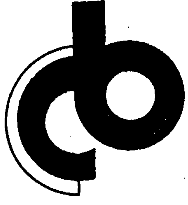

CHICAGO BEHAVIOR CONSULTANTS, Inc.

1945 West Wilson Ave., Suite 2117 Chicago, IL 60640-5256
PHONE: 773.769.9170 FAX: 773.769.9215
EMAIL: chicagobehavior@sbcglobal.net **www.chicagobehavior.com**
Alice Belgrade, M.S. Ed., LCPC, BCBA *James L. Lawyer, LCSW, DCSW*

Within this document, you will find the registration forms that need to be completed in order to begin services with Chicago Behavior Consultants, Inc. Included are the Client Data Form, Health Insurance Information sheet, Informed Consent, Credit Card Information Form, and a letter covering various policies regarding fees, insurance, etc. that should be carefully read and understood. It is also very important that you take a few moments to view our website (www.chicagobehavior.com) for pertinent information regarding our health insurance and payment policies.

Please complete all forms and either mail them to our office **(1945 W Wilson Ave, Suite 2117, Chicago IL 60640)** or fax them **(773-969-9215)**. You will be contacted by phone or e-mail to schedule your appointment.

If you have any questions, please call me at 773-769-9170.

Thank you,
James Lawyer
Administrative Director

The information disclosed in this document may contain confidential health information that is legally privileged. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to store the information securely or destroy it after its stated need has been fulfilled.

CHICAGO BEHAVIOR CONSULTANTS, Inc.

Policies and Procedures

In order to maintain our best practice standards, and in an effort to forestall fee increases, Chicago Behavior Consultants, Inc. has adopted the following policies. **Please initial next to each policy to indicate that you've read and understand it.**

1. INSURANCE CLAIMS

Effective July 01, 2007, we no longer submit claims and/or invoices to insurance companies EXCEPT for Blue Cross Blue Shield PPO. We have requested that our names be removed from provider panels for all other health insurance networks. ***Clients are responsible for making timely payments to CBC, Inc., preferably at the time of service***. We will provide a properly coded statement for submission by the client to the insurer for purposes of reimbursement. **Initial_______**

Any additional phone consultations with representatives of the insurance companies by CBC, Inc. at the request of the client or the insurer and/or any additional paperwork requested of CBC, Inc. will incur a minimum $25.00 fee. **Initial_______**

For those clients who are insured with a BCBS PPO, we will continue to file claims on your behalf and bill you for co-insurance, deductible, etc. If your particular policy includes a co-pay amount, that amount is due and payable at the time service is rendered. **Initial_______**

We are **NOT** part of any Blue Cross **HMO**, nor do we accept BCBS polices affiliated with Magellan Behavioral Health. **Initial_______**

For clients insured with other entities, your level of reimbursement will likely be un-changed. It is your responsibility to check with your provider's customer service to determine your coverage and the exact amount of reimbursement. We also advise all clients to carefully review EOB (Explanation of Benefits) notices and to challenge any and all claims that are denied or reimbursed at lesser amounts. There appears to be an industry-wide practice of denying claims arbitrarily and the element of human error on their part can also affect claim decisions. **Initial_______**

2. MISCELLANEOUS REMINDERS

- It is the established policy of CBC, Inc. to treat telephone calls that exceed **5** minutes in length as a consultation and billed as such, pro-rated in **15**-minute increments.
- E-mail responses requiring more than **5** minutes will be treated in the same manner.
- We reserve the right to suspend services to clients when an unpaid balance exceeds **$500**.
- **The Home Visit Fee (which is not covered by insurance) will be billed at the time of service to the credit card on file with our office. If you are not insured with a Blue Cross Blue Shield PPO, full payment for services provided will additionally be billed to the credit card on file.**

Initial_______

3. SESSION LENGTH

The insurance industry established a standard therapy session as 45-50 minutes in length. At CBC, Inc. we have traditionally allowed clients a 60-minute session. Effective July 01, 2007, we are using the 45-minute standard. We request your cooperation and assistance in monitoring the length of your counseling sessions. We hope that this change will lessen the inconvenience of waiting time before an appointment. **Initial_______**

CHICAGO BEHAVIOR CONSULTANTS, Inc.

CLIENT REGISTRATION

Please complete all fields.

Client Name____**Date**____________

Address____

____

*Please check your preferred method(s) of contact.

☐**Home Telephone**_______________________ ☐**Work Telephone**__________________

☐**Cell Phone** _______________________ ☐**E-mail** ______________________________

Date of Birth ________________ **Race**____________

Referral Source____

Reason for Referral____

____

Primary Physician____________________________________**Phone**_______________________

Medications (include dosage and dates of usage):

____

____

____

CHICAGO BEHAVIOR CONSULTANTS, Inc.

CREDIT CARD INFORMATION

It is the policy of Chicago Behavior Consultants, Inc. to require a valid credit card number from all new and prospective clients in order to secure a first appointment and avoid failed appointments during the course of service. A "failed appointment" is defined as any scheduled consultation, session, or meeting for which the client fails to appear or fails to provide adequate notice to the consultant or therapist that an appointment will be missed. (Generally, a telephone notification at least 24 hours in advance of the scheduled appointment is required.) We acknowledge that sudden illness, emergencies, and other reasonable causes may result in failed appointments and the consultant/therapist may exercise discretion with regard to such situations.

As of 06/01/2009, Failed Appointments will be billed as follows:

Office Visits ……………... **$ 80.00**

Home Visits ……………… **$140.00**

Please provide the following information:

MasterCard or Visa Number: ____

Expiration Date (month & year): ___________

Name (as it appears on card): ____

I have read and understand this policy.

Cardholder's
Signature: ____ **Date:** ________

Chicago Behavior Consultants, Inc. will keep this information on file and agrees to maintain it in strict confidence. Clients may elect to routinely apply fees to their credit cards by advising the consultant/therapist.

CHICAGO BEHAVIOR CONSULTANTS, Inc.

HEALTH INSURANCE INFORMATION

Please fill in all fields. Please print.

INSURED:

Name: ______________________ **I.D. Number:** ______________________

Address: ____

City, State, Zip : ______________________ **Telephone:** ______________

Date of Birth: ______________________ **Sex: M** ☐ **F** ☐

Insurance Plan Name: ______________________________________

Policy Group Number: ______________________

Insurance Plan Telephone: ______________________

Employer's Name or School Name: ______________________________

PATIENT:

Name: ______________________ **Date of Birth:** ______________

Relationship to Insured: ______________________ **Sex: M** ☐ **F** ☐

CHICAGO BEHAVIOR CONSULTANTS, Inc.

INFORMED CONSENT

This document outlines the rights and responsibilities of persons receiving services from Chicago Behavior Consultants, Inc.

CLIENT RIGHTS: ***(please check each box to indicate agreement and/or consent)***

☐I have chosen to receive services, in the form of either behavior therapy, management or training, from Chicago Behavior Consultants, Inc. This choice is completely voluntary, and I may terminate services at any time.

☐I understand that behavior therapy is a process involving many variables. There is no assurance that I will feel better or that my behavior will be easily changed or modified.

Chicago Behavior Consultants, Inc. is not an emergency or crisis intervention service. I understand that my therapist will respond to requests in a timely manner, but not on a 24-hour per day basis.

☐I understand that Chicago Behavior Consultants, Inc. utilizes a strict behaviorist philosophy and treatment protocol. The rationale and scientific basis of interventions will be explained to me and I reserve the right to make an informed decision whether to accept or refuse therapy.

☐I have the right to humane care and protection from harm, abuse, or neglect in the least intrusive method in the least restrictive environment.

☐I have the right to confidentiality under federal and state laws and professional regulations and ethics.

CLIENT RESPONSIBILITIES:

Behavior therapy and behavior change are the result of cooperative efforts between the client and the therapist. I agree, therefore, to the following responsibilities:

☐To keep all appointments and provide at least 48-hour notification. If I need to cancel for any reason.

☐To complete all project assignments and keep data as directed by my therapist(s).

☐To implement all techniques and provide honest and forthright information on the results.

☐To provide medical and psychological collateral information that may relate to my treatment by Chicago Behavior Consultants, Inc.

☐To ensure payment for services in a timely manner as agreed upon with my therapist(s).

I HAVE READ AND UNDERSTAND THE RIGHTS AND RESPONSIBILITIES OUTLINED IN THIS DOCUMENT AND AGREE THERETO…

Client Signature ____ Date___________