Client Information – Individual Form

Name: ____ Date: _________________

Date of Birth: ____________________ Age: ______ Gender:____________________

Pronoun(s): ______________________ Ethnicity: ___________________________________

Home Address: ____

City: _________________________ State: ___________________ Zip:_________________

Preferred Phone: ________________________________ (Circle: Cell / Work / Home / Other)

Ok to leave a voicemail? Yes _____ No _____

Email Address: ____

Emergency Contact: ____

Relationship: ____

Phone: ____ (Circle: Cell / Work / Home / Other)

In case of a medical or safety emergency, I consent to the above person being contacted by Chicago Clinical Associates and consent to the release relevant information in order to secure my stability or safety.

____ ________________________

Signature Date

111 N. Wabash Ave Suite 1400, Chicago, IL 60602
Ph. 312-436-1657 / Fx. 312-284-4505
www.chicagoclinical.org

Name of Insurance Company: ____

ID #: ____

Group #: ____

***If primary insurer is someone other than client, please provide:**

Name of Primary Insurer: ____

Primary Insurer DOB: ____

Primary Insurer Address: ____

____

Why are you seeking therapeutic services at this time? _________________________________

____

____

____

If referred, by whom? ____

Have you ever sought therapeutic services in the past? If so, when & where? ________________

____

____

____

____

Fee Policy

Unless other arrangements are made, payment or co-payment for services is expected upon receipt of services. The minimum amount of information about you and your treatment will be shared with third-party payers or insurance companies. Access to this information will be limited to determine benefits and will be available only to those who assist in determining payment and/or benefits. This consent may be revoked at any time by providing written consent.

Please be advised that insurance plans do not cover cancelled sessions. Therefore, in the case of missed or cancelled sessions, regardless of the reason for cancellation, without 24 hour advanced notice, you will be billed and are responsible for a cancellation fee for the session(s) offered.

You understand that your Visa/Master Card account will be billed for any fees uncollected after 60 days and that you are furthermore responsible for fees not paid by your insurance company.

We are glad to speak with you further should you have any questions or concerns regarding the financial policies above.

Signature of Patient or Responsible Party: ______________________________ Date:_________

Visa/MC #: ____

Expiration Date: _______________ Three Digit Security Code (listed on back of card) ________

Name on Card: ____

Full Billing Address: ____

____

111 N. Wabash Ave Suite 1400, Chicago, IL 60602
Ph. 312-436-1657 / Fx. 312-284-4505
www.chicagoclinical.org

Insurance Authorization Form

This form, when completed and signed below, authorizes Chicago Clinical Associates to release protected health information from my clinical record to my insurance company for the sole purpose of processing healthcare claims and obtaining payment. This information may only be released to: ____________________________________ and its benefits coordination services, if any.

My signature below also assigns to Chicago Clinical Associates all money to which I am entitled for expenses relative to my received therapeutic services. I understand that I am financially responsible for all charges not covered by my insurance company.

This authorization shall remain in effect until the termination of my therapeutic services or until the following date: ______________________.

I have the right to revoke this authorization at any time by submitting a written notification to the office address provided. However, my revocation will not be effective to the extent that Chicago Clinical Associates has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that I have the right to inspect and copy the disclosed mental health information at any time.

I understand that if I refuse to provide this authorization, Chicago Clinical Associates will not be able to provide information to my health insurance company that is necessary to coordinate payment and I will be responsible for the full fee for therapeutic services.

I understand that Illinois law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such re-disclosure.

____
Client Name

____
Client Signature

____
Date

____
Witness Name

____
Witness Signature

____
Date

Medical Information

Medical history *(diagnoses, allergies, significant procedures, hospitalizations)*:

Medications *(past and present):*

Do you have a primary care physician (PCP) or psychiatrist?

Yes ______ No ______

Name: ____

Address: ____

Phone: ____

Fax: ____

(Check one): *I consent* _____ *I do not consent* _____ for Chicago Clinical Associates to confer with my medical provider regarding my mental health treatment for relevant coordination of care.

____ ________________
Signature Date

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ___________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ___________________
In a typical week, approximately how much time do you spend with the individual? ____________________ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.