Family Resilience Group

3285 N Arlington Heights Road, Suite 201
Arlington Heights, IL 60004
847/398-0499
www.familyresilience.org

REGISTRATION INFORMATION

I. PATIENT INFORMATION

Name: _____Date Of Birth: _____

Street Address: _____

City, State: _____ Zip code: _____

Phone – Home: _____ Cell: _____

Where should we leave messages? _____

Email address: _____

II. IF PATIENT IS A MINOR, PARENT OR GUARDIAN INFORMATION

Mother's Name: _____

Street Address: _____

City: _____ Zip code: _____

Phone – Home: _____ Cell: _____

Email address: _____

Father's Name: _____

Street Address: _____

City: _____ Zip code: _____

Phone – Home: _____ Cell: _____

Email address: _____

Child resides with: _____ Custody arrangement? _____

III. RESPONSIBLE PARTY

Name of Party Responsible for Bill: _____

Is a party other than the patient or parent listed above to be billed? YES NO

If so, who? (Billing information can be collected in session) _____

IV. INSURANCE INFORMATION

Policy Holder: _____ Date Of Birth _____

Employer: _____

Name of Insurance Co.: _____

Policy/ ID #: _____ Group #: _____

Phone number of Insurance Co. on card: _____

If known, deductible: _____ Copay: _____

V. RESPONSIBLE PARTY -- PLEASE INITIAL EACH

_____ I consent for any information to be released that is necessary to bill insurance, including but not limited to identifying information, diagnosis, progress in treatment, medications taken and treatment goals.

_____ I allow payment of my Insurance benefits to be directed to The Family Resilience Group, LLC. I am aware that I am ultimately responsible for any and all charges. I understand that The Family Resilience Group, LLC will attempt to bill the insurance company as a courtesy but that if insurance difficulties arise, it will be my responsibility to either resolve payment issues or to pay the expenses myself. I understand that if I ask that a third party is billed for the cost of treatment, I still remain ultimately responsible for my bill if they choose not to pay and give permission for The Family Resilience Group, LLC to release information necessary for any collection measures necessary to resolve a debt.

_____ I have been given, in this initial packet, a copy of the Policies and Procedures of The Family Resilience Group, LLC. It is mine to keep for future reference and I may request another copy at any time. They have been reviewed with me in the initial session and I agree to the terms. They are subject to change over time, and The Family Resilience Group agrees to send out notification of any changes if I am a current patient during the month of the changes. If I lapse from treatment and return, however, it is my responsibility to ask about changes in Policies and Procedures or request a current copy

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_____ I understand The Family Resilience Group's confidentiality and HIIPA policies. I can ask for copies for my records if I choose. I understand that patients between the ages of 12-18 have different confidentiality rights from a child under 12 or an adult. These will be discussed further with me in my first session.

_____ I release The Family Resilience Group, LLC from responsibility for any injury resulting from my leaving counseling against clinical advice, from not following clinical advice or from not informing my clinician. I waive my right to take legal or licensure action against The Family Resilience Group, LLC except in cases in which malicious negligence can be proven.

MY SIGNATURE HERE GIVES CONSENT FOR TREATMENT AND AN ACCEPTANCE OF THE POLICIES AND PROCEDURES OF THE FAMILY RESILIENCE GROUP, LLC.

_____ _____

Print name -- Patient, if age 12 or older **Print name -- Parent** if child is under age 18

_____ _____

Signature -- Patient, if age 12 or older **Signature -- Parent** if child is under age 18

_____ _____

Dated Dated

Witnessed: _____ _____

Date

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CREDIT CARD / BILLING FORM

Unfortunately, we have had too many experiences with clients who have not paid copays and deductibles as requested, essentially walking away from their bill. If you choose not to allow a credit card to be on file, we will ask for payment in full every session – not just copays, but full payment of fees. This policy includes clients that we are billing to insurance. We apologize that we find this necessary. The Family Resilience Group pledges that this information will be kept in a locked area, secured location and destroyed upon the completion of services and full payment of your bill.

Date: _____ Credit card type: (Circle) Mastercard Visa Discover AMEX

Name of the cardholder : _____ Billing Zip Code: _____

Card number: _____ Exp. Date:_____

3 digit Security Code: _____ Billing house/apt number in address: _____
(ie. 3285 N. AH Road = 325)

Delinquent balances greater than 60 days after being invoiced will be charged to the credit card: (Initial)

_____ Please charge my credit card monthly for all my copays, deductibles and any outstanding charges.

OR

_____ Please send me a monthly invoice and I will make payments by one of the following methods:

___ Reply by email or phone to Patrick James to run my credit card on file
___ Bring a check or cash at my next appointment
___ Pay via the Client Portal

_____ _____
Cardholder Signature Dated

Witnessed: _____

For any payment questions please contact Patrick James at (847) 398-0499 x21 or pjames@familyresilience.org

CANCELLATION POLICY

If you find yourself in a situation where you need to cancel an appointment, we ask that you cancel any sessions at least 24 hours in advance. We understand that problems arise but want to balance our time as well. Since many of us have other clients waiting for appointments on a "cancellation list", we can give those time slots to another person in need. Without 24 hours-notice of cancellation, our staff is out the income, another client cannot be seen.

So, you will be charged half of your normal session fee for sessions that are cancelled less than 24 hours or not kept without notice. This includes forgetting sessions, sick children, traffic problems and work emergencies. We are moving to the smaller charge, instead of charging a whole session, as many other practices do. Hopefully, that will feel fair to FRG clients.

Please keep in mind that a phone session can occur with your therapist in case of bad weather, traffic or sickness. Your therapist can consider this charge under more extreme circumstances.

Thank you for your understanding as we try to make a policy that will be fair to both sides of the equation. Please talk to your therapist about any concerns you have and make sure you agree on the best way to get a hold of you therapist should you need to cancel.

Scheduling Appointments and Cancellation Policy For Teens and Young Adults

Many of our teen drivers and young adults schedule their own sessions with their therapist without their parent(s) present. If you agree to your teen scheduling their own appointment, we ask that either parent and/or teen give 24-hour notice if teen is unable to make appointment.

If client does not show or cancel within the 24-hour window there will be a charge of half of your normal session fee. Please note insurance does not cover this fee.

If a teen/young adult does not show up for two consecutive scheduled sessions, your teens therapist will reach out to the parent and going forward the parent(s) will have to schedule appointments.

By signing this form, I (we) have read the above and accept:

_____ _____

Parent Signature Date

_____

Client Signature

Family Resilience Group

Creating an emotional safety net for today's families.