David C Clinton PC
at
ARTISAN CLINICAL ASSOCIATES, LLC
121 N. Washington Street—Suite 2N
Naperville, IL 60540
Ph: (630) 923-6830 F: (630) 923-6831

REGISTRATION INFORMATION

Date: _____ /_____ /_____

Demographics

Client Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email Address (*optional: for appointment reminders and/or practice updates*) _____

Sex: M _____ F _____ Date of Birth: _____/_____/_____ Age: _____

Marital Status (circle one): Single Married Widowed Separated Divorced

Employment Status (circle): Full-Time Part-Time Self-Employed Retired Unemployed Student

Employer: _____ Address: _____

In case of emergency, who should we notify? _____ Phone: _____

Whom may we thank for referring you? _____

Reason for Visit: _____

Known Medical Issues: _____

Signatures

Signature of Client: _____

Signature of Parent (*if client is under age of 18*): _____

Signature of Second Parent (*if required by divorce decree*): _____

Insurance

Complete this section if you have Blue Cross Blue Shield PPO insurance, and provide the information for the Policy Holder:

Insurance Company: _____ ID# _____ Group# _____

BCBS Address: _____ BCBS Phone: _____

Policy Holder Name (*as it appears on card*): _____

Date of Birth: _____ Employer: _____ Employer Phone: _____

Employer Address: _____

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NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you may be used and disclosed and how you can get access to your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY.

Our practice is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the diagnosis, treatment and services we provide to you. We are required to:

- Maintain the privacy of your health information.
- Provide you with a notice of our legal duties and privacy practices with respect to information we collect.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you have to communicate health information by alternative means or at alternative locations.

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times and you may request a copy of our most current Notice.

B. USE AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS.

The following categories describe the different ways in which we may use and disclose your health information.

1. **Treatment.** We may use your health information to treat you and reach a diagnosis. Additionally, we may disclose your health information to others who may assist in your care.
2. **Payment**. We will use and disclose your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs. Also, we may bill you directly.
3. **Health Care Operations**. We may use and disclose your health information to operate our business. For example we may use and disclose your information to evaluate the quality of care you received from us.
4. **Release of Information to Family/Friends**: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, and general condition.
5. **Disclosure required by Law**. We will use and disclose your health information when we are required to do so by federal, state or local law.

C. SPECIAL CIRCUMSTANCES FOR DISCLOSURE OF YOUR HEALTH INFORMATION.

The following categories describe unique scenarios in which we may use or disclose your health information.

1. **Public Health Risks**: Our practice may disclose your health information to public health authorities for the purpose of: reporting child abuse or neglect, reporting elder abuse or neglect, and/or protecting you or someone else from imminent harm.
2. **Lawsuit and Similar Proceedings**: Our practice may use and disclose your health information in response to court or administrative order, if you are involved in a lawsuit or similar proceedings. We may disclose your health information in response to a discovery request, subpoena or other lawful process by another party involved in the

dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

3. **Military:** Our practice may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
4. **National Security**: Our practice may disclose your health information to federal officials for intelligence and national security activities authorized by law.
5. **Workers' Compensation**: Our practice may release your health information for worker's compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding the health information we maintain about you:

1. **Confidential Communications**: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. In order to request a type of confidential communication, you must make a written request to David C Clinton PC specifying the requested method of contact of the location where you wish to be contacted. Our practice will accommodate reasonable requests.
2. **Inspection and Copies**: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to David C Clinton PC in order to inspect/obtain a copy of your health information. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another health care professional chosen by us will conduct the review.
3. **Requesting Restrictions**: You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction you must make written request describing the following:
    - the information you wish restricted;
    - whether you are requesting to limit our practice's use, disclosure or both, and
    - to whom you want the limits to apply.
4. **Amendmen**t: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. You must make this request in writing and must provide us with a reason to support your request for amendment. Our practice will deny your request if it is not in writing and you fail to provide the reason for your request. Also, we may deny your request if you ask us to amend information that is in our opinion (a)accurate and complete; (b) not part of the patient information kept by our practice; (c) not part of the patient information which you would be permitted to inspect or copy, or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information
5. **Accounting of Disclosures**: You have the right to request a list of certain non-routine disclosures our practice has made of your patient information for non-treatment or operations purposes. All requests for this information must be made in writing and must state a time period which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. Our practice may charge you for lists of more than a 12 month period. Our practice will notify you of the costs involved and you may withdraw your request before you incur any costs.
6. **Right to a paper copy of this Notice**: You are entitled to receive a paper copy of our notice of privacy practices. To obtain a copy contact David C Clinton PC.
7. **Right to File a Complaint**: If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures**: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing.

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AGREEMENTS AND CONSENTS

Welcome to Artisan! We are committed to providing you with the highest quality care, which begins with a clear understanding of our services. You will find below a brief description of our office, privacy, and financial procedures. Please initial where appropriate and sign at the bottom of the page. Your therapist will be happy to discuss any questions you might have.

SCHEDULING AND CANCELLATIONS

Each therapist schedules his or her own appointments and will arrange those with you directly. Sessions are typically 45-60 minutes long. Your therapist will explain his or her treatment approach with you—including risks and benefits—and collaborate with you toward setting meaningful treatment goals.

Due to the policy of reserved appointment times, any appointment that cannot be kept must be canceled no less than 24 hours before the appointment time. Appointments that have not been properly canceled are eligible to be charged the regular session fee. Insurance companies will not pay for missed sessions, so payment for these will be your sole responsibility. Your therapist will discuss with you his or her personal policy for missed appointment.

FINANCIAL POLICIES

By the end of your first session, your therapist will explain your financial obligations, based upon your particular insurance plan or lack thereof, as well as answer any questions you may have regarding the cost of and payment for treatment. If we are submitting claims to your insurance company, you authorize us to receive the reimbursement directly. If we are not contracted with your insurance company, the agreed upon fee will be required at the time of service and you will be given a superbill with the information necessary to submit to your insurance company for reimbursement. If you are not submitting your claims to an insurance company, the agreed upon fee will be due at the time of service.

_____ *I have read the financial policies, including the cancellation policy above, and I understand my responsibilities. I will not hesitate to seek any needed clarification from my therapist.*

_____ *I authorize David C Clinton PC to process payments on my credit card ending in* _____ *for co-pays, co-insurance, and cancellation charges.*
Last 4 Digits

COMMUNICATION POLICIES

Our general policy is to leave our name and phone number when we return phone messages. Please initial if you give your consent for us to leave more detailed treatment information on the voicemail of your choice:

_____ *I authorize David C Clinton PC to leave treatment information on my voicemail at the following number: (_____)* _____ -_____.

You also have the option of receiving free appointment reminders and periodic Artisan Clinical updates via email. Please initial below if you give consent for one or both types of email. By initialing, you acknowledge that email is not a secure form of communication and confidentiality cannot be guaranteed. You further acknowledge that the email accounts are not monitored by our therapists and thus no treament information, urgent or otherwise, should be communicated via email.

_____ *I authorize David C Clinton PC to send appointment reminders to* _____ *@* _____.
_____ *I authorize David C Clinton PC to send Artisan Clinical updates to* _____ *@* _____.

_____ *Please initial here, acknowleding that, in an emergency, you agree to call 911 or go to your nearest emergency room.*

PRIVACY AND CONFIDENTIALITY POLICIES

_____ *I have received the Notice of Privacy Practices, describing how my confidential information may be used and disclosed.*
_____ *I consent to the use or disclosure of any information in the patient record of* _____ *for the purpose of conducting treatment, payment, or health care operations. I understand this consent is valid until revoked by me.*

I understand and take full responsibility for the information above.
Client Signature _____ Date _____/_____/_____
Therapist Signature _____ Date _____/_____/_____

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FINANCIAL RESPONSIBILITY AGREEMENT

Date: _____ /_____ /_____

Instructions: The financial guarantor is the person responsible for payment of the account. Complete this form in its entirety if the financial guarantor for this account is someone other than the client listed on the Registration Information form. If you are both the client and the guarantor, fill in the bold items below (Client Name, Date of Birth, Age, write "Self" in Relationship to Client), and sign.

Client Name: _____ **DOB**: _____**Age**: _____

Name of Guarantor: _____ DOB: _____

Relationship to Client: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Guarantor Employer: _____

Employer Address: _____

Occupation: _____

Driver's License # _____

As guarantor for this account, I acknowledge my responsibility for payment of this account, until revoked in writing by me. I understand that, if I am using BCBS PPO insurance, David C Clinton PC will verify insurance benefits and submit claims on my behalf, but this verification is not a guarantee of payment. I am responsible for any and all balances on the account (i.e., any charges not reimbursed by the insurance company). If I have questions regarding the payment of claims, I will contact my BCBS for clarification.

_____ _____
Guarantor's Signature Date