# New Client Information

## Patient:

Name:________________________ Birthdate:__________ Social Sec #:__________

Home Address:____________________________________________

City:____________________________ State:__________ Zip:__________

Home Phone #:____________________ Cell Phone #:____________________

Email:____________________________________________

Emergency Contact Name:________________________ Relationship:__________

Home Phone #:____________________ Cell Phone #:____________________

*Reason for Visit today:*

____________________________________________

____________________________________________

**Religious Affiliation:** ☐ Yes ☐ No ____________________________

## Therapist / other mental health provider information: *(If applicable)*

*May we contact this person in order to coordinate care?* ☐ Yes ☐ No

Name:____________________________________________

Office Address:____________________ City:__________ State:_______ Zip:______

Office Phone #:____________________ Fax #:____________________

## Primary Care Physician Information:

*May we contact this person in order to coordinate care?* ☐ Yes ☐ No

Name:____________________________________________

Office Address:____________________ City:__________ State:_______ Zip:______

Office Phone #:____________________ Fax #:____________________

**ALLERGIES:(with reaction):**

______________________________________________________________________

______________________________________________________________________

**CURRENT MEDICATIONS/SUPPLEMENTS: (Please continue on reverse if needed)**

| MEDICATION NAME | DOSAGE | SCHEDULE (E.G. AM,PM) | REASON FOR MEDS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Medical Issues:**

| DIAGNOSIS | TREATING PHYSICIAN | YEAR DIAGNOSED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Inventory of Medical Wellness (please describe if there is an issue):**

Eyes/Nose/Ears/Mouth/Throat: ☐ Yes ☐ No ________________________________

Cardiac(Heart) issues: ☐ Yes ☐ No ________________________________

Neurological issues (i.e. seizures, fibromyalgia, multiple sclerosis, etc.): ☐ Yes ☐ No

______________________________________________________________________

Gastrointestinal (stomach) issues: ☐ Yes ☐ No ________________________________

Previous Head Injury: ☐ Yes ☐ No ________________________________

Musculoskeletal issues: ☐ Yes ☐ No________________________________

Female issues (if applicable): ☐ Yes ☐ No ____________________

Male issues (If applicable): ☐ Yes ☐ No ____________________

Pulmonary (lung) issues: ☐ Yes ☐ No ____________________

Kidney/bladder issues: ☐ Yes ☐ No ____________________

Developmental Delay: ☐ Yes ☐ No ____________________

Alcohol/substance abuse: ☐ Yes ☐ No ____________________

Psychiatric Hospitalizations: ☐ Yes ☐ No ____________________

History or active self injury: ☐ Yes ☐ No ____________________

Attempted Suicide: ☐ Yes ☐ No ____________________

Eating Disorder issues: ☐ Yes ☐ No ____________________

**Family History (please circle all that apply and note any extra ones not mentioned and family relationships below):**

Diabetes, Seizure, Cardiac problems, high blood pressure, high cholesterol, auto immune disorders, cancer, Suicide, Depression, Bipolar Disorder, Attention Deficit Disorder, Anxiety, Panic Disorder, Autism, Developmental delays, Alcoholism and other substance abuse issues.

**Family Relationships and other significant family history:**

____________________

____________________

____________________

**Signature:**____________________

**Signature** *(guardian if under 18)*:____________________



18 E. Dundee Rd. Bldg., Ste 140, Barrington, Il. 60010 T: 847-737-5277 F: 847-737-5280 W: selahhealthcare.com

## For Patients that are under 18 years of age

### Father

NAME:______________________________BIRTHDATE:______________

OCCUPATION______________________________________________

STREET
ADDRESS:_________________________________________________

CITY:_____________________________STATE:________ZIP:__________

HOME PHONE:___________________CELL PHONE:___________________

### Mother

NAME:______________________________BIRTHDATE:______________

OCCUPATION______________________________________________

STREET ADDRESS (can list same as above):___________________________

CITY:____________________________STATE:__________ZIP:_________

HOME PHONE:___________________CELL PHONE:___________________
(can list same as above)

ARE BIOLOGICAL PARENTS (CIRCLE ONE): MARRIED DIVORCED SEPARATED



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Allen Kuo, D.O.
Selah Healthcare Professionals, LLC

# Financial Information Form

Patient Name:______________________________ Date of Birth: ____________________

Gender: M/F Marital Status: S/M/ W/D Email Address: _________________________

Okay to send correspondence or statements to email? Y/N

If minor (under 18) please write name of legal guardian:_____________________________________

Social Security Number:____________________ Contact Number:__________________________

Employer Name:___________________________________ Okay to call? Y / N

## Primary Insurance:

Carrier Name:_________________________________ Phone Number:_____________________

Identification Number:___________________________ Group Number:_____________________

Subscriber Name:________________________________Subscriber DOB:___________________

Insurance Claims Mailing Address:______________________________________________________

_____________________________________________________________________________

## Secondary insurance (if applicable):

Carrier Name:_________________________________ Phone Number:_____________________

Identification Number:___________________________ Group Number:_____________________

Subscriber Name:________________________________Subscriber DOB:___________________

Insurance Claims Mailing Address:______________________________________________________

_____________________________________________________________________________

I give permission to Allen Kuo, D.O. and billing staff to send required information to my insurance company or my EAP. I am aware that I am placing my signature on file. I also understand that any unpaid balance such as copays, deductibles and non covered services will be my responsibility. Missed appointments, cancellations under 24 hours, long phone sessions, and repeated emergency refill requests during non business hours can result in an additional fee of which I am responsible for and will not be covered by my insurance or EAP. Continued unpaid balances which have not been dealt with in a timely manner can result in being placed in collections.

Signed:________________________________________

Date:________________________

# ALLEN KUO, D.O.

SELAH Healthcare Professionals, LLC

## Office Policy and Procedures

I am honored and pleased to be working with you towards improving and stabilizing your mental health as well as possibly helping you in other ways i.e. physically, spiritually, etc. Collaboration between myself, possible family members and you is of utmost importance to me in helping you improve, and it is expected of all my patients that they would be cooperative and forthright with their treatment. In return I will hope to keep you well informed and to work with you as a team so that you will have a better understanding of your illness, the approaches that are recommended for treatment, and any other questions you might have. Solid quality of care and understanding is what I am committed to. Below are some of the policy and procedures of my practice. Please take time to review this with full disclosure and sign this when you are done. Thank you.

1) Payment (either self pay or deductible) is required at time of service.

2) If you are unable to make your appointment, please notify my office of the cancellation at least **24 hours** before the appointment time and reschedule another appointment. Please also give a reason for the cancellation. Since my schedule is very busy and many others are also trying to get appointments as well, I do ask that you respect this policy as to give others the opportunity to make an appointment if you so choose to reschedule. Understand that repeated "no shows" or last minute cancellations can result in a charge of **$100** that is **NOT** covered by insurance.

3) If you happen to arrive **10 minutes** late for your appointment, efforts will be made to try to fit you in, but it will be my discretion whether this can be done, and you may have to be asked to reschedule.

4) In a severe emergency such as suicidal thinking, overdose, loss of consciousness, excessive bleeding, please **dial "911"** and go to the nearest emergency room to be evaluated. For urgent calls but not emergencies please dial extension **100** for the urgent line and I will be paged. Please be mindful of usage of this extension as I am on call for myself 24/7. If there are prescription refill messages left on this line, they will **NOT** be addressed. Leaving a message on my normal extension **101** will result in having your calls answered as soon as I can during business hours.

5) Prescriptions should be filled during your appointment times. Messages can be left at the reception desk extension 1 and will be filled during business hours. Please allow at least one to two days to have your prescription filled. If your insurance requires a prior authorization for prescriptions, this will incur a **$10 fee**.

6) If there is a continued pattern of having your prescriptions urgently refilled during weekends or off business hours, than a **$25 fee** will be applied which is **NOT** covered by insurance. Please note that stimulants for ADHD must be filled every month and if this prescription is not electronically sent in but must be in writing. They will **not** be filled during weekends or non-business hours. Be certain you have enough medications before entering long holidays or weekends and make appropriate accommodations to obtain your refill in a timely manner.

7) Filling out forms for insurance is a common occurrence. Simple forms do not incur a fee. Lengthy forms or forms needing excessive copying of records will incur a copy and service fee of **$25** which is not covered by insurance. In the event your insurance company denies your claim or there is significant delay in payment you will be required to settle the amount due and contact your insurance to settle the dispute on your own behalf.

8) Notice of Privacy Policies: Confidentiality is your right, and my duty. The privacy of all records pertaining to your treatment will be maintained securely by me. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. Pursuant to Illinois statute 735 ILCS 5/8-2000(d) states the charges begins at $28.44 with additional charge of $1.07 per page for the first 26 pages and $.71 for additional pages over 25. You have the right to review your records (including the record of disclosures made). If at any time you feel your privacy has been violated, you have the right to file a grievance with me and/or the Secretary of the U.S. Department of Health and Human Services. Please note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, or when there is suspicion of child or elder abuse, and when records are demanded by Court Order.

**Thank you for understanding my Policy and Procedures. If you have any questions, do not hesitate to ask myself or office staff. We are here to assist you in any way we can. Please sign below that you have read these policies and understand them and agree to abide by it. Thank you.**

**Signature**_______________________________________________ **Date:**___________

**Signature (Guardian):**_________________________________________ **Date:**___________

Selah Healthcare Professionals

*Dr Allen Kuo, D.O.*

18 E. Dundee Road, Bldg 2, Suite 140 • Barrington, IL 60010

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## Authorization For Disclosure, Use and Release of Information

I, ______________________________ hereby authorize the release or use of information pertaining to my medical records, laboratory results, therapist correspondence, psychiatrist notes, psychological testing and hospital records. I understand that signing this release is completely voluntary and that I may refuse to sign at any time with the understanding that withholding/sharing necessary information may affect Dr. Kuo's ability to deliver comprehensive care. I also understand that if the organization receiving the information is not a health plan or health care provider, that this organization might disclose my information might disclose my information which would no longer be protected by federal privacy regulations.

*Person(s) Organizations authorized to release and/or receive information:*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**The patient/patients representative must review these statements and initial below:**

1. I understand that this authorization can be revoked at any time and would be done so by requesting, in writing, specifics of what is being revoked, dated, signed and submitted to Dr. Kuo for review.

   Initials: ________

2. I understand that in extreme circumstances Dr. Kuo may wish to engage in a telehealth Consultation. I understand the potential risks to this technology and it's possible technical difficulties. I understand that during this appointment I had the opportunity to ask any questions regarding my condition and have them appropriately answered by Dr. Kuo. I understand that my insurance will be billed the same as if I were seen in the office and all copays and deductibles will be collected at the time of service.

   Initials: ________

Printed name: ________________________________________

Signature of patient or Guardian ________________________________ Date: __________