NEW PATIENT PACKET

Welcome to the Institute for Personal Development.

The Institute for Personal Development provides the highest quality of mental health care. Our goal is to assist with alleviating emotional pain and suffering for individuals, families and communities. Our plan for treatment is to improve each individual's quality of life.

We feel that your emotional health is a priority! Our plan is to provide services that are individualized for each and every client. Our clinicians will work with you to provide services that are comfortable for each individual while meeting their personal needs. It is important to us that you recognize improvement and obtain results in improving your quality of life.

Our team of clinicians is professional and well trained with scientific knowledge of useful treatment techniques. Such techniques can be used to assist individuals to cope with stressful situations at home, at work, at school and in the community. Within treatment, we use traditional and complementary approaches with the highest level of clinical and ethical standards.

As a new patient, there are several things we will be asking for:

1. Please fill out all forms completely.
2. We will need a copy of your (guarantor's if patient is a minor) driver's license. (If you are writing checks for services rendered, we need this on file.)
3. A copy of your current insurance card(s).
4. Please verify that your physician/therapist is a member of your insurance plan. You can do that by calling your insurance company.
5. Depending on whether you are here for medical or mental health reasons, your benefits might be different. Find out if you are required to pre-certify your visits. It might mean the difference in how, or if, your insurance company pays.

New Patient Information Sheet

Personal Information (must be filled out completely)

Doctor/Therapist you are seeing today _____ Today's Date _____

Patient Name _____

Home Address _____
Street City State Zip

E-Mail Address _____

Home Telephone (_____) _____ Work Telephone (_____) _____

Cell Telephone (_____) _____ Other Telephone (_____) _____

Patient Date of Birth _____ Patient Social Security Number _____

Employer _____

Employer's Address _____
Street City State Zip

Employer's Phone (_____) _____ Extension _____

Spouse's Name _____ Spouse's Work phone (_____) _____

Referral Source (i.e.: Doctor, phone book, etc) _____

Referral Address_____
Street City State Zip

Referral Phone Number (_____) _____

Patient's Mothers Maiden Name _____

Whom may we contact in an emergency? _____

Telephone number (_____) _____ **Relationship** _____

Address _____
Street City State Zip

Insurance Information

PRIMARY Insurance _____

Group Number _____ Policy Number _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Social Security Number _____

SECONDARY Insurance _____

Group Number _____ Policy Number _____

Insured's Name _____ Insured's Date of Birth _____

Insured's Social Security Number _____

What is your ethnic background?

_____ American Indian and Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian and Other Pacific Islander
_____ White
_____ Hispanic or Latino

Institute for Personal Development

Administrative Policies & Procedure Overview:

Thank you for choosing the Institute for Personal Development for your health care needs. We are committed to providing high quality, personalized and comprehensive patient care. We ask that these policies be reviewed and initialed so that we can provide quality service and ensure reimbursement. Please initial next to each policy indicating that you have read the terms and conditions and agree to abide by them:

1. **Consent for Treatment:**
   a. I hereby authorize, and acknowledge to work with, the authorities of the Institute for Personal Development, and the physician(s)/therapist(s) in charge of my/the case, to administer such medications and treatments as may be deemed necessary for the interest and care of me/the patient described on this form.

2. **Pre-Authorization for Benefits:**
   a. I acknowledge that I am also required to call my insurance company to verify my benefits and insurance coverage for services rendered and that a quote of benefits is not a guarantee of payment:

3. **Payment Guarantee:**
   a. Sessions shortened by the patient will still be charged at full reserved fee.
   b. Full payment is due at time of each appointment, unless managed care insurance covers authorized services in full or payment arrangement made with IPD Billing Department.
   c. Co-payments are due in FULL at time of each visit.
   d. Checks written and returned NSF/Account Closed will be charged an additional **$35.00**.
   e. All future payments must be made via Cash/Credit or Debit card if any personal check is returned NSF.
   f. **If you do not have insurance**, payment is due in full at each visit and services may be turned away at the discretion of the physician.
   g. RESPONSIBILITY of an account balance is always the Patients, NOT the insurance company.
   h. IPD bills primary and secondary insurance companies as a courtesy. IPD does not bill tertiary (3rd) insurances.

4. **Release of Insurance-Related Information:**
   a. I authorize insurance payment(s) to be made directly to providers of the Institute for Personal Development.
   b. I authorize the Institute for Personal Development to release any information about me to insurance carriers needed to process claims.

5. **Delinquent Accounts:**
   a. Patients must settle past due account balances prior to scheduling future appointments.
   b. All outstanding balances are due in full at the time of service unless payment arrangements have been made with IPD Billing Department.
   c. Non-payment of delinquent balances will be grounds for termination of services rendered by IPD until the delinquent balance is resolved in its entirety.

d. Delinquent balances will be sent to our collection agency. In the event that services are not paid in full and we must pursue legal action, all attorneys' fees, court costs, and filing fees will be the responsibility of the patient/guarantor.

6. Overpayments:

I understand patient overpayments for actively treated patients will be used toward future copays/deductibles/coinsurance/balances. I understand should I decide to no longer continue treatment at IPD, I must submit a written request to the IPD Billing Department for a refund of any patient overage on my account. I understand that refunds will not be processed until all claims billed to my insurance have been processed by my insurance. I understand refunds take 90 days to process. I also understand after I have received my refund that if my insurance at some point takes back their payment made to IPD on my behalf creating an amount owed, that I am responsible to pay that balance.

7. Phone Consultation with Clinician

IPD clinicians do charge for clinical phone consultations with patients. Charges are according to the Individual Clinician's specific fee schedule. You will see such charges on your patient statements. Please be aware that phone consultations cannot be billed to insurance. All phone consultation charges are solely patient's responsibility.

8. Medical Records Charge:

a. We take the time and consideration to ensure your records are kept confidential. There is a standard processing fee of $30 for any medical records that are released.
b. Medical Record releases take in minimum of 10 business days from the date IPD receives a signed release form.

9. Completion of Forms/Letters

The charge for the completion of forms/letters typically can range between $30 - $150. However, please note that depending upon the length of the forms or documentation being requested, this charge could be higher.

Please sign below to authorize treatment indicating that you acknowledge your full financial responsibility for services rendered:

_____ _____
Printed Name of Patient Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Guarantor Date

If patient is a minor or unable to sign, state reason:

_____

_____

THE INSTITUTE FOR PERSONAL DEVELOPMENT

Aurora - 1029 E New York St. Aurora, IL 60504
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Orland Park - At SW Pediatrics, S.C. 16622 S. 107th Court Orland Park, IL 60467
Chicago - Garland Building 111 N. Wabash Ave. Suite 1116 Chicago, IL 60602
Morris - 1401 Lakewood Dr., Suite A Morris, IL 60450
Ottawa - 410 East Stevenson Road Suite D, Ottawa, IL 61350
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Romeoville - 1239 Windham Pkwy. Romeoville, IL 60446

Notice of Privacy Practices

Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Type of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: X_____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

INSTITUTE FOR PERSONAL DEVELOPMENT

Late Cancellation/ Missed Appointment Policy

At the Institute for Personal Development, treatment begins with a partnership. We cultivate a clinician- patient partnership that is based on trust and collaboration, focusing on patients as individuals. Our clinicians and support staff strive to be fair and courteous in all of our dealings.

The following policy has been established to help us serve our patients better. It is necessary for IPD to make appointments in order to see our patients as efficiently as possible. No-shows and late cancellations cause problems beyond financial impact to our practice. When a patient is scheduled for an appointment, our clinician is reserving his or her time specifically for that patient. When an appointment is made, it takes an available time slot away from another patient in need of care. Not cancelling an appointment in a timely fashion restricts our ability to make the appointment available to another patient. For these reasons we have developed the following No- Show/Late Cancellations policy.

A No-Show is defined as missing a scheduled appointment without calling IPD in advance to cancel the appointment. A Late Cancellation is defined as failing to cancel or reschedule a scheduled appointment at least 24 hours before your scheduled appointment. If you need to cancel or reschedule your appointment, you must contact our office no later than 24 hours before your scheduled appointment so that we may offer the appointment time to another patient who is in need of attention.

The following is our policy regarding appointment cancellations.

1. Fee for failure to provide 24-hour advanced notice.
   a. When a patient misses an appointment with less than 24-hour advance notice the patient will be charged $75 for the late cancellation.
2. Fees for failure to attend scheduled appointment.
   a. When a patient misses an appointment the patient will be charged $125 for the no show.
3. Waiver of fees by IPD clinical providers
   a. We understand that the circumstances beyond your control may arise, where adequate notice is not possible. These limited situations will be considered on a case by case basis. While we value the input of the clinical providers when it is required, please note that IPD clinical providers are unable to personally waive any fees regarding this policy.
4. Patient responsibility for failure to provide 24-hour advance notice of appointment cancellation
   a. Patients are advised that fees charged for failure to provide 24-hour advance notice of an appointment cancellation are not covered by insurance. These fees are the responsibility of the financially responsible party.
5. When a patient misses or late cancels 4 or more appointments within a 12-month period, the financially responsible party will be required to put a credit card on file to schedule future appointments. A billing representative will reach out to the financially responsible party to obtain the credit card information to maintain on file. If a subsequent appointment is missed or late cancelled a $100 fee will automatically be charged to the credit card on file.

PATIENT NAME: _____ PATIENT NUMBER: _____

GUARANTOR NAME: _____ RELATIONSHIP TO PATIENT: _____

GUARANTOR SIGNATURE: _____ DATE: _____

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Dear IPD Patients,

At The Institute for Personal Development we pride ourselves on being a state of the art mental health practice. With that in mind we are currently introducing the next advancement in behavioural health care called "Measurement Based Care."

In Measured Based Care, we use standardized tests in order to determine precisely how well patients are doing. The goal in treating patients is not just to help them get better but to try to treat their condition to remission (no longer having any significant symptoms which interfere with their life). In order to do this it is critical that your clinician not just get a sense of how you are doing but to specifically ***measure*** how you are doing based on scientifically validated tests.

In addition, patients looking to choose a doctor or therapist do not just want to know what doctors and clinicians "specialize in" but actually how effective they are in treating certain conditions by looking at their ***outcomes***. Lastly, insurance companies are asking clinicians to demonstrate that they are cost-effective in treating patients and are asking us to demonstrate how effective our clinicians are in treating conditions.

WHAT THIS MEANS FOR OUR PATIENTS

For our patients this means in the beginning of your session your clinician may ask you to take a brief computerized test to determine how well your condition is doing on a standardized test. In addition, it means that there will be a charge associated with the test. Typically the test is paid for by your insurance company and ***you may have a small copayment for the test***. If the test is not covered by the insurance company, please call our billing department and we will investigate this and assist you. The charge for the testing goes to pay for the cost of the technology and implementation of state of the art care in our practice.

The testing ***is not optional*** as we have to be able to know ***objectively*** how well we are caring for you.

Sincerely,

Ronald Wuest, MD
Medical Director
The Institute for Personal Development

INSTITUTE FOR PERSONAL DEVELOPMENT

MEDICAID/ILLINOIS PUBLIC AID ACKNOWLEDGEMENT

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333 N. Hammes Ave. Ste 108
Joliet, IL 60435
(815) 725-6511

I,_____ understand that the Institute for Personal Development is not accepting Medicaid/Illinois Public Aid Insurance for **primary or secondary** insurance. If Medicaid/Illinois Public Aid insurance is needed to be obtained during treatment here at I.P.D., I understand that I will be accepted as a cash patient and agree to pay my account in full at time of service. **

_____ _____
Signature of Patient (or Legal Guardian) Date

** In the event that services are not paid in full and we must pursue legal action, all attorneys' fees, court costs and filing fees will be the responsibility of the patient/guarantor.**

Note: ALL MENTAL HEALTH INFORMATION IS PRIVILEGED AND HIGHLY CONFIDENTIAL. The information you share is STRICTLY BETWEEN YOU AND YOUR DOCTOR OR THERAPIST! No information will ever be released without your written permission!

INSTRUCTIONS:

Please fill out this form completely. If you are the parent/guardian of the patient, please ask the patient any questions that he/she is able to answer according to his/her age. Otherwise, answer the questions below to the best of your knowledge of the patient. The answers to these questions are very important in allowing us to care for the patient. Some of these questions we ask may seem silly or that they don't apply to you. Regardless, answer all questions to the best of your ability.

Date: _____

Name: _____ Age: _____ Sex: Male/Female Date of birth: _____

If you are the parent/guardian of the patient and completing this form for the patient listed above, please write your name: _____ Relation to Patient: _____

Who is your primary care physician? _____

May we contact your primary care physician with our initial findings? Yes No

In the event that you request us to contact your primary care physician to coordinate your care, please provide his or her:

Address _____

Phone Number (_____) _____ Fax number _____

***Please make sure to sign an IPD Release of Information Form**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates or ~year of infection:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Allergies/ medication reactions	
Name the Drug	Reaction You Had
Food sensitivities	
Name the Food	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Other Modalities (ex: massage, yoga, meditation, etc)	☐ Yes, please list:_____			☐ No		
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No

Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Would you like information on the preparation of these?			☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children?**	☐ M ☐ F	
Mother			Yes: ☐, #___	☐ M ☐ F	
Siblings?	☐ M ☐ F		No: ☐	☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
Where are you in your family's birth order? # ____ of____ children	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

CURRENT MEDICATIONS/SUPPLEMENTS:

NAME:	DOSE:

Institute for Personal Development

Authorization to Release Information

_____ I authorize Institute for Personal Development to request records from the following office:

_____ I authorize Institute for Personal Development to release records to the following office:

_____ I give the Institute for Personal Development permission to speak verbally with the following individual/office:

_____
(Name of Facility or Clinician)/Nature or Relationship to Patient

_____
(Address) (City, State, Zip)

_____ _____
(Phone Number) (Fax Number)

The following information on _____ _____
(Patient's Name) **(Date of birth)**

Please release the following information (or specify):

_____ Verbal Information
_____ Medical Records
_____ Medical History/Physical
_____ Psychologist Evaluation
_____ Social History
_____ Prescription/Sample Pick-Up
_____ Other (specify) _____

_____ ALL INFORMATION
_____ Lab Results
_____ Treatment Plan/Patient Progress
_____ Discharge Summary
_____ Results of Drug and Alcohol Treatment or Testing
_____ Mental Health Records

For the Purpose of: Coordination of care

Approximate Dates of Service: _____

Release Expiration Date: _____***Not to exceed 90 days*** (Consent subject to revocation at any time.)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.

_____ _____
Signature of Patient/ Responsible Party if Minor Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Clinician #I Date

_____ _____
Signature of Clinician #2 Date

_____ _____
Signature of Clinician #3 Date

*** There is a standard processing fee of $30.00 for any medical records that are released
All patients 12 years of age or older need to sign this authorization to release.***