InStep Behavioral Health
Navigating Paths to Mental Wellness

1024 W Main St
St Charles, IL 60174
Main: 630-262-2640
Fax: 888-409-5576
www.InStep360.org

I. 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

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____
PREFERRED PHARMACY: _____ PHARMACY PHONE NUMBER: _____

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

Email: _____@_____
My email will not be distributed to third parties and I can opt out at any time.

How did you hear about us?

□ Physician (name): _____
□ Friend (whom? We'd like to thank them): _____
□ Web/Online ◯ Google ◯ Bing ◯ Yelp ◯ Yahoo ◯ MSN ◯ Hospital Website ◯AAD Website ◯ Other: _____
□ Insurance □ Phonebook □ Urgent Care □ 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: _____ **A copy of your insurance card will be taken at the office.

Employer: _____

IV. Secondary Insurance Information

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

Insurance Name: _____ **A copy of your 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 □ Black or African American
□ Native Hawaiian or other Pacific Islander □ White □ Other Race _____ Preferred Language: _____

I have reviewed the above information and find it to be correct. (Sign/Date): _____

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FINANCIAL POLICY

We would like to thank you for choosing In Step Behavioral Health as your provider. We are committed to making your treatment a success by providing you with the care you deserve. Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your rights and responsibilities as a patient.

Insurance Coverage

Please provide us with your current insurance information at the time of scheduling each visit and notify us of any changes. We must be able to verify your eligibility prior to your visit or your appointment may be rescheduled. In addition, failure to inform us of a change in insurance may result in exceeding the limits of the time allowed to file a claim and you will be responsible for all charges. We will scan a copy of your insurance card and photo ID to copy and keep on file for our records in accordance with insurance plan requirements.

Your health insurance policy is a contract between you and your health insurance company. It is **your responsibility** to become familiar with your policy coverage. In addition, it is your responsibility, as the policy holder, to understand the coverage and benefits and be knowledgeable of any deductibles, copayments and/or coinsurances. If a referral is required, that would be your responsibility. If the visit is telehealth it is your responsibility to determine if it is covered by your insurance. We encourage you to call your insurance company before you begin treatment so you can be aware of your payment responsibility.

Self-Pay Policy:

Self-pay patients are those patients without insurance coverage or are receiving a service not covered by their plan. Self-pay patients are required to pay for any charges at time of service. Self-pay rates are dependent upon the provider being seen. If the service is telehealth we require a credit card on file that would be charged at time of visit. It is **your responsibility** to keep your account current.

Payments

All co-payments and past due balances are due at the time of service. In addition, we may collect a portion of your deductible if it has not yet been met. We accept cash, checks or credit cards.

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 collection agency for payment. Ultimately, you are responsible for making sure your claims have been paid.

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Returned Checks

There will be a $35.00 fee assessed on returned checks.

After Hours Calls

Any after-hours call that the patient requests the answering service to place to the physician on call that is not deemed a true emergency by the physician may result in a $100 charge to you. This charge will not be covered by insurance and will be patient responsibility.

Cancellation / No Show Policy

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

- $350 fee for initial appointment

- $110 fee for subsequent medication management visits

- $140 fee for subsequent 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.

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.
For additional information about our practice please utilize our website **www.instep360.org** or feel free to contact us directly.
Thank you for entrusting your care to **In Step Behavioral Health**.

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Assignment of Benefits

I authorize the release of any information, including but not limited to the diagnosis and the records of any treatment/therapy or examination rendered to my child or myself during the period of such care to third party payers and/or other health 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 services. I agree to be responsible for payment of all services on my behalf or my dependents.

I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance to issue payment directly to In Step Behavioral health.

Signature:_____ **Date:** _____
(Patient or parent/guardian of minor)

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HIPAA COMMUNICATION/NOTICE OF PRIVACY PRACTICES

Request to Receive Confidential Communications of Protected Health Information

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 or parent/guardian (if minor)

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 or parent/guardian (if minor)

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Health Information Form

Note: 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.

General Information

Date:_____

Name:_____Date of Birth: _____

Male ( ) Female ( ) Age _____

Cell Phone: (____) _____

Purpose of Visit

Briefly describe the reasons for this visit: _____

_____

_____

_____

Briefly describe your treatment objectives: _____

_____

_____

_____

_____

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Psychiatric History

Do you have a history of behavioral health issues or hospitalizations? ( ) y ( ) n

If yes, please list the diagnosis, date and length of treatment and name of attending professional(s).

_____

_____

_____

_____

Are you currently receiving any form of professional behavioral health services? ( ) y ( ) n

If yes, by whom?_____Phone (_____)_____

Please list medications you have taken that were prescribed in association with any form of behavioral health treatment. To the extent possible, please provide the dates and dosages of medications taken and whether they were helpful.

_____

_____

_____

_____

_____

Suicide Risk Assessment

Have you ever had feelings so bad that you have had thoughts that you didn't want to go on, or that you might want to kill yourself? ( ) y ( ) n

IF YES, please answer the following.

Is this unhappy feeling so strong you ever wish you were dead? ( ) y ( ) n

How often have you had these thoughts?_____

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Has anything happened recently to make you feel like this? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Have you ever tried to kill or harm yourself before? _____

Did things change as a result of these attempts? _____

Is there anything that would stop you from killing yourself? _____

If you could look into the future, what do you feel you could look forward to?

_____

_____

Do you have a history of:

	Yes	No
Depression	( )	( )
Bipolar Disorder	( )	( )
Anxiety	( )	( )
Panic Attacks	( )	( )
Hallucinations/Delusions	( )	( )
Paranoia	( )	( )
Obsessions or Compulsions	( )	( )
Cutting or self injury	( )	( )

Medical Information:

Current medical problems/diagnosis: _____

_____

Do you have a history of:

	Yes	No
Anemia	( )	( )
Asthma/respiratory problems	( )	( )
Cancer	( )	( )
Chronic fatigue	( )	( )
Chronic pain	( )	( )

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Diabetes	( )	( )
Epilepsy or seizures	( )	( )
Fibromyalgia	( )	( )
Head trauma	( )	( )
Heart disease	( )	( )
High blood pressure	( )	( )
High cholesterol	( )	( )
Kidney disease	( )	( )
Liver disease	( )	( )
Stomach or intestinal problems	( )	( )
Thyroid disease	( )	( )

Are you bothered by problems with sleep? ( ) y ( ) n

If yes, please complete the sleep survey.

In a 1 to 10 scale, with 10 being the most pain, what number would you rate your current physical pain now?_____What number is it normally? _____

Name of your primary health care provider:_____

Phone:_____Address:_____

Date and place of last physical exam:_____

Have you ever had an EKG? ( ) y ( ) n Date: _____

Past medical problems, hospitalizations or surgeries: _____

_____

Current prescription medications and how often you take them: (if none, write none)

_____

_____

Current over-the-counter medications or supplements: _____

_____

Allergies: _____

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For women only:

Date of last menstrual period _____

Are you currently pregnant or do you think you might be pregnant? ( ) y ( ) n

Are you planning to get pregnant in the near future? ( ) y ( ) n

Birth control method _____

How many times have you been pregnant?_____How many live births?_____Family

Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

	Yes	No	(if yes, who)
Alcohol Abuse	( )	( )	_____
Anger	( )	( )	_____
Anxiety	( )	( )	_____
Bipolar disorder	( )	( )	_____
Depression	( )	( )	_____
Post-traumatic stress	( )	( )	_____
Schizophrenia	( )	( )	_____
Suicide	( )	( )	_____
Violence	( )	( )	_____
Other substance abuse	( )	( )	_____

Has any family member been treated with a psychiatric medication? ( ) y ( ) n

If yes, what medications and how effective were they?

_____

_____

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Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) y ( ) n

If yes, for which substances?_____

If yes, where were you treated and when? _____

_____

How many alcoholic drinks do you consume each week? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you used any street drugs in the past 3 months? ( ) y ( ) n

If yes, which ones? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) y ( ) n

Have people annoyed you by criticizing your drinking or drug use? ( ) y ( ) n

Have you ever felt bad or guilty about your drinking or drug use? ( ) y ( ) n

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) y ( ) n

Do you think you may have a problem with alcohol or drug use? ( ) y ( ) n

Check if you have ever tried the following:

	Yes	No	(if yes, when did you last use?)
Alcohol	( )	( )	_____
Cocaine	( )	( )	_____
Ecstasy	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Methadone	( )	( )	_____
Methamphetamine	( )	( )	_____
Pain killers *(not as prescribed)*	( )	( )	_____
Stimulants (pills)	( )	( )	_____

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Tranquilizer/sleeping pills ( ) ( ) _____

Other:_____

How many caffeinated beverages do you drink a day? _____

Do you smoke? ( ) yes ( ) no

Did you smoke in the past? ( ) yes ( ) no

If yes, what did you smoke, how much per day, for how long and when did you quit (please include history of chewing tobacco use?_____

Social History:

Marital History and Current Family:

Are you currently dating, sexually active, or in a relationship(s)? ( ) y ( ) n

How would you identify your sexual orientation:

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual

( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

Do you have concerns related to your sexual orientation? ( ) y ( ) n

Are you currently ( ) Married ( ) Divorced ( ) Single ( ) Widowed ( ) In relationship

For how long? _____

What is your significant other's occupation? _____

Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) y ( ) n If so, how many? _____

For how long? _____

Do you have children? ( ) y ( ) n Ages: _____

Describe your relationship with your children: _____

Household members and relationship to you: _____

_____

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Family Background and Childhood History:

Please list your brothers and sisters and their ages: _____

_____

Did your parents divorce? ( ) y ( ) n If so, how old were you when they divorced?_____

If your parents divorced, who raised you? _____

Has anyone in your immediate family died? _____

Who and when? _____

Educational History:

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Not working

How long in present position? _____

What is your occupation? _____

Where do you work? _____

Have you ever served in the military?_____If so, what branch and when? _____

_____

Legal History:

Have you ever been arrested?_____Do you have any pending legal problems?_____

Trauma History:

Do you have a history of trauma from childhood abuse, military combat, workplace trauma, domestic violence, rape, or medical trauma? _____

Spiritual Assessment:

Do you belong to a particular religion or spiritual group? ( ) y ( ) n

If yes, what is the level of your involvement? _____

Do your beliefs or philosophy of life affect how you think or feel about your illness? ( ) y ( ) n

If so, how? _____