MidAmerican Psychological Institute, P.C.

www.TheMPInstitute.com

1415 Maple Road, Joliet 60432
♦
1890 Silver Cross Blvd. Pavilion A-Suite 227, New Lenox 60451
♦
815-735-0732 [Office]
815-722-7310 [Fax]
TheMPInstitute@comcast.net [email]

Please complete the following form so we can establish a client record. If at any time your original information needs to be updated, please inform your clinician immediately. Items left blank or incorrectly entered may lead to insurance claim denials that you will be responsible to pay.

Client's Last Name	First Name	Middle Name
Gender:	Phone Number (Cell)	Phone Number (Alternate)
Address, City & State, ZIP Code		
Marital Status of client (*Circle*): Single Married Other	Social Security Number	Birthdate (mm/dd/yyyy) Age
Employment status of client (*Circle*): Full-time Part-time F/T Student P/T Student Other		Driver's License Number Driver's License State: ___________

Primary Insurance Company		
Name of insured person if other than the client	Insured's Address, City, State & ZIP Code	
Insured's birthdate (mm/dd/yyyy)	Relationship to the insured	
Employer of Insured	Employer's Address, City, State & ZIP Code	
Name of Insurance Company	Insurance Company Address, City, State & ZIP Code	
Identification Number	Group Number	
Effective Date of Coverage:	Is this an HMO Plan? Yes No	Is authorization required? Yes No

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Secondary Insurance Company		
Name of insured person if other than the client	Insured's Address, City, State & ZIP Code	
Insured's birthdate (mm/dd/yyyy)	Relationship to the insured	
Employer of Insured	Employer's Address, City, State & ZIP Code	
Name of Insurance Company	Insurance Company Address, City, State & ZIP Code	
Identification Number	Group Number	
Effective Date of Coverage:	Is this an HMO Plan? Yes No	Is authorization required? Yes No

Would you like to receive appointment reminders? If so, choose an option below:	
Email to:	Phone call to:
Text message to:	None. Check here: ☐ (No reminder will be sent)

My signature below indicates that I give this office permission to release any information obtained during examinations or treatments of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that I am responsible for all charges, regardless of insurance coverage. I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the MidAmerican Psychological Institute. A photocopy of this assignment is to be considered as good as the original. The undersigned agrees that when an account has not been paid for more than 60 days, then arrangements will be made eligible for collection proceedings from an external agency. This may involve legal action, hiring a collection agency, or going through small claims court. The undersigned agrees to pay all fees related to these proceedings. This "Signature on File" will be valid from this date.

____

Client (or parent/ guardian) signature, indicating agreement to the above statement — Date

____

Print name

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Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information about:

Printed name: ____Date of Birth: ___________________________

I authorize this person or organization: The MidAmerican Psychological Institute, P.C.

To use or disclose the following information: Pre-Bariatric Surgery Psychological Assessment

The information will be used/ disclosed for the following purposes: Pre-Bariatric Surgery Psychological Assessment

To this person or organization (the client's potential surgeon): ____

- ❖ I understand and agree that this Authorization will be valid and in effect for ***one calendar year*** from date of authorization. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new authorization.
- ❖ I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- ❖ I understand that I may inspect and have a copy the health information described in this authorization.
- ❖ I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that the information may be sent electronically, and may be unencrypted.
- ❖ I affirm that everything in this form that was not clear to me has been explained and I now understand all of it.
- ❖ I understand that the MidAmerican Psychological Institute will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.

____ ____________________
Signature of client or his or her personal representative Date

____ ____________________
Printed name of client or personal representative Relationship to client

________ I acknowledge that I received a copy of this completed form if requested.

I have discussed the issues above with the client and / or his or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent:

____ ______________
Signature of professional Date

____
Printed name of professional

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OUTPATIENT SERVICES CONTRACT

Welcome to the MidAmerican Psychological Institute, P.C. This document contains important information about our professional services and business policies. Please read it carefully and note any questions you might have. When you sign this document, it will represent an agreement between us.

CONFIDENTIALITY

In general, law protects the privacy of all communications between a client and a therapist. MidAmerican Psychological Institute will only release information to others about you and our work together if we have your written permission; however, please note that there are exceptions to this policy.

In case of legal proceedings, a client has the right to prevent us from providing any information about his or her treatment. In some proceedings involving child custody and those in which a client's emotional condition is an important issue, a judge may order our testimony if he or she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect others from harm, even if it is necessary to reveal some information about a client's treatment. For instance, if we believe that a child, elderly person, or disabled person is being abused, we are required to file a report with the appropriate state agency.

If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, we may be obligated to seek hospitalization for him or her, or to contact family members or others who can provide protection.

These situations have rarely occurred in our practice. If a situation arises, we will make every effort to fully discuss it with you before taking any action.

PRE-SURGERY PSYCHOLOGICAL ASSESSMENT SERVICES

Assessment results and reports are considered confidential information. All surgery candidates are required to have a psychological assessment to evaluate their readiness for surgery and the post-surgery lifestyle.

We routinely conduct program evaluation in order to make sure we are providing the best possible services to our clients. If we learn something valuable we may use your data, along with data from other clients in our practice, in published research; however, you would remain anonymous and the data you provide would be completely confidential.

____
(Client initials)

PROFESSIONAL FEES

Full payment for each session, or in the case of insurance coverage, the required co-payment, is due at the time of service. An account that has not been paid for more than 60 days without payment arrangements will be eligible for collection proceedings. This may involve legal action, hiring a collection agency, or going through small claims court. If legal action is necessary, these costs will be included in the claim. In most collection situations, the only information we release regarding a client's treatment is his or her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

If you have health insurance coverage, it will usually provide some benefits for mental health treatment. You should carefully read the section in your insurance booklet about these benefits. If you have any questions about the coverage, call your plan administrator to find out exactly what services your insurance coverage provides.

Ultimately, you, not your insurance company, are responsible for full payment of our fees.

In recent years, insurance benefits have become increasingly more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. You are responsible for determining if you require pre-authorization.

You should also be aware that most insurance companies require you to authorize your mental health professional to provide them with a clinical diagnosis. Sometimes it is necessary to provide the insurance company with additional clinical information, such as treatment plans or summaries or, in rare cases, copies of the entire record. This information will become part of the insurance company's files and may be stored in a computer. Although all insurance companies claim to keep such information confidential, MidAmerican Psychological Institute, P.C. has no control over their practice once it is in their hands. In some cases, they may share the information with a national information databank. You have the right to contact your insurance company to find out more about their policies.

There is a 1.5% monthly late charge assessed on all balances after 60 days past due. Checks, which are declared non-sufficient funds, will be charged a $75 service fee. Also, the undersigned agrees to allow the MidAmerican Psychological Institute to use a collection agency for past due fees, and the undersigned will pay a collection fee of 25% of the total owed when sent to collections, and will also pay all attorney fees and court costs incurred by the creditor.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your professional relationship with MidAmerican Psychological Institute, P.C.

I understand that I am ultimately responsible for the assessment fees, even if I do not have the surgery, and even if my insurance denies payment.

Client's Name: ____

Signature: ____ Date: ____________________