ROSALIND FRANKLIN UNIVERSITY
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Behavioral Health Patient Registration Packet – Adult
PATIENT INFORMATION

Patient's Name: Last_____ First_____ MI_____

Date of Birth:_____ Social Security#: _____

Address:_____ Apt./Suite#:_____

City:_____State:_____Zip:_____Home Telephone: (_____)_____Cell Phone: (_____) _____

Name of Employment:_____Work Address: _____

City/State/Zip:_____Work Phone: _____

Preferred Method of Contact: ❒ Home ❒ Cell ❒ Work ❒ Email: _____

Ethnicity: ❒ African American ❒Hispanic/Latino ❒ Caucasian ❒ Asian ❒ Other_____

Preferred Language: ❒ English ❒ Spanish ❒ Other:_____Do you need an Interpreter? ❒ Yes ❒ No

Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Preferred Pharmacy: _____
(Name) (Address) (Phone)

Emergency Contact Name:_____Phone: (_____)_____

FINANCIAL RESPONSIBLE PARTY/GAURANTOR
(Please complete if different from patient or patient is a minor)

Last Name:_____First Name:_____Middle Initial: _____

Date of Birth:_____ Social Security#: _____

Address:_____ Apt./Suite#:_____

City:_____State:_____Zip:_____Telephone: (_____)_____E-mail: _____

Relation to Patient: ❒ Spouse ❒ Parent ❒ Grandparent ❒ Legal Guardian ❒ Other: _____

I hereby acknowledge that I am the guarantor and financially responsible for payment of all services rendered, and that I have received and I am subject to all the terms on the Financial Responsibility Agreement form.

Patient Signature (18 and older):_____Date:_____/_____/ _____

Parent/Guardian Signature:_____Date:_____/_____/ _____

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WARD OF THE STATE/OTHER LEGAL GAURDIAN

Is this patient either a current of has had a prior designated ward of the state or has another deemed legal guardian? If so please indicate the relationship below. **** Please note: As part of the required paperwork, we will require that you submit supportive documents*** ❒ Yes ❒ No

❒ Legal Guardian ❒ Ward of the State ❒ Other _____

Last Name:_____First Name:_____Middle Initial: _____

Address:_____ Apt./Suite#:_____

City:_____State:_____Zip:_____Home Telephone: (_____)_____Cell Phone: (_____) _____

Email: _____

REFERRAL SOURCE(S)

❒ Friend/Patient
❒ Event/Health Fair
❒ Physician/Specialist
❒ Insurance directory
❒External Referral
❒Staff/Student
❒Current Patient
❒ Marketing (List): _____
❒ Website
❒ Social Media
❒ Other: _____

INSURANCE INFORMATION

Name of Policy Holder: _____ Policy **Identification Number:** _____

Primary Insurance: _____ Group **and Number:** _____

Primary Insurance Address: _____**Primary Insurance Phone:** _____

Name of Policy Holder: _____ **Policy Identification Number:** _____

Secondary Insurance: _____ Group **and Number:** _____

Secondary Insurance Address: _____**Primary Insurance Phone:** _____

PHARMACY INFORMATION

Pharmacy name: _____

Pharmacy Address: _____

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City State Zip Code

Pharmacy Phone: _____ Pharmacy **Fax:** _____

A note to our patients: Please complete this questionnaire as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except if you have provided us with written authorization. Thank you for your help.

TYPE OF SERVICE REQUESTED (please check one)

□ Therapy/Counseling □Psychological Testing □ Psychiatric Assessment/Medication Management □ Not Sure

Briefly explain why you are seeking behavioral health services:

PRIMARY CARE PHYSICIAN

Primary Care Physician Name:_____ Phone:_____Last PCP Visit Date:_____

Address:_____City:_____State:_____Zip: _____

SOCIAL HISTORY

Current or past tobacco use: Amount/packs per day:___How long:_____Quit date: _____

MEDICAL HISTORY

Do you have children? □ Yes □ No If yes, what are their ages: _____

Do you exercise regularly? □ Yes □ No If yes, please describe type of exercise and how often below:

_____

Do you have any **medication allergies or any allergic reactions** to anything? □ Yes □ No If yes, please explain below:

_____

Do you have an EPI Pen for severe allergic reactions? □ Yes □ No □ N/A

Do you have any history of head injury with or without loss of consciousness? □ Yes □ No □ N/A

If yes, please explain below:

FOR WOMEN ONLY:

Date of your last menstrual period? _____

Do you use any form of birth control? □ Yes □ No If yes, please specify: _____

Are you currently Pregnant? □ Yes □ No

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Please list all medications and supplements you are taking including prescriptions, over-the-counter medications, vitamins, minerals, herbs and homeopathic remedies. ***Attach another page if needed.***

Name of medication/supplements: *(such as Synthroid, Vitamin D, etc.)*	**Strength:** *(88mcg, etc.)*	**Directions:** *(such as 1 tab twice a day, as needed, etc.)*
❒ ***Check if none***		

Please list any surgeries or hospital stays (including psychiatric illness in the past six months) you have had and their approximate date/year:

Type of surgery/reason for hospitalization:	Date:
_____	_____/_____/ _____
_____	_____/_____/ _____
_____	_____/_____/ _____

If you have received counseling or psychiatric treatment in the past, please complete the following table:

Facility or Course of Treatment	**Inpatient or Outpatient**	**Illness or Symptoms Treated**	**Dates of Treatment**	**Name of Medication/ Dosage/Frequency**	**Response to Medication**
❒ ***Check if none***					

Please check box to indicate if you or a family member has ever had the following conditions. If condition does not apply leave blank. Please indicate which relative has the condition.

Condition	**Self**	**Mother**	**Father**	**Sibling**
Allergies				
Anemia				
Anxiety				
Arthritis				
Asthma				
Cancer				
Cataracts				
Congestive heart failure				
Depression				
Diabetes				
Fibromyalgia/chronic fatigue				
Nervous or Emotional Problem				

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Have you used any of the following illegally or excessively either in the past or recently? □ Yes □ No

Please check all that apply.

□ Alcohol	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Marijuana	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Cocaine	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Heroin or Opium	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Barbiturates	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Valium or Librium	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ PCP	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ LSD	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Mushrooms	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Inhalants	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Pain Medication(s)	# of Years Used ___	Amount Used _____	Date of Last Use_____
□ Other _____	# of Years Used ___	Amount Used _____	Date of Last Use_____

Did you have treatment for any of the above alcohol or illicit drug use? □ Yes □ No

If yes, please indicate the type and dates of treatment: _____

_____

_____

_____

Have you been involved with self-help groups (i.e. AA, NA, etc…)? □ Yes □ No

If yes, please indicate the type and dates of treatment: _____

_____

_____

_____

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DEVELOPMENT

During your childhood/adolescence did you exhibit any of the following problems?

Yes □ No Fear of School_____
Yes □ No Tics___
Yes □ No Frequent Falls
Yes □ No Truancy_____
Yes □ No Ran Away from Home_____
Yes □ No Lied to Family or Others____
Yes □ No Moved Often_
Yes □ No Sleep Disturbances___
Yes □ No Awkward at Games__
Yes □ No Speech Problems____
Yes □ No Wet the Bed Past Age 5_____
Yes □ No Animal Cruelty_____
Yes □ No Arson_
Yes □ No Were (Are) Left Handed____
Yes □ No Sexually Promiscuous_____
Yes □ No Other_____

During your childhood, were you ever abused? □ Sexually □ Verbally □ Physically □ Neglected □ Other

Are there any special, unusual, or traumatic circumstances you experienced growing up? □ Yes □ No

If yes, please explain. _____

When your mother was pregnant with you, did she have any problems with the pregnancy? □ Yes □ No

If yes, please explain. _____

When your mother was pregnant with you, did she have any problems during labor? □ Yes □ No

If yes, please explain. _____

Did you have any developmental milestone delays in sitting, walking, talking, or etc.? □ Yes □ No
If yes, please explain: _____

FAMILY INFORMATION

Does anybody in the family have a nervous or emotional problem? □ Yes □ No

If yes, please explain. _____

_____

_____

_____

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Annual Consent for Medical Care and Services

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

A. Consent for Diagnosis, Care, and Treatment: I consent to the diagnosis, medical care and treatment that I have agreed to receive and is considered necessary or recommended by the Rosalind Franklin University Health Clinic's (RFUHC) provider(s), including treatment and services may be in-person, as well as through telehealth technologies such as telephonic, interactive audio-visual communications, and other virtual care (For example through use of the Athena Patient Portal). I understand that for services I receive using telehealth technologies may be in a different location than the provider. I understand that no guarantees have been made to me about the result of my examination or treatment.

B. Acknowledgement of Educational and Research Missions: RFUHC and their affiliates share a common mission in in advancing knowledge and discoveries through research and education with Rosalind Franklin University of Medicine and Science (RFUMS). I understand that my care will be provided within a teaching environment and the Physicians, Nurses, residents, fellows, and other health care professionals in training may be involved in my care and treatment. I also understand that my health information may be used within the within the RFUHC and its affiliates and released in accordance with the law and the RFUHC notice of Privacy Practices. I understand that my provider(s) may discuss various research opportunities that may be of interest for me and that I have the option of participating but may decline at any time.

C. Personal Property: I understand that the RFUHC and its affiliates will not be responsible for the loss, theft, or destruction of any personal property that I bring with me to RFUHC's. I release RFUHC from responsibility and liability for any personal property.

D. Photography and Recordings: I understand that I am not allowed to take pictures or use video or audio recordings of care, other patients, RFU Employees, providers, or students while within RFU facilities.

E. Language Assistance: A wide range of communication options are available based on the patient's individual needs. I understand that RFUHC utilizes qualified interpreter services and other language assistance services at no cost to me. I may request these services at any time during my visit by notifying a member of the patient care team, including my preferred language.

F. In Loco Parentis and Consent for Minors: RFUHC recognizes there may be instances when a parent/guardian is unable to accompany a minor patient to the clinic. Under Illinois law, a minor is a person who has not attained the age of 18 years and a minor cannot consent to medical treatment. A parent/guardian or person in loco parentis must consent to the treatment of a minor. The term "in loco parentis" might include an aunt or uncle or some other adult who does not have legal guardianship but who otherwise stands in the shoes of a parent. RFUHC requires the parent/guardian or loco parentis of the minor patient accompany the patient at minimum annually to provide written consent as a loco parentis designee to consent to medical consent on behalf of the minor.

HEALTH INFORMATION

A. My health information may include diagnostic information, lab tests, medications, allergies, history and assessment, treatment plans, profess or presence in treatment, clinical notes, discharge summaries and other records pertaining to my treatment. I agree that RFUHC can create recordings and images containing my health information for treatment, education and RFUHC operations as described in the RFUHC notice of Privacy Practices.

B. I understand that RFUHC and the Health System workforce adheres to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This law requires that Rosalind Franklin protect the privacy and security of its patients' treatment, contact, and financial information. Collectively, this information is referred to as your Health Information. In addition to HIPAA, there are other Federal and State laws which protect "Sensitive" health information, including health information as it relates to HIV/AIDS, behavioral or mental health, developmental disabilities, treatment for substance use disorders (alcohol and other illicit drugs), genetic

testing and counseling, sexual assault/abuse, domestic abuse of an adult with a disability, child abuse and neglect, and if as a minor, sexually transmitted illnesses, pregnancy, and birth control.

C. Treatment and Continuity of Care. As applicable and when my consent is required by law, I consent to Rosalind Franklin and its affiliates' contacting or sharing my health information with other healthcare providers to obtain information regarding my prior and current health conditions for treatment within RFUHC or as necessary for treatment, continuity of care, mandated reporting as required by law, for payment and health care operational purposes. I understand that payment purposes include disclosure of my health information to any health plan, Medicare, Medicaid, or other government program or other payer that I identify to RFUHC.

FINANCIAL CONSENTS AND ACKNOWLEDGEMENTS

A. Responsibility of Payment: I agree that I am financially responsible to and agree to pay RFUHC for services, supplies, and use of facilities which are utilized to provide my medical or behavioral health care. If I use health insurance (such as private insurance, Medicare, Medicaid, or other governmental or additional insurance plans), I authorize RFUHC to bill such insurer for all services rendered. I understand my insurance coverage may require that a portion of these charges will remain my personal responsibility such as assigned deductibles, co-payments, and charges not covered by my health insurance. I understand that my health insurance may deny payment for services for a variety of reasons. While RFUHC will take reasonable steps to appeal these denials, I understand that I am responsible for paying for services denied by my insurer. If I claim benefits under Title XVII of the Social Security Act (Medicare), I hereby certify that the information I provide in applying for payment of such benefits is accurate.

B. As required by the **Fair Patient Billing Act**. I understand:

- I may receive separate bills from RFUHC providers for the services provide to me.
- RFUHC providers may not participate in the same insurance plans and networks. Services provided by non-participating providers in an insurance plan or network are defined as "out-of-network services". I understand I may have a greater financial responsibility for out-of-network services. I understand that it is my responsibility to contact my insurance company to determine whether RFUHC is a participating provider within my insurance plan or network.
- Any questions I have regarding my Health Insurance Coverage or benefit levels should be directed to my health plan, my employer or insurance certificate of coverage. RFUHC cannot guarantee that a service will be covered by my insurance plan.
- If I do not have health insurance or have difficulty paying my bill, RFUHC provides financial assistance options, including free care, discounted care or interest-free payments. For additional information, please contact a RFUHC financial counselors at (847) 578-8815.

MEDICAL RECORDS TO BE RELEASED

I have read, understand and agree to the statements in this Consent for Medical Care and Services agreement. I understand this consent will expire one (1) year from the date the document is signed.
Patients 12-17 years of age must sign for mental health and developmental disability, substance abuse/alcohol treatment, AIDS or HIV testing/results, sexually transmitted infections, sexual assault, pregnancy and/or birth control counseling and information.

Date Time Patient Name/Signature for patients 12 years of age or older

Date Time Signature of (Circle one): *Parent* *Legal Guardian* *Legal representative*

Date Time Witness (Required for Mental Health/Developmental Disabilities records in IL)

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Information Communication Authorization

Name of Patient: _____ Date of Birth: _____/_____/_____

As part of our efforts to deliver quality care, we may need to contact you at times when you are away from the Health Clinics. Some examples are returning your phone calls, reminding you of scheduled appointments, and notifying you of lab results or other events. We normally contact our patients between 8am and 5:00pm, Monday through Friday. In order to accommodate any request you may have, please indicate your preferences below:

Please provide the telephone number(s) that you prefer is to contact. May we leave a message at this number?_____

Home: _____ Yes or No

Work: _____ Yes or No

Cell: _____ Yes or No

Protected Health Information Release:

We recognize that our patients often prefer to involve their family members or others in their health care. One example is when that the other person accompanies you to the examination room. At other times, you might not be readily available to express your preferences. Examples of those are when you want that other person to receive status updates while you are undergoing a procedure, to pick up prescriptions or other documents for you, or get answers to billing-related questions about your care. These events would normally involve that other person hearing or seeing some of your health information. To help us better understand your preferences in this matter, please indicate below the names of those you want to be involved in your care at times when you might not be readily available: ***Please note: RFU HC will always attempt the "patient" or "Legal Guardian" for for discussion involving PHI and treatment discussions. We will utilize the approved contact as a back-up when unable to reach the patient in a timely manner.***

1._____ Relationship _____ Phone #_____

2. _____ Relationship _____ Phone #_____

3._____ Relationship _____ Phone #_____

Signature of Patient_____ Date ____/____/____

Signature of Legal Guardian (if applicable) _____ Date ____/____/____

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Request for Provider to Complete Forms Policy

Dear Valued Patient,

The clinicians and staff of Rosalind Franklin University Health Clinics are committed to providing you with the highest quality care possible. It is the policy of Rosalind Franklin University Health Clinics that requests for providers to complete forms for work, or other roles that might include, but not be limited to, ability / fitness to drive or operate machinery, other fitness for duty assessments, parking disability requests etc. cannot be entertained on a first-time visit. Such requests can significantly impact the ability of Rosalind Franklin University Health Clinics to provide quality care to you, our patient.

Effective March 1, 2021, Rosalind Franklin University Health Clinics will require of an established patient – provider relationship which, for the purpose of this matter, will be defined as a minimum of three (3) visits between patient and provider. Clinicians reserve the right to exercise their professional judgement according to individual circumstances but in general as a first-time patient there should not be an expectation that paperwork is going to be completed.

If you have any questions or concerns about this change, please feel free to discuss with our Patient Service Representatives or your assigned provider. We look forward to continuing to work with you.

Sincerely,

Rosalind Franklin University Health Clinics

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No Show / Same Day Cancellation Policy

Dear Valued Client,

The clinicians and staff of Rosalind Franklin University Health Clinic are committed to providing you with the highest quality care possible. It is the policy of Rosalind Franklin University Health Clinic that appointment cancellations be received by our office 24 hours prior to the scheduled appointment. We certainly understand that obstacles may arise from time to time that can interfere with your ability to keep all scheduled appointments. However, no-show and same-day cancelled appointments can significantly impact the ability of Rosalind Franklin University Health Clinic to provide quality healthcare for all our clients. Therefore, in an effort to continue to provide the highest quality care possible, we will be instituting and enforcing a no show/same-day cancellation policy.

Effective January 1st, 2023, Rosalind Franklin University Health Clinic will reserve the right to charge a fee of $50 for each appointment that is cancelled on the same day and $100 for each no showed appointment. No show/same-day cancellation fees must be paid prior to future appointments being scheduled or fulfilled.

Clinicians reserve the right to terminate services if more than (2) no shows/cancellations with less than 24 hours' notice occur within the same month or (3) total no shows occur over three consecutive months.

If you have any questions or concerns about this change, please feel free to let us know. We would be happy to discuss this with you. We look forward to continuing to work with you.

Sincerely,

Rosalind Franklin University Health Clinics

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

Rosalind Franklin University Health Clinics is required by law (the federal HIPAA Privacy Rule) to maintain the privacy of protected health information (PHI) and to provide you with this notice of our legal duties and privacy practices regarding PHI. We are required to abide to the terms of this notice. We may change at any time the terms of this notice for all PHI we maintain. If we do so, we will revise this notice to reflect the new terms and have it available for you upon request.

PERMITTED USES AND DISCLOSURES

At times, other federal laws and the laws of the State of Illinois impose stricter limits on the use and disclosure of PHI than the HIPAA Privacy Rule. In those cases, the HIPAA Privacy Rule states that we must follow the laws that provide you with the greater amount protection over your PHI. Subject to those stricter limits, we may use and disclose your PHI as follows:

Treatment. We may use or disclose your PHI for treatment activities of a health care provider. For example, we may use your PHI to provide medical care to you and we may disclose PHI to another physician who is providing medical care to you.

Payment. We may use or disclose your PHI for activities relating to obtaining reimbursement for the health care services you received. In addition, we may disclose your PHI for similar activities of another health care provider or a group health plan that relates to you. For example, we may use your PHI to bill you or your insurance company, as appropriate, for services rendered.

Health Care Operations. We may use or disclose your PHI for certain activities relating to the operation of the Health Clinics as a health care provider. In addition, we may disclose your PHI for those activities relating to the operation of another health care provider or a group health plan with which you have a relationship. For example, we may use and disclose your PHI for activities relating to quality assessment, training of health care professionals, fraud and abuse detection, and compliance programs.

Other Permitted Uses and Disclosures. We may use and disclose your PHI so long as certain conditions that relate to your privacy and public necessity are met:

* to **Persons Involved in Your Care or Payment of Your Care**, but you will have the opportunity to object and, if you do object, we will abide by your wishes. * to **Business Associates** who perform functions for us and who have promised in a written agreement to safeguard your PHI.
* as **Required by Law**, so long as the specifics of the use or disclosure is no more than that required by the law.
* for **Public Health Activities**, such as reporting disease, injury, and vital statistics.
* to **Report Adult Abuse, Neglect, and Domestic Violence**, under certain conditions. * to a **Health Care Oversight Agency** that oversees the health care system.
* for **Judicial and Administrative Proceedings**, so long as there is a lawful court order or other legal demand.
* for certain **Law Enforcement Purposes**, such limited PHI relating to fugitives, crime victims, suspicious deaths, crimes on our premises, and crimes in emergencies.
* certain information about **Decedents** to coroners, medical examiners, funeral directors, and organ/tissue donation entities.
* for **Research Purposes**, so long as an oversight board approves the request under strict guidelines, is preparatory work that does not leave the Health Clinics, or is about decedents.
* to **Avert a Serious Threat to Health or Safety**, as necessary under the circumstances. * for certain **Specialized Government Functions**, such as Armed Forces personnel, national security activities, correctional facilities, and government health benefit programs.
* for **Workers' Compensation** programs.
* to contact you and provide information **Useful Information**, such as appointment reminders and health-related benefits and services that may be of interest to you.

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* to contact you about the Health Clinics efforts to **Raise Funds**, but you have the right to opt out of receiving these fundraising communications.
* a **Limited Data Set**, which deletes certain information about you, so long as the PHI is only used for research, public health, or health care operations purposes and the recipient agrees in writing to safeguard your PHI.

Your Written Authorization. Other than the uses and disclosures discussed above, we will not use or disclose your PHI without your written authorization. This includes uses or disclosures made for marketing purposes, that constitute a sale of your PHI, and of most psychotherapy notes. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure that occurred prior to this Health Clinic receiving your revocation.

YOUR RIGHTS

A brief summary of your rights are as follows. For additional information regarding these rights, you may contact the office listed at the end of this notice.

Access. You have the right to inspect and obtain a copy of your PHI records. To do so, you must seek access in writing. A reasonable fee may be charged for copying and postage, if applicable.

Amendment. You have the right to seek an amendment to your PHI records. To do so, you must make your request in writing. Even if the PHI record is determined to be accurate and complete, you have the right to submit a statement of disagreement.

Accounting. You have the right to obtain a list of certain disclosures that occurred regarding your PHI. To do so, you must seek your accounting in writing. Some disclosures would not be mentioned on that list, such as those associated with treatment, payment, and health care operations and disclosures you personally authorized in writing.

Further Restrictions. You have the right to seek further restrictions on how we use or disclose your PHI. To do so, you must make your request in writing. Although we are not required to agree to most of those requests, we will review them and, if we do agree, we will document it and abide by it. We are required to agree to a request to restrict a disclosure of your PHI to a health plan for payment or health care operations purposes when the PHI relates to a health care item or service for which we have been paid in full by you or by other alternative means.

Confidential Communications. You have the right to request that we communicate with you using alternative means or at alternative locations. To do so, you must make your request in writing. If the request is reasonable, we will accommodate it.

Copy of this Notice. You have the right to receive a paper copy of this notice upon request, even if you previously agreed to receive this notice electronically.

File a Complaint. You may file a complaint with us and to the U.S. Department of Health and Human Services if you believe we have violated your privacy rights and we will not retaliate against you in any way. To file a complaint with us, you should contact the office listed at the end of this notice.

Notice of Breach. You have the right to receive notifications of breaches of your unsecured PHI.

FURTHER INFORMATION

If you have any questions, desire to file a complaint, or seek further information about matters contained in this notice, you may contact:

Jeff Espina, MBA
Vice President, Clinical Services
Privacy Officer
Rosalind Franklin University Health Clinics
3471 Green Bay Road
North Chicago, IL 60064
Tel: (847) 578-84

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