



HeartLAND
COUNSELING SM

A Division of the Center for Rural Psychology
P.O. Box 8071, Elburn IL 60119 630/365-0899

Name of Patient: _____
First (preferred) MI Last

Date of Birth: _____ SSN: _____ Sex: M F

Home Address: _____

City: _____ State: _____ Zip: _____ Township (if known): _____

Check here if you DO NOT want us to mail your bill to this address:

Home/evening phone: _____ Work/Cell phone: _____

Check here if you DO NOT want us to leave phone messages:

Marital Status: Single Married Spouse's Name: _____

Race: Caucasian African-American Hispanic Asian Native-American Other _____

Occupation: _____ Employer: _____

If Patient is a Minor (under the age of 18)

Parent/Guardian Name _____ Home Phone _____

Employer _____ Work/Cell _____

Parent/Guardian Name _____ Home Phone _____

Employer _____ Work/Cell _____

Party Responsible for billing _____ SSN: _____

My signature below indicates that I have been informed of, and given the right to review and secure, a copy of your Services Agreement and the HIPPA Notice of Privacy Practices and that I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other professionals involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company, Heartland's billing company)
- The day-to-day operation of your practice (e.g. Heartland's office staff and accountant)

I understand I may revoke this consent, in writing, at any time.

I hereby authorize payment to Heartland Counseling. I understand that I am financially responsible for any charges not covered by my insurance. I authorize the release of any information relating to this claim. I understand that verification of insurance benefits is not a guarantee of payment. (parent/guardian must sign for minor)

Signature _____

Date _____

Name: _____

Are there any medical conditions of which we should be aware? (Please include relevant medications)

Previous counseling (Please note approximate dates/duration of service and reason for seeking help):

Family/Significant Relationships (Please name, age and for spouse, significant other, children, siblings, former spouses and any other significant relationships of which we should be aware):

Name

DOB/Age (if known)

Relationship to you

In Case of Emergency, Notify: _____

Please tell us:

How did you hear about Heartland Counseling? Pastor Friend Family Member Doctor

School personnel West Towns/Conley Outreach Newspaper Ad Yellow Pages

Brochure from _____ Other: _____

Whom may we thank for referring you to us? _____

May we mail you newsletters or updates? Yes No

May we contact you via email? This can be helpful in scheduling and reminding you of appointments.

By giving my email address below I authorize my psychologist/counselor, and/or his or her administrative and clinical staff to contact me and or receive email from me related to my medical records and/or appointments. I understand that the security of email communication cannot be completely guaranteed and that unauthorized individuals could intercept email but I believe the convenience is worth the risk. I will not hold Heartland Counseling responsible if such an invasion occurs

Email address _____



A Division of the Center for Rural Psychology
P.O. Box 8071, Elburn IL 60119
T:630/365-0899 F:630/365-9150

AUTHORIZATION TO COMMUNICATE WITH PHYSICIAN

At Heartland we attempt to understand the individuals we work with in a holistic manner that considers all aspects of the person. A part of this involves working with medical professionals. We highly value working as a team with medical professionals to ensure that we are aware of any medical difficulties and how these difficulties may be impacting your mental health. This form when completed and signed by you, authorizes me to receive information from your physician and release protected information from your clinical record to your physician.

Yes. You may communicate about my treatment with the physician listed below.

No. You may not share information about my treatment

Physician _____ Phone _____

Address _____

This authorization shall remain in effect for one year unless otherwise specified. If you would like to specify another date, please fill in expiration date: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand I have the right to inspect the disclosed mental health information at any time. I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

X _____
Signature of Patient (age 12 or over) Date Printed Name of Patient
or representative*

X _____
Signature of Witness Date

*If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Notice to receiving agency/person: Under Illinois and federal law you may not redisclose any of this information unless specifically authorized by above responsible party