JANEEN SAMARTINO, LCPC

Patient Information

PATIENT INFORMATION - PLEASE PRINT CLEARLY

NAME (Last, First, Middle)			SSN#	BIRTHDATE	SEX
ADDRESS			CITY, STATE, ZIP		
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL		
EMPLOYER			EMPLOYER ADDRESS		

RESPONSIBLE PARTY INFORMAITON (If Different than above)

NAME (Last, First, Middle)			SSN#	BIRTHDATE	SEX
ADDRESS			CITY, STATE, ZIP		
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL		
EMPLOYER			RELATIONSHIP TO PATIENT		

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY# OR ID #
NAME OF INSURED	INSURED DATE OF BIRTH	GROUP#
INSURED ADDRESS		COPAY
CITY, STATE, ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY		POLICY# OR ID #
NAME OF INSURED	INSURED DATE OF BIRTH	GROUP#
INSURED ADDRESS		COPAY
CITY, STATE, ZIP		DEDUCTIBLE
RELATIONSHIP TO PATIENT		EFFECTIVE DATE

I authorize the relase of any medical or other information necessary to process claims, including information related to Mental Health, and Substance Abuse. I authorize payment of medical benefits to the physician or supplier for all services rendered. I undertand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional serices rendered.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

JANEEN SAMARTINO, LCPC
Assignment of Benefits/Release of Information

Patient: _____

I,_____, understand that services rendered to me by **Janeen Samartino, LCPC** are my financial responsibility and that the provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to **Janeen Samartino, LCPC** and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Janeen Samartino, LCPC** within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize **Janeen Samartino, LCPC** to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness _____

_____ _____

Signature of Policyholder Patient or Guardian

WELCOME TO THE OFFICE OF JANEEN M. SAMARTINO, MA. LCPC.

Thanks for choosing Janeen M. Samartino, MA., LCPC. This **Informed Consent for Treatment Agreement** contains important information about my services and business policies, State and Federal Laws, and your rights. Please read this information before signing. If you have any questions or concerns about this agreement, now or in the future, please let Janeen M. Samartino, MA., LCPC., know at your earliest convenience, so that we may address such issues as they arise. Treatment practices, philosophy, and plan limitations and risks will be discussed with you today. Our appointment today will take approximately 45-60 minutes.

Service agreement/Informed Consent for Treatment

CONFIDENTIALITY AND EMERGENCY SITUATUONS: Your verbal communication and clinical records are strictly confidential except for:

a. Diagnosis and dates of service are shared with your insurance company in order to process your claims or the information is necessary to collect payment.

b. If I have reason to believe that a child under 18yo, an elderly, mentally ill, or disabled person is being abused or neglected, then I am obligated by law to report this situation to the appropriate state agency or authority.

c. If I have reason to believe that you are threatening immediate physical harm to yourself, and if you are unwilling or unable to follow treatment recommendations, then I may have to contact a family member or another person who may be able to help ensure your safety. If I am unable to ensure your safety, then I am required by law to call 911, seek hospitalization, or a combination of these actions.

d. If I have reason to believe that you are threatening physical violence against another person, or if you are an actual threat to the safety of another person, then I am required by law to take action to ensure that the other party is safe. This means I may contact the police, notify the other person(s), seek hospitalization, or a combination of these actions.

e. If you present as a clear and present danger to yourself or others, developmentally or intellectually disabled, then I am mandated to report you to the Department of Human Services.

f. As outlined in the HIPPA Notice and Privacy Practices.

g. When information is shared with consultants.

h. When you sign a release of information to have specific information shared with other providers.

i. When the information is necessary for case supervision and consultation.

j. When required by law.

In the unlikely event that I am unable to provide ongoing services Nanette Stevenson of PMB Inc. will take over management of my practice and will maintain your records for 7 years. She can be reached at 708-362-6080.

Signature(s) _____ **Date:** _____

FINANCIAL POLICY:

Rates: Diagnostic Session $175 Individual Therapy Session $150 Family/Couples Session $150

Health Insurance: As a courtesy, for the plans in which, Janeen M. Samartino, maintains a contractual relationship, claims will be filed with your insurance company through **Priority Medical Billing INC.** Full payment of your services will be collected until your deductible and your co-insurance rate are determined. You will be responsible at the time of service for all co-pays, co-insurance, and services not covered by your plan. If a deductible has not been met the full fee is due at each session until it is satisfied. Full payment is due at time of service via cash, personal checks, and credit cards. Financial responsibility for services rendered rest with the client regardless of insurance coverage. If your insurance company denies payment or does not cover counseling, the balance will be due at that time. Credit card information will be on file and will be charged for balances that remain after 60 days.

Written communication and phone sessions are not covered by Managed Care Companies. There will be a charge of $25 for 15 minute increments of time spent on written communication and $75 for half hour phone sessions.

Reduced Fee: Fee for services are available for reduction if there is financial hardship or if insurance doesn't cover treatment. The reduced fee out of pocket or without insurance is $80.

CANCELATION POLICY: Once an appointment time is agreed upon, that time is reserved for you. **24 hour notice is required if you need to cancel or reschedule an appointment otherwise a fee of $100 will be applied.** Insurance companies cannot be billed for missed sessions. Extenuating circumstances are considered when appropriate.

Signature: _____ **Date:** _____

CONSENT FOR TELEPHONE, ELECTRONIC, MAIL, AND CRISIS CONTACT: In an effort to best service my clients' out of session needs, I make every effort to be available in a timely manner. While I do my best to be available for such contacts, I may not always be immediately available. **In the event of an emergency, call 911 or go to your nearest emergency room.** You may leave me a confidential voicemail message at 847-638-3700. **Communication via voicemail, fax, email, mail, text, and other such means are by no means absolutely secure.** While I welcome communication via such means, absolute confidentiality is never guaranteed. I strive to make every effort to protect your information, however, **I cannot guarantee absolute privacy**. Your use of such means of communication constitutes implied consent for reciprocal use of electronic and mail communication. By signing below, you agree that you accept the above stated risks. Your signature below also indicates you will **not** use email and/or text for discussing lengthy clinical concerns. Instead you agree that emails and texts will be utilized for correspondence of scheduling and other brief matters

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I have read and received a copy of the Notice of Privacy Practices and Client Rights document. It is your right to let Janeen M. Samartino, MA., LCPC., know how you would like to be contacted.

May I contact you at home? Yes/No May I contact you by cell? Yes/No May I contact you by email? Yes/No

Signature: _____ **Date:** _____

COORDINATION OF TREATMENT: Often it is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician, obstetrician/gynecologist, and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent, no information will be shared. This authorization may be revoked at any time. _____ You may inform my doctor (s) _____I decline for you to inform my doctor(s)

Physician Name: _____

Phone Number: _____

Signature: _____ **Date:** _____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ maybe treated as a client by Janeen M. Samartino, MA., LCPC. It is understood that children over the age of 12 have confidentiality protected by law. This consent to treat expires at the end of treatment or if revoked in writing.

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Your signature below indicates that you have read the information in my, Janeen M. Samartino's MA.,LCPC, "Informed Consent for Treatment" document and agree to abide by all of the policies, terms, and conditions outlined above.

Patient Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Janeen M. Samartino, MA., LCPC.

Notice of Privacy Practice (Short Form)

Effective April 14, 2003

This Notice describes how Medical Information about you may be used and disclosed and how you can obtain access to this information. Please review this notice carefully.

This Notice of Privacy Practices has been created by **Janeen M. Samartino, MA., LCPC.** to inform you of how I may use your protected health information for treatment, payment and health care operation purposes and as otherwise permitted by law. This document is a shorter version of my full Notice of Privacy Practices. Please see my full version of the Notice of Privacy Practices which contains detailed information regarding how your protected health information may be used. A copy is in my waiting room or a copy may be provided upon request. I am required by law to maintain the privacy of your protected health information, to provide you with notice and to notify you following a breach of unsecured protected health information. I abide by the terms of this Notice of Privacy Practices and the full version of my Notice of Privacy Practices currently in effect. My Privacy Officer is Janeen M. Samartino, MA., LCPC. and all communications described herein should be made in writing and sent to the Privacy Officer at the following address: 1655 N. Arlington Heights Road, Suite 303E, Arlington Heights, Illinois 60004.

Janeen M. Samartino, MA., LCPC. may use and disclose your protected health information as follows: (1) for treatment, such as coordination and management of your care: (2) payment , such as providing information to your health insurance company; and (3) healthcare operation, such as for my own business activities, including billing and conducting quality assessments and completing treatment authorizations for insurance purposes.

If I want to or you want me to use or disclose your protected health information for any other purposes, other than as required by law or as described in this document, I will discuss this with you and ask you to sign a HIPPA Authorization Form to allow such disclosure.

In certain circumstances, I am permitted or required to disclose you protected health information without a signed HIPPA Authorization from you, which are described in detail in the full version of my Notice of Privacy Practices. Examples of such circumstances include, but are not limited to: Situations in which you are given the opportunity to verbally agree or object to such disclosure; I am required to make a disclosure by law; I am required to make a disclosure for public health activities; I believe such a disclosure is necessary to prevent a serious or imminent threat to the health or safety of the public; and I am required to make such a disclosure to comply with worker's compensation laws.

You have the following rights with respect to your protected health information: (1) to request restriction of uses and disclosures of uses of your protected health information; (2) to request that I provide you with an alternative means of communication; (3) to access, inspect and copy your protected health information; (4) to request an amendment of your protected health information; (5) to receive an accounting of certain disclosures of your protected health information; and (6) to receive a paper copy of this notice. You may exercise any of these rights by making such a request in writing to the Privacy Officer as designated above.

If you believe your privacy rights have been violated or that I have not complied with my Notices of Privacy Practices, you may file a written complaint with the Privacy Officer as named above or with the Secretary of the Department of Health and Human Services. You will not be penalized or charged for filing a complaint with the above named Privacy Officer. I reserve the right to change the terms of this Notice of Privacy Practices and the full version of this Notice at any time as it applies to all protected health information in my custody. Upon occurrence of any revision of the terms of the Notice of Privacy Practices currently in effect, you may obtain a revised copy upon request from the above named Privacy Officer.

_____ _____

Signed Date

Janeen M. Samartino, MA., LCPC.
1655 N. Arlington Hts. Rd., Suite 303E, Arlington Heights, IL. 60005
847-638-3700

AUTHORIZATION TO RELEASE INFORMATION:

I. I the undersigned, hereby give permission to have Janeen M. Samartino, MA, LCPC., to release and/or obtain protected health information on the individual named below

Patient Name: _____ D.O.B ____/____/____ Age:_____

Address: _____
Street City State Zip

Home Ph:_____ Cell Ph:_____ Work Ph._____

II. The following information may be Released & Obtained for the following individual(s)/organizations

Recipient Name: _____ Recipient Phone: ( )_____
Recipient Fax: ( ) _____

Address: _____
Street City State Zip

III. The following information may be Released and Obtained (Please check all that apply):

___Continuity of Care
___Diagnosis
___Testing Information
___Billing Information
___Progress in treatment
___Academic Records
___Educational Information
___Medical Records
___Medication List
___Other (Your description should be as accurate as possible)
___Psychiatric Evaluation(s)
___Treatment plan/summary
___Behavioral Observations
___Assessment

_____

IV. I understand that this Release of Information is voluntary. I may cancel this consent to release information at any time via written notice to Janeen M. Samartino at the address listed above. I further understand that Janeen M. Samartino does not require this form as a condition of treatment. This form shall remain in effect for one year from the date of signature, unless previously revoked or otherwise indicated here:

_____
(fill in expiration date)

_____ _____
Client's Signature (Children over age 12 must sign) *Client's Printed Name*

_____ _____
Parent/Guardian's Signature (if applicable) *Parent/Guardian's Printed Name*

_____ _____
Witness' Signature *Witness' Printed Name*

Date: _____

Janeen M. Samartino, MA., LCPC.
1655 N. Arlington Hts. Rd., Suite 303E
Arlington Heights, IL. 60005
847-638-3700

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Authorization for Credit Card Billing

In order to ensure payment is processed at the time of service, Janeen M. Samartino, MA., LCPC., allows for credit card authorization to be protected on file. Please complete the information below for convenient billing.

Patient Name: ______________________________

I , ____________________________________, authorize Janeen M. Samartino, MA., LCPC., to charge my credit card for the *initialized* reasons below:

Service Fees: Pay for copays, deductibles, session charges, and other fees due at time of service. (Please initial)________

Balances on the Account: Pay balances on your account not covered by insurance, as well as balances 60 days past due, including delinquent accounts.

(Please initial)________

Missed Sessions: Pay charges for missed session fee, if there is a failure to cancel within 24 hours of your scheduled appointment. (Please initial)________

Name as it appears on Card: ____

Credit Card Number: _______-_______-_______-_______ Security Code: _____

Expiration Date: ___________ Address: _________________________________

____

I authorize Janeen M. Samartino, MA., LCPC., to keep my signature on file for future charges authorized by me as indicated above. I understand that this form is valid, and I agree to inform Janeen M. Samartino, MA., LCPC., of any changes to the above information with-in 14 days . If the above credit card is declined for any reason, I agree I will be responsible for acquired fees. I also agree that if my credit card becomes invalid, I will provide payment information with another valid credit card. By signing below, I accept the terms to charge my credit card.

Cardholder's Signature: ________________________________ ***Date:*** ____________________