Fritz Trauma Institute℠

20635 Abbey Woods Ct. N. – Ste 202
Frankfort, IL 60423
Phone: (708) 957-3303
Fax: (708)788-9333

Patient Information

Last Name	First Name
Home Address	Email Address
Phone Number	Date of Birth
Emergency Contact Name	Emergency Contact Phone Number

Responsible Party Information

Relationship to Patient: □Parent □Spouse □Other _____

Last Name	First Name
Home Address	Date of Birth
Home Phone/Cell Phone	Email Address

Primary Insurance (Please provide copy of card.)

Insurance Company	Name of Policyholder / Date of Birth
Policyholder ID#	Policyholder Group #
Relationship to Patient	

Secondary Insurance (Please provide copy of card.)

Insurance Company	Name of Policyholder / Date of Birth
Policyholder ID#	Policyholder Group #
Relationship to Patient	

Assignment of Benefits and Consent

I authorize payment of medical benefits to Fritz Trauma Institute for professional services rendered. I understand that I am ultimately responsible for the balance due on my account.

Sign:_____Date:_____

I authorize the release of medical information necessary to process claims. I understand that as part of Fritz Trauma Institute's payment and collections operations it may become necessary to disclose protected health information to another entity and I consent to such disclosures.

Sign:_____Date:_____

I acknowledge having been offered Fritz Trauma Institute's "Notice of Privacy Policies" and "Clients Rights Statement". My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment of my record, as explained in the Policy. My right to make a complaint and file a grievance under Illinois law has been explained. I understand that I may revoke in writing my consent for release of my health care information, except to the extent that Fritz Trauma Institute has already made disclosures with my prior to consent.

Sign:_____Date:_____

Contacting Your Therapist

The office phone is (708) 957-3303. Your therapist's cell phone # is _____. You are welcome to leave a message on our general mailbox which will be returned within 48 hours. If you require more immediate assistance, please contact your therapist on their cell phone. Conversations over 10 minutes with your therapist will be charged by percentage of your client fee. These charges will be out of pocket.

_____ Initial

Fees and Payments

Payment is due in full at the time of the visit unless the therapist has a contract with your insurance company. In that case, any deductible and co-payments are due at the time of the visit. Therapists collect their fees in session. The office accepts cash, check and credit card payments. All checks are to be made out to Fritz Trauma Institute. The office charges $25 for any returned check. If fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts.

_____ Initial

Appointments and Cancellations

Therapists at Fritz Trauma Institute schedule their own appointments and can be contacted directly to inquire about availability. There are often waiting lists for appointment times; therefore, your appointment is valuable to your therapist and other clients. Please notify the office or therapist as soon as possible of any appointment cancellations. ***Appointments not cancelled at least 24 hours in advance will be billed to the patient at the full session rate.***

_____ Initial

Fritz Trauma Institute SM
Telehealth Patient Consent Form

I agree to receive my outpatient behavioral health services through Telehealth. I understand that the behavioral health care provider is located in an alternative location.
A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. Fritz Trauma Institute's telehealth service uses a secure web based system for transmitting audio and video data.
This consent is valid for one year for follow-up telehealth services with the health care provider.
I also understand that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telehealth service.
- The same confidentiality protections that apply to my other behavioral health care also apply to the telehealth service.
- I will have access to all behavioral health treatment information resulting from the telehealth service as provided by law and according to the existing PIR confidentiality policies.
- The information from the telehealth service cannot be released to anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my telehealth service.
- I may exclude anyone from any site during my telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.

I have read this document carefully, and my questions have been answered to my satisfaction.

_____

Client / Parent / Guardian Signature Date

Fritz Trauma Institute℠
Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at piroffice@comcast.net. Please remember, however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 48 hours. Should you require urgent or immediate attention, this medium is not appropriate.

By consenting to using email as a form of communication, you give our office permission to send your monthly statements and payment receipts to you electronically. If you would like to opt out of receiving electronic statements, please indicate your choice below.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, you are agreeing that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

☐ **I would like to receive my statements/receipts via email.**

☐ **I would like to receive my statements/receipts via USPS mail.**

Email address: _____

_____

Client / Parent / Guardian Signature Date

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. Your email address/account information is protected and will not be distributed in any way.

Information required for Credit Card Payment

Name on card:_____

Number on card:_____

Zip code of billing address:_____ CVV: _____

Exp. Date:_____ Type of card: _____

Do you want an **emailed** receipt? _____ _____
(Email Address)

Payment Plan Options (Please choose one)

□ Bill credit card the copay/deductible amount after every session.

□ Bill credit card $_____ every **month** on _____until balance is paid in full.
(Amount) (Day of Month)

□ Bill credit card $_____ every **week** on _____ until balance is paid in full.
(Amount) (Day of week)

□ Bill credit card for full amount upon receipt of this statement.

□ I will use Zelle to make my payment(s). Fritz Trauma Institute's℠ Zelle account can be found under piroffice@comcast.net.

_____ _____
(Signature) (Date)

Fritz Trauma Institute℠
20635 Abbey Woods Ct. N., Suite 202
Frankfort, IL 60423
Phone (708) 957-3303
FAX (708) 778-9333

Notice of Privacy Policies and Client Rights
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: October 1, 2013

We respect client confidentiality and only release confidential information about you in accordance with Illinois and Federal Law. This notice described our policies related to the use of records of your care generated by Fritz Trauma Institute.

Privacy Contact: If you have any questions about this policy, or your rights, contact your individual therapist.

Use and Disclosure of Protected Health Information
In order to effectively provide your care, there are times when we will need to share your confidential information with others beyond Fritz Trauma Institute. This includes:

Treatment: We may use or disclose treatment information about you to provide, coordinate, or manage your care of any related services, including sharing information with others outside Fritz Trauma Institute that we are consulting with or referring you to.

Payment: With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations: We may use information about you to coordination our business activities. This may include setting up your appointments, reviewing your care, and training staff.

Information Disclosed Without your Consent: Under Illinois and Federal Law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow-Up Appointment Care: We may be contacting you to remind you of future appointments, of information about treatment alternatives or other health related benefits and services that may be of interest to you. We will leave appointment information on your answering machine or voice mail *unless* you tell us not to.

Amending Record: If you believe something in your record in incorrect or incomplete, you may request we amend it. To do this, contact your therapist and ask for the Request to Amend Health Information form. In certain cases, we may deny your request. If we deny your request for an amendment you have the right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures: You may request an accounting of any disclosures we have made related to your confidential information, except for information we used for treatment, payment or health care operations

purposes or that we shared with your or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after October 1, 2013, please submit your request in writing to your individual therapist. We will notify you of the cost involved in preparing this list.

Questions and Complaints: If you have any questions or have any complaints, you may contact your individual therapist in writing at our office for further information. You may also contact the Secretary of US Department of Health and Human Services if you believe Fritz Trauma Institute has violated your privacy rights.

Changes in Policy: Fritz Trauma Institute reserves the right to change its Privacy Policy based on the needs of Fritz Trauma Institute and changes in State and Federal Law.