InStep Behavioral Health
Navigating Paths to Mental Wellness
2455 Dean Street, Unit 3G, St Charles, IL 60175
Main: 630-262-2640 Fax: 630-262-2645
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 Native ☐ Asian ☐ 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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Nive Christodoss, LCPC: ***Business Administrator***

ASSIGNMENT OF BENEFITS

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENT

MEDICARE PATIENTS ONLY:

I request that payment of authorized Medicare benefits be made on my behalf for any services furnished to me by IN STEP BEHAVIORAL HEALTH, S.C., including my physician's services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and their agents any information to determine the benefits payable for related services.

____ ____________________
PATIENT SIGNATURE *DATE*

____ ____________________
PRINTED NAME *MEDICARE NUMBER (HICN)*

I authorize that payment of authorized MediGap benefits be made on my behalf to IN STEP BEHAVIORAL HEALTH, S.C. for any services furnished to me at the physician group. I authorize any holder of medical information about me to release to:

____________________________ any information to determine these benefits or the benefits payable for related services.
NAME OF SECONDAY INSURANCE

NON MEDICARE PATIENTS ONLY:

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.

____ ____________________
PATIENT SIGNATURE *DATE*

Updated 7/05/2017

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Financial Policy

We would like to thank you for choosing In Step Behavioral Health as you 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 get set up on 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.

Thank you for entrusting your care to **In Step Behavioral Health**.

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

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CANCELATION / NO SHOW POLICY

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

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

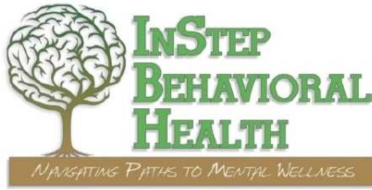
All NO SHOW/LATE CANCELATION FEES must be PAID IN FULL prior to scheduling your next appointment.

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:** ____/____/____
(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: ____

____

____

____

____

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?____

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	( )	( )
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: ____

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?

____

____

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)	( )	( )	____________________________________
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: ____

____

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? ____