



MIRJAM QUINN AND ASSOCIATES
care for the whole person

CLIENT INTAKE FORM

(Please Print)					
Today's Date:	Appt. With:	Whom may we thank for referring you?			
CLIENT INFORMATION					
Last Name, First Name, Middle Initial			Birth Date:	Pronouns:	
Street Address	City	State	Zip Code	Home Phone No.:	
PHONE NO. WHERE WE MAY LEAVE A MESSAGE ABOUT CLIENT?					
MOTHER'S INFORMATION					
Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:	
Street Address	City	State	Zip Code	Cell Phone No.:	
Employer's Name, Address and Work Phone					
FATHER'S INFORMATION					
Last Name, First Name, Middle Initial			Birth Date:	Home Phone No.:	
Street Address	City	State	Zip Code	Cell Phone No.:	
Employer's Name, Address, and Work Phone					
PRIMARY INSURANCE INFORMATION					
Insured's Last Name, First Name, Middle Initial			Birth Date:	Social Security #	
Insurance Company			Phone Number		
Insurance Billing Address:					
Policy No.:	Group no.:		Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Mirjam Quinn and Associates, Ltd. and the insurance company to release any information required to process my claims. I hereby attest that I am the legal guardian for this patient, and that I am legally entitled to make all decisions regarding this child's medical care. Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this practice.					
Guardian Signature			relationship to client		Date



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History Form

Child's Name: _____

Child's Date of Birth: _____

Parents' names: _____

Stepparents' names: _____

Who is the primary caregiver? Please provide name and relationship to the child: _____

Other caregivers – please provide names and relationships to the child: _____

Siblings:

Name	Age	Has this sibling experienced any problems (social, anxiety, etc?)? If yes, please describe

Primary questions or concerns prompting this evaluation:

1. _____
2. _____
3. _____

When did you first notice these difficulties? _____

What are your goals for therapy?

1. _____
2. _____
3. _____

Pregnancy and Birth

This child was his/her mother's _____ (enter number) pregnancy.

How many living children did this child's mother have before this child was born? _____

List any complications during pregnancy: _____

Place of birth: _____

Weight: _____ Length: _____

Type of birth (circle all that apply):

Single	twin	multiple
Vaginal	planned c-section	unplanned c-section

Any complications during labor? _____

Interventions and medications used during labor and delivery: _____

Interventions required after birth (phototherapy, oxygen, etc.): _____

If your child was adopted, where was your child born? _____

At what age was she/he adopted? _____

Developmental Milestones

How old was your child when she/he:

Smiled at caretaker _____	Walked _____
Sat unassisted _____	First words _____
Crawled _____	First phrases _____
Pretend played _____	

Family

Which of the following has your child experienced (please indicate the date, e.g. birth of a sibling, 2010)?

Divorce _____	Death of a family member (who?) _____
Birth of a sibling _____	Remarriage of a parent _____
Move _____	School change _____
Other _____	Illness of a family member(who?) _____

How does your child get along with primary caregivers? _____
 Siblings? _____
 Other family members? _____

Is your child responsible for any chores around the house? _____
 What disciplinary methods do you use? _____
 How about other caregivers? _____

What time does your child go to bed? _____

Wake up? _____

Any trouble falling asleep? _____

trouble staying asleep? _____

Does your child get regular exercise? _____

How important is spirituality in your family (please mark on the line)?

Not at all important _____ Very important

Is there a firearm in the home? Yes No

If there is a firearm in the home, is it secured in a locked safe at all times? Yes No

Please circle the words that best describe your home environment:

Peaceful organized chaotic loud calm safe predictable

Busy stressful messy unstructured harmonious fun conflicted

School

Where does your child go to school? _____

What grade does your child attend? _____

Does your child have an IEP, BIP, or 504 plan? _____

Any problems with school (slipping grades, suspensions, missed more than 10 days of school in a single year)?

Professionals currently involved

Please list any professionals (counselors, tutors, occupational therapists, etc.) involved in your child's care:

Service	Professional's name	Location	How often do you meet?	Are you satisfied with this service?

Has your child ever been diagnosed with any of the following:

Diagnosis			Who diagnosed	Date diagnosed
AD/HD	Yes	No		
Autism/Asperger's	Yes	No		
Anxiety	Yes	No		
Depression	Yes	No		
Learning Disability	Yes	No		
Other (please specify):	Yes	No		

Has your child ever participated in neuropsychological, psychological, educational, or educational testing?

Yes No

If so, please bring a copy of the testing report to your first meeting.

Please list any therapy services that your child may have had in the past:

Service	Professional's name	Location	Dates of service (e.g. June 2010 – September 2011)	Why did services end?

Please list any medications that your child is currently taking:

Medication	Dose	Date started	Prescribing physician	Treating what condition?

Is there any family history of:

	What family member?
Abuse – current or past	
Alcoholism	
Anxiety	
Autism Spectrum Disorder	
AD/HD	
Bipolar Disorder	
Borderline Personality Disorder	
Chronic pain	
Depression	
Diabetes	
Drug Addiction	
Eating Disorder	
Emergency Room Visits	
Headaches	
Head injury	
Heart Problems	
Obsessive Compulsive Disorder	
Posttraumatic Stress	
Seizures	
Self-harm	
Stroke	
Suicide attempt or completed suicide	
Traumatic brain injury	



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Practice Information Sheet

Welcome!

Thank you for entrusting us with your care. We strive to create a safe, comfortable environment in which to provide clients with empathic, state-of-the-art care for a variety of concerns. This information sheet is designed to familiarize you with our practice and to answer frequently asked questions.

Locations and Logistics

Our office is located at 10522 S. Cicero Ave., Suite 401, in Oak Lawn, IL, 60453, conveniently accessible via I-294. For patient privacy and confidentiality, we do not have a receptionist area. When you arrive for your appointment, please take a seat in the waiting area, where we will meet you at your scheduled time. We attempt to offer regularly scheduled appointment times for all clients insofar as this is possible. At our first meeting, you will be provided with a login and password for the client portal. You may either make your next appointment with your therapist at the end of each session, or schedule several appointments in advance using the portal. We make every attempt to regulate our client load so that we can accommodate clients' busy schedules; however, client flow can be unpredictable and we make it a practice never to turn former clients away. Therefore, our schedules can get very busy some weeks and the best way to ensure access to preferred appointment times is to use the online scheduler to make appointments well in advance (we recommend 4 weeks).

Contacting Us

Please feel free to contact Dr. Quinn, the practice owner, at 773-474-9840 with any concerns or questions you may have. You may also email Dr. Quinn at mirjam.quinn@gmail.com; however, please be advised that email is not a secure mode of communication and thus you may want to restrict its use to scheduling questions only. Dr. Quinn will typically return your call or respond to your email within 24 hours on business days.

Confidentiality

In general, the privacy of all communications between a patient and a psychologist is protected by law, and we can only release information about our work to others with your written permission. However, there are the following exceptions:

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues require it.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about our treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we are required to file a report with the appropriate state agency.

If we believe that you are threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you. If you threaten to harm yourself, we may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

Termination

Therapy is unique in that its ultimate goal is for you to be ready to leave therapy. It also provides an opportunity to practice a very important life skill: talking through the emotions associated with ending a relationship, and saying goodbye in a positive and relationship-affirming way. Because of this, we believe that having an identified termination session is a very important part of therapy. Termination sessions are an important time to develop closure by reviewing what you've learned about yourself, which goals you haven't reached in therapy and what to do about them, how to maintain your gains, and how you feel about the relationship ending. This is why we encourage you to address the following questions with your therapist during the first few sessions: "under what conditions will we end, and what will that ending look like?"

Fees and Billing

The initial diagnostic session is billed at \$225. Thereafter, sessions are billed at \$150 for 45-minute sessions, and at \$200 for 60-minute sessions. In-network rates apply for BCBS PPO. We are happy to accept payments in cash, check (made out to Mirjam Quinn and Associates), or credit card (in the office or by phone).

We are an in-network provider with Blue Cross Blue Shield PPO and Blue Choice Plans. Our billing department offers a preliminary verification of benefits before your scheduled appointment, so please have your insurance card available when you call to schedule an appointment. Please note that verification of benefits is not a guarantee of payment by the insurance company. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require that we provide them with your clinical diagnosis. Sometimes they request that we provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records we submit, if you request it. ***You understand that, by using your insurance, you authorize us to release such information to your insurance company. We will try to keep that information limited to the minimum necessary.***

In addition to therapy, we offer comprehensive neuropsychological testing for adults and children. This testing can help with differential diagnosis (e.g., for AD/HD, dyslexia (reading disorder), autism spectrum disorder) and treatment planning (you will receive a written report including a detailed list of helpful interventions that can be used at home, at school, and at work). A full battery may include rating scales, an intelligence test, neuropsychological testing, a continuous performance test, achievement testing as appropriate, personality testing, a semistructured interview, and school observations (if applicable). Charges vary depending on the comprehensiveness of the battery but typically range from \$1800 - \$2500.

Other services include attendance at school meetings (e.g., IEP meetings) as a support person (charged at \$200 per hour), and court appearances (charged at \$2000 for a half day or \$4000 for a full day). School and court meetings are not covered by insurance and must be fully paid in advance.

A flat fee of \$30 applies for any paperwork completed by clinicians (e.g. letters written for ADA accommodations, FMLA paperwork, etc.). A fee of \$5, with an additional fee of \$1 per page, will apply for any records requested by a client (this is exclusive of 2 copies per neuropsychological testing report that are provided a the feedback session). Phone contacts lasting 5 minutes or less are complimentary. Phone contacts made for purposes of coordination of treatment, with clients, clients' families, or other care providers, will be charged at a rate of \$20 for phone contacts lasting 6 – 14 minutes, and \$45 for phone calls lasting 15 – 29 minutes. Phone calls lasting 30 minutes or longer will be charged at the full session rate of \$150. Please be advised that insurance will not reimburse for phone contacts.

We complete billing on a weekly basis and Jade, our office manager, sends out invoices on a monthly basis (typically the first week of the month). Please be mindful that it often takes a few weeks for insurances to process claims, and so there may be a delay between your initial session and your first bill. Please note the following billing policies:

1. We will file with insurance for all clients who are insured with BCBS PPO and Blue Choice. We are unable to bill directly with other insurance carriers, but you can choose to self-pay and we are happy to provide you with the necessary paperwork to submit to your insurance company for out-of-network reimbursement.
2. Please be aware that we are unable to schedule appointments for clients carrying a balance of more than \$300.
3. We require a deposit of \$500 toward any neuropsychological testing initiated. The deposit is required after the initial intake session, but before the actual testing session. If insurance coverage plus the deposit exceeds the cost of the testing, the difference will be refunded to you within seven days.

City of Chicago Insurance and Telligen

Please note: if you are a City of Chicago employee, your health insurance covers 7 sessions of therapy per calendar year. In order to gain approval for additional sessions to be covered, your therapist will need to contact Telligen, a medical review company contracted with the City of Chicago, and provide them with clinical information about your diagnosis, functioning, and treatment. This clinical information goes beyond the information that you generally agree to have your provider give to the health insurance company when you initially sign up for health insurance, and includes diagnosis, treatment goals, dates of treatment, type of treatment used, and possibly other written records (such as progress notes) that your therapist keeps about your care. If clinical information is not provided to Telligen, Blue Cross/Blue Shield will automatically deny any coverage past the 7th session. If you decide that you agree to have your clinician provide clinical information to Telligen, you will need to complete a release of information for Telligen (on the following page). Of course, you have the right to review any documentation before we send it to Telligen before we send it. If you decide that you would rather not have your clinician share any clinical information, you can pay for sessions after the 7th session as a self-pay client and then request reimbursement from BCBS afterward. We will be happy assist you in completing the paperwork to do this.

Cancellation Policy

If for any reason you need to cancel or reschedule an appointment, please provide your doctor with at least 24 hours notice (48 hours on weekends) by either calling her cell phone or emailing her . Cancellations or changes to appointments with less than 24 hours' notice will be charged to the client at the full session fee (\$150). Missed neuropsychological testing will be charged per hour that was originally blocked out for the testing (typically three to four hours), so if a testing session must be cancelled, it is very important that you do so in a timely manner.

Please provide your signature below to indicate that you have reviewed and understand the practice policies and procedures, and have had the opportunity to review them with your doctor. Thank you! We look forward to working with you!

Supervision and Consultation

We believe that continuing to grow and develop as therapists requires ongoing consultation and supervision. We may seek professional consultation from other clinicians at Mirjam Quinn and Associates, Ltd.. All discussions among staff and supervisors are held in confidence and are for the purpose of providing the best possible client care. When consulting, clinicians take significant measures to hide the identity of their clients.

Client name

Client signature

Mirjam Quinn and Associates, Ltd

10522 S. Cicero Ave, Ste 401

Oak Lawn, IL 60453

Authorization to Secure Payment

I, _____ authorize Mirjam Quinn and Associates, Ltd. to process payment on my Visa, MasterCard, or Discover Card for services and/or for any balance due that has not been paid 30 days after it is received.

I understand that if the appointment is missed and I do not follow the cancellation policy as specified, Mirjam Quinn and Associates, Ltd. is authorized to charge my credit card the same as the missed appointment.

I have read and understand this form. I attest that the information below is true and accurate.

Please initial if you WOULD NOT like your copay to be automatically charged to my card at every visit: _____

Amount of copay: _____

Please complete the information below:

Patient Name _____

Billing Address _____

City, State, Zip _____

Phone# _____

E-mail _____

Account Type: Visa MasterCard AMEX Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX)



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

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND 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

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. 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 I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my practice. 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 my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical 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 (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- § **Child Abuse:** If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the Illinois Department of Children and Family Services.
- § **Adult and Domestic Abuse:** If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the Illinois Department of Family Services. If I have reason to suspect that sexual or physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Illinois Department of Family Services.
- § **Health Oversight:** If the Illinois Examining Board of Psychology subpoenas me as part of its investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure of state licensed psychologists, I must comply with its orders. This could include disclosing your relevant mental health information.
- § **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided to you and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena, 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 will be informed in advance if this is the case.
- § **Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.
- § **Worker's Compensation:** If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all mental health information in my possession relevant to that particular injury in the opinion of the Illinois Worker's Compensation Commission, to your employer, your representative, and the Department of Labor and Industries upon request.

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 about you. However, I am 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. Upon your request, I 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 and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial 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. I may deny your request. On your request, I 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I 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:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you by mail with a revised version of this document.

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, please contact me at my business address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, D.C. 20201 (877-696-6775 toll free).

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on 4-15-03. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

I have read and understand the HIPAA privacy policy.

Signature

Relationship to patient