

# SUMMIT CENTER FOR MENTAL HEALTH

## Client Information:

Today's Date: \_\_\_\_\_ Therapist's Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Employer: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ (Office Use Only)

## Primary Insurance Policy Information:

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Patient's Relationship to the Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government/insurance benefits to myself or to *The Summit Center for Mental Health*.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize payment of medical benefits to *The Summit Center for Mental Health* for services provided.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## The Summit Center For Mental Health

800 West Fifth Ave.  
Suite 104A  
Naperville, IL 60563  
Telephone: 815-773-0772

3033 West Jefferson St.  
Suite 107  
Joliet, IL 60435  
Telephone: 815-773-0772

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### **Notice of Privacy Practices - Short Version**

*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.*

### **Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This letter is a shorter version of the full, legally required NPP, which you received along with this so refer to it for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health, which we get from you or from others mainly to provide you with treatment, to arrange payment for our services or for some other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

### **Your rights regarding your health information**

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have *about* you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is and can be reached by phone at or by e-mail at

The effective date of this notice is April 14, 2003

**Notice of Privacy Practices**

**Receipt and Acknowledgment of Notice**

**Patient/Client Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of **The Summit Center for Mental Health’s Notice of Privacy Practices**. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Kathleen Foley at 815-773-0772 xt221

**I also verify that I understand the following:**

All the information in my sessions is confidential **EXCEPT:**

***If I am threatening to hurt myself, if I am threatening to hurt someone else, or if I tell of a child or an elderly person being abused, then the therapist must tell someone to protect me or another.***

There is a **48 hour** cancellation fee. When I schedule an appointment, the therapist reserves the hour for me and if I cannot attend a session I must give 48 hrs notice or I will be charged for the session.

If I am scheduled for a med-check with either of the doctors, I understand that I am required to be on time.

If I am late, I understand that I will be required to reschedule my med-check appointment.

Payment at time of service is expected unless other arrangements have been made

If health insurance covers my sessions, The Summit Center will help me seek reimbursement from the insurance company. **ANY** unpaid balance after insurance is **MY** responsibility to pay.

I agree that The Summit Center for Mental Health may release to my insurance company any information needed to secure payment for service.

If I do not pay my account then it may be turned over to collections.

In the event that any check I write is returned NSF (insufficient funds) I agree to pay a \$15.00 service fee.

**CONSENT TO TREATMENT**

I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by The Summit Center for Mental Health providers.

**MEDICATION REFILL POLICY**

All patients must have their pharmacy fax a medication refill request form to our office via fax @ 815-773-0771. The physician or nurse practitioner will then fax the request back to the pharmacy. We will not accept phone requests for prescription medication refills other than Schedule II medications (stimulants such as Adderall, Concerta, Ritalin, etc.).

**All requests must be made at least 3 business days before you run out of medication.** As warranted, patients will continue to receive written prescriptions at the time of their scheduled appointment with his/her health care provider.

**I understand and agree to the above provisions**

\_\_\_\_\_  
**Signature of Patient/Client** **Date**

\_\_\_\_\_  
**Signature or Parent, Guardian or Personal Representative \*** **Date**

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

**Patient/Client Refuses to Acknowledge Receipt:**

\_\_\_\_\_  
**Signature of Staff Member** **Date**

# The Summit Center

For  
Mental Health

3033 W Jefferson St., Suite 107  
Joliet, Illinois 60435  
Joliet Phone: **815-773-0772**  
Joliet Fax: **815-773-0771**

800 W Fifth Ave, Suite 104A  
Naperville, Illinois 60563  
Naperville phone: **815-773-0772**  
Naperville Fax: **630-357-3093**

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## Consent to release information to Primary Care Physician

Communication between your therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

I, \_\_\_\_\_  
Patient name – Print Date of Birth Patient Social Security #

Please check one:

I agree to release mental health/substance abuse information to my Primary Care Physician.

I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature Date Parent/Guardian Signature Date

## Information for PCP

This patient was seen by me on (date) \_\_\_\_\_ for (diagnosis) \_\_\_\_\_

\_\_\_\_\_  
Provider Signature Date Provider Printed Name

# SUMMIT CENTER FOR MENTAL HEALTH

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_

## Family History

**Father:** Living? Y N Date of Death \_\_\_\_\_ Cause: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship as a child : Great Good OK Fair Poor

Relationship as an adult: Great Good OK Fair Poor

**Mother:** Living? Y N Date of Death \_\_\_\_\_ Cause: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Relationship as a child : Great Good OK Fair Poor

Relationship as an adult: Great Good OK Fair Poor

### **Step Parent:**

Relationship as a child : Great Good OK Fair Poor

Relationship as an adult: Great Good OK Fair Poor

### **List Siblings and rate relationship**

\_\_\_\_\_: Great Good OK Fair Poor

\_\_\_\_\_: Great Good OK Fair Poor

\_\_\_\_\_: Great Good OK Fair Poor

\_\_\_\_\_: Great Good OK Fair Poor

\_\_\_\_\_: Great Good OK Fair Poor

**(if you need more room for siblings, put the rest on the back of this page)**

Religion: \_\_\_\_\_ Religion of Childhood \_\_\_\_\_

My childhood religious experience was Great Good OK  Fair  Poor  None

**Check all that are true from your childhood**

Favoritism  Physical Abuse  Sexual Abuse  Emotional Abuse

Parental Rages Religious Extremism  I never felt good enough

**Do you have a family history of:**

Alcoholism  Depression  Schizophrenia Gambling  Drug Abuse

Suicide attempts Suicide Mental Illness

Education
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Did not graduate  GED /High School Diploma  Some College

Bachelor's Degree Advanced Degree

Marital History
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Spouse's Name \_\_\_\_\_ Spouse's Age \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

How long have you been married. \_\_\_\_\_?

My marriage is Great Good OK  Fair  Poor

Number of marriages \_\_\_\_\_

Strength's of your present marriage

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Problems of your present marriage

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Employment
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Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone: \_\_\_\_\_

Your position \_\_\_\_\_ How long employed ? \_\_\_\_\_ years/months.

Do you find your work satisfying? Y N

What (if any) problems do you have with your employment?

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Military Service? \_\_\_\_\_

Arrests Y N Convictions Y N

Check List- check all that apply
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- Financial difficulties  Legal Problems  Depression  Anxiety
- Voices in my head  Suicidal thoughts  Attempts  Crying spells
- Difficulty with relationships  Loneliness  Anger  Loss of appetite
- weight gain  weight loss  Eating disorder  Self abuse  Mood Swings
- Memory loss  Agitation  Mental Illness  I have thought of hurting myself
- I have thought of hurting someone else  Previous psychiatric hospitalization

Previous Mental Health Treatment

With whom? \_\_\_\_\_ When? \_\_\_\_\_ Helpful? Y N

Medications you are taking:

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Anything else you think your therapist should know

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## The Summit Center for Mental Health

1. Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people)

**Circle Answer: YES NO**

2. Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening?

**Circle Answer: YES NO**

3. Does any near relative or close friend ever worry or complain about your drinking?

**Circle Answer: YES NO**

4. Can you stop drinking without difficulty after one or two drinks?

**Circle Answer: YES NO**

5. Do you ever feel guilty about your drinking?

**Circle Answer: YES NO**

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)?

**Circle Answer: YES NO**

7. Have you ever gotten into physical fights when drinking?

**Circle Answer: YES NO**

8. Has drinking ever created problems between you and a near relative or close friend?

**Circle Answer: YES NO**

9. Has any family member or close friend gone to anyone for help about your drinking?

**Circle Answer: YES NO**

10. Have you ever lost friends because of your drinking?

**Circle Answer: YES NO**

11. Have you ever gotten into trouble at work because of drinking?

**Circle Answer: YES NO**

12. Have you ever lost a job because of drinking?

**Circle Answer: YES NO**

13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?

**Circle Answer: YES NO**

14. Do you drink before noon fairly often?

**Circle Answer: YES NO**

15. Have you ever been told you have liver trouble such as cirrhosis?

**Circle Answer: YES NO**

16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations?

**Circle Answer: YES NO**

17. Have you ever gone to anyone for help about your drinking?

**Circle Answer: YES NO**

18. Have you ever been hospitalized because of drinking?

**Circle Answer: YES NO**

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward?

**Circle Answer: YES NO**

20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was a part of the problem?

**Circle Answer: YES NO**

21. Have you been arrested more than once for driving under the influence of alcohol?

**Circle Answer: YES NO**

22. Have you ever been arrested, even for a few hours, because of other behavior while drinking?

**Circle Answer: YES NO**

(if Yes, how many times\_\_\_\_\_)

### **Alcohol & Drugs**

At what age did you have your first drink? \_\_\_\_\_ At what age did you first try a drug? \_\_\_\_\_

**Check any of the following that you have experimented with or used:**

For each that you check, how often have you used and how much?

Barbiturates (downers) \_\_\_  Tranquilizers (Valium, Xanax, etc)\_\_\_  Sleeping Pills\_\_\_

Amphetamines (uppers) \_\_\_  Marijuana \_\_\_  Cocaine \_\_\_

Hallucinogens (LSD, STP, PCP) \_\_\_  Opiates (heroin, morphine, Demerol) \_\_\_

Ecstasy \_\_\_  Inhalants \_\_\_  other drugs \_\_\_  Over the counter medications \_\_\_