PRA Perakis, Resis, Woods & Associates

Policy and Procedures

In order to help you utilize our services effectively, it is our goal to clearly outline policies that govern our relationship with you.

Your Therapist: _____

Getting in Contact With Your Therapist

You can be contacted directly at ( ) _____-_____. Their extension is _____. If your message is urgent and you need to page your therapist, leave a message after the voicemail beep, then press the # key followed by the 9 key. This will have your therapist paged. Please make sure to leave your name and phone number, including area code where you would like your therapist to return your call as your therapist may retrieve your message while away from the office. **General office numbers are listed on the bottom of this form.**

Please note your therapist ***is in*** the office on:

Mondays Tuesdays Wednesdays Thursdays Fridays Saturdays Sundays

You can leave a message at anytime on their confidential voicemail and they will return your call. If you have an emergency that needs the attention of your therapist, follow the paging instructions above.

When contacting your therapist, please be aware that any calls that are not brief (more than about 5-10 minutes) usually indicate the need for scheduling an appointment. ***Please note that calls that are not brief may result in a charge that may not be reimbursed by your insurance company***. This includes communications with your significant others, parents, schools, primary care physicians and professionals involved in your or your child's care.

Fees and Payments

Payment is due in full at the time of your session. Your therapist will provide you with all the required documentation to file claims with your insurance company. If your therapist has a contract with your insurance company, our office will bill your insurance company for their portion; ***however***; any deductibles, co-pays and/or applicable fees are **due at the time of your office visit**. Failure to pay fees at time of service or asking to be billed, it will result in a $10 financial charge. We recommend that you keep a credit card on file to avoid this charge. We accept Cash (exact only as we do not have the ability to make change), Checks or Credit Card (Visa, MasterCard and Discover only) The office charges a $35 return check fee for any checks returned to our office by our bank.

If fees for services are not paid in a timely manner, as stated on the authorization and consent forms you signed on your first visit, continued treatment may be interrupted until a payment plan is set up or your balance is cleared.

We make every effort to ensure insurance claims are paid correctly. PRA will make one attempt to work with your insurance company to pay for services. After one attempt, balances not paid by the insurance company will be the patient's responsibility.

Parents of Patient's under 18 years of age please read the following statement: If you are a parent and are unable to accompany your child who is the patient to the appointment, please send them with a check or we can put a credit card number on file. If there is a divorce agreement between parents on financial responsibility, it is between the parents and not Perakis, Resis, Woods & Associates. The parent that accompanies the patient is responsible for making the co-payment at the time of service. PRA is not responsible for upholding the agreements made between parents in divorce situations.

Appointments and Cancellations

Your therapist schedules his/her own appointments and can be contacted directly to inquire about availability by leaving a message in their voicemail extension. Please note if you need to change an appointment time or cancel an appointment, you must contact your therapist directly as the front desk does not keep their scheduling information.

Our therapists' schedules fill up quickly and they often have patients waiting to be scheduled at the earliest opportunity. If you must cancel your session for any reason, please give your therapist a minimum of 24 hours notice so that they may offer that time to someone else. ***Appointments not canceled at least 24 hours in advance will be billed to the client at the session rate and cannot be billed to, nor reimbursed by insurance (even if our office has a contract with your insurance company).***

If you should have any questions, concerns or problems related to your treatment at PRA, you may address your concerns directly with your physician or therapist. In addition, you may contact: **Paula M. Comm, MA, Practice Administrator** (847) 598-8224

We are looking forward to working with you. Please sign the "Consent and Authorization" form indicating that you have read, understand and agree to these policies and procedures.

7.1.19

Welcome to PRA

I have received a copy of PRA's Policy and Procedures and Notice of Privacy Practices and have read them completely. My signature below indicates my understanding of PRA practice policies.

_____	_____
Printed Patient Name	**Patient Date of Birth**
_____	_____
Patient Signature (12 and over)	Date
_____	_____
Guardian/Responsible party/Parent Signature	Date

Thank you!

CLIENT INFORMATION FORM

Patient Name:_____ Appointment Date ____/____/____
Last First Middle

Preferred Name:_____ Gender (Per Insurance): ☐M ☐F

Preferred Pronoun: ☐He ☐ She ☐ They ☐ None Current Gender Identity: ☐ M ☐ F ☐ Non-Binary

Address:_____ Apt.# _____

City: _____ State: _____ Zip Code: _____

All statements and office correspondences will be sent to the above address unless otherwise indicated.

Please check the number(s) where we have your consent to contact you/leave a message:

☐Home Phone( )_____ ☐Work Phone( )_____Ext.____ ☐Cell Phone( )_____

Which number would you prefer us to try first? ☐Home ☐ Work ☐Cell Second?: ☐Home ☐ Work ☐Cell

Patient's SS#:_____ Birthdate: ____/____/_____ Age: _____ Marital Status:_____

Race: _____ Employment Status: Employed/Unemployed/Retired/Homemaker/ Disabled Student: FT / PT / Not Student

Emergency Contact Person: _____ Phone Number: ( ) _____ Relationship_____

IF MINOR: Mother's Name_____ Father's Name_____

Name(s) of ***all Legal*** Guardian(s):_____ Phone Number:( )_____

Client lives with: ☐Both parents ☐ Mother ☐ Father ☐ Other _____

PLEASE COMPLETE ALL SECTIONS

NAME OF PROVIDER YOU ARE SEEING TODAY?_____

WHO REFERRED YOU TO THE PROVIDER YOU ARE SEEING TODAY?_____

Do you want your clinician to communicate treatment information with your Primary Care Physician (PCP)?

PCP is your Internist, Pediatrician or Family Physician, not your Psychiatrist. ☐ YES ☐ NO

If you want information shared with other outside professionals, family or agencies please let your MC/Therapist know.
Please note, no information will be shared with any NON PRA professional, family or agency without your written consent.

Financially Responsible Party: ☐ Patient ☐ Insured Person (other than patient) ☐Other_____

Patient's relationship to the policy holder: (circle one) self spouse child other:_____

Insured Person's Information:

Insured Person/Responsible Party Name _____

☐ Address same as patient (Where statements are mailed)

Address:_____ Apt.# _____

City: _____ State: _____ Zip Code: _____

Home # ( )_____ Work # ( )_____ Ext. ____ **Insured Date of Birth:**____/____/____

Insurance Company:_____ ☐ HMO Site #_____ ☐ PPO ☐ POS

Insured ID#: _____ Insured SS#: _____

Group/Plan #: _____ **Insurance Co. Phone** #:( )_____

Employer of Policy holder: _____ Insurance Effective Date: _____/_____/_____

☐ **Self Pay** - I understand visits will not be billed through insurance by PRA.

Do you have a secondary insurance? ☐ YES ☐ NO **If YES, please give a copy to this office.**

OUR OFFICE DOES NOT BILL SECONDARY OUT OF NETWORK INSURANCE COMPANIES. THIS IS THE RESPONSIBILITY OF THE CLIENT. WE WILL PROVIDE ALL INFORMATION FOR THE CLIENT TO BILL SECONDARY INSURANCE COMPANIES DIRECTLY.

White Copy: Therapist/MD file **Yellow Copy: Billing**

Consents and Authorizations

Treatment and Policy Consents

1. I have the legal right to authorize and I hereby consent for services for myself or my dependent at PRA which may include evaluation, psychotherapy, medication management, group therapy or psychological testing (if indicated). For minors 17 & under, consent of all guardians is required.
2. I authorize communication within the PRA treatment team which includes your psychiatrist and therapist, covering clinicians and office personnel in order to provide comprehensive treatment services.
3. When paging a PRA MD or therapist, please turn off any privacy manager features you may have on your phone so they may return your call promptly. I understand that my failure to turn off privacy manager features or not leaving a clear phone number for my MD/therapist may result in a delay or inability for my clinician to respond. In addition, MD/therapist voicemails will guide you on how to page your clinician. Please follow the guidelines and instructions on your clinicians' voicemail to page them for urgent needs.
4. I understand that appointments not canceled at least 24 hours in advance will be billed to the patient at the session rate and cannot be billed to, nor reimbursed by insurance (even if our office has a contract with your insurance company).
5. I understand that follow up treatment is required to maintain ongoing quality care. PRA MD's require follow up every three months. Failure to follow up on the recommended basis may result in prescription refills being denied. Lack of follow up for over 6 months with any PRA clinician will automatically result in your case being made inactive with our practice and may require a new evaluation if you are requesting to be seen again should the clinician be willing to reopen your case.
6. I understand that clinicians at PRA may refer me or my family members to clinicians or services outside of the practice should they feel they cannot provide the necessary treatment needed to effectively and ethically treat you or your family members' clinical issues. In addition, reasons for termination from PRA may include but are not limited to threatening or abusive behavior; fraudulent use of controlled substances, refusal to follow treatment recommendations, frequent missed appointments or failure to follow up with appointments on a regular basis.
7. PRA does NOT use email as a method to communicate clinical, urgent, appointments or other treatment related issues especially if time sensitive. I understand that I must contact PRA by phone for all patient clinical, urgent or administrative concerns. I understand that PRA's website is for general information only and is not meant as a vehicle to communicate treatment issues.
8. PRA utilizes a web based company RXNT to send prescriptions for your convenience. I authorize PRA to send prescriptions electronically and understand that PRA follows all Federal Privacy Security Laws to protect your healthcare records. I also consent for PRA MD's to review the claims medication history on my RXNT account. I understand I may revoke this consent at anytime by giving written notice to my physician.
9. I have received a copy of PRA's Notice of Privacy Practices and understand and agree to my responsibilities as a patient receiving services from the named PRA provider listed on the Client Information Form.

For more detailed Office Policies, please see our website at www.prapsych.com

I have read, understood, and agree to the consents and authorizations above regarding my responsibilities as a patient receiving services from clinicians at PRA. <u>For patients 17 & under consent for treatment signatures for both parents are required below.</u>

Signature of Patient (age 12 and older)	Date	Signature of Responsible Party/Guardian #1 (if different than patient)	Date
Print Patient's Name		Signature of Guardian/Parent #2	Date
PRA MD/THERAPIST you are seeing today.		Witness	Date

11/2018

White Copy: Therapist/MD file **Yellow Copy: Billing** **Pink Copy: Patient Copy**

Financial Consents/Authorizations

A. I have completed the demographic and insurance information on the Client Information Form to the best of my knowledge and authorize PRA to release any medical information (including types of services, dates/times of services, diagnosis along with treatment plans, progress of treatment, case notes and summaries, if necessary) to process my insurance claim(s).

B. As a courtesy to our patients, we attempt to contact your insurance company to obtain benefit information for your care here at PRA. Benefit results given to patients by our office is not a guarantee of payment by your insurer. I understand that benefits obtained by PRA office staff are estimates based on information given to us by your insurance company.

C. I hereby assign all medical, including Major Medical benefits to which I am entitled, private insurance and any other insurance programs to PRA. A photocopy of this assignment is to be considered as valid as original. This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges, whether or not paid by said insurance and that I will be responsible for any amounts uncollected by PRA. **In addition, I understand that failure to keep current with payments may cause an interruption in treatment services until a payment plan or balance due is paid.** In addition, I agree to inform PRA of any contact or insurance information changes promptly. Failure to do so may result in claims not being filed timely with your new insurance company resulting in the responsible party being liable for any amounts unpaid by the insurance company.

D. You will be provided with all the required documentation to file claims with your insurance company. If we have a contract with your insurance company, our office will bill your insurance company for the provider portion; however; any deductibles, co-pays and/or applicable fees are due at the time of your office visit. We accept Cash, Checks, Money Orders and Credit Cards (Visa, MasterCard and Discover). We do not have the ability to make change for cash. The office charges a $35 return check fee for any checks returned to our office by our bank. You may be requested to provide a credit card number to be kept on file for forgotten payments, missed appointments, co-pays and patient balances. We will inform you in the event that we have processed a charge for payment for services that are outstanding past 60 days.

E. For patients under 18 years of age and young adults: If you are a parent and are unable to accompany your child who is a patient to the appointment, please send them with a check or we can put a credit card number on file. If there is a divorce agreement between parents on financial responsibility the parent that accompanies the patient is responsible for making the co-payment at the time of service. I understand that PRA is not responsible for upholding financial agreements made between parents in divorce situations.

F. If fees for services are not paid in a timely manner and we don't have a credit card on file authorizing us to charge for patient balances, I understand that failure to pay due balances or make agreed upon payments on my or family members account, may result in discontinuation of treatment services resulting in referrals outside PRA.

G. PRA clinicians are contracted and receive compensation for concurrently rendering services to a patient and divide the fee for such service. The fees received are made in proportion to the actual services personally performed and responsibility assumed by each clinician. I fully acknowledge the division of fees.

For more detailed Office Policies, please see our website at www.prapsych.com

I have read, understood, and agree to the consents and authorizations above regarding my responsibilities as a patient receiving services from clinicians at PRA. <u>For patients 17 & under consent for treatment signatures for both parents are required below.</u>

_____ Signature of Patient (age 12 and older)	____/____/____ Date	_____ Signature of Responsible Party/Guardian #1 (if different than patient)	____/____/____ Date
_____ Print Patient's Name		_____ Signature of Guardian/Parent #2	____/____/____ Date
_____ PRA MD/THERAPIST you are seeing today.		_____ Witness	____/____/____ Date

11/2018

White Copy: Therapist/MD file **Yellow Copy: Billing** **Pink Copy: Patient Copy**

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health .This information about you that may identify you and that relates to your past, present or future physical or mental health condition and related health care services is referred to as Protected Health Information ("PHI").This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and state law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at the time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care at PRA Behavioral LLC for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- As required by Law, such as mandatory reporting of abuse or neglect of a child, an adult with disabilities, or an elder or mandatory government agency audits or investigations (such as the licensing board or the health department).
- As required by Court Order or other judicial and administrative proceedings.
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen the threat, including the target of the threat.
- When necessary to the provision of emergency medical use.
- When necessary to initiate or continue civil commitment or involuntary treatment proceedings.
- As required by law to law enforcement.

With Authorization. Uses and disclosers not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

1710 E. Woodfield Road, Ste. 1000
Schaumburg, IL 60173-5113
Ph (847) 240-2211 • Fax (847) 240-2418

350 E. Congress Parkway, Ste. C
Crystal Lake, IL 60014-6284
Ph (815) 356-5050 • Fax (815) 356-5094

3 W. Hawthorn Parkway, Ste. 150
Vernon Hills, IL 60061-1447
Ph (847) 918-8282 • Fax (847) 918-8215

YOUR RIGHTS REGARDING YOUR PHI

You have the following right regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at any PRA office location.

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is containing in separately maintained psychotherapy notes. We may charge a reasonable, cost- based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures**. You may have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12- month period.
- **Right to Request Restrictions.** You have the right to request a restrictions or limitation on the use or disclosure of your PHI for treatment, payment or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment, or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication**. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what can you do to protect yourself.
- **Right to a Copy of this Notice**. You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 1701 E Woodfield Road suite 1000, Schaumberg, Illinois 60173 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this notice is 6/15/2018

PRA Credit Card Authorization

In order to ensure payment is processed at time of service, PRA allows for credit card authorization to be held securely to be kept on file. Please complete the information below so you can have session fees processed promptly to avoid future statement billing fees.

Patient Name: _____ Clinician's Name: _____ Account No: _____

I, _____authorize PRA Behavioral LLC to charge my credit card for the ***initialed*** reasons below:

_____ **(Initials)** Per session (if not paid by other means) – For copays, deductibles and other charges due at time of visit.

_____ **(Initials)** Balances on Account – Balances on your account not paid by insurance within 60 days may be charged. PRA will notify you of the amount to be charged prior to charging your credit card.

_____ **(Initials)** Missed Sessions – Charge for missed sessions will automatically be charged if failure to cancel within 24 hours of your scheduled appointment. You will be informed when this charge has been made.

I authorize PRA Behavioral to keep my signature on file for future charges authorized by me as indicated above. I understand that this form is valid unless I cancel the authorization through written notice.

Receipt: ☐ Give to Therapist ☐ Shred ☐ Keep on file ☐ Mail to: Client or Cardholder

_____ _____ _____
Cardholder Signature Initials Date

☐ Visa ☐ Mastercard ☐ HSA Card ☐ Discover ☐ Check Card ☐ Other _____

Credit Card #: _____-_____-_____-_____ V-Code: _____

Exp. Date:_____ Zip: _____

Cardholder Name, as it as it appears on the card: _____

Cardholder Address: _____

City_____, State _____, **Zip** _____

Phone Number for Credit Card Holder – (_____) _____ - _____

7/19

$_____-___/___/__ $_____-___/___/__ $_____-___/___/___

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PRA Perakis, Resis, Woods & Associates

PRA: Perakis, Resis, Woods & Associates
Authorization to Release Information

Return Fax Numbers by Office Location
Schaumburg Fax: 847-240-2418 Vernon Hills Fax: 847-918-8215 Crystal Lake Fax: 815-356-5094

Reason for Release: Check those that apply
O Requesting records be sent to listed name O Request communication between PRA and listed name
O To be added to Medical Record – no action needed O Other _____

Patients Name:	Birthdate:
Street Address:	Age:
City:	State, Zip:
Phone: (cell) ( ) ____-_____	Email:

I hereby authorize _____ **and**
(Your doctor/therapist at PRA)

Name: _____ Relationship: _____
(Person we are exchanging information with)
Address: _____
City_____ State_____ Zip Code_____
Phone: (____) _____ Fax: (____)_____

to ***(circle one or both)*** **release/receive** information contained in my patient records for dates
☐ all treatment dates ***or*** ☐ specific dates which include from _____ to _____, as identified and checked below:

Check box(s) of what part of your medical record you want to release:

☐	Medical History	☐	Progress Notes
☐	Chemical Dependency Evaluation/TX	☐	Discharge Summary
☐	Psychiatric Evaluation	☐	Consents/Intake/Authorizations
☐	Psychological Tests	☐	Billing/Financial Information
☐	Redisclosure of _____	☐	Other Specified: _____

The **purpose and need for disclosure**: ☐ for the purpose of assisting in the evaluation and treatment of this patient ***or***
_____.

The person or agency to whom information is disclosed may not redisclose this information unless I specifically consent to such redisclosures. This consent can be revoked in writing at any time unless the record holder has already taken action in reliance on my authorization. Without expressed written revocation, this consent expires after one year, or upon the following specific date, event or condition: ☐ treatment relationship is terminated ***or*** _____.

I understand that signing this authorization is voluntary. PRA may not limit or restrict services, treatment or care based on the signing of this authorization.

Patient Signature: _____ Date: _____
(Required for patients 12 and older)

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

For Office Use Only	**9/19**
Staff Person Releasing Information:	Date Information Released:

PRA Perakis, Resis, Woods & Associates

EXCHANGE OF INFORMATION FORM
Patient to Complete:

PATIENT NAME: _____ **DATE OF BIRTH:** ____-____-____

A. YOUR PRIMARY CARE PHYSICIAN (PCP)

Your PCP's Name: **PCP's Phone #:**

PCP's Address: City: State: Zip:

PCP's Fax #:

I hereby freely, voluntarily and without coercion, authorize the behavioral health clinician/ facility listed below in Section B to release the information contained on this form to the clinician/facility listed in section A above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last 30 days from the date signed. I understand that I may revoke my consent at any time.

Patient Signature (if 12 and older) **Parent/Guardian Signature** **Date**

Provider to Complete:

B. TREATING BEHAVIORAL HEALTH CLINICIAN/FACILITY

☐ Schaumburg Office –PRA Behavioral LLC	☐ Vernon Hills – PRA Behavioral LLC	☐ Crystal Lake – PRA Behavioral LLC
1701 E. Woodfield Road, Suite 1000	3 Hawthorn Parkway, Suite 150	350 Congress Parkway, Suite C
Schaumburg, IL 60173	Vernon Hills, IL 60061	Crystal Lake, IL 60014
Phone: 847-240-2211 Fax: 847-240-2418	Phone: 847-918-8282 Fax: 847-918-8215	Phone: 815-356-5050 Fax: 815-356-5094

C. Patient Clinical Information:

1. The patient is being treated for the following behavioral health problem(s):

☐ ADHD/ Behavior D/O ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar D/O
☐ Depressive D/O ☐ Anxiety D/O ☐ Eating Disorder ☐ Adjustment D/O
☐ Mood Disorder ☐ OTHER: _____

2. The patient is taking the following prescribed psychotropic medication/s:

_____

3. Outpatient care:

☐ Medication Management ☐ Individual Therapy ☐ Family Therapy ☐ Other:_____

4. Expected length of treatment: ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

5. Coordination of care issues/Other significant information impacting medical or behavioral healthcare:

_____

_____

Behavioral Health Clinician **Date**

DATE FORM MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: _____
(PLACE A COMPLETED COPY OF THIS FORM ON THE PATIENT'S MEDICAL RECORD)

THIS IS NOT A REQUEST FOR MEDICAL RECORDS