



Patient Name _____ Patient ID# _____ Patient SS# _____
 Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
 24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
 630-621-5824

CLIENT REGISTRATION INFORMATION

First Name _____ Last Name _____
 Street Address _____ City _____ State _____ Zip _____
 Billing Address Same as above See below
 Billing Street Address _____ City _____ State _____ Zip _____
 E-mail Address _____
 Preferred Address for correspondence or statements Billing Address E-mail Address
 Birth Date _____ Age _____ Social Security # _____
 If minor (under age 18) please write name of legal guardian _____
 Employer/School _____
 Employer/School Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 Cell Phone _____ How late can calls be returned? _____
 Preferred Phone Number Home Phone Work Phone Cell Phone Referred by _____
 Relationship to insured: Self Spouse Child Other
 Marital Status: Single Married Widowed Divorced Other
 Employment Status: Employed Full-time Student Part-time Student

POLICY HOLDER/GUARDIAN'S INFORMATION (if different from above)

First Name _____ Last Name _____
 Street Address _____ City _____ State _____ Zip _____
 Birth Date _____ Age _____ Social Security # _____
 Employer/School _____
 Home Phone _____ Work Phone _____
 Caseworker's Name _____ Phone _____

PRIMARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____
 Insured's ID # _____ Group/Policy # _____ Agency/Insurance Phone _____
 Insurance Claims Mailing Address _____
 City _____ State _____ Zip _____
 Subscriber Name _____ Subscriber Date of Birth _____
 Co-pay amount _____ Authorization # _____ Number of Sessions Authorized _____
 Secondary Insurance No Yes – Complete Secondary Insurance Information Form
 Are services pertaining to psychotherapy or testing? _____

A copy of your insurance or Medicaid card is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Agor Behavioral Health Services, Inc. and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signature of Responsible Party _____ Date _____



Patient Name _____ Patient ID# _____ Patient SS# _____

Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
 24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
 630-621-5824

SYMPTOM CHECKLIST

Place a check mark in the appropriate column.

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
aggressive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	laxative/diuretic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	need to repeat actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
believe someone is watching you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bingeing/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	oppositional behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
circumstantial symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
concomitant medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	paranoid ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
conduct problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
crying/tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	physical trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
difficulty getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	poor grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	self-mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elimination disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotional trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotional trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sexual trauma victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	significant weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling empty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	social isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thoughts of death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	use of alcohol/recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hearing voices that others do not	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wishing you were dead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDICATIONS

Please list all medications.

Medication

Dosage

PRESENTING PROBLEMS

Please list presenting problems

Duration (months)

Additional Information



Patient Name _____ Patient ID# _____ Patient SS# _____

Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
 24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
 630-621-5824

EMOTIONAL/PSYCHIATRIC HISTORY

No Yes Prior outpatient psychotherapy?

If yes, how many occasions? ___ Longest Treatment by _____ (Provider Name) for ___ sessions from ___/___ to ___/_____.
 (Month/Year) (Month/Year)

Prior Provider Name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

No Yes Has any family member had outpatient psychotherapy? If yes, who/why (list all)?

No Yes Prior inpatient treatment for psychiatric, emotional or substance use disorder?

If yes, on ___ occasions. Longest treatment at _____ from ___/___ to ___/_____.
 (month/year) (month/year)

Inpatient Facility Name	City	State	Phone	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

No Yes Has any family member had inpatient treatment for a psychiatric, emotional or substance use disorder? If yes, who/why (list all)? _____

No Yes Prior or current psychotropic medication usage? If yes:

Medication	Dosage	Frequency	Start Date	End Date	Physician	Side Effects	Beneficial?
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

No Yes Has any family member used psychotropic medications? If yes, who/what/why (list all)?:

FAMILY HISTORY

Family of Origin

Present During Childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parents' Current Marital status:

- married to each other
- separated for ___ years
- divorced for ___ years
- mother remarried ___ times
- father remarried ___ times

Describe parents:

Father	Mother
full name _____	_____
occupation _____	_____
Education _____	_____
General health _____	_____



Patient Name _____ Patient ID# _____ Patient SS# _____
 Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
 24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
 630-621-5824

- Stepmother mother involved with someone
- Stepfather father involved with someone
- Brother(s) mother deceased for __ years
- Sister(s) age of patient at mother's death __
- Other (specify) father deceased for __ years
- _____ age of patient at father's death __

Describe childhood family experience:

- outstanding home environment
- normal home environment
- chaotic home environment
- witnessed physical/verbal/sexual abuse towards others
- experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ Circumstances: _____

Special circumstances in childhood: _____

Medical History

Check all that apply

Describe current physical health Good Fair Poor

List name of primary care physician

Name _____ Phone _____

List name of psychiatrist (if any)

Name _____ Phone _____

List any medications currently being taken (give dosage & reason)

List any known allergies: _____

List any abnormal lab test results:

Date _____ Result _____
 Date _____ Result _____

Is there a history of any of the following in the family:

- tuberculosis heart disease
- birth defects high blood pressure
- emotional problems alcoholism
- behavior problems drug abuse
- thyroid problems diabetes
- cancer Alzheimer's disease/dementia
- mental retardation stroke
- other chronic or serious health problems

Describe any serious hospitalization or accidents:

Date _____ Age _____ Reason _____
 Date _____ Age _____ Reason _____
 Date _____ Age _____ Reason _____

Substance Use History

Check all that apply

Family alcohol/drug abuse history:

- father stepparent/live-in
- mother uncle(s)/aunt(s)
- grandparent(s) spouse/significant other
- sibling(s) children
- other _____

Substance use status:

- no history of abuse
- active abuse
- early full remission

Substances used:

(complete all that apply)

(complete all that apply)	First use age	Last use age	Current use (yes/no)	Frequency	Amount
<input type="checkbox"/> alcohol	_____	_____	_____	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____	_____
<input type="checkbox"/> barbiturates/owners	_____	_____	_____	_____	_____
<input type="checkbox"/> caffeine	_____	_____	_____	_____	_____
<input type="checkbox"/> cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> crack cocaine	_____	_____	_____	_____	_____
<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____	_____



Patient Name _____ Patient ID# _____ Patient SS# _____

Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
630-621-5824

- early partial remission
- sustained full remission
- sustained partial remission

Treatment History:

- outpatient (ages[s] _____)
- inpatient (age[s] _____)
- 12-step program (age[s] _____)
- stopped on own (age[s] _____)
- other (age[s] _____)
describe: _____

- nicotine/cigarettes _____
- PCP _____
- prescription _____
- other _____

Consequences of substance abuse (check all that apply):

- hangovers withdrawal symptoms sleep disturbance binges
- seizures medical conditions assaults job loss
- blackouts tolerance changes suicidal impulse arrests
- overdose loss of control amount used relationship conflicts
- other _____

Developmental History

Check all that apply

Problems during mother's pregnancy:

- none
- high blood pressure
- kidney infection
- German measles
- emotional stress
- bleeding
- alcohol use
- drug use
- cigarette use
- other _____

Birth:

- normal delivery
- difficult delivery
- cesarean delivery
- complications _____
- birth weight ____lbs____oz

Infancy:

- feeding problems
- sleep problems
- toilet training problems

Childhood health:

- chickenpox (age _____)
- German measles (age _____)
- red measles (age _____)
- rheumatic fever (age _____)
- whooping cough (age _____)
- scarlet fever (age _____)
- autism
- ear infections
- allergies to _____
- significant injuries _____
- chronic, serious health problems _____
- lead poisoning (age _____)
- mumps (age _____)
- diphtheria (age _____)
- poliomyelitis (age _____)
- pneumonia (age _____)
- tuberculosis (age _____)
- mental retardation
- asthma

Delayed developmental milestones

(Check only those milestones that did not occur at expected age)

- sitting controlling bowels
- rolling over sleeping alone
- standing dressing self
- walking engaging peers
- feeding self tolerating separation
- speaking words playing cooperatively
- speaking sentences riding tricycle
- controlling bladder riding bicycle
- other _____

Emotional/behavior problems (Check all that apply)

- drug use repeats words of others distrustful
- alcohol abuse not trustworthy extreme worrier
- chronic lying hostile/angry mood self-injurious acts
- stealing indecisive impulsive
- violent temper immature easily distracted
- fire-setting bizarre behavior poor concentration
- hyperactive self-injurious threats often sad
- animal cruelty frequently tearful breaks things
- assaults others frequently daydreams other _____
- disobedient lack of attachment _____

Social interaction (Check all that apply)

- normal social interaction inappropriate sex play
- isolates self dominates others
- very shy associates with acting-out peers
- alienates self other _____

Intellectual/academic functioning (Check all that apply)

- normal intelligence authority conflicts mild retardation
 - high intelligence attention problems moderate retardation
 - learning problems underachieving severe retardation
- Current or highest education level _____



Patient Name _____ Patient ID# _____ Patient SS# _____
Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
630-621-5824

Describe any other developmental problems or issues _____

Socio-Economic History

Check all that apply

Living situation:

- housing adequate
- homeless
- housing overcrowded
- dependent on others for housing
- housing dangerous/deteriorating
- living companions dysfunctional

Employment:

- employed and satisfied
- employed but dissatisfied
- unemployed
- coworker conflicts
- supervisor conflicts
- unstable work history
- disabled: _____

Financial situation:

- no current financial problems
- large indebtedness
- poverty or below-poverty income
- impulsive spending
- relationship conflicts over finances

Social support system:

- supportive network
- few friends
- substance-use-based friends
- no friends
- distant from family of origin

Military history:

- never in military
- served in military – no incident
- served in military – **with** incident

Legal history:

- no legal problems
- now on parole/probation
- arrest(s) not substance-related
- arrest(s) substance-related
- court ordered this treatment
- jail/prison _____time(s)
- total time served: _____
- describe last legal difficulty: _____

Sexual history:

- heterosexual orientation
- homosexual orientation
- bisexual orientation
- currently sexually active
- currently sexually satisfied
- currently sexually dissatisfied
- age first sex experience _____
- age first pregnancy/fatherhood _____
- history of promiscuity age ___to___
- history of unsafe sex age ___to___

Additional information _____

Cultural/spiritual/recreational history:

Cultural identity (e.g., ethnicity, religion): _____

Describe any cultural issues that contribute to current problem: _____

- Currently active in community/recreational activities? Yes No
- Formerly active in community/recreational activities? Yes No
- Currently engage in hobbies? Yes No
- Currently participate in spiritual activities? Yes No
- If answered "yes" to any of the above, describe: _____

Sources of Data Provided Above

Patient self-report for all A variety of sources (if so, check appropriate sources below):

Presenting Problems/Symptoms

- patient self-report
- patient's parent/guardian
- other(specify) _____

Family History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Developmental History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Emotional/Psychiatric History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Medical/Substance Use History

- patient self-report
- patient's parent/guardian
- other(specify) _____

Socioeconomic History

- patient self-report
- patient's parent/guardian
- other(specify) _____



Patient Name _____ Patient ID# _____ Patient SS# _____

Provider Name _____ Date _____

Agor Behavioral Health Services, Inc.
24402 W Lockport Street, Suite 204 ♦ Plainfield, Illinois 60544
630-621-5824

SECONDARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____

Insured's ID # _____ Group/Policy # _____ Agency/Insurance Phone _____

Insurance Claims Mailing Address _____

City _____ State _____ Zip _____

Subscriber Name _____ Subscriber Date of Birth _____

Co-pay amount _____ Authorization # _____ Number of Sessions Authorized _____

Are services pertaining to psychotherapy or testing? _____

A copy of your insurance or Medicaid card is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Agor Behavioral Health Services, Inc. and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will be responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signature of Responsible Party

Date



Notice of Privacy Practices

Effective September 24, 2011

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Agor Behavioral Health Services, Inc. may use and disclose your PHI in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Agor Behavioral Health Services, Inc. is required to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Agor Behavioral Health Services, Inc. is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. Agor Behavioral Health Services, Inc. will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

How Agor Behavioral Health Services, Inc. may use and disclose Health Information about you.

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. We may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.



Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by Court Order.
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Agor Behavioral Health Services, Inc. at 24402 West Lockport Street, Unit 2B, Plainfield, Illinois, 60544:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI Agor Behavioral Health Services, Inc. have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Agor Behavioral Health Services, Inc. at 24402 West Lockport Street, Unit 2B, Plainfield, Illinois, 60544 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 24, 2011.



Notice of Privacy Practices Receipt and Acknowledgment of Notice

Client Name: _____

Date of Birth: ____/____/____

Social Security Number: ____-____-____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Agor Behavioral Health Services, Inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Agor Behavioral Health Services, Inc. at 630-621-5824 or at dragor@doctoragor.com.

Client Signature: _____ Date: ____/____/____

Parent, Guardian or Personal Representative Signature*:

_____ 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.)*

_____ Client Refuses to Acknowledge Receipt

Signature of Witness: _____ Date: ____/____/____



Authorization for Release of Confidential Health Information

I, _____, hereby authorize Agor Behavioral Health Services, Inc.
(Name of Client or Authorized Agent)
to release to/or secure from

(Name of Health Care Facility, Physician, Agency etc.)

(Street Address, City, State and Zip Code)

the following information contained in the client record of

_____ Born: ___/___/___
(Client's Name) (Birth date)

To be disclosed, the following items must specifically be checked:

- O Account Information O Treatment Summary
O Office Psychotherapy Notes O Verbal Discussion of Case
O Psychological Testing Report O Other (specify): _____

The purpose(s) of the authorization is (are):

- O At the request of the individual O Coordination of Mental Health Treatment
O Payment of Account O Other (specify): _____

I understand that the practice may not condition treatment on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to
redislosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the
practice of my desire to do so. I also understand that I will not be able to revoke this authorization
in cases where the therapist has already relied on it to use or disclose my health information.
Written revocation must be sent to the practice. Absent such written revocation, this Authorization
for Release of Confidential Health Information will terminate on _____.

(Date)

Date: ___/___/___

Signature of Client**

Signature of Witness

Signature of Parent or Guardian

**Client signature is required in addition to the parent or guardian signature for clients ages 12-17.



What To Expect at Your First Appointment

Hours and Cancellations

Psychotherapy sessions are typically 45 - 50 minutes long. If it becomes impossible for you to keep an appointment, it is important that you call to inform us of your cancellation. **Due to the policy of reserved appointment times, an appointment that you cannot keep must be canceled no fewer than 24 hours before the appointment time. Appointments that have not been properly canceled will be charged the regular session fee.** Insurance companies and probation departments will not pay for missed sessions, so these will be your sole responsibility. **Unfortunately, we cannot call to remind people of appointments.**

Phone Calls

Our general policy is to leave only our name and phone number when phone calls are returned. Please indicate your consent for our office to leave treatment information: appointment changes, account information, etc.

- I authorize Agor Behavioral Health Services, Inc. to leave treatment information on my answering machine and voice mail.
- I do not authorize Agor Behavioral Health Services, Inc. to leave treatment information on my answering machine and voice mail.

Print Client Name: _____

Fees and Insurance

Charges for sessions are consistent with standard psychotherapy fees in the community. **PAYMENT IS REQUESTED AT THE TIME OF SERVICE.** Please make checks payable to **Agor Behavioral Health Services, Inc.**

DCFS Clients, Referrals and those using Post-Adopt (post adoption services) must contact 312-808-5250 to get pre-authorization **before** the first session. (For more information on the post adoption assistance subsidy, visit <http://www.adoptinfo-il.org/postsupport6-subsidy.htm>.)

In divorce situations, the parent who brings in the child(ren) is obligated to pay the session fee or co-payment (even if he/she is not the insurance carrier). The parent bringing the child(ren) to the session is also responsible for sharing the information with the other parent. If the other parent would like to schedule a session to discuss the progress of the child(ren), the usual session fee is charged and must be paid at the time of the appointment.

Many insurance plans will reimburse you for some or all of the charges for psychotherapy. If you are eligible for reimbursement under your plan, you may attach the receipt from each session to your insurance claim form when you submit the claim. Any specific questions about your bill may be discussed with us. Fees not paid will be sent to collections. Please discuss any payment concerns with us immediately.

Late Fees and Non-Payment Information

Patient bills are mailed monthly. Payment is due within 30 days. Balances over \$50 may be paid at a minimum of 20% of the total account balance each month. A **\$15.00 late fee** will be applied to all accounts when the minimum amount due is not received within 30 days. Payment plans are available on **current accounts**; payment arrangements must be authorized by the Billing Department. If no payment is received within 3 billing cycles, the account will be turned over to a collection agency. The patient will be responsible for all collections fees. The Billing Department may be contacted by calling 630-621-5824 or emailing billing@doctoragor.com.

Court Reports and Sessions

Ideally, we do not attend court sessions. With very few exceptions, a court report can be written to bring to court. If we are required to attend a court session, the fee is double the per hour rate because it requires many standing clients to lose their appointment times. A written court report is a more economical way to work with court issues.

Emergencies

In the event of an emergency, you may contact my cell phone. However, we do not usually accept calls if in session. If we are not available in case of emergency, please call your local crisis line, contact your primary care physician, or proceed to your local emergency room.

Confidentiality

We are committed to making this a safe place for you to get help. To that end, we adhere to all legal protections of your confidentiality. Limitations include staff consultation, life-threatening behavior, child abuse, elder abuse and judge's orders to release information. *Good communication between us is vital to our ability to serve you well. Please tell us about problems and questions that might arise. If you don't understand an answer or if new problems arise, let us know. We want to provide you with the best possible care, and we need your cooperation to succeed. Please contact us if you have a concern.*

All items have been fully explained to me; I understand them and take full responsibility for their contents.

Client Signature: _____ Date: ____/____/____

Provider Signature: _____ Date: ____/____/____



Authorization for Release of Confidential Health Information

I, _____, hereby authorize Agor Behavioral Health Services, Inc.
(Name of Client or Authorized Agent)
to release to/or secure from

(Name of Health Care Facility, Physician, Agency etc.)

(Street Address, City, State and Zip Code)

the following information contained in the client record of

_____ Born: ___/___/___
(Client's Name) (Birth date)

To be disclosed, the following items must specifically be checked:

- O Account Information O Treatment Summary
O Office Psychotherapy Notes O Verbal Discussion of Case
O Psychological Testing Report O Other (specify): _____

The purpose(s) of the authorization is (are):

- O At the request of the individual O Coordination of Mental Health Treatment
O Payment of Account O Other (specify): _____

I understand that the practice may not condition treatment on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to
redisclosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the
practice of my desire to do so. I also understand that I will not be able to revoke this authorization
in cases where the therapist has already relied on it to use or disclose my health information.
Written revocation must be sent to the practice. Absent such written revocation, this Authorization
for Release of Confidential Health Information will terminate on _____.

(Date)

Date: ___/___/___

Signature of Client**

Signature of Witness

Signature of Parent or Guardian

**Client signature is required in addition to the parent or guardian signature for clients ages 12-17.