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:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Pronouns:				

Street Address:	City:	State:	ZIP Code:
Home phone no.: Can leave message? ( )	Cell no.: Can leave message? ( )	Social Security no.:	Birth Date: / /	Sex: ❑M ❑ F
Employer:	Occupation:	Work phone no.: ( )	
Street Address:	City:	State:	ZIP Code:
Notify Primary Care Physician? ❑ YES ❑ NO	Name of Primary Care Physician	Contact no.: ( )	

IN CASE OF EMERGENCY

Emergency Contact Name:	Home phone no.: ( )	Cell phone no.: ( )

INSURANCE INFORMATION

Insured's Last Name **(if different):**	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street Address **(if different)**	City:	State:	ZIP Code:		
Home phone no.: **(if different)** ( )	Cell no.: ( )	Social Security no.:	Birth Date: / /	Sex: ❑M ❑ F	
Insurance Company:	Insurance Billing Address:	Insurance phone no.: ( )			
ID number:	Group no.:	Relationship to Insured:	❑ Self	❑ Spouse	❑ 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. Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this practice.

Client signature *Date*

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History Form

What are your current concerns and/or what prompted you to seek services at this time?

1. _____
2. _____
3. _____

When did you first notice these issues, or when did they first become a problem?

_____

Is this the first time you have noticed these concerns, or have they been an issue before?

_____

Who currently lives in your house?

Name	Age	Relationship to you	Occupation or grade in school

Please circle the words that best describe your home environment:

Peaceful	organized	chaotic	loud	calm	safe	predictable
Busy	stressful	messy	unstructured	harmonious	fun	conflicted

What is your highest level of education? _____

Are you currently employed? Yes No

Current place of employment: _____

Job Title: _____

Who is your primary care physician? _____

Date of last visit to primary care physician: _____

Do you have any chronic health concerns? If so, please list below: _____

_____

Are there any firearms in your home? Yes no
If yes, are they secured in a safe? Yes no

Do you or anyone in your family have any history of the following (please check if applicable):

	Self	Family member (please specify)
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		

Have you had treatment with a therapist, psychologist, or psychiatrist before? Yes No

If yes, please indicate the type of treatment and dates:

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

Please list all past hospitalizations:

Approximate date	What hospital	Length of stay	Reason (e.g., childbirth, heart surgery)

Which of these major experiences have occurred in your life in the past year (please check all that apply)?

Death of a spouse or life partner	
Death of a child	
Serious illness of spouse or life partner	
Serious illness of child	
Divorce	
Separation from your partner	
Chronic illness (self)	
Hospitalization	
Losing a job	
Reconciliation with life partner	
Getting married	
Birth of a child	
Pregnancy	
Pregnancy loss	
Starting a new job	
Retirement	
Starting or finishing school	
Moving	
Job change	
Child leaving the home	

Please list any medications that you are currently taking:

Medication	Dose	Date started	Prescribing physician	Treating what condition?

How much free time do you have each week? _____ hours

What do you like to do in your free time?

_____

_____

When you have a difficult day or a hard week, what do you typically do to help yourself feel better?

_____

_____

When things are difficult, who do you turn to for support (e.g., family, friends, partner, religious community)?

_____

Do you exercise regularly? If so, what kind of exercise do you do and how many times per week?

_____

How important is spirituality in your life? _____

Is there anything else about you that you think is important for your therapist to know?

_____

_____

_____

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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

Release of Information Form (optional)

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This form, when completed and signed by me, authorizes my therapist, _____, to exchange protected information from my clinical record with _____.
(name and telephone number of the individual with whom information will be exchanged)

I authorize my therapist and _____, to exchange verbal and written information about _____, in order to coordinate treatment,

client name and date of birth

This authorization shall remain in effect until _____ (if no date is provided, the information may be released only on the day the authorization form is received by the psychologist.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, my revocation will not be effective to extent that my psychologist has already taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purposes of creating health information for a third party.
I understand that I have the right to inspect the disclosed mental health information at any time.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

_____ _____
Signature of patient date Signature of parent or guardian (if minor) date

- If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

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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Mirjam Quinn and Associates, Ltd.

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