LUXMED BEHAVIORAL HEALTH LLC

2S631 State Route 59 Ste E Warrenville, IL 60555
(630) 216-9098
Email: info@luxmedbh.com

PATIENT REGISTRATION FORM			
Date:			
How did you hear about us? (circle one)	Referral(insurance/Doctor/Therapist/Friend/Family);internet; advertisement; other		
PATIENT INFORMATION			
Last Name:	First Name:	Middle Name:	
Street Address:	City:	State:	Zip:
Cell Phone:		Email Address:	
Date of Birth:	sex: Male / Female		
Notify Primary Care Physician? Yes/No Name of Primary Care Physician:		Contact Info:	
IN CASE OF EMERGENCY			
Emergency Contact Name:	Contact number:		

PREFERRED PHARMACY			
Pharmacy Name:			
Address: Phone:	City:	State:	ZIP:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize LUXMED BEHAVIORAL HEALTH LLC, those acting on the practice's behalf, and my insurance company to release any information required to process my claims. Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

______________________________ ______________________

Patient/Guardian Signature Date

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HEALTH HISTORY QUESTIONNAIRE

Mental Health History			
Have you ever seen a mental health provider for any reason (this includes psychiatrist, psychologist, counselor, etc? (please circle) yes/no			
If yes, when and why?			
Year	**Reason**	**Hospitalized (please circle)**	
		yes	no
		yes	no
		yes	no
		yes	no
		yes	no
Have you ever made a suicide attempt or thought about it? (please circle) yes/no			
If so, when?			

Symptom Screen (please circle)	
Have you ever been sad or depressed for more than two weeks?	**yes / no**
Have you ever had so much energy that you didn't need to sleep and/or made big plans or bad decisions?	**yes / no**
Have you ever been so anxious that you couldn't do anything or even leave the house?	**yes / no**
Do you often feel that you need to count, check or clean things in a special way?	**yes / no**
Do you ever have several minutes of extreme anxiety or fear that just comes of out the blue?	**yes / no**
Do you feel that you can't control your thoughts or that people can read or control your mind?	**yes / no**
Have you ever thought about someone so much that you followed them?	**yes / no**
Do you have trouble sleeping?	**yes / no**

Medical History	
Do you have any non psychiatric medical illnesses? (please circle) yes / no	
If yes, please list problem and approximate year it was diagnosed	
Problem	**Year Diagnosed**

Hospitalizations		
Year	**Reason**	**Hospital**

List all prescribed medications and over the counter drugs including vitamins		
Name of drug	**Strength (mg)**	**Frequency (times taken per day)**

Allergies to medications	
Please list name of drug and reaction seen with drug	
Name of Drug	**Reaction**

Health Habits		
Alcohol	Do you drink alcohol? If yes what kind? (Please circle type) Beer Wine Hard Liquor	**yes / no**
	How many drinks per week? Please list approximate number of drinks in the space provided	
	Are you concerned about the amount of alcohol you drink?	**yes / no**
	Have you ever experienced blackouts?	**yes / no**
	Are you prone to binge drinking?	**yes / no**
	Have you received treatment for drug or alcohol addiction?	**yes / no**
Tobacco	Have you ever used tobacco?	**yes / no**
	Do you currently use tobacco?	**yes / no**
	If yes please provide type and amount per day. Cigarettes__________ How many years have you smoked? ______________ If you no longer smoke please list year you quit:___________	
Vaping	______________________ Do you vape? If yes, how often _________________________	
Drugs	Do you currently use recreational or street drugs?	**yes / no**
	Have you ever given yourself street drugs with a needle?	**yes / no**

Family Mental Health History		
Family Member	**Age**	**Mental Health Problem**
Father		
Mother		
Brother		
Sister		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Any other family members with mental/emotional problems? If so who?		

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CONSENT FOR TREATMENT

LUXMED BEHAVIORAL HEALTH, LLC offers superior behavioral health services for all adults. The following policies are imperative in order to provide effective and efficient treatment.

Financial Policy: Payment for any copay, past balance, or deductible is due upon time of arrival of your appointment. LUXMED Behavioral Health, LLC will verify all insurance benefits prior to appointment. If a deductible has not been satisfied, payment will be the responsibility of the patient at time of service. If you do not have insurance or your insurance will not cover Mental Health Services, you will be considered "self-pay" and payment is due in full prior to appointment.

No show policy: Failure to show up for an appointment without calling to cancel at least twenty-four hours prior to the scheduled appointment will result in a "No Show" charge. Patients will be charged the full fee ($150.00 for follow up visits and $350.00 for new patient visits) of the appointment. Our voicemail system comes with a timestamp, therefore any messages left will have a recording date and time.

Cancellation policy: Should you need to cancel an appointment, please notify LUXMED Behavioral Health, LLC at least twenty-four hours prior to the scheduled appointment via phone. Failure to call and notify your provider will result in a cancellation fee ($150.00 for follow up visits and $350.00 for new patient visits).

Medication policy: Medication renewals or adjustments will occur during scheduled appointments. In the event that a patient needs a refill before the scheduled appointment, LUXMED Behavioral Health, LLC will require 48 hours to complete the request so that the physician has time to review the request.

Request of medical records: Medical records will only be released once a patient signs a release form. Please allow 7 - 10 business days for the request to be completed. The first request will be completed at no additional costs. Additional requests will be subject to a fee of $50.00

Notice of privacy practices: LUXMED Behavioral Health LLC is required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please contact our office at (630) 216-9098

Your signature below indicates you have read, understand and agree to the above policies of LUXMED Behavioral Health, LLC.

Patient Signature:______________________________ **Date**:_______________

LUXMED BEHAVIORAL HEALTH LLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

________________________________ ________________ ____________________
Name of Patient DOB Social Security Number

This release will include DRUG and ALCOHOL history, treatment and/or diagnosis unless specifically excluded. I authorize LUXMED Behavioral Health LLC and its clinical and professional staff to:

___________Release information to the following:
___________Receive information from the following:
___________Exchange information with the following:

____
Name/Title/Facility

____
Street Address, City, State, ZIP

Phone Number Fax Number
Specifically requested records consent:
___________Discharge Summary
___________Psychiatry / therapist evaluation
___________Medical information
___________Other information___________________

Record information NOT to be released:
____

The purpose of this release:________Insurance / 3rd party payment______Pending legal action
_________Continuity of care__________Assist in evaluation
_________other, specify: ____

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from LUXMED Behavioral Health or health care benefits. This authorization shall expire 1 year from the date of signing, and is subject to revocation by the patient at any time prior to the expiration date, but not made retroactive to any information already released. The request to retract this release shall be in writing, signed, dated and sent to LUXMED Behavioral Health, LLC. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected. I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release.

Signature of Patient:____Date: ______________

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Authorization to Secure Payment

I ,____authorize LUXMED BEHAVIORAL HEALTH, LLC to process payment on my credit card for services rendered in the office.

Full payment for services are due at time of service and will be collected prior to the start of each visit.

I understand that if my card is declined, LUXMED BEHAVIORAL HEALTH, LLC may contact me in order to process the payment. If I am contacted I will need to provide a new card for the payment to be processed.

I also understand that in order to ensure consistency in my care and treatment, if I miss a scheduled FOLLOW-UP appointment and/or fail to provide 24 hour advanced cancellation notice, my credit card will be charged at the full fee of $150. I also understand that if I miss a scheduled New Patient Visit and fail to provide 48 hours advanced cancellation notice, my credit card will be charged at the full fee of $350.

I have read and understand this form. I also confirm and verify that the payment information is also true and accurate.

______________________________ ____________________

Signature Date

Credit Card Information

Cardholder's Name	**Patient's Name**	
Credit Card Number	**Exp Date**	**CVC**

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NOTICE OF PRIVACY PRACTICES

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

This Notice describes the privacy practices of LUXMED Behavioral Health and all business associates with whom we may share your protected health and medical information. We provide the Notice of Privacy Practices to every patient we have a direct treatment relationship. This Notice is also available to any member of the public and is posted within our reception area. Every effort will be made to obtain a signed Receipt of Notice of Privacy Practices from each patient that will be kept on file. If the patient refuses to sign the form, it will be noted that the Notice was given but the patient refused to or could not sign the Receipt. We understand that your medical or PHI ("protected health information") is confidential and we are committed to maintaining its privacy. Federal law requires that we provide you with this Notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice when we use or disclose your PHI and are also required by law to notify you if you are affected by a breach of your secured PHI.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION OR PHI ABOUT YOU

Treatment Purposes. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. In addition, we may contact individuals through telephone, mail and email with appointment reminders and may utilize facsimile transmissions for specific authorizations and prescription refills through pharmacies. We may also disclose your PHI to other providers involved in your treatment.

Payment Purposes. We may use and disclose PHI to obtain payment for the treatment services provided. For example, we send PHI to Medicare, Medicaid, your health insurer, HMO, or other company or program that is to pay for your health care so they can determine if they should pay the claim. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

Health Care Operations. We may also disclose PHI to other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, and peer review. We may share your PHI with third parties that perform various business activities such as an outside billing company, appointment reminder service or electronic practice management vendor provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.

Disclosure to Family, Close Friends and Other Caregivers. In an emergency situation, we may disclose PHI to those involved in a patient's care when the patient approves or, when the patient is not present or not able to approve, when such disclosure is deemed appropriate in the professional judgment of the practice or such as necessary. When the patient is not present, we determine whether the law requires the disclosure of the patient's PHI, and if so, disclose only the information directly relevant to the person's involvement with the patient's health care.

Disclosures Required by Law. As a behavioral health provider, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. However, we may also

use or disclose PHI about you without your prior authorization, subject to certain requirements and as required by law.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If PHI is disclosed for this reason, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. We may disclose PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Health Oversight Activities. We may use and disclose your PHI to state agencies and federal government authorities when required and as authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control. We may use and disclose your PHI in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs.

Judicial and Administrative Proceedings. We may use and disclose your PHI in judicial and administrative proceedings such as pursuant to a subpoena, court order, administrative order or similar process. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement. We may use or disclose PHI to law enforcement to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Specialized Government Functions. We may review requests from US military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Dept of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Work-Related Injuries. We may use or disclose PHI to an employer to evaluate work-related injuries.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm or to provide treatment in an emergency situation. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

For any purpose other than the ones described above, we will only use or disclose your PHI when you give us your written authorization. For instance, we will obtain your written authorization before we send your PHI to your employer or health plan sponsor, for underwriting and related purposes for a life insurance company or to the attorney representing the other party in litigation in which you are involved.

Highly Confidential Information. Federal and Illinois law requires special privacy protections for highly confidential information about you. Highly Confidential Information consists of PHI related to: psychotherapy notes; mental health and developmental disabilities services; alcohol and drug abuse services; HIV/AIDS testing, diagnosis or treatment; venereal disease(s); genetic testing; child abuse and neglect; domestic abuse of an adult with a disability; or sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS REGARDING YOUR PHI

Right to Receive an Accounting of Disclosures. You have the right to request an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization. If you request an accounting more than once during a twelve (12) month period, we will charge you $25. A request for disclosures must be made in writing to the Privacy Officer.

Right to Inspect and Copy Your PHI. You have a right to inspect or get a copy of your medical record file and billing records maintained by us. In some circumstances, we may deny you access to a portion of your records. If you desire access to your records, submit your request in writing to the Privacy Officer. A reasonable fee, not to exceed limits allowed under Illinois law, will be charged for the copying and mailing.

Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please submit your request in writing to the Privacy Officer. We are not required to agree with your request to amend.

Right to Request Restriction of Disclosures. You may submit a request in writing to the Privacy Officer to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Receive Confidential Communications. We accommodate all reasonable requests to keep communications confidential and to allow you to receive your PHI by alternative means of communication or at alternative locations. A request for confidential communications must be in writing, must specify an alternative address or other method of contact and must provide information about how payment will be handled. The request should be submitted to the Privacy Officer. We will determine the reasonableness based on the administrative difficulty of complying with the request. We will reject a request due to administrative difficulty if no independently verifiable method of communication (such as a mailing address or published telephone number) is provided for communications; or if the requestor has not provided information as to how payment will be handled.

Authorization. We obtain written authorization from a patient or a patient's representative for the use or disclosure of PHI for reasons other than treatment, payment or health care operations. We will not, however, get an authorization for the use or disclosure of PHI specifically allowed under the

Privacy Rule in the absence of an authorization. We do not condition treatment of a patient on the signing of an authorization, except disclosure necessary to determine payment of claim (excluding authorization for use or disclosure of psychotherapy notes); or provision of health care solely for the purpose of creating PHI for disclosure to a third party (pre-employment or life insurance exams). A specific written authorization is required to disclose or release mental health treatment notes, alcoholism treatment, drug abuse treatment or HIV/Acquired Immune Deficiency Syndrome (AIDS) information.

Right to Revoke Your Authorization. You have the right to revoke your written authorization, except to the extent that we have taken action in reliance upon it, by submitting your request in writing to the Privacy Officer.

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of the breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this Notice which may be obtained by contacting the Privacy Officer.

For Further Information or Complaints. If you have questions, are concerned that your privacy rights have been violated, or disagree with a decision made about access to your PHI, you may contact our Privacy Officer who serves as the contact person for all issues related to the Privacy Rule. Written complaints may also be filed with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington, D.C. 20201. Complaints must name the practice, describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time you became aware or should have become aware of the violation. We will not retaliate or take any adverse action against you if you file a complaint.

I have received LUXMED Behavioral Health LLC Summary of Privacy Practices

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

____

Patient's Last Name Patient's First Name Patient's DOB

Patient Signature:______________________________ Date: ________________________