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: ________________

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

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

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

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 health information, 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 bye-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 ext221.

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**

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

The Summit Center
Child & Adolescent New Client Form

Today's Date: ______________________

Client's Name: ____ Birth Date: _____________________

Guardian Name: ____ Relationship to Client: ___________

In your own words, tell us why you are seeking care through Summit: ______________________________

____

____

____

____

____

____

____

What kind of treatment are you seeking? ☐ Therapy ☐ Medication ☐ Both ☐ Undecided

What is/are your goal(s) for seeking care through Summit? _______________________________________

____

____

____

____

____

____

What have you tried that has helped your child? ____

____

____

____

____

____

____

Child Intake Symptom Check List – Please check all that apply.

☐ Financial difficulties ☐ Legal problems ☐ Depression ☐ Anxiety ☐ Problems sleeping

☐ Voices in my head ☐ Suicidal thoughts ☐ Suicide attempts ☐ Crying spells ☐ Hyperactivity

☐ Difficulty with relationships ☐ Loneliness ☐ Anger ☐ Loss of appetite ☐ Trauma or abuse

☐ Weight gain ☐ Weight loss ☐ Eating disorder ☐ Self-injury ☐ Mood swings

☐ Memory loss ☐ Agitation ☐ Poor concentration ☐ History of delayed development

☐ Thoughts of hurting myself ☐ Thoughts of hurting someone else ☐ Hallucinations

☐ Difficulties at school ☐ Problems using or understanding nonverbal communication

☐ Difficulty with social interactions or situations ☐ Poor impulse control ☐ Poor grades

☐ School refusal or truancy ☐ Bullying ☐ Victim of bullying ☐ Vandalism or stealing

☐ Sexting ☐ Viewing Pornography ☐ Gambling ☐ Cruelty to people or animals

☐ Fire-starting ☐ Nightmares ☐ Sibling rivalry ☐ Picky eater

☐ Accident-prone ☐ Problems separating from parents/family ☐ Perfectionism

☐ Other symptom(s):____

Mental Health History

If your child has received mental health treatment/hospitalization in the past, please tell us:

Provider: ______________________ When Seen: ______________ Helpful? Y N

Provider: ______________________ When Seen: ______________ Helpful? Y N

Provider: ______________________ When Seen: ______________ Helpful? Y N

Provider: ______________________ When Seen: ______________ Helpful? Y N

Please list any mental health diagnoses given to your child in the past: ______________________

____

____

Please list any mental health medications that your child has taken in the **past**: ____________________

____

____

____

____

Please list all of your child's **current** medications (including herbs and over the counter medicines): ____

____

____

____

____

Medical History

Medication Allergies: ____

Food/Environmental Allergies: ____

Please list any conditions that your child has been diagnosed with or takes medication for: ___________

____

____

____

Medical History Check List - Check all that apply.

☐ Hospitalizations ☐ Surgeries ☐ Prematurity ☐ Asthma ☐ Head trauma

☐ Heart murmurs ☐ Heart palpitations ☐ Head trauma ☐ Fainting ☐ Seizures

☐ Use of tobacco, alcohol, recreational drugs, or pills (including one time use)

☐ Sexual activity in the past 3 years ☐ Birth control pill or injection

☐ Other: ___________________

Birth & Developmental History

Were there complications during the pregnancy? Y N

If so, what happened? ____

Was there tobacco, alcohol, drug, or toxin exposure during the pregnancy? Y N

If so, what exposure occurred? ____

Were there any complications during the delivery? Y N

If so, what happened? ____

Birth Weight: ___________ ☐ Full term ☐ Premature (___ weeks early) ☐ Other: ___________

Did you child leave the hospital within 2-3 days of birth? Y N

If not, why was there a delay? ____

Please tell us when your child:

Spoke his/her first word(s): ______________ Began using 2-3 word phrases: _______________

Began sitting unassisted: ________________ Began walking: ____________________________

Completed toilet training: _______________

Has your child ever regressed or unexpectedly lost developmental milestones? Y N

If so, what skills were affected? ____

Does your child have any current problems with wetting or soiling him/herself? Y N

If so, please explain. ____

Social History

Child's Father: Living? Y N Date of Death: ___________ Cause: ___________

Age: _________ Occupation: _________________________ Education: _____________________

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Child's Mother: Living? Y N Date of Death: ___________ Cause: ___________

Age: _________ Occupation: _________________________ Education: _____________________

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Child's Parents Status:

☐ Never Married ☐ Married ☐ Separated since _____ (year) ☐ Divorced since _____ (year)

Child's Siblings: (If additional room is needed for siblings, please use the back of this page.)

Name: ____________________________________ Age: _________ Gender: M F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ____________________________________ Age: _________ Gender: M F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ____________________________________ Age: _________ Gender: M F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ____________________________________ Age: _________ Gender: M F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Name: ____________________________________ Age: _________ Gender: M F

Relationship with child is: ☐ Great ☐ Good ☐ Okay ☐ Fair ☐ Poor

Please tell us who lives in the home with your child: ____

____

Family Religion/Belief System: ____

Name of Child's School: ____ Grade Level: ______

Does your child receive any of the following services?

☐ IEP ☐ Special education ☐ Speech therapy ☐ Physical therapy ☐ Occupational therapy

Does the school system/teachers report any concerns? If so, please explain. ________________________

____

____

Family History

Is there any family history of:

☐ ADHD ☐ Bipolar disorder ☐ Anxiety ☐ Depression ☐ OCD ☐ Heart problems

☐ Autism/Asperger's/PDD ☐ Cognitive/Learning Disabilities ☐ Schizophrenia/Psychosis

☐ Alcoholism ☐ Drug abuse ☐ Gambling ☐ Legal problems or incarceration ☐ Seizures

☐ Mental health hospitalizations ☐ Suicide attempts ☐ Suicide completion ☐ Emotional abuse

☐ Physical abuse ☐ Sexual abuse ☐ Domestic Violence

Please list any other mental or medical illnesses that occur in the family: ____________________________

____

____

Is there anything else that you would like your child's provider to know? ___________________________

____

____

____

____

____

____

____

The Summit Center

Adolescent Alcohol and Substance Abuse Screen

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 tobacco products? _____

At what age did you first try a drug? _____

Check any of the following that you have experimented with or used:
For each item that you check, please indicate how often have you used it 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/prescription meds _____ ☐ Over the counter medications _____