Harris Clinical Group
155 N. Michigan Ave.
Suite 734
Chicago, IL 60601

Patient and Insurance Information (please print)

Patient information

Name (incl. MI) _____ Today's date _____

Gender: ☐ Female ☐ Male Ethnicity _____ Date of birth _____

Address _____ City, Zip _____

Phone: Cell/Home _____ Work _____ Where may we call you? _____

Marital status: ☐ Single ☐ Engaged ☐ Married (___ years married) ☐ Separated ☐ Divorced

☐ Widowed ☐ Remarried (how many times? _____) ☐ Living with someone

Emergency contact name _____ Phone _____

Referred by: ☐ Friend ☐ Physician ☐ Psychotherapist ☐ Pastor ☐ Website ☐ Other

Name of referral source _____

Do you have a primary physician or provider? ☐ Yes ☐ No Date of last physical _____

His/her name and telephone number(s) _____

What brings you to therapy at this time? _____

_____

Insured's information

Insured's name: ☐ Same as above or _____

Insured's address: ☐ Same as above or _____
Number Street City, State, Zip

Name of insured's employer _____ Insured's date of birth _____

Primary insurance company _____

Address _____
Number Street City, State, Zip

Insured's insurance ID number _____ Group number _____

Plan name or code _____ Customer service phone _____

OFFICE: Insurance verification: Effective date _____ *Deductible* _____ *Deductible met?* _____
Co-pay/Co-ins. _____ *Max. # sessions/year* _____ *Pre-auth. required?* _____
Pre-existing wait period? ☐ Yes ☐ No _____

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Authorization Form for Insurance Clients

This form, when completed and signed by me, authorizes Harris Clinical Group to release protected health information from my clinical record to my insurance company for the purpose of processing health care claims and obtaining payment. This information may only be released to _____ and its benefits coordination service, if any.
(name of insurance company)

My signature also assigns to Harris Clinical Group all money to which it is entitled for expenses relative to my counseling services provided by the Group. I understand that I am financially responsible for all charges not covered by my insurance company.

This authorization shall remain in effect until:
_____ termination of therapy, or
_____ the following date: _____.

I have the right to revoke this authorization, in writing, at any time by sending such written notification to Harris Clinical Group at the office address above. However, my revocation will not be effective to the extent that the Group has taken action in reliance on the authorization, nor 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, Harris Clinical Group will not be able to provide information to my health insurance company that is necessary to coordinate payment. I will be responsible for the full fee for professional services received.

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	Witness Name
_____	_____
Client Signature	Witness Signature
_____	_____
Date	Date

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Policies and Payment Procedures

Office Copy

Please read and sign below to acknowledge receipt and understanding of this document.

Harris Clinical Group is a clinical practice dedicated to the highest standards of care in clinical psychology and professional counseling. Your counselor has been professionally trained and is licensed by the state to provide clinical services. We understand the courage it takes to call for professional help and we commend you for your courage. We will strive to make your counseling experience one that will be helpful to you and your family. While we cannot make guarantees, we know that people can find healing through therapy and we will do our very best to be a part of your healing process.

Professional services are completely confidential except instances where an individual's personal safety is at risk (intent to harm self or others, and child or elder abuse, as required by law).

We have several policies we want you to be aware of:

We have a 24-hour cancellation policy. If cancellation is not provided 24 hours prior to a missed appointment (except in an emergency), we must bill you the full amount for that missed session and, by law, cannot bill insurance for any portion of it, meaning you will be responsible for full session cost.

Since electronic communication is not a secure form of contact, therapists may use email or texting for purposes of cancelling, scheduling or rescheduling appointments only. They will not respond directly to clinical information communicated via email or text.

We will file insurance claims for you, and you will be responsible for any part of the bill that your insurance denies and/or does not otherwise cover. It is important for you and your therapist to know your annual deductible and co-pay/co-insurance so that your financial responsibility is clear from the start of treatment. We are "in network" providers for Blue Cross/Blue Shield PPO; all other insurance carriers or plans consider us out of network.

Payment is due at time of service. Please pay your portion at the beginning of your session, at each session. If you know you have a deductible, please pay this at the time of service as well. This helps us keep our fees and costs as low as possible.

Payment can be made by cash, check, money order, Visa, MasterCard or Discover. Please write checks out to Harris Clinical Group.

By signing below, you acknowledge that you have read and understand these policies.

_____ _____

Print name Signature and date

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_____ _____

Print name Signature and date

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Symptom Checklist

Name _____Date _____

Check any of the following behaviors/emotions that apply to you:

☐ Feeling depressed	☐ Feeling anxious	☐ Feeling worthless	☐ Feeling guilty
☐ Fatigue	☐ Panic attacks	☐ Phobias	☐ Loss of interest/pleasure in life
☐ Crying	☐ Angry outbursts	☐ Hallucinations	☐ Lack of motivation
☐ Thoughts of death	☐ Work too hard	☐ Delusions	☐ Agitation or irritability
☐ Procrastination	☐ Aggressive behavior	☐ Loss of control	☐ Period of time with extreme focus
☐ Isolation	☐ Take too many risks	☐ Repetitive behavior	☐ Thoughts of suicide/self-harm
☐ Drink too much	☐ Impulsiveness	☐ Unusually high energy	☐ Other_____

Any changes in:	☐ Weight/appetite?	☐ Increase	☐ Decrease
	☐ Sex drive/desire?	☐ Increase	☐ Decrease
	☐ Short term memory?	☐ Increase	☐ Decrease
	☐ Ability to concentrate?	☐ Increase	☐ Decrease
	☐ Sleep habits?	☐ Increase	☐ Decrease

Check any of the following physical sensations that apply to you:

☐ Headaches	☐ Back pain	☐ Fainting spells	☐ Rapid heart beat
☐ Dizziness	☐ Numbness	☐ Hearing things	☐ Don't like to be touched
☐ Palpitations	☐ Tics	☐ Hearing problems	☐ Blackouts
☐ Muscle spasms	☐ Tremors	☐ Visual disturbances	☐ Excessive sweating
☐ Tension	☐ Skin problems	☐ Bowel disturbances	☐ Burning or itchy skin
☐ Twitches	☐ Dry mouth	☐ Flushes	☐ Unable to relax
☐ Tingling	☐ Stomach trouble	☐ Chest pains	☐ Other _____

Check any of the following that apply to you or members of your family:

Self	Family		Self	Family		Self	Family	
☐	☐	Arthritis	☐	☐	Gastrointestinal disease	☐	☐	Infertility
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Kidney disease
☐	☐	Cancer	☐	☐	Heart disease	☐	☐	Neurological disease
☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Prostrate problems
☐	☐	Epilepsy	☐	☐	Infectious disease	☐	☐	Thyroid disease

Use of substances:

Do you drink alcohol? If so, how many times in an average week? How many drinks each time, and of what type? (identify beer, wine and/or spirits)? Do you drink alone? _____

_____

Do you smoke cigarettes/cigars? If so, how many in an average day? _____

Do you use illegal substances? If so, what are the substances and the frequency of your use? _____

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_____

Injuries/Accidents:
Have you ever had a head injury or loss of consciousness? Please give details _____

_____

Please describe any surgeries you have had (give dates) _____

_____

Please describe any accidents or injuries you have suffered (give dates) _____

_____

Check any of the following that apply to you:

	Never	Rarely	Sometimes	Frequently		Never	Rarely	Sometimes	Frequently
Aches/Pains	☐	☐	☐	☐	Nausea	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	Vomiting	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐	Diarrhea	☐	☐	☐	☐
Diuretics	☐	☐	☐	☐	Constipation	☐	☐	☐	☐
Painkillers	☐	☐	☐	☐	Sexual dys-function	☐	☐	☐	☐
Tranquilizers	☐	☐	☐	☐	Poor appetite	☐	☐	☐	☐
Anti-depres-sants	☐	☐	☐	☐	Overeat	☐	☐	☐	☐
Stimulants/ Diet pills	☐	☐	☐	☐	Fitful sleep	☐	☐	☐	☐
Sedatives	☐	☐	☐	☐	Early morning awakening	☐	☐	☐	☐
Caffeinated beverages	☐	☐	☐	☐					

Have you ever engaged in self-harm behaviors to any part of your own body, such as cutting, scratching, picking, burning, etc.? Please give details _____

_____

Is there anything else regarding what you have been experiencing that you want your therapist to know?

_____

_____

_____

_____