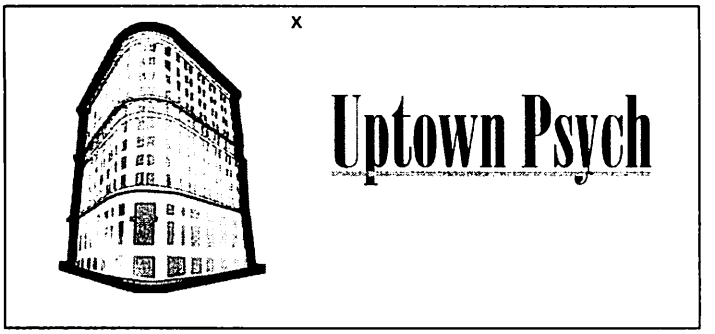


Uptown Psych

4753 N. Broadway St.
Suite 900/910/925
Chicago, IL. 60640
Phone: 773-989-2780
Fax: 773-989-2781
info@uptownpsych.com
www.uptownpsych.com

Intake Form

Patient Name: _____ Date of Birth: _____

Legal Name (if different from above)_____

SSN: _____Birth Gender _____Gender Identity_____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

Physical Address

_____

City: _____State: _____Zip Code: _____

Is Mailing Address the same? Yes____ No____

Mailing Address

_____

City:_____ State;_____ Zip Code_____

Telephone: _____Email: _____

Insurance Information (Patients under 26 that have insurance under parents, please sign ROI form for billing communication)

Insurance Provider: _____ Identification #: _____

Group #: _____Policy Holder Name _____

Policy Holder DOB _____ Policy Holder SSN_____

Secondary Insurance:_____

Insurance Provider:_____ Identification#: _____

Group #: _____

From whom or where do you receive your primary medical care?

From whom or where do you receive your primary medical care?

Clinic/Doctors Name: _____

Phone: _____ Address: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? **Yes** ☐ **No** ☐

If Yes, by whom: _____

Emergency Contact

Name: _____ Relationship: _____

Telephone Number: _____

Pharmacy Information

*We are partnering with **Capsule Pharmacy** - offering free same-day prescription delivery, saving you money with automatic coupons, and providing extra care while looking after your medication needs.* ***Check to use Capsule as your pharmacy*** _____

Other Pharmacy: _____

Address: _____ Telephone Number: _____

How did you hear about us: _____

Office Financial Policy

Self-Pay Services Only:	**Discounted Rate Fees**	**Out of Network Fees**
Initial psychiatric evaluation -- up to 60 minutes	$350	$350
Follow up psychiatry appointment -- 15-30 minutes	$165	$265
Initial therapy service --1 hour	$135	$300
Therapy service -- 1 hour	$135	$200
Group therapy – 1 hour	$80	$100
Family/Couples therapy –1 hour	$135	$165
Miscellaneous Fees:		
Initial visit no show fee	$150	
Follow-up no show fee	$100	
Lost controlled substances prescriptions	$25	
Refill (Future appointment must be scheduled)	$15	
Letters or medical records	$20-$150	

Self-Pay Discounted Policy:

- I understand that because I am being offered a discounted price for services, I will not be provided claim information to submit to my insurance for reimbursement.

Out of Network Reimbursement Policy:

- I understand that it is my responsibility to submit any claims to my insurance company for reimbursement.
- I understand that it can take up to a week to be provided an itemized receipt for my visit.
- I understand that I am being charged $265 upfront for psychiatry follow ups. Depending on the services provided that can range from $100-$300. If any differences in charges are found, the office will bill/refund me.

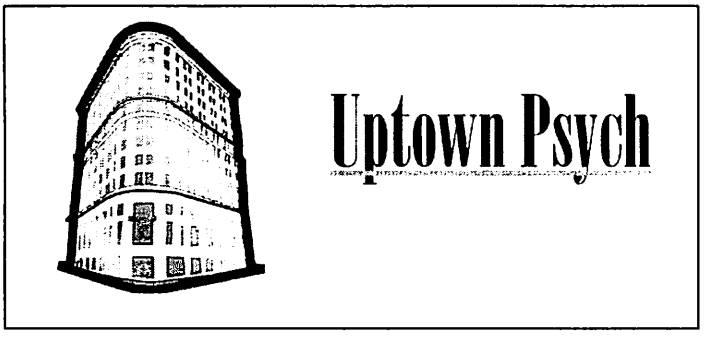
Clinical Intake Policy:

- I understand that if psychiatrists ends up treating me during clinical intake, I am responsible for copay/ded/coins and appointment with therapist will be rescheduled

Signed_____ **Date**_____

Patient/Guarantor

☐ **By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above.**



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Office Financial Policy

Cancellation/Missed Appointment Policy:

- Failure to show up to an appointment without 24 hours' notice will be subject to a $150.00 (initial) or $100.00 (follow up) charge.
- Cancellations made at the time or after a scheduled appointment will be considered as a missed appointment and card on file will be charged.

Individual Financial Responsibility:

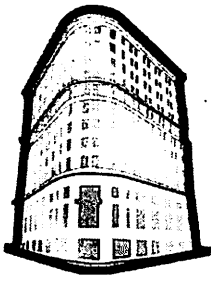
- Uptown Psych will verify benefits prior to an appointment but a quote of benefits is not a guarantee of payment.
- I understand that the amount that is calculated at the time of my appointment is an estimate and depending on what is billed by my provider, there might additional be credit or balance after the service.
- I understand that it is my responsibility to provide the office with any changes of insurance coverage prior to my visit or I will be charged the self pay rate until benefits are verified.
- I understand that in the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- I understand that copays/deductible/coinsurance are due at time of service and any outstanding balances need to be paid prior to being seen.
- I understand that if payment cannot be made, my current/future appointments will be cancelled until full payment is received.
- I understand that I am financially responsible for any copay, deductible, coinsurance or non-covered service and may be contacted by email or phone call/text message.
- I understand that services rendered by therapists will be billed under the supervising physician on site.
- I understand that Providers may access records for administrative reasons.
- I consent to electronic signature with credit card swiped.
- I agree that refunds will be sent by check and the process can take up to 45 days

I authorize Uptown Psych to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays, deductibles and/or coinsurance after all attempts Uptown Psych has made in collecting the balance.

Signed_____ **Date**_____

Patient/Guarantor

☐ **By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above.**



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Phone Consultation & Documentation Requests Policy

As a reminder, phone calls to your provider should be for emergency purposes only. All other matters are best discussed in session. In order to provide you with the best care, with your permission, our clinicians may communicate with other providers or collect outside information. At times, this information may be beneficial and inform your treatment.

Scheduling an appointment with one of our psychotherapists to complete any ancillary paperwork or discuss collateral information is highly recommended. For our Psychiatrists, appointments for these purposes are absolutely required. Please note, phone contact that our psychotherapists have with outside providers and paperwork completion time are not payable by your insurance company. These services may be billed directly to you from the fee schedule below.

Requests for documentation are granted on a case by case basis at the sole discretion of your provider. Typically, several sessions and consistent engagement in treatment is required for a provider to feel comfortable providing documentation of any kind.

Beneficial information sources by phone include, but are not limited to:

Outside providers such as past individual therapists or Psychiatrists, group therapy counselors, social workers, and psychological testing specialists. For minors, teachers, school psychologists or social workers, and Individualized Education Plan or 504 involved specialists can also be helpful.

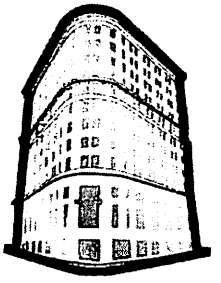
Documentation requests can include, but are not limited to:

Clinical summaries of diagnostic impressions or treatment plans, FMLA (Family Medical Leave Act) paperwork completion, background check documents for employment, bariatric surgery candidate requirements, letters to verify work absences for mental health reasons, documentation to show attendance of mental health appointments (sometimes required for court ordered treatment and minors involved with Department of Child and Family Services), disability paperwork, and summaries of clinical recommendations or impressions as requested by outside medical professionals.

Rates for phone consultation: $75.00 **Rates for documentation completion:** $60.00

Signed_____ **Date**_____

Patient/Guarantor



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Credit Card On File Form

We require keeping your credit/ debit/HSA card on file as a convenient method of payment when authorized.

I authorize Uptown Psych to charge my credit/debit/HSA card for any late fees as outlined in the 'office financial policy' form.

I authorize Uptown Psych to charge my credit/debit/HSA card for services not paid by my insurance company after 90 days from services rendered, including copays, deductibles and/or coinsurance after all attempts Uptown Psych has made in collecting the balance.

I will inform Uptown Psych if my credit card information or expiration date changes.

☐ **Visa** ☐ **MasterCard** ☐ **Amex** ☐ **Discover**

Card Number _____

Expiration Date _____

CVV Code _____

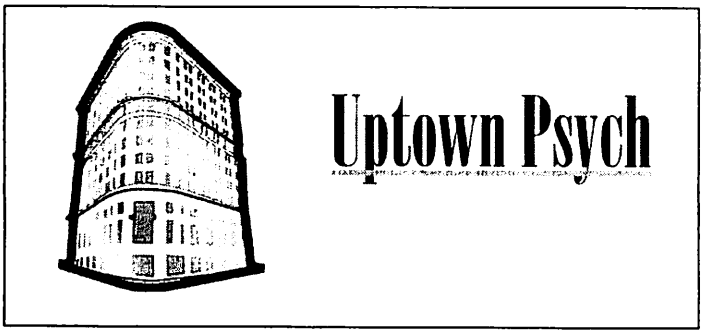
Name on Card _____

Address _____

Zip Code _____

I understand that this form is valid without expiration unless I cancel in writing.

Signed_____ **Date**_____
Patient/Guarantor



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Email Policy

To better serve our patients, this office has established an email address for some form of communication. For routine matters that do not require response, please feel free to contact us at info@uptownpsych.com. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 12 hours. The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

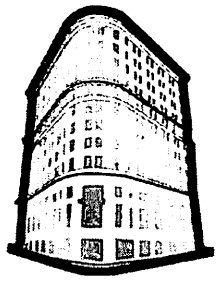
Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

_____ I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.
_____ I understand and agree that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

_____ _____
Patient signature Witness (optional)

_____
Date



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Email Policy

When requested this office will communicate some forms of information via email. This medium will be used with an eye towards medical and legal prudence.

- Email communications will only be used with established patients.
- Patients who elect to use email must be advised of this office's email policy and sign an informed consent (see attached).
- A copy of the consent will be given to the patient, if requested and another copy will be filed in the patient medical record.
- Email communications are restricted to conditions and situations which do not require immediate attention (see consent).
- Protected health information [PHI] will be transmitted in a secure format to render the information unusable, unreadable or indecipherable to unauthorized individuals. http://csrc.nist.gov/publications/nistpubs/800-66-Rev1/SP-800-66-Revision1.pdf
- Email communications are a permanent part of the patient medical record. They should be retained in the paper record and/or electronically consistent with the Illinois medical records retention rules http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021000850K6.17
- When a patient request has been completed, the staff member responsible for completing that task will be responsible for sending a confirmation message to the patient.
- As with any form of medical record documentation, unprofessional remarks or comments in email communications are prohibited.
- Confidentiality of patient information will be maintained at all times to protect the integrity of patient-identifiable information.
- When sending patient information via email, the sender is expected to double check all "To" fields before transmitting.
- Maintaining a master list of patients email addresses is discouraged.
- Outgoing messages will contain discreet subject headers and a banner of the top of each message stating "This is confidential medical communication."
- Each desktop workstation will have a password protected screen saver.

_____ _____

Patient signature Witness (optional)

_____

Date

HIPAA Consent Form

This form is an agreement between you and Uptown Psych. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____

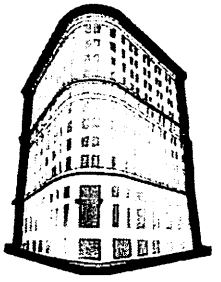
When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carryout certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use your information, how we share your information, and may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.uptownpsych.com, or by calling us at (773) 989-2780. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing and have it submitted to us. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of Patient: _____ Date: _____
Printed Name of Patient: _____

If Patient is under 18 years of age:

Signature of Parent/Guardian: _____
Printed Name of Parent/Guardian: Relationship to Patient: _____



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Patient Responsibilities

1. All required patient forms must be completed and returned to front office staff before the time of your appointment; otherwise, the appointment may need to be rescheduled.
2. Patients are responsible for knowing what medications they are currently taking when scheduling an appointment. Some practitioners may not be able to provide certain medications and patients should be aware of this in advance.
3. Individual practitioners also may have different limitations and restrictions as to what they are able to prescribe with regards to controlled substances. These policies may be further outlined in the accompanying paperwork. If provided in advance, it is the patient's responsibility to be familiar with these policies as they will not change during the course of the appointment.
4. If additional paperwork is being requested from the provider such as FMLA, short term disability, emotional support animals, court documents etc., it is the patient's responsibility to discuss this in advance, provide the appropriate forms, and understand that certain requirements may need to be met for the provider to fill out such forms, and understand that certain requirements may need to be met for the provider to fill out such forms, if bale to do so at all. Before being considered for such requests, patients need to be established (e.g. have been seen for multiple appointments with engagement in care). In addition, paperwork completion is subject to additional fees varying from $25 to $200.
5. Missed appointments and cancellations less than 24 hours in advance, including initial evaluations, will be subject to a standard cancellation fee. The cancellation fee may be waived one time for an excusable or emergency situation, at the discretion of the provider. All subsequent missed appointments or cancellations (less than 24 hours in advance) will be subject to the standard fee without exception. Missed appointments beyond the third may result in transfer of care or care termination of the case as patients are expected to maintain appropriate follow up care as recommended by their provider.
6. Arrival to an appointment either in-person or virtual should be made in a timely manner. Beyond a certain period, your appointment may need t be rescheduled as having a significantly shorten appointment may not be therapeutic to treatment, and providers make their best efforts to provide each patient with their allowed time so as not to take away from the time of the next scheduled patient. Your appointment may need to be

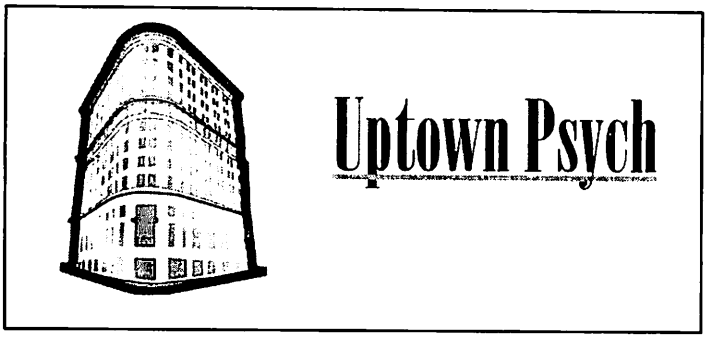
rescheduled if you arrive more than 10 minutes late to an intake appointment or more than 5 minutes late to a follow up appointment.

7. Refills for medications are completed during appointment times. Parents are responsible for scheduling follow up appointments in a timely manner such as they do not run out of medications. For all refill requests outside of appointments, patients are required to have an upcoming appointment scheduled. A partial refill until the upcoming appointment may be considered at the discretion of the provider, subject to a $20 charge.
8. Providers may take 48 hours (2 business days) to return messages and phone calls. If it is an urgent matter or an emergency, please call 911 or go to the emergency room.
9. If a patient has not been seen for 6 months or more, they will be considered inactive and their case at Uptown Psych will be closed.
10. If patients email their providers, they should send a separate email regarding each matter and not send multiple emails regarding same issue.

Patient signature_____

Guardian Signature_____

Date _____



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YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues

- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- If you have concerns, contact the Privacy Officer with Uptown Psych at 773-989-2780
- We never market or sell personal information