Kusinski & Associates

PATIENT INFORMATION

Name:_____DOB:_____Age:_____

Address:_____

City/State/Zip: _____

SS Number: _____Employer:_____

Address/Phone number: _____

Spouse name:_____DOB:_____Age:_____

Spouse's SS number: _____Spouse's Employer: _____

Address/Phone number: _____

Is patient a minor? Yes: _____ No: _____

Mother's Name: _____DOB: _____Age: ____

Address (if different):_____

Phone number: _____SS number: _____

Place of Employment: _____ Phone: _____

Father's Name: _____DOB: _____Age: ____

Address (if different): _____

Phone number: _____SS Number: _____

Place of Employment: _____ Phone: _____

INSURANCE INFORMATION

Name of Insurance Company: _____ Phone: _____

Policy ID #: _____ Group #: _____

Relationship to Patient: _____DOB: _____SS:_____

Secondary Insurance: _____ Phone: _____

Policy ID#: _____ Group#: _____

Relationship to Patient: _____DOB:_____SS:_____

CREDIT CARD ON FILE POLICY

At Kusinski & Associates, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Any balances that are over 60 days without payment will be charged to the credit card on file. Without this authorization, a billing fee of 3% will be added to your account for any balances that we must attempt to collect through monthly statements.

Your credit card information is kept confidential and secure and payments to your card are issued only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Kusinski & Associates to charge the portion of my bill that is my responsibility to the following credit or debit card:

____ Amex ____Discover ____Mastercard ____Visa

Credit Card Number: _____

Expiration Date: ___/___/_____ CVV: _____

Cardholder's Name: _____

Signature: _____

Billing Address: _____

City: _____ State_____ Zip_____

I (We), the undersigned, authorize and request Kusinski & Associates to charge my credit/debit card, indicated above, for balances due for services rendered that my insurance company has identified as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Kusinski & Associates.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Kusinski & Associates in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

FINANCIAL/INSURANCE POLICY

As a courtesy, Kusinski & Associates will bill your insurance company, responsible party or third-party payer. Insurance companies require that we collect all co-pays at each session. If your deductible has not been met, the full fee is due at each session until it has been met. If your insurance company denies payment or denies coverage for services rendered, payment in full is required for the balance due.

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise a missed appointment/late cancel fee will be charged. **This fee is $75.00**

Checks which are declared non-sufficient funds or stop payment, will be charged a $25.00 service fee. Accounts turned over to a collection agency for non-payment will have a 25% fee accessed on the account balance.

I authorize my insurance benefits to be paid directly to Kusinski & Associates. I understand that I am financially responsible for any balance. I also authorize Kusinski & Associates or insurance company to release any information required to process my claims. I have received a copy of the Kusinski & Associates fee schedule. I have read and accept the Kusinski & Associates financial policy noted above.

Signature_____Date_____

(Patient signature 12 years and older)

Signature_____Date_____

(Parent/Legal Guardian-Guarantor)

INFORMED CONSENT

Thank you for choosing Kusinski & Associates. Today's appointment will take approximately 50-60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

We at Kusinski & Associates are licensed and or credentialed in our respective fields. Our therapists practice standard cognitive-behavior therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for:

a) Information (diagnosis & dates of service) to your insurance company for claims

b) Information you and/or your child or children report about physical or sexual abuse, then by Illinois State Law, are obligated to report this to Department of Children and Family Services

c) Where you sign a release of information to have specific information shared

d) If you provide information that informs us that you are in danger of harming yourself or others

e) Information necessary for case supervision or consultation

f) Or when required by law:

As of 2008, the new FOID Law requires reporting on any patient whose mental condition is of such a nature that is manifested by violent, suicidal, threatening, or assaultive behavior or reported behavior, for which there is reasonable belief by a clinician that the condition poses a clear and present or imminent danger to the patient, and other person, or the community meaning the patient's condition poses a clear and present danger in accordance with subsection (f) of Section 8 of the Firearm Owners Identification Act.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Kusinski & Associates clinicians will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s)_____Date_____

(Patient signature if 12 years or older)

Signature(s)_____Dare_____

(Parent / Legal Guardian)

HIPPA NOTICE OF PRIVACY PRACTICES

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

Kusinski & Associates has been and will always be totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT:

We may need to use or disclose health information about you to provide, manage, or coordinate your care or related services which could include consultants and potential referral sources.

PAYMENT:

Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS:

We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your health information which does not require your consent

These are some instances where we may be required to use and disclose information without your consent. For example, but not limited to:

a) Information you and/or your child or children report about physical or sexual abuse; they by Illinois State Law, we are obligated to report this to the Department of Children and Family Services

b) If you provide information that informs us that you are in danger of harming yourself or others

c) Information to remind you of/or to reschedule appointment or treatment alternatives

d) Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law, such as a subpoena or court order.

CLIENTS RIGHTS

RIGHT TO REQUEST HOW WE CONTACT YOU: It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you a different way.

RIGHT TO RELEASE YOUR MEDICAL RECORDS: You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

RIGHT TO CONFIDENTIALITY: Every client has the right to confidentiality. Confidentiality at Kusinski & Associates is maintained in a manner consistent with the Federal Confidentiality of Alcohol and Drug Abuse Patient Records, the Federal Health Insurance Portability and Accountability Act (HIPPA), and the Mental Health and Developmental Disabilities Confidentiality Act (Illinois Civil Liabilities 740 ILCS 110). The client must give his or her consent in writing for Kusinski & Associates to obtain or release any written or oral information concerning current or past medical, psychiatric or addiction treatment.

EXCEPTIONS TO CONFIDENTIALITY REGULATIONS:

1) In life threatening situation or when a client's condition precludes the possibility of a written consent, pertinent medical information may be released to medical personnel responsible for the individual's care without the consent of the client, the guardian, or the clinician. The client and/or guardian is informed of what information was released as soon as possible after the event.

2) In situations involving state mandated reporting such as cases of suspected physical or sexual abuse or neglect of a child (this applies only to the initial reporting of the incident or suspected incident).

3) With an authorizing court order only if: a) It is necessary to protect against a threat to life of serious bodily harm, b) It is necessary to investigate or prosecute an extremely serious crime or, c) It is in connection with a proceeding at which the client has already presented evidence concerning confidential communication.

RIGHT TO CONFIDENTIALITY OF HIV / AIDS STATUE: All information regarding HIV status, including any HIV testing, will not be documented in the client record. This information is not released to any other agencies or shared with any other Kusinski & Associates staff members without explicit authorization from the client to release such information.

1) This section does not apply to HIV and/or AIDS risk education and/or counseling, or other HIV and/or AIDS education which is provided to all individuals in DUI Risk Education classes.

2) An individual who wishes to be tested for HIV antibodies shall be informed that he or she may undergo testing on an anonymous basis at the local health department. No testing is conducted at the offices of Kusinski & Associates.

RIGHT TO NOT BE DISCRIMINATED: You have the right to not be discriminated against in any way based on race, gender, national origin, religion, ancestry, age, economic condition, HIV status, sexual orientation, or disability. Every client has the right to be treated humanely and with dignity.

RIGHT TO TREATMENT IN THE LEAST RESTRICTIVE ENVIRONMENT: Services at Kusinski & Associates are completely voluntary. You have the right to be treated in the least restrictive clinically appropriate setting. Any client consenting to treatment must agree to follow the conditions established by Kusinski & Associates.

RIGHT TO INSPECT AND COPY YOUR MEDICAL AND BILLING RECORDS: You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies. You may be required to meet with your clinician to review such records prior to their release.

RIGHT TO ADD INFORMATION OR AMEND YOUR MEDICAL RECORDS: If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will plan on your request within 60 days, or some cases, within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You may request an accounting of any disclosures, if any, we have made related to your medical information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for specific time period no longer than six years and after February 2, 2015, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

RIGHT TO REQUEST RESTRICTIONS ON USES & DISCLOSURES OF YOUR HEALTH INFORMATION: You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

RIGHT TO COMPLAIN: If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file

a written complaint with the U.S. Department of Human Services. An individual will not be retaliated against for filing such a complaint.

RIGHT TO EXPRESS OPINIONS AND RECOMMENDATIONS: All clients are encouraged to express opinions and recommendations to any Kusinski & Associates staff member, either orally or in writing. You have the right to be assured that each written comment will receive the prompt attention and, on request, a prompt response from the Kusinski & Associates staff member.