SUMMIT CENTER FOR MENTAL HEALTH
Adult Form

CLIENT INFORMATION:

Today's Date: _____ Summit Clinician:_____

First Name: _____ Middle: _____ Last: _____ Preferred name: _____

Address: _____ City:_____ State: _____ Zip:_____

Home Phone: _____ **OK to Leave message? (circle one) Yes No**

Cell Phone: _____ **OK to Leave message? (circle one) Yes No**

Social Security Number: _____ Sex: _____ I identify as: _____ Preferred Pronouns: _____

Email Address_____**OK to email sensitive info? Yes No**

Circle one: Married Divorced Single Widow/erSeparated Date of Birth: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Policy ID#: _____

Group #: _____ Provider's Line #: _____Employer Name: _____

Insured's Name: _____ Insured's SS#: _____

Insured's Birthdate:_____Insured's Address: _____

City, State, Zip: _____Patient's Relationship to the Insured: Self ___ Spouse ___ Child ___ Other ___

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Policy ID#: _____

Group #: _____ Provider's Line #: _____Employer Name: _____

Insured's Name: _____ Insured's SS#: _____

Insured's Birthdate:_____Insured's Address: _____

City, State, Zip: _____Patient's Relationship to the Insured: Self ___ Spouse ___ Child ___ Other ___

AUTHORIZATION

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, Inc (SCMH).*

X Signed: _____ Date: _____

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

X Signed: _____ Date: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different than the patient, please complete and sign:

Guarantor Name:_____DOB: _____

Address: _____City/State/Zip:_____

Home Phone:_____ Cell Phone: _____

Soc Sec Number:_____Relationship to Patient:_____

E-mail Address_____

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signature_____ **Date** _____

This authorization will remain in effect until revoked in writing by myself or The Summit Center for Mental Health.

Summit Center Psychiatric Adult Intake Form

X Name_____ Date_____ Date of Birth _____

NOTICE OF PRIVACY PRACTICES (NPP) - SHORT VERSION

This notice describes how your medical information may be used and disclosed and how you may access this information.

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. This is a shorter version of the full, legally required NPP. If you have questions or concerns about the privacy of your information, please contact our Privacy Officer (see the end of this page).

We use information about your health, which we get from you or from others, for treatment, to arrange payment for our services, or for other business activities referred to as health care operations. At the end of this NPP is a Consent Form to be signed allowing us to use and share your information. ***If you do not consent and sign this form, we cannot treat you.***

For treatment purposes, SCMH can use your health information and share it with other professionals who are treating you. If your information is to be disclosed (sent, shared, released) for any other purposes, we will discuss this with you and ask you to sign a separate authorization to allow this.

We will keep your health information private, but there are situations when we are required to use or share it; they are described in the full version of the NPP. Examples of these situations are, but not limited to (a serious threat exists to your health and safety or the health and safety of others. We only share information with a person or organization able to prevent or reduce the threat, some lawsuits and legal proceedings, when required by law enforcement, Workers' Compensation and similar benefit programs.)

Your rights regarding your health information:

You can specify how we communicate with you. 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.

You have the right to ask us to limit what we tell individuals (such as family and friends) who are involved in your care or the payment for your care except if it is against the law, or an emergency.

You have the right to look at your health information (such as medical and billing records). You can get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records.

If you believe information in your records is incorrect or incomplete, you can ask us to make some changes (called amendments) to your health information. This request must be in writing and sent to our Privacy Officer. You must tell us the reasons you want to make the changes.

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.

You have the right to file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

I hereby acknowledge that I have received a copy of SCMH's Notice of Privacy Practices and that I have been given an opportunity to read it. ***I understand that if I have questions about the Notice or my privacy rights, I can contact the Privacy Officer, Meghan Crandall at 815-773-0772 ext. 104.***

X _____ _____ _____ _____
Patient/Client Signature Date Parent/Guardian Signature Date

*Patient/Client Refuses to Acknowledge Receipt*_____ _____
Signature of Staff Member *Date*

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 SCMH providers. Further, **I understand and agree to the above policies and I authorize my clinical and account information to be discussed as indicated above.**

X _____ _____ _____
Patient/Client Signature Date of Birth Date

_____ _____ _____
Parent/Guardian Signature Date of Birth Date

This authorization will remain in effect until revoked in writing by myself or The Summit Center for Mental Health.

Summit Center Psychiatric Adult Intake Form

Name_____ Date_____ Date of Birth _____

OFFICE POLICIES

Appointments:

_____ Initials

Starting January 1st, 2022, there is a 24 hour cancellation fee of **$75**, unless otherwise stated by your therapist. The clinician reserves that time for me, ***if I can't attend I must give 24 hours notice or I will be charged.***

The initial visit is considered to be evaluation only and not a guarantee that treatment will be the result. This includes the prescribing of medication.

If I am scheduled for a medication management appointment with a psychiatrist, I understand that I am required to be on time. If I am late, I understand that I will be required to reschedule appointment.

Medication Refills:

All requests for prescription refills must be made at least 3 business days before I run out of medication. The psychiatrist may require me to be seen before refilling a prescription.

Payments and Billing:

-I agree to be financially responsible for the full payment of any and all charges and fees associated with this patient's behavioral health services (BHS) rendered at SCMH. As a courtesy, and for your convenience, SCMH will bill this patient's insurance carrier(s) when we have been provided with the required accurate insurance information to do so. You agree to be responsible for paying for any and all policy deductibles, co-payments, co-insurances, and uncovered services associated with the BHS provided to this patient at the time the services are rendered (unless the patient's insurance carrier requires us to delay collecting such payments). Although we will verify this patient's insurance coverage prior to providing any BHS, we strongly encourage you to do the same on your own so you know the specifics of this patient's insurance coverage. If SCMH does not receive payment from this patient's insurance carrier within 60 days of submitting a bill for the provided services, I agree to be immediately financially responsible for full payment of this patient's account balance for those provided services.

I understand that if I choose not to have SCMH bill this patient's insurance carrier for the provided services or if this patient does not have insurance coverage, I agree to assume financial responsibility for any and all charges and fees associated with the services provided to this patient by SCMH providers and/or staff.

-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 ***$25.00 service fee.***

-I agree to keep a valid credit card on file for billing of balances after insurance has paid their portion, according to my medical plan.

-I understand that all credit card charges will include a 3% processing fee. This fee does not go to SCMH, but to the credit card processing company.

Signed: _____ **Date:** _____

D. AUTHORIZATION TO DISCUSS MY MEDICAL INFORMATION AND ACCOUNT:

You may discuss my **medical** information with:

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

You may discuss my **appointment** information with:

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

You may discuss my **account** information with:

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

Signed: _____ **Date:** _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between SCMH 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. You may revoke this consent at any time in writing

I, _____ _____
Name Date of Birth

□ 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 Phone: _____ Fax: _____

_____
Signature of Patient/Client Date

_____ _____
* Signature of Parent, Guardian or Personal Representative Relationship/Authority Date

Summit Center Psychiatric Adult Intake Form

Name_____ Date_____ Date of Birth _____

Problems are you seeking help with today:_____
_____

Current Symptoms

□ Depression	□Mood swings	□Anger/Irritability/Temper	□Thoughts of death/dying	□Suicidal thoughts	□Crying spells
□Hearing Voices	□Helplessness	□Loss of Motivation	□Withdrawal/Avoidance	□Fatigue □Increase energy	□Sleep Problems
□Self-injury	□ Racing thoughts	□Anxiety or Panic attacks	□Suicidal Thoughts	□Hearing voices	□Agitation
□Impulsivity	□Suspiciousness	□Increase in risky behavior	□Change in libido	□Appetite Change	□Seeing Things
□ADHD	□Problems with attention/concentration/focus		□Gender Disphoria	□Problems with memory	□Worry

□Other – please describe:_____

Suicide Risk Assessment

Have you had thoughts that you don't want to live? □No □Yes Do you have those thoughts now? □No □Yes
Have you ever tried to kill yourself? □No □Yes Number of times _____ When was most recent attempt? _____
Has anyone in your family died by suicide? □No □Yes Who?_____

Past Treatment History

Have you received treatment in the past for mental health problems? □No □Yes Type of treatment: □Talk therapy □Medications □Inpatient:
times? _____ When most recent_____Past Diagnosis, if known:_____

Family Psychiatric History

Please check if family members have (or might have) of any of the following problems and indicate relationship/self

□Depression:_____ □Bipolar:_____
□Anxiety:_____ □ADHD/ADD:_____
□Schizophrenia:_____ □Addictions:_____
□PTSD:_____ □Other:_____

Substance Use/Addiction History

Do you use tobacco products? □No □Yes – what do you use, and how much? _____
Do you have problems with alcohol, drugs or prescription drugs? □No □Yes – Describe_____
_____
Have you been treated for problems with alcohol or drugs? □No □Yes -Describe:_____
_____

Social History

Where did you grow up? _____ Quality of childhood □Great □Adequate □Difficult
Raised by_____ # Brothers _____# Sisters_____
Abuse in the home? □No □Yes- check all that apply: □Physical □Emotional □Sexual □Neglect
Marital Status: □Single, never married □Married/Partnered for_____ years □Divorced □Widowed # past marriages _____
Relationship with spouse/partner: □Great □Adequate □Difficult Do you have children? □No □Yes – what are their ages:
_____ How far did you go in school?_____ How did you do in school: _____
Occupation: □Employed _____ □Not working by choice □Unemployed □Retired □Disabled
Military History: □No □Yes: Branch_____ When_____ Type discharge_____
Legal History: Have you ever been arrested □No □Yes: describe _____
Current legal issues? □No □Yes Describe:_____
_____
_____

Summit Center Psychiatric Adult Intake Form

Name_____ Date_____ Date of Birth _____

Medical History

Primary Care Physician: _____ Approximate Date of last exam:_____

How would you describe your physical health?_____

Please check any of the following health conditions for which you are being treated:

□High blood pressure □Diabetes □Liver Disease □Heart Disease □Thyroid Problem □Stomach/Intestinal
□High Cholesterol □Seizures □Sleep Apnea □Stroke □Headache/Migraines □Seizures
□Pain where:_____ □Asthma □COPD/Bronchitis □Cancer type:_____

Medical problems not included above: _____

Past surgeries: _____

_____

_____

Allergies (medications or other):_____

Current Medications: _____

_____

_____

Review of Systems

Please check if you are having any of the following problems/symptoms:

□Physical pain □Dizziness/Passing out □Chest pain □Shortness of breath □Cough □Night sweats
□Too hot/cold □Movement/balance issues □Vision problems □Hearing loss □Taste problems □Urinary problems
□Nausea/Vomiting □Diarrhea/Constipation □Bloody stools □Menstrual problems

Past Medication Trials

Check any of the following medications that you have been prescribed in the past. Please comment about how a medication worked for you.

Antidepressants: □Prozac/fluoxetine □ Cymbalta/duloxetine □Pristiq/desvenlavaxine □ Lexapro/escitalopram
□Celexa/citalopram □Luvox/fluvoxamine □ Effexor/venlaxine □ Wellbutrin/bupropion □ Paxil/paroxetine
□Zoloft/sertraline □Remeron/mirtazapine □Viibryd/vilazodone □ Elavil/amitriptyline □Pamelor/nortiptyline

How did the medication(s) affect you?_____

Mood Stabilizer: □Tegretol/carbamazepine □Lamictal/lamotrigine □Depakote/valproate □Topamax/topiramate
□Lithium □Trileptal/oxcarbazepine

How did the medication(s) affect you?_____

Antipsychotic/Mood stabilizer: □Seroquel/quetiapine □Geodon/ziprasidone □Abilify/aripiprazole
□Latuda/lurasidone □Risperdal/risperidone □Invega/paliperidone □Zyprexa/olanzapine □Fanapt/Iloperidone
□Clozaril/clozapine

How did the medication(s) affect you?_____

Sleep Aids: □Sonata/zaleplon □Lunesta/eszopiclone □Restoril/temazepam □Trazodone□Ambien/zolpidem

How did the medication(s) affect you?_____

Antianxiety Medications: □BuSpar/Buspirone □Vistaril/hydroxyzine □Xanax/alprazolam
□Ativan/lorazepam □Klonopin/clonazepam □Valium/diazepam □Tranxene/clorazepate

How did the medication(s) affect you?_____

Treatment of ADHD/ADD: □Stimulant (eg,Adderall, Ritalin, Concerta,Focalin, Metadate, Daytrona, Vyvanse)
□Strattera □Tenex □Clonidine □Other_____

How did the medication(s) affect you?_____

For each of the following questions indicate "Yes" or "No"		Yes	No
1	Do you feel you are a normal drinker ("normal"- drink as much or less than most people)		
2	Have you ever awakened in the morning after drinking the night before and found you couldn't remember a part of the evening?		
3	Does any near relative or close friend ever worry or complain about your drinking?		
4	Can you stop drinking without difficulty after one or two drinks?		
5	Do you ever feel guilty about your drinking?		
6	Have you ever attended an Alcoholics Anonymous (AA) meeting?		
7	Have you ever gotten into physical fights when drinking?		
8	Has drinking ever caused problems between you and a near relative or close friend?		
9	Has any family member or close friend gone to anyone for help about your drinking?		
10	Have you ever lost friends because of your drinking?		
11	Have you ever gotten into trouble at work because of your drinking?		
12	Have you ever lost a job because of drinking?		
13	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14	Do you drink before noon fairly often?		
15	Have you ever been told you have liver trouble such as cirrhosis?		
16	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17	Have you ever gone to anyone for help with your drinking?		
18	Have you ever been hospitalized because of drinking?		
19	Has your drinking ever resulted in your being hospitalized on a psychiatric ward?		
20	Have you ever gone to any doctor, social worker, clergy, or mental health clinic for help with any emotional problems in which drinking was a part of the problem?		
21	Have you ever been arrested more than once for drinking under the influence of alcohol?		
22	Have you ever been arrested, even for a few hours, because of other behavior while drinking?		

	Age of 1st Use	When was Your Last Use	Type of Use (eg, heavy, recreational)
Alcohol			
Cocaine			
Methamphetamine			
Other Amphetamines (eg, Ritalin)			
Bath Salts			
Hallucinogens (eg, LSD, Mushrooms, PCP, salvia, ketamine)			
Heroin			
Prescription Pain Pills			
Benzodiazepines (Xanax, Valium, Klonopin, etc)			
Other Prescription Medications			
Inhalants			
Cold Medicines			
Marijuana			
K2/Spice ("Synthetic Marijuana")			
MDMA (Ecstasy/Molly)			
Other Club Drugs			
Steroids (Anabolic)			
Other:			

the Summit Center

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Telephone: 815-773-0772
Fax: 815-773-0771

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Suite J
Naperville, IL 60563
Telephone: 800-786-3033
Fax: 630-357-3093

Credit Card Authorization

For internal use only.

I, _____, authorize The Summit Center to keep my signature on file and to charge my credit card listed below for:

All patient balances (less than $250) for services rendered once the claim has been processed by my insurance company. I understand that SCMH will charge my card for any outstanding balances at the end of each month, when the monthly billing cycle is completed. I understand that SCMH will contact me by telephone for all patient balances exceeding $250 prior to charging my card. I also understand that there will be a 3% charge on any credit card transactions.

**Cards will be run on the last weekday of the month. If you prefer to pay by check or cash, we will notate your account. If payment is not received by the next billing cycle, your card will be automatically run.

Recurring charges for services rendered for the following family members:

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

Check One: Visa _____ Master Card _____ Discover _____
(Sorry, we do not accept American Express)

Billing Address:_____City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____ CVV: _____ (on back)

X Cardholder Signature: _____ Date: _____ Cardholder contact number: _____