Welcome to **Primary Care Psychology Associates (PCPA)**! We are looking forward to meeting with you. Before your first appointment, we kindly ask that you take some time to complete these consent forms. These forms will remain in effect throughout the entirety of the treatment with PCPA, unless revoked by patient/guardian. Please contact our administrative assistant at **847-686-0090** or intake@pcpachicago.com with any questions.

Patient Information

Full Name (as it appears on the insurance card):_____
Preferred Name (if different from above):_____
Address:_____
Email Address:_____ Phone Number:_____
Date of Birth:__/__/____ ____ Age:____ Race/Ethnicity:_____ Gender:_____
Sexual Orientation:_____ Relationship Status:_____
Primary Care Physician (PCP):_____ Referred by (if different than PCP):_____

Treatment Guidelines

Psychological Services: PCPA staff engaged exclusively in evidence-based psychological services. Your therapist will continuously collaborate with you on identifying and practicing specific methods and techniques that match your needs and presenting concerns. Receiving psychological services can have benefits and risks. Because conversations with your therapist often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Therapy also involves a large commitment of time, money, and energy. On the other hand, psychotherapy has also been shown to have tremendous benefits for people who go through it. Therapy often leads to better relationships, solutions to specific and general problems, and significant reduction in feelings of distress. While our staff has been trained to provide the highest quality of psychological services, there are no guarantees as to what you will experience. What we do guarantee is that should you at any time have questions or concerns about the services you are receiving, your therapist will be happy to address them. If your concerns about the services you receive at PCPA persist, please contact PCPA's Director of Adult Behavioral Health, Dr. Valerie Weed at 847-686-0090, ext. 130, or at vweed@pcpachicago.com.

HIPAA Notice: A copy of the PCPA's full HIPAA policy was provided with the email confirming your first appointment and is also available on our website at www.pcpachicago.com/formspaperwork.html. By signing below you are stating that you are aware PCPA follows all requirements outlined by HIPAA.

Limits of Treatment: There are rare circumstances in which a therapist may be obligated to make a unilateral decision to terminate therapy. Such circumstances include, but are not limited to: threats are made against the therapist or his/her family; the therapist does not believe he/she has the necessary training to address a specific problem; or there is a significant therapeutic impasse. In such cases, the therapist will attempt to find a suitable referral. The therapist cannot be responsible as to whether this referral is accepted.

Emergency Contact: Please know that our therapists are not available on an emergency or "on-call" basis. Patients may leave a message, but there may be an extended period of time (up to 24 hrs), before the therapist receives it and/or responds. Patients requiring immediate assistance must call 911 or go to the

nearest emergency room. In non-emergency situations, patients who would like to receive counseling during after-hours are encouraged to contact one of the following local or national crisis phone lines:

Presence Health 24-hour emergency line: 708-681-4357
Northwestern Memorial 24-hour emergency line: 312-926-8100
National Suicide Prevention Lifeline: 800-273-8255
National Domestic Violence Hotline: 800-799-7233
National Sexual Assault Hotline: 800-656- 4673

If patients require additional support, beyond what is available at PCPA, our therapist will provide a referral to an outside agency that can provide it.

Intoxicated Patients: Patients who present to the clinic intoxicated will not be offered services. A late cancellation fee of $100 will be charged to the account of any patient who is deemed by their therapist to be under the influence of alcohol and/or other substances at the time of their appointment.

Firearm Concealed Carry Act: Firearms are not allowed on PCPA premises. PCPA therapists are mandated mental health reporters. If a patient with a Firearm Owner Identification is deemed to be a clear and present danger, developmentally disabled, or intellectually disabled, we are mandated by law to report this to the Firearm Owner Identification (FOID) Mental Health Reporting System.

Agreement for Co-Therapy: Primary Care Psychology Associates, LLC is licensed in the state of Illinois as a Group Practice with a practice NPI (National Provider Identifier). All professional services are provided under the general supervision of Dr. Paul Kredow, Chief Psychologist and President of PCPA. Your insurance plan may recognize Dr. Kredow, or another one of our licensed therapists, as your network provider, and his or her name may appear on the Explanation of Benefits that you will receive from your insurance company. Our licensed therapists provide ongoing program supervision as well as clinical and peer supervision to all therapists at PCPA. Thus, information about a patient may be discussed by two or more therapists within PCPA for supervision purposes. PCPA is also a training program for advanced graduate students (already possessing an Masters Degree or equivalent) and postdoctoral fellows in clinical psychology. If you are being offered treatment by one of our trainees, you will be asked to complete a separate consent form describing our training program and supervision in more detail.

Insurance: Some insurance companies require the release of clinical information to obtain justification for coverage of services. If the insurance company makes such a request, we will provide this information on your behalf to support coverage of services through your insurance company.

Duty to Update Billing and Insurance Information: If at any time during the course of your treatment at PCPA, your billing or insurance information should change, it is your responsibility to inform us as soon as possible by contacting our administrative assistant at **847-686-0090**, **option** 2 or krhea@pcpachicago.com. This includes, but is not limited to insurance information, physical and email address, phone number, and credit card number.

Email Communication: By signing below, you consent to have an e-statement sent to your email address for services rendered by PCPA. You also consent for scheduling and logistical information to be sent to your email address. The email address you provide is private and not shared or accessible by any person outside of PCPA. Email is not a totally secure medium of communication. Email communication should be limited to issues related to scheduling and billing. If you have clinical concerns or questions, they are best addressed during your session, or in some cases over the phone. Email is not an appropriate way of communicating urgent or emergency information. Your therapist will use reasonable means to protect the security and confidentiality of email information sent and received. However, because email is not a totally secure medium, your therapist cannot guarantee the security of email communication, and is not liable for improper disclosure of confidential information that is not caused by the therapist's intentional misuse.

Closed Charts: If a patient has not returned calls/emails about scheduling and has not attended a session in 5 weeks or more, treatment will be considered concluded, and their chart will be closed. Treatment can be resumed in the future if the therapist and patient mutually agree this is in the best interest of the patient.

Late Cancellation/No Show Fees: As a patient, you are responsible for attending your appointments regularly and being on time. If you have questions about when or where your next appointment is going to be, or if you would like to cancel or reschedule your appointment, please contact your therapist via phone or email, or contact our administrative assistant at 847-686-0090 or intake@pcpachicago.com. If you do not give 24-hour notice when canceling an appointment, or if you no show for an appointment, you will be charged a $100 fee for a therapy appointment and a $200 fee for a testing appointment. These fees are non-refundable and not covered by your insurance plan, and will be charged to the credit card on file.

By signing below, I acknowledge that I understand and agree with treatment guidelines described above and agree to receive services from my assigned therapist(s) at Primary Care Psychology Associates, LLC (PCPA).

Patient/Guardian Signature:_____ Date:__/__/____

Payment and Financial Agreement

Primary Care Psychology Associates (PCPA) requires that all patients keep a valid credit or debit card on file. All copays, current account balances and fee-for-services will automatically be charged to the card on file at each appointment. For testing services, your credit card or debit card will automatically be charged at each appointment for any fee-for-service, deductibles, or out of pocket expenses according to your insurance plan benefits. In an effort to be environmentally responsible, all monthly statements will be sent through email only. These statements will be coming from the following email address: **reply@psyquel.com**. It is your responsibility to verify these emails do not go to your spam folder.

Name of Person Responsible for Payment:_____ Relationship to Patient: _____
Date of Birth of Responsible Person:__/__/____ Responsible Person Phone Number:_____
Responsible Person Address:_____
Responsible Person Email Address:_____
Name on Credit Card (if other than that of Responsible Person):_____
Credit Card #: _____ Exp. Date: _____Security Code: _____

☐ (Initial) I understand and agree that I am financially responsible for all charges for any services rendered, including late cancellation fees as described in the Treatment Guidelines within PCPA's Consent for Treatment.

☐ (Initial) I understand that if I do not give 24-hours' notice when canceling an appointment, or if I no show for my appointment, I will be charged a $100 late cancellation fee for a therapy appointment and a $200 late cancellation fee for a testing appointment. These fees will be charged to the credit card on file.

☐ (Initial) I understand and agree that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balances.

☐ (Initial) I understand and agree that it is my responsibility to know if my insurance has a deductible, co-payment, co-insurance, out-of-pocket, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to be financially responsible for all.

☐ (Initial) I understand and agree that if my insurance requires a referral from my primary care physician, it is my responsibility to obtain the referral. Without a referral, my insurance will not pay for any services and I will be responsible for payment.

☐ (Initial) I understand and agree that it is my responsibility to inform PCPA in case of any changes to my insurance coverage prior to my next appointment. Claims denied due to submission to an expired insurance plan may be denied and may become my responsibility.

☐ (Initial) I understand and agree that any phone/video consultations 15 minutes or longer may be billed to my insurance and I would be responsible for any patient fees according to my plan.

☐ (Initial) If the credit card on file changes/expires, I am responsible for informing my therapist.

☐ (Initial) I understand and agree, if my account is considered closed (see treatment guidelines), the remaining balance will be charged to the credit card on file to close the account.

☐ (Initial) I understand and agree that a $25 fee for any returned checks will be charged to my account.

☐ (Initial) I understand and agree that if my account balance is over $300, I will be required to pay the balance in full or initiate a payment plan before additional appointments at PCPA can be scheduled.

☐ (Initial) I understand that unpaid balances that are more than 120 days late may be turned over to a collection agency. If my account is turned over to a collection agency, I will be responsible for an additional 33.33% of the unpaid balance to account for collection services expenses. I further agree to pay reasonable administrative fees, attorney fees, and cover costs arising out of any litigation concerning the collection of this account or any other fees deemed necessary.

By signing this form, I acknowledge that I understand and agree with all of the above, and that I accept responsibility for the charges incurred for treatment or assessment at Primary Care Psychology Associates, LLC (PCPA), regardless of any other arrangements with third parties, including insurers. This form will remain in effect throughout the entirety of the treatment with PCPA, unless revoked by patient/guardian.

Patient/Guardian Signature: _____ Date: __/__/____
Signature of Person Responsible for Payment (if different from patient): _____ Date: __/__/____

PRIMARY CARE PSYCHOLOGY ASSOCIATES LLC
Adult and Pediatric Psychology

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INFORMED CONSENT FOR TELEPSYCHOLOGY

Telepsychology refers to providing psychological services remotely using telecommunications technologies, such as video conferencing or telephone. Telepsychology allows for the provision of psychological services when patient and therapist are unable to be physically present at the same location.

There are several ways in which telepsychology at Primary Care Psychology Associates, LLC (PCPA) differs from in-person therapy. Telepsychology provides limited opportunity for the therapist to observe and respond to the patient's body language, affect and general mental status. As a result, the scope and effectiveness of interventions provided by your therapist may be limited and you may be limited in your ability to build rapport with your therapist.

Telepsychology is not an appropriate vehicle for assessing and evaluating patient safety or responding to other patient-related emergencies compared to in-person therapy. To address some of these difficulties, patients are encouraged to consult with their therapist regarding an emergency response plan before engaging in telepsychology services. PCPA recommends that all patients receiving telepsychology identify an emergency contact person who can be contacted in the event of a crisis or emergency to assist in addressing the situation. If you would like to identify a contact person, and authorize Primary Care Psychology Associates, LLC to exchange information with them for the purposes of crisis/emergency response, please enter their name and phone number here:_____. If your appointment is interrupted for any reason, such as a technological issue, while you are having an emergency, please call 911, or proceed to your nearest emergency room, then contact your therapist after you have called or obtained emergency services. If there is a technological failure and you are unable to resume telepsychology with your therapist in non-emergency situations, you can resume your appointment via telephone. In such situations, your therapist will call you at the number you provided on the PCPA intake form.

Telepsychology appointments shall not be recorded in any way, unless agreed to in writing by mutual consent. Your therapist will maintain a written record of your appointment in the same way they maintain records of in-person appointments, and in accordance with PCPA policies. Because telepsychology sessions take place outside of the therapist's private office, there is an increased risk of other people to overhear information you discuss during your appointment. Your therapist will only conduct telepsychology while in a private room that is reasonably soundproofed, and where other people are prohibited from entering. You are encouraged to attend telepsychology when situated in an area where other people are not present and cannot overhear or interrupt the conversation. PCPA uses HIPAA compliant web-based video-conferencing service to provide telepsychology. However, for your safety, it is important that you be aware that because of the nature of electronic communications, even channels that are secure and encrypted may be at risk of being intercepted by a third party.

This agreement is intended as a supplement to PCPA's general informed consent forms and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions. If you are no longer comfortable receiving telepsychology, you can always inform your therapist that you revoke this consent and will be offered alternative comparable treatments or procedures.

_____ _____
Patient/Legal Guardian Date

_____ _____
Clinician Date

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Permission for Release/Request of Confidential Information

_____
Name of Patient's Primary Care Practice

_____
Street address, City, State, Zip Phone Fax

Re: _____ _____
Patient name Date of birth

I, _____(**name of patient/guardian**), hereby authorize Primary Care Psychology Associates, LLC and _____(**name of <u>your</u> Primary Care Practice or Physician**) to exchange information and for notes to be documented in your patient medical record when applicable.

The type of information to be disclosed:
□All relevant information □Medical Records only □Psychotherapy Notes only
□Psychological/Medical Test Results □Mental Health Record Summary
□Other _____
Exceptions:_____

The purpose of such disclosure: <u>Coordination of Care</u>
Dates of records requested: <u>First appointment to present</u>

This consent is in effect for one year from the date signed below. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place. I hereby release all parties stated within this form from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original. I understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization with certain exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children. I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations. I also understand that a fee may be associated with the release of my records, and that my records may not be released until I, or the responsible party, pay the fee. Furthermore, I recognize that my records may not be released if I have an outstanding balance with Primary Care Psychology Associates and until the balance is paid. This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

_____ _____
Patient/Guardian signature Date

_____ _____
Clinician/Witness Signature Date

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

PRIMARY CARE PSYCHOLOGY ASSOCIATES LLC
Adult and Pediatric Psychology

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Patient Information Form

Name: _____

Briefly state the main concerns you would like to discuss: _____
_____
_____

How long have you had these concerns? _____
_____
_____

What things have you tried to deal with these concerns? _____
_____
_____

Have you had any prior therapy experience? (Please describe length of treatment and frequency of visits)
_____
_____
_____

Please check any of the following stresses that apply to you or your family and describe.
□Major Relocations: _____
□Job change/Retirement: _____
□Deaths: _____
□Illnesses: _____
□Marital/Relational Problems: _____
□Experiencing/Witnessing a traumatic event: _____
□Physical or sexual abuse or neglect: _____
□Division of Family Child and Family Services (DCFS) involvement: _____
□Legal issues: _____

Occupational History:
Are you currently employed? Yes□ No□ How long have you worked in this position? _____
Job/Type of Work:_____

Medical History:

Current Medication	Dosage	Name of Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List of Past Psychiatric Medications : _____
_____

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Medical/Psychiatric Hospitalization History (Please include description and dates of admission & discharge):

_____
_____
_____
_____

Please indicate if you have had any history of the following medical problems:

		Ages	Describe
☐	Respiratory Problems	_____	_____
☐	Traumatic Brain Injury	_____	_____
☐	Headaches	_____	_____
☐	Hearing/Ear Problems	_____	_____
☐	Vision/Eye Problems	_____	_____
☐	Chronic Pain	_____	_____
☐	Hallucinations	_____	_____
☐	Disordered Sleep	_____	_____
☐	Seizures	_____	_____
☐	Weight Management	_____	_____
☐	Cardiovascular Problems	_____	_____
☐	Major Surgeries	_____	_____
☐	Tics/Twitching	_____	_____
☐	Loss of Mobility	_____	_____
☐	Alcohol Use/Abuse	_____	_____
☐	Other Substance Use/Abuse	_____	_____
☐	Risky Behaviors	_____	_____
☐	Other Medical History	_____	_____

Family History of emotional, behavioral, psychological concerns:

_____
_____

Family History of Medical Problems:

_____
_____

Additional Information:

Please list some of your personal strengths and any additional information you would like to provide:

_____
_____
_____

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐

For office coding: Total Score T____ = ____ + ____ + ____

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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Patient Health Questionnaire – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thought that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

For office coding: Total Score T____ = ____ + _____ + _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐

Somewhat difficult ☐

Very difficult ☐

Extremely difficult ☐

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