Instructions for using the Document Portal:

1. Put your mouse in the blue area of the portal and make sure you scroll down
   to see the download/upload buttons.
2. Download the file and save it to your computer somewhere (e.g., the desktop).
3. You must open it from your computer after you have downloaded (instead of clicking on the link on the portal) to fill it in.
4. You can fill it in from the PDF, but, again you have to save it to your computer in order for the form fields to work.
5. You are welcome to download, fill it in with ink, and scan it, upload it back to the portal if you prefer.

Laura Jansons, Psy.D., A.B.N.

Clinical Neuropsychologist

355 W Dundee #210 ◆ Buffalo Grove, IL 60089

224-636-6333

PATIENT INSURANCE INFORMATION

Patient Name _____ DOB _____Gender _____

Parent Name (IF CHILD PATIENT) _____

Problem_____

Referred By _____

Type of service (check one):

☐ Psychotherapy Requested CPT CODES: 90791 and 90837

Primary Insurance Information (BCBS only)

Insurance _____ Policyholder _____

Policy /ID Number_____ Policyholder DOB _____

Group Number _____

- DR JANSONS ONLY HAS ABILITY TO PROCESS BLUE CROSS CLAIMS
- FOR OTHERS WITH DIFFERENT POLICIES, SHE IS CONSIDERED OUT OF NETWORK
- DR JANSONS DOES NOT KNOW HOW MUCH YOUR INSURANCE WILL PAY AND WILL NOT BE ACCOUNTABLE FOR KNOWING YOUR DEDUCTIBLE, COPAYS ETC. PLEASE CONTACT YOUR INSURANCE DIRECTLY,

CREDIT CARD AUTHORIZATION

PATIENT NAME:_____

DATES OF SERVICE:_____

NAME ON CREDIT CARD: _____

CREDIT CARD TYPE:_____

CREDIT CARD NUMBER:_____

EXP DATE:_____

SEC CODE:_____

BILLING ZIP CODE:_____

I AUTHORIZE THE USE OF THE ABOVE CREDIT CARD FOR SERVICES RENDERED, TO INCLUDE COPAYS, COINSURANCES, DEDUCTIBLES, AND CHARGES NOT COVERED BY INSURANCE.

AMOUNT TO BE BILLED (if known):_____

SIGNATURE_____

DR JANSONS OFFICE HAS NO WAY OF GUARANTEEING YOUR INSURANCE WILL PAY.

INSURANCE COMPANIES ONLY VERIFY YOU HAVE COVERAGE BUT WILL NEVER FINALIZE OR PROMISE ANYTHING IN REGARDS TO WHAT THEY ARE WILLING TO PAY UNTIL **AFTER** THE SERVICE IS CHARGED.

OUR OFFICE WILL NEVER SPEAK ON BEHALF OF INSURANCE OR QUOTE/ GUARANTEE WHAT YOUR INSURANCE COMPANY WILL END UP PAYING. WE ARE NEVER GIVEN THAT INFORMATION PRIOR TO THE SERVICE--**BECAUSE IT DOES NOT EXIST.** COPAY/DEDUCTIBLE/COINSURNACE RESEARCH IS THE RESPONSIBILITY OF THE POLICY HOLDER NOT DR JANSONS OFFICE.

Dr. Laura Jansons
Neuroscience and Psychological Services

355 W. Dundee Rd
Suite 210
Buffalo Grove IL 60089
224-636-6333

These are instructions for how to fill out the release of information below
Completing a release of information is optional, see form below.

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System.
A facsimile of this original shall have the same force and effect as the original.

The Standards for Privacy of Personally identifiable Health Information, 45 CFR Parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987; 52 FR4 1997, November 2, 1987)

NOTE: Your refusal to sign an Authorization to Disclose/Obtain Information will not prevent treatment, payment, or enrollment in a health plan or eligibility for benefits

---

INSTRUCTIONS: Authorizations to Disclose/Obtain Information

(1) Identify whether the form will be used to disclose, to obtain or to disclose/obtain (share) information and whom you are authorizing to perform this function.

(2) Check the specific information you wish to disclose/obtain. Check only what is the minimum necessary to fulfill the purpose of disclosure. Enter a service date - if unknown, indicate "last service date" and only checked information from last service dates will be released or obtained.

(3) Complete the individual's name, date of birth, social security number and aliases or a maiden name to help correctly identify the individual.

(4) Check the purpose or reason why the information needs to be disclosed/obtained.

(5) Circle all manners which the information may be disclosed/obtained. If you wish to restrict any of these, please specify. If nothing is specified, all manners of release will be considered authorized. (Information will only be faxed if URGENT.)

(6) Complete the name and address of the agency, facility or person to whom you will disclose the information or complete the name and address of the agency, facility or person from whom you are obtaining the information. If you wish it to be phoned or faxed, include area code and numbers.

(7) Complete the calendar date (month, day and year) on which this authorization will expire. Information cannot be disclosed/obtained without a specific date of expiration.

(8) Sensitive information will be released/obtained unless you specifically check an exclusion. **If no items are checked all information within the patient record is subject to disclosure.**

(11) Self-explanatory. (10) Self-explanatory. (11) Self-explanatory.

NOTE: In accordance with federal and state privacy laws only the following persons shall be entitled to consent in writing to the inspection, copying and/or the release of the individual's protected health information.

- The individual if they are 12 years of age or older.
- The parent or guardian of an individual less than 12 years of age **(If both parents have co-custody, both individuals must sign - one on line 13, the other on line 14.)**
- The parent or guardian of an individual between the ages of 12 and 17, provided the individual does not object and has signed the authorization.
- The guardian of a person 18 years of age or older.
- An attorney or guardian ad litem who represents a minor 12 or older provided the court has entered an order granting this right.

(12) Individual to sign and date here if - age 12 or older.

(13) Parent to sign and date here if -

- Individual is less than 12 years of age or
- If individual is between 12 and 18 and has signed on line 12 or Guardian to sign here if -
- If individual is 18 years of age or older but is legally disabled. **You must provide a copy of the Guardianship court order granting you this right.**

Guardian to sign here if -

- If you are a guardian ad litem or attorney representing a minor 12 or older in any judicial or administrative proceeding. **You must provide a copy of the court order granting you this right.**

(14) Witness to sign and date here. **All authorizations require a witness signature to attest to the identity of the person entitled to give consent** (person signing line 12/13) **Line may be used by a co-custodial parent.**

(15) Staff person disclosing/obtaining information signs here. Specific dates when disclosed/obtained shall be documented in the individual's clinical record and/or the Disclosure Tracking system.

Laura Jansons, Psy.D.
Neuropsychology and Psychological Services

Complete only if you want Dr. Jansons to release report to someone (MD, therapist, etc) or if you would like her to receive information from someone. Instructions on previous page.

Authorization to Disclose/Obtain Information

355 W. Dundee Rd
Ste 210
Buffalo Grove IL, 60089
224-636-6333

(1) I authorize _____ to ☐ disclose ☐ obtain ☐ disclose and obtain
(Hospital/Agency/Individual)

(2) ☐ Discharge Summary ☐ Discharge Staffing ☐ Psychiatric Evaluation ☐ Social History ☐ History and Physical
☐ Treatment/Hab Plans ☐ Assessments (Specify Type) _____ ☐ Physicians Orders
☐ Med. Administration Records ☐ Progress Notes ☐ Behavioral Plans ☐ Consultations ☐ Lab/X-Ray
☐ Photos ☐ Record Abstract ☐ Patient Review ☐ Other (specify) _____

Concerning the care of the below named person from DATE (or RANGE OF DATES): _____

(3) About (Name) _____ Social Security Number: _____
Date of Birth: _____ Alias: _____

(4) For purposes of: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Financial/Benefits
☐ Attorney ☐ State Law/Court ☐ Death ☐ Other (specify) _____

(5) Information may be disclosed/obtained: Mail, In-Person, Phone, E-Mail or by Fax (For Urgent/Emergency Needs). *Restrictions if any:*
_____

(6) ☐ Disclose To	☐ Obtain From
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:

(7) This authorization is valid until calendar date: _____ _____ _____
Month Day Year

(8) It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs. **CHECK BELOW FOR EXCLUSION ONLY.**
☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Developmental Disabilities ☐ HIV/AID's
☐ Other (specify)

(9) I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/ plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

(10) I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

(11) Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED/OBTAINED.

(12) _____ _____
Signature of individual (age 12 or older) Date/Time

(13) _____ _____
Signature of parent/guardian (Under 18 or Disabled) Date/Time

(14) _____ _____
Witness OR (2nd parent/guardian, if co-custodial, may sign here) Date/Time

(15) _____ _____
Signature of staff person disclosing/obtaining information Date/Time:

DR. LAURA JANSONS
NEUROSCIENCE AND PSYCHOLOGICAL SERVICES

NEW PATIENT NFORMATION				
Patient's Name	Street Address	City, State, Zip Code	Email Phone	
Birth date	Age	Referred by	Marital Status (choose one)	Choose One

Problem
What are your reasons for seeking testing?

PAST PSYCHIATRIC HISTORY	
Have you ever seen a psychiatrist, psychologist or therapist in the past? choose	If yes, who?
Were you ever prescribed a medication to help your mood, anxiety or thinking? Yes/No	If yes, what medication?
Have you ever been hospitalized in a psychiatric facility? choose	If yes, where and when?
Have you ever tried to take your life? choose	if yes, when and what did you attempt to do?
Do you have medical problems? choose	If so, please list them:
Please list the medications you currently take:	Have you ever seriously hit your head or lost consciousness? choose

SUBSTANCE USE HISTORY	
Do you use alcohol? choose	if yes, please answer the following questions:
	What type of alcohol do you drink?
	How many days per week?
	How many drinks per day?
	What is the most you've ever drank?
Do you use cannabis, or other recreational drugs? choose	If yes, please list the drugs, the frequency, duration and quantity of use.
Do you smoke cigarettes? choose	if yes, please list frequency, duration and quantity of use.

FAMILY HISTORY	
Does anyone in your family have psychiatric problems? choose	If so, who and what type?
Does anyone in your family have substance abuse problems? choose	If so, who and what type?

OTHER	
Have you been under a lot of stress lately? choose	If yes, please list what events have been stressful.
Are you currently employed? choose	If yes, where and what type of work do you do? Do you enjoy your work?

Do you have children? choose	IF yes, how many, how old (and what are their names)?
Have you ever suffered physical, emotional or sexual abuse? choose	If yes, please indicate which.
Have you ever been in trouble with the law? choose	If yes, please describe
Have you ever served in the armed forces? choose	If yes, what branch, when and for how long?
What is the highest level of education you have completed?	Describe yourself in school (examples: outgoing, withdrawn, dropped out, no problems):
What else is important for us to know about?	

Please check the following if they apply to you:

- ☐ Sad, blue or blah feelings
- ☐ Low energy
- ☐ Difficult concentration
- ☐ Low motivation
- ☐ Difficulty with memory
- ☐ Low self esteem
- ☐ Hopelessness
- ☐ Loss of control
- ☐ Waking up at night
- ☐ Sleeping too much
- ☐ Changes in mood for no reason
- ☐ Thoughts of not wanting to go on
- ☐ Thoughts of ending your life
- ☐ Plans to follow through on taking your life
- ☐ Change in sexual interest
- ☐ Feeling nervous
- ☐ Feeling restless
- ☐ Worrying a lot
- ☐ Difficulty controlling worry
- ☐ Low pep during the day
- ☐ Onset of nervousness for no expected reason
- ☐ Pounding heart or chest pains
- ☐ Shortness of breath
- ☐ Dizziness or unsteadiness
- ☐ Upset stomach when nervous
- ☐ Feeling of going out of your mind
- ☐ Feeling of impending doom
- ☐ Feeling like you might die
- ☐ Feelings like you are out of your body
- ☐ Feelings like things are not real

Have you ever:

- ☐ Seriously hurt someone else
- ☐ Heard a voice when no one was there
- ☐ Thought others might be out to hurt you
- ☐ Thought something which you were not sure was true or not
- ☐ Noticed a change in your personality
- ☐ Had weakness or numbness in any part of your body?
- ☐ Had new onset of headaches
- ☐ Felt like you have to do something over and over again for no reason
- ☐ Had a thought in your mind which you could not get out of your head
- ☐ Problems with respect or relationships
- ☐ Fears that seem to interfere with your life

Thank you. (Provide details below as needed)

DR. LAURA JANSONS
NEUROSCIENCE AND
PSYCHOLOGICAL SERVICES

355 W Dundee
Suite 210
Buffalo Grove, IL 60089
www.drlaurajansons.com
224-636-6333

OUTPATIENT SERVICES CONTRACT ADULT

Welcome to our practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods we may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, you will be offered some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working together. At the end of the evaluation, we will both have an initial sense if I am the right therapist for you and, if not, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one session (one appointment hour of [45-60] minutes duration) per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours] advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $200. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $200 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $2 per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy,

some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by the insurance contract.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by Katie our office assistant who knows where to reach me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY (for adult patients)

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking

hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PATIENT SIGNATURE _____ DATE _____