DATE: _____

OAK BROOK BEHAVIORAL HEALTH
PATIENT DATA ENTRY FORM: ADULT

NAME (Last): _____ (First): _____ (M.I.): ____

ADDRESS: _____

_____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____

SEX ASSIGNED AT BIRTH: Male ◯ Female ◯ Prefer not to disclose ◯

GENDER IDENTITY: Male ◯ Female ◯ Non-Binary ◯ Other: _____

TRANSGENDER: Yes ◯ No ◯ Prefer not to disclose ◯

CELL PH: _____ HOME PH: _____

EMAIL: _____

TYPE OF WORK: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

CHILDREN (With Ages): _____

_____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____

IN THERAPY: CURRENTLY ☐ PREVIOUSLY ☐ NEVER ☐

SEEING PSYCHIATRIST: CURRENTLY ☐ PREVIOUSLY ☐ NEVER ☐

CURRENT PSYCHOTROPIC MEDICATIONS: YES ◯ NO ◯

What would you like to accomplish through this evaluation?

Date: _____

OAK BROOK BEHAVIORAL HEALTH
PATIENT MEDICAL INFORMATION SHEET

NAME (Last): _____ **(First)**: _____ **BIRTHDATE**:_____

Sex Assigned at Birth: MALE ◯ FEMALE ◯ Prefer not to disclose ◯

GENDER IDENTITY: MALE ◯ FEMALE ◯ NON-BINARY ◯ OTHER: _____ Prefer not to disclose ◯

TRANSGENDER: YES ◯ NO ◯ Prefer not to disclose ◯

Language(s) Spoken in Home: _____

Ethnicity: Hispanic or Latino ◯ Not Hispanic or Latino ◯

Race: American Indian/Alaskan Native ◯ Asian ◯ Black/African American ◯
Native Hawaiian/Other Pacific Islander ◯ White/Caucasian ◯

Medical Problems or Surgeries	**Current Medications**

Do you or your family have a history of:	**Self**	**Family**		**Self**	**Family**
Coronary artery disease	☐	☐	Lung disease	☐	☐
Diabetes	☐	☐	Cancer	☐	☐
Stroke	☐	☐	Gastrointestinal disease	☐	☐
Vein or artery disease	☐	☐	Neurological disease	☐	☐
Kidney disease	☐	☐	High Blood Pressure	☐	☐
Liver disease	☐	☐		☐	☐

Do you have any allergies to medications? Yes ◯ No ◯ If yes, please list: _____

_____

_____

Allergic to: PENICILLIN? Yes ◯ No ◯ LATEX? Yes ◯ No ◯ SEAFOOD? Yes ◯ No ◯ DYE? Yes ◯ No ◯

Do you drink alcohol? Yes ◯ No ◯ If yes, how many per day/week? _____

Do you smoke cigarettes? Yes ◯ No ◯ If yes, for how long? _____ How many per day? _____

Do you use Cannabis? Yes ◯ No ◯ If yes, how often per day/week ?_____

Do you use street drugs? Yes ◯ No ◯

Do you have AIDS or an AIDS-related illness? Yes ◯ No ◯

Do you have a "DO NOT RESUSCITATE" ORDER or a LIVING WILL in place? Yes ◯ No ◯

Who filled out this form if the patient is a minor? _____ Relationship: _____

OAK BROOK BEHAVIORAL HEALTH
1401 Branding Ave., Suite 312
Downers Grove, IL 60515
630-424-0652

Pharmacy Information

Date: _____

PATIENT

Last Name: _____ First Name: _____ M.I. ____

Date-of-Birth: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Phone: _____

LOCAL PHARMACY

Pharmacy Name: _____

Address: _____

City: _____ ST: _____ ZIP: _____

PH: _____ FAX: _____

MAIL ORDER PHARMACY

Pharmacy Name: _____

PH: _____ FAX: _____

Notes: _____

_____

_____

OAK BROOK BEHAVIORAL HEALTH

1401 Branding Ave., Suite 312, Downers Grove, IL 60515
(630) 424-0652 - Adult Services

REGISTRATION

Patient's Last Name_____ **First Name**_____ **MI**_____

Address_____**City**_____ **State**_____ **Zip**_____

Phone #_____ **Date of Birth** _____ **Soc. Sec. #** _____

CONSENT FOR DIAGNOSIS AND TREATMENT
This authorizes Oak Brook Behavioral Health to provide psychiatric/neuropsychological and psychological evaluation. I understand that I have the right to revoke this consent at any time. I agree to communication with my primary care physician.

AUTHORIZATION FOR RELEASE OF INFORMATION TO PRIMARY and/or SECONDARY INSURANCE
I authorize Oak Brook Behavioral Health to release verbal and written information to the primary and/or secondary insurance that I have presented. I understand that the information to be released may contain identity, diagnosis, prognosis or treatment information and/or all other information gathered necessary for payment of bill. I also understand that this consent is revocable upon written notice to Oak Brook Behavioral Health. I understand that this authorization shall remain valid for the purpose of its original intent and that the consequence of a refusal to consent the release of information may be potential denial of insurance benefits.

ASSIGNMENT OF BENEFITS
I agree to assign any and all insurance benefits to which I may be entitled to Oak Brook Behavioral Health for services rendered. In the event the benefits are not assignable, I will forward any payment received to Oak Brook Behavioral Health.

FINANCIAL OBLIGATION
I guarantee payment of all charges for all services by Oak Brook Behavioral Health. I understand that the fees set by Oak Brook Behavioral Health may not be equivalent to the Usual and Customary fees of my insurance company. I am responsible for the difference in these rates and/or I am responsible for all co-pays (a finance charge will be applied to all outstanding balances of 90 days). I also understand that it is my financial responsibility to assume any debt remaining after 90 days. Should this account ever be referred to outside collections, I will be responsible for all associated expenses. Records will not be released until an account is paid in full.

CANCELLATION NOTICE
In the event I cancel a scheduled appointment after noon of the preceding business day, I agree to pay the full fee for this appointment.

MISSED APPOINTMENT FEE
I am aware that there is a $100 fee for a missed appointment for which no cancellation notice was given.

TERMINIATION OF TREATMENT
If the patient has not been seen at our office for a period of one (1) year, patient's file at this office will be closed.

PATIENT Signature: _____ **DATE:** _____

GUARDIAN Signature: _____ **DATE:** _____

OAK BROOK BEHAVIORAL HEALTH

Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to that information. Please review carefully.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528, one free in a 12 month period
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Oak Brook Behavioral Health is required to:

- maintain the privacy of your health information
- provide you with notice as to your legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or To Report a Problem

If you have questions and would like additional information, you may contact the Office Manager by phone at 630-424-0652 ext. 133, or by mail at: Oak Brook Behavioral Health, 2803 Butterfield Rd., Suite 200, Oak Brook, IL 60523. There will be no retaliation for filing a complaint. For more information you may contact the Secretary of Health and Human Services at Region V, Office for Civil Rights, U.S. Dept. of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.

OAK BROOK BEHAVIORAL HEALTH

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

_____ _____
Signature of Patient or Legal Representative Date

Printed last name: _____

If signed by a legal representative, relationship to patient: _____

Last name of patient if different from signer: _____

OAK BROOK BEHAVIORAL HEALTH

TELEHEALTH CONSENT FORM

I, _____, hereby consent to engage in telehealth. Telehealth is a form of psychiatric and/or psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I understand that telehealth involves the communication of my medical/mental health information, both orally and/or visually.

Telehealth has the same purpose or intention as treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that telehealth may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. Nobody will record the session without the permission from the other person(s). However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general consent form I receive at the start of my treatment.

2. I understand that there are risks and consequences of participating in telehealth, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

3. I agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it. I need to use a webcam or smartphone during the session. I am responsible for providing the necessary computer, telecommunications equipment and internet access for my telehealth sessions. It is important to use a secure internet connection rather than public/free wi-fi.

Continued next page…

4. I accept that telehealth does not provide emergency services. If I am experiencing an emergency, I understand that I can call 9-1-1 or proceed to the nearest hospital emergency room for help.

5. **It is important to be in a quiet, private space that is free of distractions** (including cell phones or other devices) during the session. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telehealth. I am responsible for arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.

6. It is important to be on time. If I need to cancel or change my telehealth appointment, I will notify the provider in advance by phone or email.

7. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to other entities shall not occur without my written consent.

8. The provider may determine that due to certain circumstances, telehealth is no longer appropriate and that sessions should resume in person at the provider's office.

9. I, the client, have the right to withhold or withdraw consent to telehealth at any time without affecting my right to future care or treatment.

I have read, understand and agree to the information provided above regarding telehealth.

_____ _____

Patient's Signature Date

_____ _____

Parent's/Guardian's Signature (if patients is a minor) Date