Depression & Anxiety Specialty Clinic of Chicago
3047 N. Lincoln Ave., Suite 400
Chicago, Illinois 60657
(773) 494-5505
www.dascchicago.com

# PATIENT INFORMATION

**DEMOGRAPHICS**

Legal Name: ________________________________________ Chosen Name: ________________________________________

Suffix: __________ Pronouns: ______________________________________________________________________________

Address: ___________________________________________ City: ____________________ State: ________ Zip: _________

Email:_______________________________________________________________________________OK to contact? Yes/No

Living Arrangements, Housing (Include who is living with client): __________________________________________________

Household Income: ________________________________ Family Household Size (Including client): __________________

Client Income: _______________________________ Primary Phone (Home/Mobile) (Circle):_______________________________________

Alternate Phone (Home/Mobile) (Circle): _________________________________ Work Phone: ________________________________

Date of Birth: _______________________ Age: _______ Legal Sex: _____________ Gender Identity: __________________

Relationship Status: __________________ Sexual Orientation: _________________________ Race: _____________________

Education: ______________________________________ Employment: ____________________________________________

Primary Language: ___________________________ ESL? Yes/No

Special Needs: Hearing ___ Mobility ___ Vision ___ Religious ___ Intellectual ___ Other ___

Describe Checks: ________________________________________________________________________

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Do you have a Firearm Owner Identification (FOID) card? yes/no

Do you own and/or possess a firearm? yes/no If so, do you have a license to carry a concealed firearm? yes/no

**REFERRAL INFORMATION (Person/Doctor/Phone #)** ____________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

Emergency Contact: __________________________________________ Phone #: ____________________________________

Relationship to client: ________________________________________________________________________________________

___________________________________________ ___________________________

Clinician Signature Date

___________________________________________

Print Name

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**INSURANCE INFORMATION**

Last Name: _________________________ Legal First Name: _____________ M.I. _____

Name of Insured Person: __________________ Relationship to Client:________________

Name of Insurance Company: ________________________________________________

Managed Care Co. for Mental Health Benefits: __________________ (    ) _____-_______

Insured ID #: ________________________________ Group #: ____________________

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## RIGHTS OF CLIENTS

Participation in any program at this clinic does not remove or in any way diminish your rights and privileges as an individual. Chapter Two of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-100 et seq.) and the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1, et seq.) describe specific rights of consumers of mental health services. Copies of these documents may be obtained by writing to the Illinois Department of Mental Health and Developmental Disabilities, 402 Stratton Office Building, Springfield, IL 62706. There may be a nominal charge.

1. You have the right to impartial access to treatment regardless of race, religion, sex, ethnicity, age, or handicap.
2. You are entitled to adequate and humane care and services in the least restrictive environment, in accordance with an individual treatment plan that you participate in developing, reviewing, and revising.
3. Any unusual, hazardous, or experimental services require your written and informed consent.
4. Except in emergencies, no services will be provided to you without your informed consent.
5. All clients shall be free from abuse and/or neglect.
6. You may be contacted to provide appointment reminders, information about treatment alternatives or other health-related benefits or services, or to disclose protected health information to a group health plan sponsor.
7. You have the right to obtain a copy in electronic format of your Electronic Health Record that contains your Protected Health Information. You may also request to transmit such copy directly to a designee. A fee, if any, will never be greater than the labor costs of processing this request.
8. You have the right to request the opinion of a consultant, at your expense, to review your individual treatment plan.
9. You have the right to inspect and copy your record if you are age twelve or older.
10. You reserve the right to correct your paper or electronic medical record if an error is discovered.
11. You have the right to request restrictions on the uses and disclosures of your protected health information through written documentation of this request. The covered entity is not required to agree to the request.
12. You have the right to restrict certain disclosures of Protected Health Information to a health plan if you pay out of pocket in full for the healthcare items or services, or a family member or other person pay in your behalf. The covered entity is required to agree to the request under these circumstances.
13. You have the right to refuse services. You (or your guardian on your behalf) have the right to refuse services at any time. If you refuse, you will not be given such services except when necessary to prevent you from causing serious harm to yourself or others. You will also be informed of alternate services available and the risks of such alternatives as well as the possible consequences to you of refusal of such services.
14. You have the right to expect that all measures will be taken to ensure the confidentiality mandated by the Mental Health and Developmental Disabilities Confidentiality Act. In limited circumstances, information about your treatment may be released without your permission, such as during emergencies. These circumstances are defined in the Mental Health and Developmental Disabilities Confidentiality Act, which can be obtained as noted above.

15. Sale of protected health information is prohibited unless you authorize the Covered Entity. Section 13405(d)(2) contains several exceptions to the authorization requirement for circumstances where the purpose of the exchange is for: (1) public health activities, as described at § 164.512(b) of the Privacy Rule; (2) research purposes as described at §§ 154164.501 and 164.512(i) of the Rule; (3) treatment of the individual; (4) the sale, transfer, merger or consolidation of all or part of a covered entity and for related due diligence; (5) services rendered by a business associate pursuant to a business associate agreement and at the specific request of the covered entity; (6) providing an individual with access to his or her protected health information pursuant to § 164.524; and (7) other purposes as the Secretary deems necessary and appropriate by regulation.
16. Uses and disclosure of psychotherapy notes, protected health information for marketing purposes, disclosures that constitute a sale of protected health information, and those not otherwise described in this document will be made only with your authorization.
17. You have the right to obtain a list of individuals or entities with whom we have shared your information.
18. You have the right to receive notifications of breaches of your unsecured protected health information in the event of such an occurrence.
19. Clients have the right to expect that all measures will be taken to ensure the confidentiality mandated by the federal alcohol and drug abuse confidentiality regulations (Federal Regulations 42 CFR pt. 2 passed in July, 1987) as well as any applicable state laws.
20. Clients have a right to expect that information about their AIDS/HIV status will be kept confidential, as mandated by state regulations. Clients cannot be required to disclose this information as a condition of treatment.
21. Individually identifiable health information is no longer Protected Health Information under the HIPAA Privacy Act after an individual has been deceased for more than 50 years.
22. You have a right to legal counsel and other due process.
23. You have a right to file a complaint if you believe your privacy rights have been violated.
24. If your rights are restricted, the facility must notify:
    a. your parent or guardian if you are under age eighteen,
    b. you and the person of your choice,
    c. the Guardianship and Mental Health Advocacy Commission if you say you want the commission to be contacted. The Commission's address and telephone number are:

        160 North LaSalle, Suite S-500
        Chicago, IL 60601
        (312) 793-5900

    d. Equip for Equality if you say you want this organization to be contacted. Equip for Equality's address and telephone number are:

        11 E. Adams, Suite 1200
        Chicago, IL 60603
        (312) 341-0022 or (800) 537-2632

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25. *You may not be denied services, or have services suspended, terminated, or reduced in any way for exercising any of your rights as an individual.*

*I have read and understand these rights.*

________________________________________ ________________
Signature of Client or Guardian Date

__________ Client refuses to sign Rights of Clients

________________________________________ ________________
Therapist or Clinic Representative Date

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TREATMENT CENTER GUIDELINES

Welcome to the Depression & Anxiety Specialty Clinic of Chicago. We will do our absolute best to be of help to you. We will gladly answer any questions about this material or your overall treatment in your sessions. Please feel free to offer your opinions or request any information you need.

***First Visit***
On your first visit, you will be asked to do a number of things. First, you will be asked to arrive a little early for your appointment to fill out some needed paperwork. Second, this appointment will be for assessment purposes. To best serve you, I need to know a little about you and what brings you to the center.

***Insurance***
If you have Blue Cross/Blue Shield PPO, Aetna, Optum, Medicare or TriCare, we are contracted providers. You will receive "in network benefits" at this center. Bring your insurance card to your first visit and we'll do the rest. Your co-pay (which varies based on your plan) is due at the time of service. Please bring a check or cash to cover those costs to each appointment.

If you have any other health insurance, you might need to do a few things to be reimbursed. While we are willing to assist you in the process of being reimbursed for services, **payment is due at the time of service**. Please bring check or cash to cover costs with you to each appointment. If you want to be reimbursed by your insurance company, start with the following:

- Please contact your insurance company to be sure the services here will be covered under your plan and to find out what your co-payment will be. Mental health coverage is often different from coverage for other types of health care.
- Ask if there is any limitation to the number of visits they will cover.
- Inquire if "pre-certification" is required for continued treatment. We will call the insurance company to obtain pre-certification, if needed, but it is ultimately **your responsibility** to secure reimbursement.

***Parking***
There is not reserved parking at our clinic, but street parking is plentiful. You can park on Lincoln Avenue for a fee, or you can typically find free street parking on the side streets. Public transportation is a great option to get to our clinic, as the CTA's Red, Purple, and Brown line trains are all nearby. There are also several bus routes that pass very close to us.

***Appointments and Cancellations***
If you need to cancel or reschedule an appointment, please call 773-494-5505 ***with 24 hours notice*** for daytime appointments (before 5:00 pm). For evening (5:00 pm and later) and weekend appointments, ***please call with at least 48 hours notice.*** Evening and weekend appointments are in very high demand. Please only book these appointments when you are sure you can attend. Your appointment times are reserved exclusively for you. We promise to never double-book an appointment time. With this in mind, we require the above specified notice for cancellations. ***If you do not provide the appropriate notice as outlined above, you are responsible for the full fees for that appointment.***

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***Fees and Payment***
***All payments are due at the time of service.*** Cash, check, Visa, MasterCard, or money orders are the only acceptable forms of payment. We will do what is reasonable to work with your insurance company to help you secure reimbursement, but payment is ultimately your responsibility. In limited cases, we do offer reduced fee or sliding scale fee to students or patients with lower income. Please ask for details to apply.

***Emergencies***
***This treatment center is not properly equipped to handle psychiatric emergencies. If you are in a crisis, especially if you are near harming yourself or someone else, call 911. If you need to speak with someone immediately, go to the nearest emergency department or call 911. If you are not in a crisis situation and would like to speak to your therapist as soon as is possible, call 773-494-5505. Our goal is to return your call as soon as possible, usually within the same day.***

***Confidentiality***
All information regarding you, your care, and the fact that you are receiving care in our clinic is confidential and is not released to anyone outside the clinic without your written consent. **However, the law does require release of confidential information in a situation of potential harm to yourself or others, when the court demands records, or in cases of suspected child or elder abuse or neglect, or if your insurance company requests your records. Also, we are required by the State of Illinois to report to the State if you are a danger to yourself or someone else and you are a firearm owner (Public Act 095-0564).**

Consultation may be sought by your therapist from other independent practitioners within the Depression and Anxiety Specialty Clinic (DASC). The following provides their workforce and participates in an Organized Health Care Arrangement and are presenting you with this document as a joint Notice:

Rodney Benson, Ph.D., ACT
Molly McLeese, LCPC
Lauren Neaman, Psy.D., ACT
Dipali Bharadwaj, Psy.D
Caroline "CC" Burke, LCSW
Kerry Curran, LCSW, ACT
Elizabeth Dahll, LSW
Jaclyn Goldman, LCSW
Elaine Gordon, LCSW, CADC, ACT
Shannon Konecny, LSW
Rebecca Martin, LPC
Katherine Lenahan, LCPC, CADC
Vince Henneburg, LCSW
Zinal Patel, LCSW
Chelsea Ragsdale, LCSW
Emma Schwartz, LCSW
Danielle Walsh, LSW
Elinor Marboe, LSW
Jenna Schloss, LCSW

*Please see the clinician section of the website for the most up to date information for current staff*

Information will be shared among these participants as necessary to carry out treatment, payment, and health care operations. Doctors and other caregivers may have access to such health information in their offices to assist in reviewing past treatment, as it may affect current treatment.

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There are times when it may be beneficial for your therapist to consult with colleagues outside of DASC as part of their practice for mutual professional consultation. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

____ I hereby consent to allow my therapist to consult with other colleagues in the manner outlined above
____ I wish to deny my therapist the ability to seek consultation with the certain DASC independent practitioners (strike through above)

We can be reached by the following means:

Phone/Voicemail: (773) 494-5505

Mail: Depression & Anxiety Specialty Clinic of Chicago
3047 N. Lincoln Ave., Suite 400
Chicago, IL 60657

Email: rbenson@dascchicago.com

_______________________________ _______________
Client Signature Date

_______________________________
Client Name (please print)

_______________________________
DASC Representative Signature

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DASC CHICAGO, LLC
Credit Card Payment Authorization Form

NAME ON CARD:______________________________________________________

BILLING ADDRESS:___________________________________________________

_________________________________________________________________

_________________________________________________________________

Circle one: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

ACCOUNT #: _______________________________________________

EXPIRATION DATE: ___________________ CVC # (ON BACK OF CARD): ________

I hereby grant permission to charge my credit card after every ____ session(s) or if my balance reaches $_______ without further authorization (optional)

AUTHORIZED SIGNATURE:______________________________________________

Thank you for choosing DASC Chicago, LLC.

<u>OFFICE POLICY:</u> You agree that should your account be 30 days overdue, you authorize our office to automatically debit your credit card number on file for the outstanding balance. To avoid this type of charge, please bring appropriate payment in-full to each of your appointments. Thank you!