FOX BEND
COUNSELING

123 W. Washington St., Suite 321
Oswego, IL 60543
Phone: 630-383-2077

Patient Information: **Date:** _____

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

S.S.#: _____ Sex: _____ Birth Date: _____

Email Address: _____

Primary Phone: _____(circle one) HOME CELL WORK OTHER

Secondary Phone: _____(circle one) HOME CELL WORK OTHER

Marital Status (circle one) SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Language (circle one) ENGLISH SPANISH OTHER

Race (circle one) WHITE BLACK OR AFRICAN AMERICAN HISPANIC INDIAN ASIAN MIDDLE EASTERN NOT GIVEN

Ethnicity (circle one) NON-HISPANIC MEXICAN NOT GIVEN

Responsible Party:

Responsible Party Name: _____

Responsible Party Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Employer: _____

Insurance Information:

Insurance Company: _____

Policyholder Name: _____

Policyholder Birth date: _____ S.S.#: _____

Patient Relationship to Insured (circle one): SELF SPOUSE CHILD OTHER

Office Hours:

Monday – Friday	9:00 a.m. – 8:00 p.m.
Saturdays	9:00 a.m. – 3:00 p.m.

Responsibility Statement:

Your insurance is a method for you to receive reimbursement for fees you have paid to Fox Bend Counseling for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them and not with our office. It is your responsibility to pay in advance for the copay, and also pay for deductible, coinsurance, or any other balance not paid for by your insurance. We will assist you in receiving as much reimbursement as possible; **YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL.**

Insurance Patients:

It is the patient's responsibility to inform our office if your insurance carrier changes within a timely matter. We will bill according to insurance guidelines as long as the proper insurance information is provided to us within the timely filing limit. **If the patient's insurance company does not pay within a certain time limit, the professional fees are due and payable in full from the patient.** If insurance pays to the patient for the services provided by us, payment is expected to be sent to our office promptly.

Copayments are due IN FULL at the time of service.

Prescription Medication Guidelines:

We **DO NOT** accept phone request for prescriptions medication refills other than Schedule II medications (Adderall, Concerta, Ritalin, etc.). All patients must have their pharmacy fax a medication refill request form to our office at (630) 383-2077. The physician or nurse practitioner will then fax the request back to the pharmacy if approved. Written medication refill information needs to be left on the medication refill line at (630) 383-2077. **ALL REQUESTS MUST BE MADE AT LEASST 3 BUSINESS DAYS BEFORE YOU RUN OUT OF YOUR MEDICATIONS! MEDICATION IS NOT REFILLED FRIDAY THRU SUNDAYOR AFTER OFFICE HOURS, NO EXCEPTIONS!**

Cancelling or not showing up for appointments:

There is a 24-hour cancellation fee. When an appointment is scheduled, that time is reserved for the patient and if the patient cannot attend at the time, **the patient must give 24- hour notice or will be charged a $75 fee.** If patients fail to let the office know and no show for their appointment, patient will also be charged a $75 fee. These fees CANNOT be billed to insurance companies and the patient is responsible for the total amount. **If you incur two (2) consecutive no shows, you will be terminated from the facility. If you have an appointment and believe you might be late, you should call to inform the staff as early as possible. However, we still may require you to reschedule in order to be respectful and courteous to other patients.**

Non-emergency Telephone Calls:

A minimum fee of $15 will be charged to the patient's account for non-emergency telephone calls made to the practice. This includes telephone calls for medication refills, and test results, and other non-emergency requests, unless the patient was directed specially by the doctor to call. This charge may change at the discretion of the practice. This fee is payable directly by the patient, with credit card over the telephone prior to the message being answered, as it is not a covered expense by insurance companies.

Financial Responsibility:

By signing this statement, you agree to be financially responsible for all charges. If an account goes unpaid, a finance charge of 33.33% is added to accounts sent out to Collections. If you check is returned from your financial institution, we will no longer be able to accept them. **All returned NSF checks will be charged a service fee of $25.00** and in the future you will be required to pay with either cash credit/debit card.

Authorization to Release Medical Information:

In order to obtain/release your medical records, a separate Release of Information form must be filled out and signed in our office. This will remain in effect one year from the date it is signed. When medical records are requested for legal reasons, there is a $25 fee that is usually paid by the attorney's office. The fee for medical records by patient request or for personal use is $25. There is no charge if our clinic doctor refers a patient to another physician. This fee is payable directly to the patient as it is not a covered expense by insurance companies.

Paperwork and Miscellaneous Forms:

To request any type of paperwork of forms to be completed, one will be charged a fee of **$100**, which **must be paid** in advance, **prior** to the physician completing the paperwork. This fee is billable directly to the patient as it is not a covered expense by insurance companies. When requesting these forms, one must allow up to 7 (seven) business days to receive paperwork. **COMPLETION OF THESE FORMS IS DONE AT APPOINTMENTS ONLY.**

Appropriate Conduct

We have a ZERO tolerance policy for any patient who behaves inappropriately to clinical staff, office staff, and/or physicians and will be discharged immediately (ex: cursing, violence, verbal threats, sexual inappropriateness, etc.)

By signing below, I agree to all the terms and conditions of this form and also certify that all the information I have provided is true.

Patient/Responsible Party Name: _____

Signature of Patient Date

Signature of Parent, Guardian, or Personal Representative* Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

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Consent to Release Information to Primary Care Physician

Communication between your psychiatrist/therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been take in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

I, _____
Patient Name – Printed Date of Birth Patient SS#

Please Check One:

- ☐ I agree to release mental health/substance abuse information to my Primary Care Physician.
- ☐ I **DO NOT** give my consent to release any information to my Primary Care Physician.

Physician Name: _____

Physician Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

_____
Signature of Patient Date

_____
Signature of Parent, Guardian, or Personal Representative* Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

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Please let us know **how you were referred** to our practice by circling and/or indicating one of the following options:

Primary Care Physician	Who: _____
Hospital/Facility	Which: _____
Other Doctor	Who: _____
Insurance Company	Insurance Name: _____
Other	Specifics: _____
Self-Referral	Additional Info: _____

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Paperwork and Miscellaneous Forms Disclosure

To request any type of paperwork or forms to be completed, one will be charged a fee of **$100**, which **must be paid** in advance, **prior** to the physician completing the paperwork. This fee is billable directly to the patient as it is not a covered expense (7) business days to receive paperwork.

COMPLETION OF THESE FORMS IS DONE AT APPOINTMENTS ONLY.

By signing below, I acknowledge to all the terms and conditions regarding paperwork and miscellaneous forms.

Patient/Responsible Party Name: _____

Signature of Patient Date

Signature of Parent, Guardian, or Personal Representative* Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)