DIRKSEN CENTER

Welcome!
There are 3 ways to return forms:

Email forms to:
info@dirksencenter.com
*As with all electronic communications, we cannot guarantee confidentiality or security of emailed information.

Or fax to:
847-701-3275

Or mail to:
Dirksen Center
855 E. Golf Road
Ste., 2139
Arlington Heights, IL 60005

Provider Name _____

Dirksen Center for Neurobehavioral Health

___ **AH** ___ **CL** ____ **DF** ___ **FRG**

PATIENT INFORMATION

Last Name_____ First_____MI_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Marital Status_____Date of Birth_____Age_____Sex_____

Soc Sec Num_____Language Preference _____

Race: ☐ Asian ☐ American/Alaskan Indian ☐ Black/African American ☐ Hawaiian ☐ Other/Unk ☐ White ☐ Declined

Ethnicity: ☐ Hispanic / Latino ☐ Non Hispanic /Non Latino ☐ Declined

Email Address_____ Emergency Contact Name_____

Emergency Contact Phone:_____ Relationship_____

GUARANTOR INFORMATION

WHOMEVER BRINGS IN MINOR CHILD MUST COMPLETE THIS SECTION

Last Name_____ First_____MI_____Marital Status_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Date of Birth_____Age_____Sex_____Soc Sec Num_____

Email Address_____

POLICYHOLDER INFORMATION

Last Name_____ First_____MI_____Marital Status_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Ok to leave message? Yes ☐ No ☐

Date of Birth_____Age_____Sex_____Soc Sec Num_____

	PRIMARY	**SECONDARY**	**OTHER**
INS COMPANY NAME			
POLICY HOLDER NAME			
POLICY NUMBER			
RELATIONSHIP TO PT			
EMPLOYER OF INSURED			

All signatures contained herein apply to services rendered at:

Dirksen Center for Neurobehavioral Health

Informed Consent for Treatment:
I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____Date_____

Relationship to patient (if applicable)_____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third-party payor.
5. I understand that my report and data will not be released until the balance has been paid in full.
6. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient Name_____ Date_____

Patient OR Guarantor Signature (if patient is a minor)_____

Release of Information:
I give my consent to DCN to release the report and communicate with members of my treatment team and/or referring provider listed below. I also understand that I can revoke my consent for any reason by contacting DCN in writing or speaking with a DCN clinician:

1. Name: _____ Phone: _____ Date:_____

2. Name: _____ Phone: _____ Date:_____

3. Name: _____ Phone: _____ Date:_____

Signature_____ Date_____

HIPAA Privacy Notice Acknowledgement:

I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

Signature_____ Date_____

DIRKSEN CENTER

This form is required for all DCN patients under age 18 and must be completed by the child's guardian.

Minor (Child) Patient Information

First Name: _____ Last Name _____

Date of Birth: _____ Phone contact: _____

Address: _____

City: _____ State: _____ Zip code: _____

Guardian 1 Information (Person completing this form)

First Name: _____ Last Name _____

Date of Birth: _____ Phone contact: _____

Address: _____

City: _____ State: _____ Zip code: _____

Guardian 2 Information

First Name: _____ Last Name _____

Date of Birth: _____ Phone contact: _____

Address: _____

City: _____ State: _____ Zip code: _____

Guardian Questions

Does the minor listed above have legal guardians not listed in the spaces above?

_____

Are both biological or adoptive parents' legal guardians for the minor listed above?

_____

DIRKSEN CENTER

DIRKSEN CENTER FOR NEUROBEHAVIORAL HEALTH INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information regarding psychotherapy and neuropsychology services using the phone or the internet. Please read this carefully, and let us know if you have any questions. When you sign this document, it will represent an agreement between you and your treating psychologist at the Dirksen Center.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychological services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician is otherwise unable to continue to meet in person. Telepsychology requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychological services and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the psychologist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. We will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get unauthorized access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. In most cases, telepsychology is not the preferred way to work with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, an emergency response plan will be developed to address potential crisis situations that arise.

- Efficacy. Most research shows that telepsychology is about as effective as in-person services. However, some psychologists believe that something is lost by not being in the same room. For example, there is debate about a psychologist's ability to fully understand non-verbal information when working remotely.

Electronic Communications
Dirksen Center currently uses Doxy for provision of services. If that changes, we will make sure that you have ample notice and time to make appropriate arrangements. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, DCN will only use email communication and text messaging with your permission and only for administrative purposes. This means that email exchanges and text messages should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that Dirksen Center cannot guarantee the confidentiality of any information communicated by email or text. Therefore, clinical information will not be discussed by email or text. Also, Dirksen Center emails are not regularly checked, nor are clinicians able to respond immediately, so these methods **should not be used in case of emergency**.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach your psychologist by phone. We do our best to return calls within 24 hours except on weekends and holidays. If you are unable to reach your psychologist and feel that you cannot wait for your call to be returned, contact your primary care physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your psychologist will be unavailable for an extended time, Dirksen Center will provide you with the name of the covering psychologist.

Confidentiality
Dirksen Center has a legal and ethical responsibility to make best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that Dirksen Center cannot guarantee that communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that electronic communications may be compromised, unsecured, or accessed by others who are not authorized to view them. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that were outlined in our original paperwork still apply in telepsychology. Please let us know if you have any questions about exceptions to confidentiality or if you would like a copy of the HIPAA policy to keep for your records.

Appropriateness of Telepsychology
From time to time, in-person sessions to “check-in” may be necessary and scheduled. Your psychologist will let you know if telepsychology is no longer feasible due to changes at the Dirksen Center or if telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person treatment/consultation or provide referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, an emergency plan is necessary before engaging in telepsychology services. We will ask you to identify an emergency contact person who is near your location and who will be contacted in the event of a crisis or emergency to assist in addressing the situation. We will ask that you sign a separate authorization form allowing your psychologist to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call your psychologist back; instead, call 911, or go to your nearest emergency room. Call your psychologist back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and re-enter your psychologist's waiting room with the web link originally provided. Your psychologist will wait three (3) minutes for your name to reappear in the virtual waiting room and reconnect with you. After three (3) minutes, your psychologist will attempt to call you if you have not re-entered the virtual waiting room. If you have not connected with your psychologist by either the telepsychology platform or by phone within five (5) minutes, then call your psychologist on the phone number provided to you before beginning your session. **Dr. Tria Murphy 847-801-9158**

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees
The same fee rates will apply for telepsychology as for in-person meetings. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please check with your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records
The telepsychology sessions shall not be recorded in any way by you or Dirksen Center unless agreed to in writing by mutual consent. We will maintain a record of our session in the same way we maintain records of in-person sessions in accordance with Dirksen Center policies.

Informed Consent
This agreement is intended as a supplement to the general informed consent that you signed at the outset of your work with psychologists at Dirksen Center and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____
Patient Name (PRINT) Date

_____ _____
Patient Signature Date

_____
Guardian Name (if patient is a minor)

_____ _____
Guardian Signature (if patient is a minor) Date

_____
Guardian relationship to minor patient

_____ _____
Witness Date

Please provide the name of an emergency contact to be used for safety purposes in the case of an emergency.

_____ _____
Emergency Contact Name Emergency Contact Phone Number

_____ _____
Parent or Guardian Signature Today's Date