PRIMARY CARE PSYCHOLOGY ASSOCIATES LLC
Adult and Pediatric Psychology

400 SKOKIE BLVD, SUITE 245
NORTHBROOK, IL, 60062
847.686.0090 Phone or Fax

Welcome to Primary Care Psychology Associates! We are looking forward to meeting with you. Before your first appointment, we ask that you complete these forms and either bring them with you to your first appointment or email them to your clinician. These forms can be completed and signed electronically by typing within the document. If you have any questions, please contact your clinician at 847-686-0090. We look forward to working with you.

Patient Information:

Full Name (as it appears on the insurance card): _____ Date of Birth: _____

Preferred Name:_____

Primary Care Physician (PCP): _____

Referred by (if different that PCP): _____

Consent for Services: By signing below, I agree to receive services from the assigned clinician(s) at Primary Care Psychology Associates, LLC (PCPA).

_____ _____
Patient/Guardian Signature Date

HIPAA: Please sign below stating that you are aware PCPA follows all requirements outlined by HIPAA. A copy of the 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.

_____ _____
Patient/Guardian Signature Date

Consent for Sending Statement of Account for Services by E-Mail:

Email Address:_____

☐ Please check box if you would like an email reminder for sessions.

I consent to have an e-statement sent to my email address for services rendered by Primary Care Psychology Associates, LLC. I also consent for scheduling and logistical information to be sent to my email address. The email address is private and not shared or accessible by any other person than myself. I understand that email is not a totally secure medium.

_____ _____
Patient/Guardian Signature Date

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Payment Agreement

PCPA requires that all patients keep a valid credit or debit card on file. For therapy services, your copay, all current account balances, and any fee-for-service charges will be automatically charged on the credit or debit card on file at each appointment. For testing services, the credit or debit card on file will automatically be charged either the fee-for-services amount or estimated out-of-pocket expenses at each appointment. If your chart is considered closed (see treatment guidelines below), we will also automatically charge any remaining balances to close the account. I understand that if I do not give 24-hours notice when canceling an appointment, I will be charged a $100 cancellation fee for a therapy appointment and a $200 cancellation fee for a testing appointment. Phone consultations 15 minutes or longer may also be billed to my account and insurance. Please note, in an effort to be environmentally responsible, PCPA sends monthly emailed statements only. These statements will come from the following email address: noreply@psyquel.com. It is your responsibility to verify that these emails do not go to your spam folder.

Name of Person Responsible for Payment: _____

Responsible Party's Date of Birth: _____

Responsible Party's Address: _____

Name of Cardholder_____

Credit/Debit Card #_____ (MC, Visa, Amex, Disc)

Expiration Date_____

Security Code_____

I hereby accept responsibility for the charges incurred for this patient's treatment or assessment, regardless of any other arrangements with third parties, including insurers. In the unlikely event that a patient fails to remit payment or the credit card is denied, we will be forced to send the account to collections and/or pursue legal action. Patients will be held responsible for all associated fees, including, but not limited to, the cost of collection services, attorneys, administrative support, and therapist's time. If my credit card expires or changes, I am responsible for letting my clinician know about this change prior to my next appointment. I also understand that if my account balance gets to $300 or more, I will be required to pay the balance or initiate a payment plan before additional appointments can be scheduled.

_____ _____

Patient/Responsible Party Signature Date

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Permission for Release/Request of Confidential Information

To: _____
Name of primary care practice

_____
Street address, City, State, Zip

Re: _____ _____
Patient name Date of birth

I, _____(name of patient/guardian), hereby authorize Primary Care Psychology Associates and _____(name of primary care practice) to exchange information and for notes to be documented in the patient's medical record when applicable.

The type of information to be disclosed:

☐ Evaluations ☐ Medical Records ☐ Diagnosis ☐ Treatment Plan

☐ Psychological/Medical Test Results ☐ Mental Health Record Summary

☐ Course of Treatment ☐ Psychotherapy Notes ☐ Other _____

Exceptions:_____

The purpose of such disclosure: Coordination of Care

Dates of records requested: First appointment to present

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.

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Treatment Guidelines

Emergency Contact: Clinicians are not available on an emergency or "on-call" basis. Patients may leave a message, but there may be an extended period of time before the clinician receives it and/or responds. Patients requiring immediate assistance must call 911 or go to the nearest emergency room. If patients require additional support, the clinician will provide a referral to an outside agency that can provide emergency staff.

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: the current treatment appears to be ineffective; threats are made against the clinician or his/her family; the clinician 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 clinician will attempt to find a suitable referral. The clinician cannot be responsible as to whether this referral is accepted.

Firearm Concealed Carry Act: PCPA clinicians 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.

Closed Charts: If the patient has not returned calls/emails about scheduling and has not attended a session in 5 weeks, the patient chart will be considered closed. The chart can be re-opened again in the future if the clinician and patient mutually agree this is in the best interest of the patient.

Agreement for Co-Therapy: All professional treatment given is under the general supervision of Dr. Paul Kredow, Chief Psychologist and CEO of Primary Care Psychology Associates. Your insurance plan may also recognize Dr. Kredow, or other licensed professional, as a network provider and his or her name may appear on your explanation of benefits that you will receive from your insurance company. Primary Care Psychology Associates is also licensed in Illinois as a Group Practice with a practice NPI (National Provider Identifier). Dr. Kredow provides ongoing program supervision as well as clinical supervision or collaboration to all clinicians at PCPA. PCPA is also a training program for advanced graduate students (already possessing an MA or equivalent) and postdoctoral fellows in clinical psychology. All trainees are supervised by licensed psychologists, under the general supervision of Dr. Kredow. 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.

Email 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.

_____ _____

Patient/Guardian Signature Date

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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: _____
□ Deaths: _____
□ Illnesses: _____
□ Marital/Relational Problems: _____
□ Someone significant moving out of the area_____
□ Experiencing a traumatic event: _____
□ 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? ☐ How long have you worked in this position? _____
Job/Type of Work:_____

Are you taking any medications on an ongoing basis? ☐

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

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Medical/Psychiatric Hospitalization: (Please describe)

_____

_____

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

		Ages	Describe
☐	Asthma		
☐	Chronic Ear Infections		
☐	Headaches		
☐	Hearing/Ear Problems		
☐	Loss of Consciousness		
☐	Nightmares		
☐	Seizures		
☐	Sleep Apnea/Snoring		
☐	Surgeries		
☐	Tics/Twitching		
☐	Vision/Eye Problems		
☐	Alcohol Use/Abuse		
☐	Illicit Drug 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.

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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 ☐