Spectrum
Behavioral Health

PATIENT INTAKE FORM

(Please Print)			
Today's Date:	Appt. With:		Whom may we thank for referring you?
Social Security Number:			
Last Name: First: Middle:		Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐	Marital status (circle one): Single / Mar / Div / Sep / Wid ☐ ☐ ☐ ☐ ☐
Street Address:	City:	State:	ZIP Code:
Home phone no.: ( )	Cell no.: ( )	Email:	Birth Date: / Sex: M ☐ F ☐
Employer:	Occupation:	Work phone no.: ( )	
Street Address:	City:	State:	ZIP Code:
Referring Doctor			
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

Primary Insurance	Secondary Insurance:
Insurance Company Name: _____	Insurance Company Name:
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Policy Holder Name: _____	Policy Holder Name: _____
Policy Holder Birth Date: _____	Insured Person's Name: _____
Policy Holder Social Security #:_____	Relationship to Policy Holder: _____
Relationship to Policy Holder: _____	

My signature below authorizes the release of any medical or other information necessary to process my insurance claims, if I choose to submit them.

Signature:	Date:

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PATIENT ACKNOWLEDGEMENT OF AGREEMENT AND UNDERSTANDING

- I acknowledge that I have received, read, understand, and agree to abide by the Spectrum Behavioral Health (SBH) policies. I have reviewed the policies with my therapist, have had all of my questions fully answered, and am being given a copy of this policy for my records.
- I acknowledge that I have received and read the HIPAA Notice of Privacy Practices. I understand that SBH has the right to change its Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy of the Notice of Privacy Practices.

My signature below indicates that I understand and agree with all of these statements.

Patient's Signature: _____ Print Name: _____

Parent/Guardian's Signature: _____ Print Name: _____

Date: _____

☐ A copy of this agreement has been given to the patient.

☐ A copy of this agreement has been kept by the treatment provider for patient records

CONTACT PREFERENCES

I consent to allow my provider from Spectrum Behavioral Health to use electronic methods of communication to transit to me the following protected health information:

- Information related to scheduling meetings or appointments.
- Information related to billing and payment.
- In response to patient communication of any kind

I have been informed of the privacy and confidentiality risks to my protected health information associated with the use of non-secure email and text communications, including, but not limited to, the reasonable possibility that a third party may be able to intercept such communications. I understand that I am not required to sign this authorization in order to receive treatment. I also understand that I may terminate this authorization at any time.

Please check ALL that are acceptable:

☐ **Email**
☐ **Text Message**
☐ **Voicemail on Cell Phone**
☐ **Voicemail on Home Phone**

Patient's Signature: _____ Print Name: _____

Parent/Guardian's Signature: _____ Print Name: _____

Date: _____

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PAYMENT POLICY

If you are covered by health insurance with mental health benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Therefore, any unpaid balances by your plan will be the responsibility of your guarantor.

It is the policy of Spectrum Behavioral Health that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

We highly recommend that you also contact your insurance carrier and check into your coverage for Spectrum Behavioral Health. Do not assume that you will not owe anything if you have more than one insurance policy.

_____ _____

Guarantor Signature Date

APPOINTMENT CANCELLATION POLICY AGREEMENT

Spectrum Behavioral Health is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (815)418-6070 for the New Lenox office or (630) 270-7717 for the Hinsdale office by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.** If prior notification is not given, you will be charged $50 for the missed appointment.

Please sign below to consent to these terms.

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date

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AUTHORIZATION TO SECURE PAYMENT

I, _____ authorize Spectrum Behavioral Health to process payment on my Visa, MasterCard, or Discover Card for services.

I understand that if an appointment is missed and I do not follow the cancellation policy as specified, Spectrum Behavioral Health is authorized to charge my credit card the same amount as the missed appointment.

I agree that if my account balance is more than 60 days past due Spectrum Behavioral Health may charge my credit for any outstanding amount.

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

Signature of Card Holder: _____

My credit card information is as follows:

Cardholder's Name _____

Patient's Name _____

Credit Card Account Number:_____

Expiration Date: _____

CVV: _____

Billing Zip Code: _____

Is this a debit card:

Yes ☐ **No** ☐

Signature: _____

Date: _____