EST MMXII
CREEKWOOD ASSOCIATES

NEW PATIENT FORMS AND SIGNATURES

This document includes the following forms to be returned to your provider:

- Patient Information Form (Required)
- Consent to Treatment Signature Form (Required)
- Patient Questionnaire/Symptom Checklist/Child Development History (Required)
- Credit Card on File Policy
- Authorization to Obtain/Disclose Protected Health Information

If you plan to use insurance, please provide a copy/image of the front and back sides of your insurance card.

PATIENT INFORMATION FORM

PATIENT INFORMATION

First Name | MI | Last Name | Preferred/Nickname | DOB

Street Address | City/State | Zip

Gender | Pronouns | Gender on Insurance Card ☐ M ☐ F | Marital Status | Race/Ethnicity

Phone Numbers (*Include area code)*

☐Home _____ ☐Mobile_____ ☐Work_____

*Put **X** next to your preferred number to reach you.* *OK to leave detailed voicemail at preferred number?* ☐ Yes☐

Email | How did you hear about Creekwood Associates?

Emergency Contact Name | Relationship to Patient | Phone Number

IF PATIENT IS A MINOR

Parent/Guardian 1 Name | Relationship to Patient | Phone Number

Parent/Guardian 2 Name | Relationship to Patient | Phone Number

Custody Arrangements

FOR PSYCHIATRY PATIENTS/MEDICATION

Pharmacy Name | Street Address | City/State/Zip | Phone Number

FINANCIALLY RESPONSIBLE PARTY ☐ Self ☐ Other – *if not the patient, provide information below:*

Full Name | DOB | Relationship to Patient | Phone Number

Street Address | City/State | Zip

IF USING INSURANCE ** Creekwood Associates accepts BCBS PPO and BCBS HMO - NMP Group only**

Insurance Company Name | ID#/ | Plan# | Employer/Plan Sponsor Name

Policy Holder's Full Name | SS# | DOB | Phone Number

CONSENT TO TREATMENT SIGNATURE FORM

Please initial next to each statement:

_____ I consent to participate in the treatment at Creekwood Associates. I have received and read the **Notice of Practice Guidelines** explaining the risks and benefits of treatment, the fees for services, and practice policies, and I agree to its terms.

_____ I have received and read the **Notice of Private Information Practices** as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the Practice Guidelines or Privacy Notice that I do not understand.

_____ **I understand that I am responsible for my bill**. While Creekwood Associates will assist me in pursuing insurance reimbursement, I understand that unpaid bills will become my responsibility and that failure to make payment within 60 days may result in turning my account over to a collection agency. I understand that Creekwood Associates may elect to end treatment if timely payment for services is not made.

_____ **I understand that I will be charged $125 for failing to show to an appointment without notice or for failing to give at least 24 hours' notice when canceling an appointment, and I may be charged $40/$125 for excessive tardiness to an appointment that impacts ability to bill my insurance.** I understand that insurance companies cannot be billed for this fee; therefore, this fee will be my responsibility. Though automated appointment reminders may be sent as a courtesy, I am still responsible for my appointment in the event that I do not receive a reminder.

_____ If I elect to use insurance benefits to pay for services, I authorize the release of the insurance-required information to my insurance company in order for Creekwood Associates, acting as my agent, to pursue payment for the services provided to me. I authorize insurance payments to be sent directly to Creekwood Associates.

Signatures of Consent
Please indicate your consent to treatment with your signatures below:

Client Name *(age 12+ must sign)*	Signature	Date
Parent/Guardian 1 Name *(if client age <18)*	Signature	Date
Parent/Guardian 2 *(if client age <18)* *Signatures of both parents may be required if divorced*	Signature	Date
Witness/Additional Participant Name	Signature	Date
Additional Participant Name	Signature	Date

PATIENT QUESTIONAIRE

Please answer the following questions. If completing for a child/adolescent patient, please answer from their perspective by completing this form with them.

_____

Patient First Name | Patient Last Name | Preferred Name/Nickname

_____

DOB | Gender | Pronouns | Date Completed

What is the primary reason you are seeking treatment now?

_____

_____

How long have you had these concerns or symptoms?

_____

How does this issue impact your daily life? (school/work/relationships/caring for self/home/responsibilities?

_____

_____

List your history of mental health concerns:

_____

_____

List previous therapists, psychiatrists, and psychiatric hospitalizations (inpatient, partial hospitalization, intensive outpatient, residential, or other mental health treatment programs):

_____

_____

List any history of trauma, abuse, or other significant transitions or losses (death, moves, divorce):

_____

_____

What is your current relationship status?

_____

_____

What is your family structure (marriages, divorces, parents, children, siblings, etc)?

_____

_____

Have other members of your family dealt with mental health issues, such as learning disabilities, depression, anxiety, suicidality, psychiatric hospitalizations, or substance use? If so, please list the family member and issue:

_____

_____

How many days each week do you use the following?

_____Alcohol

_____THC (flower, edibles, dabs, wax, vape)

_____Nicotine (cigarettes, chew, vape)

_____Other (specify) _____

Are you concerned, or have others expressed concern, about your use of the above substances?

_____

Are you or any of your family members/loved ones affiliated with the military? Describe:

_____

Is religion/spirituality important to you? Was it significant to your upbringing or current struggles? Describe:

_____

_____

What is your current grade level/education status and highest education level attained/professional training?

_____

Describe general school performance, strengths, motivation level, and concerns

_____

_____

List history of learning difficulties/school behavioral issues (ex: IEP/504 plan, alternative placements, expulsion):

_____

_____

What is your current employment? Please note F/T, P/T, hrs/week.

_____

Describe your legal history or current legal involvement (ex: lawsuits, DUI, custody disputes):

_____

_____

Describe your current physical health and activity level:

_____

Describe any significant medical history (ex: allergies, surgeries, long-standing health issues):

_____

_____

List your current medications, supplements, and vitamins (name, dose, reason for prescription, and prescribers):

_____

_____

List your other treatment providers (doctors, physical therapists, psychiatrists, case managers):

_____

_____

List significant developmental history (birth complications, adoption/foster care, developmental delays, DCFS involvement, major adverse events):

_____

_____

Describe your interests and strengths – what do you enjoy? What are you good at?

_____

SYMPTOM CHECKLIST

*Mark any symptoms or issues you have had in previous two weeks, past six months, or at anytime.in your history with an **X** in the appropriate column.*

	2 weeks	6 months	any history		2 weeks	6 months	any history
Family conflict/loss				Anxiety			
Friendship conflict/loss				Excessive worry			
Romantic conflict/loss				Racing thoughts			
Grief				Panic attacks			
Difficulty forming relationships				Intrusive thoughts			
History of unstable relationships				Missing/avoiding school			
Communication issues				Missing/avoiding work			
Social skills issues				Financial stress			
Difficulty trusting others				Obsessions			
Difficulty falling asleep				Compulsive behavior			
Difficulty staying asleep				Skin Picking			
Sleeping too much				Hair Pulling			
Sleeping too little				Anger			
Nightmares				Aggression			
Wetting/Bathroom Accidents				Thoughts of harming others			
Low appetite				Violence/Aggression			
Restrictive eating				Flashbacks			
Binge eating				Dissociation			
Purging after eating				Memory Issues			
Body image concerns				Feelings of unreality			
Avoiding people/responsibilities				Parenting concerns			
Isolation				Tantrums			
Depression				Defiant behavior			
Sadness				Separation anxiety			
Hopelessness				Difficulty controlling impulses			
Helplessness				Pregnancy/postpartum concerns			
Loss of interest/pleasure				Fertility issues			
Low motivation				Sexual difficulty			
Difficulty following through				Gender identity concerns			
Difficulty concentrating				Sexual orientation concerns			
Feeling like a burden				High-risk behavior			
Feeling worthless				Using substances to cope			
Excessive guilt				Hypersexuality			
Not wanting to be alive				Excessive porn use			
Thoughts of suicide				Excessive spending			
Suicide attempts				Excessive video gaming			
Self-harm				Excessive phone use			

CHILD DEVELOPMENT HISTORY ***Complete this page if patient is a minor or if directed by therapist*

Parents' attitude toward pregnancy/adoption:_____

Ease of conception: _____

Pregnancy complications: _____

Birth Weight _____ Length _____ Labor Duration _____ APGARS: ____ Time in hospital: _____

Delivery: □ Vaginal □ C-section □ Premature □ History of Jaundice

Any other complications: _____

Postpartum issues/parent health after delivery/adoption: _____

□ Breastfed □ Formula/Bottle-fed □ Eating/Feeding Difficulties □ Food Allergies:_____

Sleep Behavior (list history of sleep walking, nightmares, recurrent dreams, and current problems)

_____

_____

Separations from Parents/Caregivers:_____

Motor Development (Normal Range)

_____Rolled Over (3-5 months)

_____Sat Without Support (5-7 months)

_____Crawled (5-8 months)

_____Walked Well (11-15 months)

_____Ran Well (2 years)

_____Rode Tricycle (3 years)

Fine motor coordination (writing, drawing) _____

Gross motor coordination (running, jumping, balance) _____

Language Development (Normal Range)

_____Several words (1 year)

_____Three-word Sentences (2 years)

Vocabulary: _____ Articulation: _____Comprehension: _____

Social Development (Normal Range)

_____Smiled (2-3months)

_____Stranger Anxiety (6-10 months)

_____ Separated easily (2-3 years)

_____Cooperative Play (4 years)

_____Imaginative Play Early peer relationships

Current peer relationships _____

Quality of attachment to Parent #1 _____

Quality of attachment to Parent #2_____

Describe early temperament: _____

_____

Describe current personality traits, mood, fears/phobias, and habits:

_____

_____

CREDIT CARD ON FILE POLICY AND AGREEMENT

Patient Agreement:
I understand that I am responsible for all services and fees associated with my treatment at Creekwood Associates. I understand health insurance (if using) may not reimburse Creekwood Associates for all therapy and psychiatry services rendered, and that I am responsible for any remaining balance for these services, as well as unpaid/uncovered fees (e.g., late cancellation/missed appointments, consultations, service charges).

Patient Name (PRINT) Signature Date

Guardian Name (PRINT) Signature Date

Cardholder Agreement:
By signing this authorization, I, as the cardholder, understand that I have given Creekwood Associates permission to charge my credit card listed below for agreed upon charges.

I understand that it is my responsibility to plan so that such charges will not exceed my maximum allowable credit limit. In the event that Creekwood Associates is unable to obtain payment by charging the credit card I have given (for any reason other than bank error), I understand I may be responsible for an additional service charge of $25.

I understand this card will be saved on file for future charges to the patient's account, including: copayments, co-insurances, and fees for services rendered, balances remaining after insurance adjustments/payments, and additional services fees, , including missed/late cancellation of appointments ($125) or excessively late attendance that impacts ability to bill insurance for the appointment ($40/$125). If this card is an HSA card, I understand it may only be used for medical services rendered.

I understand that this authorization is in effect until cancelled. You may contact Creekwood Associates at any time to cancel this authorization.

I authorize Creekwood Associates to charge the portion of my/the patient's bill that to the following credit or debit card:

☐ Visa ☐ Mastercard ☐ Discover Is this an HSA card? ☐ Yes ☐ No
If yes, you may wish to add a secondary card for fees not covered by HSA.

Card # (if processing through Square, only provide last 4 digits) Expiration Sec Billing Zip

Cardholder Name (PRINT) Signature Date

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

I, _____authorize Creekwood Associates to:
CLIENT NAME (PRINT) DOB (MM/DD/YYYY)

☐ disclose information to ☐ obtain information from ☐ disclose to and obtain from

Name of Person/Facility: _____

Street Address/City/State/Zip: _____

Phone/Fax/Email: _____

I authorize the following information to be shared:

- ☐ Psychiatric Evaluation/Assessment
- ☐ Diagnosis
- ☐ Recent Physical Exam Records
- ☐ Mental Health/Crisis Assessment
- ☐ Psychiatric or Progress Notes
- ☐ Mental Status Exam
- ☐ Medical/Medication Information
- ☐ Psychological Evaluation/Test Results
- ☐ Discharge Summary
- ☐ Most Recent Contact/Progress
- ☐ Treatment Plan/Summary
- ☐ Recommendations
- ☐ Attendance
- ☐ Financial
- ☐ Insurance

Initial, if the following will be disclosed:

_____ Mental Health/Developmental Disabilities information and/or records
_____ HIV/AIDS related information and/or records
_____ Drug/Alcohol diagnosis, treatment and/or referral information

Information shared will be for the purpose off:

- ☐ Continuity of care and treatment planning
- ☐ Family Involvement
- ☐ Referral/Determine Eligibility for Services
- ☐ Other:_____

Information may be shared by phone call, fax, mail, in person, or email. Restrictions, if any:

_____

I understand that:

1) If the person or entity receiving 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 these regulations. However, the recipient may be prohibited from disclosing information regarding mental health and developmental disabilities, substance use/abuse or AIDS under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Federal Substance Abuse Confidentiality Requirements, and the Illinois AIDS Confidentiality Act. I understand that the named agency/facility/individual authorized to receive the information has the right to inspect and copy the information disclosed.
2) The person I am authorizing to use the information may receive compensation for doing so. I understand that I may inspect and copy the information disclosed. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
3) I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

This authorization will remain in effect: ☐ indefinitely until revoked in writing ☐ until date specified:_____

_____
Patient Name (PRINT) Signature (ages 12+ required) Date

_____
Guardian Name (PRINT) Signature Date

_____
Witness Name (PRINT) Signature Date