provided in full at the next scheduled appointment.
7) Non-urgent calls (e.g., scheduling or other non-urgent matters) are best managed by making use of the HCG voicemail system at (847) 680-0755, leaving a message for the specific provider.
8) In the event of an after hours emergency, it is recommended that patients contact the treating clinician as instructed on the HCG voicemail service or contact the nearest hospital emergency room.
9) I understand that I am responsible for making payment for each session immediately following each appointment as set forth in the accompanying Payment Agreement.

I certify that I have read the above information and signify my agreement with my signature below:

X_____ _____
Signature of Patient Date

X_____ _____
Signature of Parent/Guardian Date

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PATIENT RIGHTS & RESPONSIBILITIES Patient Name: _____

As a Consumer of Healthcare Services, Your Rights Include The Following

- ✓ To individualized service, to participate in treatment planning and to see your clinical record.
- ✓ To be advised at the time that treatment is initiated of the cost of the services to be provided.
- ✓ To know the professional status, licensure, training and experience of the staff members responsible for your treatment.
- ✓ To confidentiality of all records and communications, within the extent prescribed by law (see below), including the confidential handling of personal and medical records and to approve or refuse the release or records to any individual outside Hawthorn Counseling Group (HCG).
- ✓ Upon request, to know the risks, side effects, benefits and/or experimental nature of all treatment procedures and to be advised of known alternate treatment procedures available, their indications and foreseeable outcome.
- ✓ Upon request, to a clear and concise explanation of the proposed treatment and procedures, the goals of treatment and anticipated outcome of treatment.
- ✓ To refuse treatment. Should you choose to refuse recommended treatment, you shall be provided, upon request, a clear description of anticipated consequences of the decision to refuse treatment to the extent these consequences are foreseeable.

As a Consumer of Healthcare Services, Your Responsibilities Include The Following

Missed appointments & late cancellation policy

You are responsible for scheduling and keeping appointments with the treating clinician. HCG requires notice by telephone no later than 24 hours in advance of a scheduled appointment (or for Monday appointments and Tuesday appointments which follow holiday weekends, no later than 5:00pm on the preceding Friday afternoon). It is sufficient to leave a voicemail message for your specific clinician when calling to cancel a scheduled appointment. Please note that patients are responsible for payment of the full usual & customary fee, per the HCG fee schedule in effect at the time the appointment was scheduled, for a failed appointment or late cancellation. Please note, too, that your insurance company will not be billed for the late cancellation or failed appointment. Other than circumstances such as sudden illness, family emergency or severe inclement weather, we are unable to make exceptions to this policy.

Fees

Fees are discussed and set at the time of the initial appointment, based upon the HCG fee schedule in effect at the time of service delivery. Payment arrangements are detailed on the *Payment Agreement* form. Collections procedures for HCG are described in policy, which is available for review upon request. You hereby authorize HCG to utilize the credit card billing information provided at the outset of services for collection of unpaid balances. In event of prolonged nonpayment for services HCG reserves the right to implement its collections policy which could include the use of collections agencies, alternative dispute resolution procedures and/or small claims court filing.

Insurance reimbursement

Some services provided by HCG may be eligible for reimbursement by your health insurance. If you plan to use health insurance benefits you are responsible for determining the nature and extent of your coverage. Upon request and with consent, your treating clinician will arrange to submit claims on your behalf to your insurance company. However, you are ultimately responsible for payment for all services, including payment for denied services. Additionally, you are responsible for participating in any appeals processes for denied claims.

Information Concerning Confidentiality

As a recipient of psychological services through HCG, your treatment is confidential within the limits prescribed by law. In general, no information about you or your treatment will be released to anyone without your written permission. However, relevant laws require that your therapist contact others about your safety if you present a danger to yourself and/or others, or if your therapist learns of child abuse/neglect or, under certain circumstances, if so ordered by a court. In addition, your therapist may consult with a clinical supervisor, or other qualified clinician, without your consent to improve the quality of care provided. If the recipient of services is under 12 years of age, your therapist may discuss the treatment with the recipient's parent or legal guardian without consent. If the recipient is 12 through 17 years of age, the therapist may discuss the treatment with a parent or legal guardian when the recipient is informed and does not object to sharing information with his/her parent or guardian, or if the therapist does not feel there are compelling reasons not to disclose information with the parent or guardian. Information may also be disclosed to the guardian of a recipient who is 18 years or older. Information may also be disclosed to outside agencies & organizations to support collections and billing procedures. Otherwise, except as provided by law, no information may be disclosed without the written consent of a recipient who is 18 years or older. Further information on confidentiality is provided in the related Privacy Notice, provided at time of intake.

I certify that I have read the above information and signify my agreement with my signature below:

X_____ X_____

Signature of Patient Date Signature of Parent/Guardian Date

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Patient Name: _____

RELEASE OF INFORMATION FOR
PROCESSING HEALTH INSURANCE CLAIMS & CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby authorize Hawthorn Counseling Group (HCG) to release any of the following information for the purpose of obtaining reimbursement for treatment services provided to me and/or my dependents. Information to be released may include:

1. Admitting diagnosis
2. Treatment summary/dates of service
3. Billing summary & charges
4. Verbal/written exchange of information
5. Progress notes
6. Treatment plan
7. Final diagnosis and/or termination summary

This information may be released to any or all of the following parties/organizations as needed:

1. Any third-party payor having responsibility for payment of charges incurred through rendering of psychological services by HCG.
2. Review agents or auditors of third party payors
3. Managed care utilization review agents
4. Collection agencies utilized by HCG.
5. Legal representatives related to small claims court processing (e.g., court representatives, judges, attorneys).

This consent is valid until such time that all claims have been settled to the satisfaction of HCG or up to three years from the date of discharge form HCG, whichever is longer. I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured, or for which there is more than one insured. In this case, I authorize HCG to contact the actual or additional insured (e.g., my spouse or other guarantor), and to obtain or provide such information necessary to submit claims for reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate this consent at any time before the expiration date so long as I submit my revocation in writing to HCG. Finally, this consent does not permit any agency reviewing clinical information and/or records to redisclose my records to any other agency/person/organization without my written consent. I understand that HCG has no power to prevent such redisclosure.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance carrier, as described in the accompanying Payment Agreement. Additionally, I understand that failure to grant this authorization would prevent HCG from filing claims on my behalf, resulting in being billed-in-full for services.

I certify that I am the client; if I am not the client I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

X_____ X_____
Signature of Patient Date Signature of Parent/Guardian Date

ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me, or to my dependent, I hereby assign, transfer and set over to HCG all of my rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits as they pertain to charges incurred for services rendered by HCG. I understand that I am financially responsible to HCG for charges not covered by my insurance and/or managed care company by this assignment for any reason

X_____ X_____
Signature of Patient Date Signature of Parent/Guardian Date

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PATIENT IS TO RETAIN THIS FORM FOR HIS/HER OWN RECORDS & SIGN ACKNOWLEGEMENT THAT THE FORM WAS RECEIVED

PRIVACY NOTICE

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Hawthorn Counseling Group (hereafter referred to as "HCG") may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  - Treatment is when HCG provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when HCG consults with another health care provider, such as your family physician or another psychologist.
  - Payment is when HCG obtains reimbursement for your healthcare. Examples of payment are when HCG disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of HCG. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within HCG offices such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my HGC offices such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is the patient's written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

HCG may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when HCG is asked for information for purposes outside of treatment, payment, or health care operations, HCG will obtain an authorization from you before releasing this information. HCG will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes made about conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that HCG has already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage—law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

HCG may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If HCG has reasonable cause to believe a child known through a professional capacity may be an abused child or a neglected child, HCG must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If HCG has reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, HCG must report this belief to the appropriate authorities.
- Health Oversight Activities – HCG may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and HCG must not release such information without a court order. HCG can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to HCG a specific threat of imminent harm against another individual or if an HCG clinician believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, HCG may make disclosures believed necessary to protect that individual from harm. If HCG believes that you present an imminent, serious risk of physical or mental injury or death to yourself, HCG may make whatever disclosures considered necessary to protect you from harm.
- Worker's Compensation – HCG may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, HCG is not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, HCG will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, HCG will discuss with you the details of the request for access process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. HCG may deny your request. On your request, HCG will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, HCG will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- HCG clinicians are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- HCG reserves the right to change the privacy policies and practices described in this notice. Unless notified of such changes, however, HCG is required to abide by the terms currently in effect.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact HCG or John D. Jochem, Psy.D., or contact the Illinois Guardianship & Advocacy Commission. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 1, 2003.

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Patient Name: _____

PRIVACY NOTICE ACKNOWLEGMENT

By signing below, I acknowledge that I have received a copy of *Notice of Polices and Practices to Protect the Privacy of Your Health Information* regarding the care I am receiving through Hawthorn Counseling Group.

X_____ X_____
Signature of Patient Date Parent/Guardian Date

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PAYMENT AGREEMENT **Patient Name:** _____

In consideration of the services to be rendered by the clinicians of Hawthorn Counseling Group (HCG), I agree to pay HCG for all services provided to the patient, at the established rates listed in the HCG fee schedule in effect at the time services are received, or as otherwise negotiated with HCG.

I also understand that I am financially responsible for any deductibles, co-payments and/or other charges not covered by third-party payors, including failed appointment & late cancellation charges.

I certify that the information provided to HCG is, to the best of my knowledge, complete and accurate. I will make arrangements for prompt and regular payment of fees to HCG for services. I understand that payment is due either in-full or in-part at the time services are provided, as arranged when services are initiated.

I understand that I may pay by cash or check. I grant permission to HCG to bill my credit card account or flex spending account noted below for payment of any charges. This includes payment of any unpaid balances which are 30 days or more past due, including co-payments, deductibles, failed appointment & late cancellation charges.

In understand that credit card charges will show on billing statements as "Hawthorn Counseling Group".

All patients are asked to provide credit card billing information below:

TYPE OF CREDIT CARD: ☐ VISA ☐ M/C ☐ FLEX SPENDING ACCOUNT ☐ DEBIT CARD

NAME OF CARD HOLDER:

PRINT

ACCOUNT NUMBER:

EXPIRATION DATE:

AGREEMENT AND AUTHORIZING SIGNATURE:

X _____

☐ Patient ☐ Parent/Guardian Date

Hawthorn Counseling Group is a registered dba in the State of Illinois for John D. Jochem, Psy.D., P.C.