Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex: F
Date of Birth:
Social Security No.:
Patient email:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone:

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:_____

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: , Sex (please circle): M or F
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: , Sex (please circle): M or F
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize and give consent for my provider to bill me directly for services performed that are not covered by my health plan.
- I authorize my provider to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- A fee for no shows may apply.

Signed _____ Date _____

Arrival and Cancellation/No Show Policy

1. **Late Arrival Policy** Is applicable to all the patients we serve. We aim to provide quality attention to our patient's needs and hope you arrive promptly at your scheduled appointment time. If, for any reason, you cannot make it to your scheduled time promptly please call our office and let us know you will be arriving late. You will be able to see your Doctor/Therapist for the remaining time of your scheduled appointment. Please note that late arrival appointments are charged the full appointment fee.

2. **Late Cancellation and No Show Policy** is applicable to all the patients we serve. If you need to cancel an appointment please call 24 hours prior to your scheduled appointment time. Calling ahead of time allows us to rearrange our schedule and best meet our patient's needs. Please note that appointments canceled on the same day or without a 24 hour notice of the scheduled appointment time or not showing up at all will incur a **$100** charge to your account. This charge is not covered by insurance therefore it is the sole responsibility of the patient/responsible party.

Financial Agreement

Self Pay Fees
Fees for services vary with provider. The Initial Evaluation is charged at $300 or $185 and Follow-Up sessions are $150 or $145. There is a $35 fee for prescription refills over the phone and toxicology screens are charged at $50 (if applicable)

Insurance

We will gladly file your insurance claim with your insurance carrier and assist you in receiving maximum benefits due to you. However, please realize your insurance is a contract between you and your insurance company. Our services are rendered for you and charged to you. Medical insurance varies widely in the services that they cover and the fees they will pay for these services. We set our fees to be customary and reasonable for this region and there is no guarantee your insurance will pay the charges in full.

I hereby authorize Comprehensive Clinical Services, P.C. to furnish information to my insurance company concerning my care. I further hereby assign all payments for medical services rendered to me or my dependants by the above. I understand that I am fully responsible for any portion of these services that are not covered by my insurance benefits.

Account Balances

Account balances must remain in good standing. Unless the account is in good standing future appointments cannot be made until the balances have been paid in full or a payment plan has been signed and maintained.

Acknowledgement of Terms

Payment for services may be made by credit card, approved check or cash and is required at time of service. Returned checks will be issued a $25 return fee. In the event of nonpayment, any account sent to collections will be charged with all collection fees incurred.

I have read, understand the content and agree to abide by the terms set forth in this document.

Patient's name _____

Parent/Guardian (if applicable) _____

Signature _____

Acknowledgement of Receipt

Comprehensive Clinical Services

NOTICE OF PRIVACY PRACTICES

By signing this page you acknowledge that you have received a copy of our Notice of Privacy Practices.

Name of Patient _____

Signature of Patient _____
(or Personal Representative)

Print Name of Personal Representative _____
(if not Patient)

Date Signed _____

Witnessed by _____

Effective Date: 01-01-2012

COMPREHENSIVE CLINICAL SERVICES
CONSENT TO OBTAIN MEDICATION HISTORY

I or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with Illinois State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Comprehensive Clinical Services uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Comprehensive Clinical Services. _____.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Comprehensive Clinical Services.
3. I have the right to revoke this authorization at any time by writing to Comprehensive Clinical Services. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE COMPREHENSIVE CLINICAL SERVICES TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____

Signature/Date