1024 W Main St
St Charles, IL 60174
Main: 630-262-2640
Fax: 630-262-2645
www.InStep360.org

Registration Packet (Child and Adolescent Version)

Thank you for entrusting In Step Behavioral Health to provide your child or adolescent with mental health services. Please take your time to completely and accurately provide the information requested in this registration packet. In this document you will find the following forms, each of which must be signed and dated:

- Patient Information
- Assignment of Benefits
- Financial Policy
- Cancellation/No-Show Policy
- HIPAA Communications/Patient Receipt of Privacy Practices
- Health Information

Patient Information

Legal Name: (*Last*) _____ (*First*) _____ (*MI*) _____

Birthdate: _____/_____/_____ SSN ---------- _____ Sex: Male ☐ Female ☐
MM/DD/YYYY

Address: _____ City/State/Zip: _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone: (_) _____

Preferred Number: Cell ☐ Home ☐ Work ☐

Person filling out this form (if different than patient) _____

Relationship to patient (note if step-parent) _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

PREFERRED PHARMACY: _____ PHARMACY PHONE NUMBER: _____

In Case of Emergency Call: _____ Phone: (_____) _____

Relationship to patient (note if step-parent) _____

Parent 1: Email (will not be distributed to any third parties)
_____@_____ (Name: _____)

Parent 2: Email (will not be distributed to any third parties)
_____@_____ (Name: _____)

How did you find out about us? If appropriate, please name the source of your referral.

☐ Physician _____ ☐ Online Physician Finder _____

☐ Friend _____ ☐ Search engine _____

☐ Other _____

II. Guarantor Information (Parent or person responsible for account)

Legal Name: _____ SSN: ___-___-___

Relationship to Patient: _____ Birthdate: ___/___/___ Sex: ☐ Male ☐ Female

Address: _____ City/State/Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Work Phone: (___) _____

III. Primary Insurance Information

Policy Holder Name: _____ Birthdate: ___/___/___ Relationship to Patient: _____

Insurance Name: _____ NOTE: A copy of this insurance card will be taken at the office.

Employer: _____

IV. Secondary Insurance Information

Policy Holder Name: _____ Birthdate: ___/___/___ Relationship to Patient: _____

Insurance Name: _____ NOTE: A copy of this insurance card will be taken at the office.

Employer: _____

Electronic Health Record reporting as requested by the US Government. As a provider that bills Medicare, we must capture this information per Medicare/Medicaid Services. Please note, you do have an option to refuse to report.

Refuse to report ☐

Ethnicity ☐ Latino/Hispanic ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race _____

Preferred Language _____

I attest the above information is correct. (Sign/Date) _____

ASSIGNMENT OF BENEFITS

I authorize the release of any information including the diagnosis and the records of any treatment/therapy or examination rendered to my child or me during the period of such care to third party payers and/or other health practitioners. I hereby voluntarily consent to care encompassing routine diagnostic procedures and/or medical/mental psychotherapy/medication management treatment authorized by any provider at IN STEP BEHAVIORAL HEALTH, S.C. I authorize and request my insurance company to pay directly to the physician or physician's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services on my behalf or my dependents.

_____ _____

(Parent/guardian of minor) *Date*

FINANCIAL POLICY

We would like to thank you for choosing In Step Behavioral Health as your mental health provider. We are committed in making your treatment a success by providing you with the care you deserve. As a provider's office, we have certain guidelines to follow for billing procedures. Since the insurance contract is between you and your insurance carrier, it is still **your responsibility** to keep your account up to date and current. It is also your responsibility to supply the office with the correct insurance/billing information.

Insurance Coverage:

It is your responsibility to become familiar with your policy coverage. If a referral is needed, it is to be obtained before the time of first/next visit. If a referral has not been obtained by the time of your visit, the services provided may not be covered you will be required to pay for the visit. We encourage you to call your insurance company before you begin treatment so you can be aware of your payment responsibility. We are participating providers with most PPO's and we will file your claims accordingly. Services rendered at In Step Behavioral Health will be billed from this office. In the event that your insurance does not pay within 60 days of receipt of your claim, we expect the balance pending to be paid by you, the patient. It must be paid in full within 30 days. If you are having difficulty paying your outstanding bill, please contact the billing office to set up a payment plan. Accounts with balances due after that may be forwarded to an outside collections agency for payment. Ultimately, you are responsible for making sure your claims have been paid.

Self-Pay Policy:

If you are a self-paying patient, payment is due at the time of service. This claim will not be billed to an insurance company now or in the future. Once again, it is **your responsibility** to keep your account current.

Our Commitment to you:

We promise to bill your claims in a timely manner to ensure prompt payment by your insurance company. We promise to make the appropriate adjustments to your claim according to your insurance carrier's Explanation of Benefits. We promise to be available to you if you have any questions regarding your account.

Note: For dependents, accounts will be billed to the Guarantor of Record on the account. The office will collect copays from the parent/guardian who is present with the dependent/minor at the time of visit. We will split bills or balances or bill a second party.

For additional information about our practice please utilize our website **www.InStep360.org** or feel free to contact us directly.

Signature:_____ **Date:** _____

(Parent/guardian of minor)

CANCELLATION / NO SHOW POLICY

APPOINTMENTS: ISBH requires 24-hour advance notice for cancelation of your appointment. All NO SHOWS or LATE CANCELLATIONS will result in the following fees:

- $110 fee for medication management visits
- $140 fee for Psychotherapy visits.

All NO SHOW/LATE CANCELLATION FEES must be PAID IN FULL prior to scheduling your next appointment.

LATE ARRIVALS: Please notify ISBH if you will arrive more than 10 minutes late for an appointment.

- Late arrivals for a medication management visit may require a reschedule.
- Late arrivals for psychotherapy may reduce your session time.

We normally provide reminder calls as a courtesy, however, it is your responsibility to remember your appointment time and date.

Signature:_____Date:____/____/____
(Parent/guardian of minor)

HIPAA COMMUNICATION/PATIENT RECEIPT OF PRIVACY PRACTICES

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding communication:	**YES**	**NO**	**Does Not Apply**
Appointment Confirmations			
Leave message on my cellular/mobile phone			
Leave message on my home answering machine/voice mail			
Leave message with persons at my home			
Confidential Information			
Contact me on my cellular/mobile phone			
Contact me on my cellular/mobile phone*:* *(if unavailable*, may leave confidential information on my voice mail)			
Contact me at home			
Contact me at home: (*if unavailable*, may leave confidential information on my answering machine or voice mail)			
Send sealed confidential information to my home address			
Send sealed confidential information to the address below:			

Address: _____

_____

_____

I allow/permit the release of information to the following people listed below:	Relationship

_____ *Date:* _____

Patient Signature (including minors aged 12 -17)

_____ *Date:* _____

Parent or Guardian Signature

Patient Receipt of Notice of Privacy Practices

I have received a summary of the Notice of Privacy Practices from my physician or office and have been made aware that I may request a copy of the complete Notice at any time. I am also aware that the notice is available on our website at **www.InStep360.org.**

_____ *Date:* _____

Patient Signature (including minors aged 12 -17)

_____ *Date:* _____

Parent or Guardian Signature

HEALTH INFORMATION

All information will be held confidential in conformance with HIPAA regulation (Health Information Portability and Accountability Act) as enacted by the U.S. Congress in 1996.

Please complete this form to the best of your ability and bring it to the first visit. This information is critical for a thorough and comprehensive diagnostic evaluation.

Family and Household Data

Mother's name _____ Occupation _____

Education_____Age _____

Home Phone_____Work phone _____

Father's name _____ Occupation _____

Education_____Age _____

Home Phone_____Work phone _____

Stepparent's name _____ Occupation _____

Education_____Age _____

Home Phone_____Work phone _____

Stepparent's name _____ Occupation _____

Education_____Age _____

Home Phone_____Work phone _____

Marital status of parents (circle all that apply)

Single Co-habitating Married Separated Divorced Widowed Remarried

If parents are separated or divorced how old was the child at the time? _____
If parent(s) or siblings died, how old was child at the time? _____

Fill out table with household members (including non-relatives) and siblings outside the home.

Name	Relationship to child	Age	Lives at home? (Check if yes)

Primary language used at home _____

Additional languages spoken _____

Presenting Problem

Briefly describe your child's current difficulties:

_____

_____

_____

_____

_____

How long has this problem been a concern for you and when was if first observed:

_____

What seems to help with the problem?

_____

Have there been prior evaluations or treatment for this or similar problems? _____

If yes, when and with whom? _____

List any current medications the child is currently taking _____

Social and Behavior Checklist

Circle specific terms that apply in the following groups of words.

Difficulty with speech, hearing, language, vision, coordination, clumsiness.

Prefers to be alone, shy or timid, gives up easily, does not get along with siblings/peers, more interested in things than people.

Aggressive, teases/harms animals, plays with fire, stubborn, dangerous to self/ others, engages in risk-taking behavior.

Much too active, has frequent tantrums, rocks back and forth, holds breath, bangs head

Frequent nightmares, trouble sleeping, eats poorly, poor bladder control, wets bed, bites nails, sucks thumb.

Special fears, habits, mannerisms, blank spells, slow to learn, impulsive.

Other_____

_____

_____

Educational History

Place a check mark by those that apply.

Has difficulty with reading_____ Has difficulty with math _____

Has difficulty with spelling_____ Has difficulty with writing _____

Difficulty with other subjects (describe) _____

Does not like school _____

List special education classes or N/A _____

Has child been held back a grade and, if so, why _____

Describe tutoring or therapy in school, if applicable _____

Development History

During pregnancy describe the following or mark N/A:

Medication(s) taken by mother, if applicable _____

If smoking, how many cigarettes/day _____

If drinking alcoholic beverages, how much per day _____

Other drugs taken, amount and frequency _____

Were forceps used during delivery?_____Birthweight _____

Was Caesarian section performed and, if so, for what reason _____

_____

Was child premature and, if so, by how many weeks _____

Describe birth defects or complications, if any _____

_____

Describe feeding problems, if any _____

_____

Describe sleeping problems, if any _____

_____

Was the child quiet as an infant? _____

Did the child like to be held as an infant? _____

Was the child alert as an infant _____

Describe any special problems in the growth and development of the child _____

_____

_____

_____

Indicate the age at which child displayed the following infant and preschool behaviors. Add a question mark next to ages you are approximating. For those that you don't remember place only a question mark.

Showed response to mother _____ Babbled _____ Rolled over _____

Crawled _____ Spoke first word _____ Sat alone _____

Put several words together _____ Stayed dry at night _____ Was toilet trained _____

Fed self _____ Walked alone _____ Dressed self _____ Rode tricycle _____

Medical History

Note age or, as appropriate, age range during which child had any of the following illnesses or conditions.

Allergy _____ Anemia _____ Asthma _____

Bleeding problems_____ Bone or joint disease _____

Broken bones _____ Cancer_____ Chicken pox _____

Convulsions _____ Diabetes _____ Dizziness _____

Difficulty concentrating_____Diphtheria _____

Eczema or hives _____ Epilepsy _____ Encephalitis _____

Extreme tiredness or weakness _____ Fainting spells _____

Frequent or severe headaches _____ German measles _____

Gonorrhea or syphilis_____Hay fever_____Heart disease _____

High blood pressure_____High fever _____

Hospitalizations _____ Injuries to head _____ Ear problems (disease, infection, injury or impaired hearing)_____Jaundice/hepatitis _____

Loss of consciousness_____Measles_____Mumps _____

Meningitis_____Memory problems_____Paralysis_____

Operations _____ Rheumatic fever _____

Scarlet fever _____ Suicide attempt _____ Self-injury _____

Tuberculosis_____Whooping cough_____Visual problems _____

Other (describe) _____

Family Medical History

Check illnesses or conditions applicable to child's immediate family and note relationship.

Condition	Relationship to Child
Alcoholism _____	_____
Cancer _____	_____
Diabetes _____	_____
Heart trouble _____	_____
Nervous or psychological problem _____	_____
Depression _____	_____
Suicide attempt _____	_____
Learning disability _____	_____
Drug abuse/addiction _____	_____
Other _____	_____

Additional Information

List, in order of preference, your child's favorite activities.

_____

_____

_____

_____

What activities would the child like to engage in more frequently than he/she does at present?

_____

_____

What activities does the child like the least?

_____

_____

Has the child ever been in trouble with the law and, if so, please briefly describe.

_____

_____

_____

Check disciplinary techniques that are used when child behaves inappropriately.

Ignore problem behavior _____ Time out _____ Scold child _____

Tell child to sit on chair _____ Spank child _____ Threaten child _____

Reason with child _____ Redirect child's interest _____

Send child to his/her room _____ Take away some activity or food _____

Don't use any technique _____ Other (describe) _____

Which disciplinary actions, and for what problems, are usually effective? _____

_____

Which disciplinary actions, and for what problems, are usually ineffective? _____

_____

What have you found to be most satisfactory way of helping the child? _____

_____

What are the child's assets or strengths? _____

_____

Please describe any other information that you think will be of help in working with the child.

_____

_____

_____

_____