CLIENT INFORMATION

CLIENT FIRST NAME	CLIENT LAST NAME	BIRTHDATE	AGE	GENDER

STREET ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	CELL PHONE #	HOME PHONE #	EMAIL

EMERGENCY CONTACT	RELATIONSHIP TO CLIENT	EMERGENCY CONTACT PHONE #

WHO REFERRED YOU TO EDGEWOOD?	PHONE NUMBER #	ORGANIZATION

DO YOU REQUIRE ASSISTANCE DUE TO A DISABILITY? YES _____ NO _____

IF YES, PLEASE DESCRIBE NEEDED ASSISTANCE

INSURANCE INFORMATION

IS INSURANCE BEING USED? YES _____ NO _____ IF NO, PLEASE COMPLETE SELF-PAY AGREEMENT FORM

ARE YOU COVERED BY MEDICAID OR MEDICARE? YES _____ NO _____ IF YES, PLEASE COMPLETE OPT-OUT AGREEMENT FORM

PRIMARY INSURANCE

INSURANCE NAME	EFFECTIVE DATE	MEMBER ID
POLICY HOLDER	POLICY HOLDER BIRTHDATE	GROUP #

SECONDARY INSURANCE

INSURANCE NAME	EFFECTIVE DATE	MEMBER ID
POLICY HOLDER	POLICY HOLDER BIRTHDATE	GROUP #

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM CLIENT)

FIRST NAME	LAST NAME	RELATIONSHIP TO CLIENT

STREET ADDRESS	CITY	STATE	ZIP CODE

CELL PHONE #	HOME PHONE #	EMAIL

HOUSEHOLD MEMBERS

FAMILY MEMBER NAME	BIRTHDATE	RELATIONSHIP

PHONE NUMBER	EMAIL	INSURANCE COMPANY

FAMILY MEMBER NAME	BIRTHDATE	RELATIONSHIP

PHONE NUMBER	EMAIL	INSURANCE COMPANY

FAMILY MEMBER NAME	BIRTHDATE	RELATIONSHIP

PHONE NUMBER	EMAIL	INSURANCE COMPANY

PLEASE REQUEST ADDITIONAL REGISTRATION FORMS IF YOU HAVE ADDITIONAL HOUSEHOLD MEMBERS TO LIST

I hereby authorize Edgewood to release to the above insurance companies information needed for claims reimbursement. I hereby assign, transfer, and set over to Edgewood all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Edgewood.

_______________________________ _______________________________ __________________

Client Signature (18 & over) Client Printed Name (18 & over) Date

_______________________________ _______________________________ __________________

Parent/Guardian Signature (under 18) Parent/Guardian Printed Name (under 18) Date

CONSENTS AND NOTIFICATIONS

CONSENT FOR TREATMENT

I consent to the evaluation and treatment process with Edgewood and I understand that this process may include myself, spouse, children, and/or other family members. I understand that I have the right to withdraw from treatment at any time. I understand that if my child is the client, the child's other legal or biological parent or guardian may be informed of our child's treatment. I understand that the number of visits I receive will depend on the type(s) of issues that exist, the recommendations made, and the effort that I put forth by following suggested recommendations. Initials _____

ELECTRONIC COMMUNICATION

I consent to sending and receiving email communications with Edgewood. I understand electronic communication is not encrypted and third parties may have access to my email. I assume responsibility for any compromised communication. Initials _____

NEWSLETTER COMMUNICATION

I consent to receive Edgewood newsletters and service update and opportunities notifications via email. Initials _____

TELEPHONE COMMUNICATION

I consent to receiving telephone communications with my clinician about treatment. Initials _____

CONSENT FOR SMS TEXT NOTIFICATIONS

I consent to receive appointment reminder SMS texts from 847.973.5686. I understand that I must contact Billing@EdgewoodServices.com to discontinue this notification and that normal cell charges will apply. Initials _____

CONFIDENTIALITY

I understand that all clinical information is kept strictly confidential and will not be released without my written authorization except in the cases of suspected child abuse, child neglect, lethal danger towards self or others or treatment and payment operations as required under Illinois state law. Further, I have protected health information rights to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I received a summary of the Notice of Privacy Practices and understand a complete notice of patient rights and grievance policy may be obtained at EdgewoodServices.com. Initials _____

CRISIS/EMERGENCY NEEDS

I understand that Edgewood **DOES NOT** provide crisis/emergency services. I must call 911, go to the nearest emergency room, or visit Linden Oaks Naperville if I need immediate attention. Initials _____

My signature reflects my understanding and acknowledgement of the above initialed consents and notifications.

______________________	______________________	__________
Client Signature (12 & over)	Client Printed Name (12 & over)	Date
Parent/Guardian Signature (under 12)	Parent/Guardian Printed Name (under 12)	Date

CONSENT TO RELEASE INFORMATION TO OTHER MEDICAL PROFESSIONALS

By signing below, I am electing to share relevant treatment information with a Primary Care Physician or other Health Care Provider to support coordination of my health care needs. _____ I refuse permission to share my treatment information.

PROVIDER NAME	PROVIDER ADDRESS	
PROVIDER PHONE NUMBER	EMAIL	PROVIDER SPECIALTY

______________________	______________________	__________
Client Signature (18 & over)	Client Printed Name (18 & over)	Date
Parent/Guardian Signature (under 18)	Parent/Guardian Printed Name (under 18)	Date

CLIENT FINANCIAL RESPONSIBILITY POLICIES

INSURANCE BILLING

As a courtesy, we will verify your insurance coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of fees associated with any services provided. Fees may include co-pays, co-insurance, deductibles, no show/cancellation fees, or additional services not covered by your insurance carrier. If your insurance carrier denies part or all of you claim, you will be responsible for any balance remaining.

Once payment has been received from your insurance carrier, your debit/credit card on file will be immediately charged the remaining balance as deemed by your insurance carrier. Any charges that cannot be collected immediately will generate a statement and be considered immediately due upon receipt by the financially responsible party. We accept checks, cash, FSA/HSA accounts, and all major credit cards. Payments can be made in person, by phone, and online at EdgewoodServices.com

Failure to meet all financial obligations may result in the account being referred to a collections agency. Any additional fees incurred on behalf of Edgewood to collect outstanding balances will become your financial responsibility. If you are unable to pay account balances, please contact our Billing Department immediately to explore options ***BEFORE*** balances are sent to a collections agency.

Initials _____

DEBIT/CREDIT CARD ON FILE POLICY

All clients are ***REQUIRED*** to keep a debit/credit card on file in order to receive services. This information will not be held by Edgewood. It will be maintained in a secure First Data database. All co-pays will be charged to this card at the time of visit. All remaining balances, as deemed by your insurance carrier, will be charged to this card upon receipt of notification by Edgewood from your insurance carrier. **YOU WILL BE REQUIRED TO PROVIDE A DEBIT/CREDIT CARD ON YOUR FIRST VISIT. IF YOU SEND AN UNACCOMPANIED MINOR FOR HIS/HER FIRST VISIT, YOU MUST SEND IN A COMPLETED CREDIT CARD AUTHORIZATION FORM WITH HIM/HER.**

Initials _____

CO-PAY COLLECTION

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated for the clients to pay their co-pay at EACH VISIT when the service is rendered. Your debit/credit card on file will be immediately charged upon check in for appointments.

Initials _____

LATE CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we ***REQUIRE*** you to call 24 hours prior to the appointment to cancel it. Failure to provide 24 hours' notice to Edgewood will result in a cancellation charge of $50 for groups, $100 for counseling appointments, $150 for follow-up psychiatric appointments and $300 for initial psychiatric appointments. Your credit card on file will be immediately charged at scheduled appointment time.

Initials _____

My signature reflects my understanding and acknowledgement of the above initialed provisions of the Client Financial Responsibility Policy.

______________________________	______________________________	________________
Client Signature (18 & over)	Client Printed Name (18 & over)	Date
______________________________	______________________________	________________
Parent/Guardian Signature (under 18)	Parent/Guardian Printed Name (under 18)	Date