

**IPD***For a Better Tomorrow*

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## **NEW PATIENT PACKET**

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*Welcome to the Institute for Personal Development.*

The Institute for Personal Development provides the highest quality of mental health care. Our goal is to assist with alleviating emotional pain and suffering for individuals, families and communities. Our plan for treatment is to improve each individual's quality of life.

We feel that your emotional health is a priority! Our plan is to provide services that are individualized for each and every client. Our clinicians will work with you to provide services that are comfortable for each individual while meeting their personal needs. It is important to us that you recognize improvement and obtain results in improving your quality of life.

Our team of clinicians is professional and well trained with scientific knowledge of useful treatment techniques. Such techniques can be used to assist individuals to cope with stressful situations at home, at work, at school and in the community. Within treatment, we use traditional and complementary approaches with the highest level of clinical and ethical standards.

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As a new patient, there are several things we will be asking for:

1. Please fill out all forms completely.
2. We will need a copy of your (guarantor's if patient is a minor) driver's license. (If you are writing checks for services rendered, we need this on file.)
3. A copy of your current insurance card(s).
4. Please verify that your physician/therapist is a member of your insurance plan. You can do that by calling your insurance company.
5. Depending on whether you are here for medical or mental health reasons, your benefits might be different. Find out if you are required to pre-certify your visits. It might mean the difference in how, or if, your insurance company pays.

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**New Patient Information Sheet**  
*Personal Information (must be filled out completely)*

Doctor/Therapist you are seeing today \_\_\_\_\_ Today's Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

E-Mail Address \_\_\_\_\_

Home Telephone ( ) \_\_\_\_\_ Work Telephone ( ) \_\_\_\_\_

Cell Telephone ( ) \_\_\_\_\_ Other Telephone ( ) \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ Patient Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

Employer's Phone ( ) \_\_\_\_\_ Extension \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Work phone ( ) \_\_\_\_\_

Referral Source (i.e.: Doctor, phone book, etc) \_\_\_\_\_

Referral Address \_\_\_\_\_  
Street City State Zip

Referral Phone Number \_\_\_\_\_

**Patient's Mothers Maiden Name:** \_\_\_\_\_

**Whom may we contact in an emergency?** \_\_\_\_\_

Telephone number ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**Insurance Information**

PRIMARY Insurance \_\_\_\_\_

Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_

SECONDARY Insurance \_\_\_\_\_

Group Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's Social Security Number \_\_\_\_\_

- What is your ethnic background?
- \_\_\_\_\_ American Indian and Alaska Native
  - \_\_\_\_\_ Asian
  - \_\_\_\_\_ Black or African American
  - \_\_\_\_\_ Native Hawaiian and Other Pacific Islander
  - \_\_\_\_\_ White
  - \_\_\_\_\_ Hispanic or Latino

**Institute for Personal Development**  
**Administrative Policies & Procedure Overview:**

Thank you for choosing the Institute for Personal Development for your health care needs. We are committed to providing high quality, personalized and comprehensive patient care. We ask that these policies be reviewed and initialed so that we can provide quality service and ensure reimbursement. Please initial next to each policy indicating that you have read the terms and conditions and agree to abide by them:

**1. Consent for Treatment:**

- a. I hereby authorize, and acknowledge to work with, the authorities of the Institute for Personal Development, and the physician(s)/therapist(s) in charge of my/the case, to administer such medications and treatments as may be deemed necessary for the interest and care of me/the patient described on this form.

**2. Pre-Authorization for Benefits:**

- a. I acknowledge that I am also required to call my insurance company to verify my benefits and insurance coverage for services rendered and that a quote of benefits is not a guarantee of payment.

**3. Payment Guarantee:**

- a. Sessions shortened by the patient will still be charged at full reserved fee.
- b. Full payment is due at time of each appointment, unless managed care insurance covers authorized services in full or payment arrangement made with IPD Billing Department.
- c. **Co-payments are due in FULL at time of each visit.**
- d. Checks written and returned NSF/Account Closed will be charged an additional **\$35.00**.
- e. All future payments must be made via Cash/Credit or Debit card if any personal check is returned NSF.
- f. **If you do not have insurance**, payment is due in full at each visit and services may be turned away at the discretion of the physician.
- g. **RESPONSIBILITY of an account balance is always the Patients, NOT the insurance company.**
- h. IPD bills primary and secondary insurance companies as a courtesy. IPD does not bill tertiary (3<sup>rd</sup>) insurances.

**4. Release of Insurance-Related Information:**

- a. I authorize insurance payment(s) to be made directly to providers of the Institute for Personal Development.
- b. I authorize the Institute for Personal Development to release any information about me to insurance carriers needed to process claims.

**5. Delinquent Accounts:**

- a. **Patients must settle past due account balances prior to scheduling future appointments.**
- b. All outstanding balances are due in full at the time of service unless payment arrangements have been made with IPD Billing Department.
- c. Non-payment of delinquent balances will be grounds for termination of services rendered by IPD until the delinquent balance is resolved in its entirety.
- d. Delinquent balances will be sent to our collection agency. In the event that services are not paid in full and we must pursue legal action, all attorneys' fees, court costs, and filing fees will be the responsibility of the patient/guarantor.

**6. Overpayments:**

I understand patient overpayments for actively treated patients will be used toward future copays/deductibles/coinsurance/balances. I understand should I decide to no longer continue treatment at IPD, I must submit a written request to the IPD Billing Department for a refund of any patient overage on my account. I understand that refunds will not be processed until all claims billed to my insurance have been processed by my insurance. I understand refunds take 90 days to process. I also understand after I have received my refund that if my insurance at some point takes back their payment made to IPD on my behalf creating an amount owed, that I am responsible to pay that balance.

**7. Phone Consultation with Clinician**

IPD clinicians do charge for clinical phone consultations with patients. Charges are according to the Individual Clinician's specific fee schedule. You will see such charges on your patient statements. Please be aware that phone consultations cannot be billed to insurance. All phone consultation charges are solely patient's responsibility.

**8. Medical Records Charge:**

- a. We take the time and consideration to ensure your records are kept confidential. There is a standard processing fee of \$30 for any medical records that are released.
- b. Medical Record releases take in minimum of 10 business days from the date IPD receives a signed release form.

**9. Completion of Forms/Letters**

The charge for the completion of forms/letters typically can range between \$30 - \$150. However, please note that depending upon the length of the forms or documentation being requested, this charge could be higher.

**Please sign below to authorize treatment indicating that you acknowledge your full financial responsibility for services rendered:**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Date

If patient is a minor or unable to sign, state reason:

\_\_\_\_\_

# THE INSTITUTE FOR PERSONAL DEVELOPMENT

Morris, IL • (815) 942-6323

Romeoville, IL • (630) 226-9303

Joliet, IL • (815) 725-6511

Also Serving: Aurora, Chicago, Ottawa

## Notice of Privacy Practices Patient Acknowledgement

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Type of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_



**INSTITUTE FOR PERSONAL DEVELOPMENT**  
**Late Cancellation / Missed Appointment Policy**

At the Institute for Personal Development, treatment begins with a partnership. We cultivate a clinician-patient partnership that is based on trust and collaboration, focusing on patients as individuals. Our clinicians and support staff strive to be fair and courteous in all of our dealings.

The following policy has been established to help us serve our patients better. It is necessary for IPD to make appointments in order to see our patients as efficiently as possible. No-shows and late cancellations cause problems beyond financial impact to our practice. When a patient is scheduled for an appointment, our clinician is reserving his or her time specifically for that patient. When an appointment is made, it takes an available time slot away from another patient in need of care. Not cancelling an appointment in a timely fashion restricts our ability to make the appointment available to another patient. For these reasons we have developed the following No-Show/Late Cancellations policy.

A No-Show is defined as missing a scheduled appointment without calling IPD in advance to cancel the appointment. A Late Cancellation is defined as failing to cancel or reschedule a scheduled appointment at least 24 hours before your scheduled appointment. If you need to cancel or reschedule your appointment, you must contact our office no later than 24 hours before your scheduled appointment so that we may offer the appointment time to another patient who is in need of attention.

The following is our policy regarding appointment cancellations.

1. Fee for failure to provide 24-hour advanced notice.
  - a. When a patient misses an appointment with less than 24-hour advance notice the patient will be charged \$50 for the late cancellation.
2. Fees for failure to attend scheduled appointment.
  - a. When a patient misses an appointment the patient will be charged \$75 for the no show.
3. Waiver of fees by IPD clinical providers
  - a. We understand that the circumstances beyond your control may arise, where adequate notice is not possible. These limited situations will be considered on a case by case basis. While we value the input of the clinical providers when it is required, please note that IPD clinical providers are unable to personally waive any fees regarding this policy.
4. Patient responsibility for failure to provide 24-hour advance notice of appointment cancellation
  - a. Patients are advised that fees charged for failure to provide 24-hour advance notice of an appointment cancellation are not covered by insurance. These fees are the responsibility of the financially responsible party.
5. When a patient misses or late cancels 4 or more appointments within a 12-month period, the financially responsible party will be required to put a credit card on file to schedule future appointments. A billing representative will reach out to the financially responsible party to obtain the credit card information to maintain on file. If a subsequent appointment is missed or late canceled a \$100 fee will **automatically** be charged to the credit card on file.

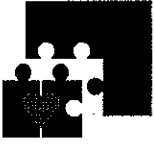
PATIENT NAME: \_\_\_\_\_ PATIENT NUMBER: \_\_\_\_\_

GUARANTOR NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

GUARANTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Institute for Personal Development**  
**[www.ipd.md](http://www.ipd.md)**

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Dear IPD Patients,

At The Institute for Personal Development we pride ourselves on being a state of the art mental health practice. With that in mind we are currently introducing the next advancement in behavioral health care called "Measurement Based Care."

In Measured Based Care, we use standardized tests in order to determine precisely how well patients are doing. The goal in treating patients is not just to help them get better but to try to treat their condition to remission (no longer having any significant symptoms which interfere with their life). In order to do this it is critical that your clinician not just get a sense of how you are doing but to specifically measure how you are doing based on scientifically validated tests.

In addition, patients looking to choose a doctor or therapist do not just want to know what doctors and clinicians "specialize in" but actually how effective they are in treating certain conditions by looking at their outcomes. Lastly, insurance companies are asking clinicians to demonstrate that they are cost-effective in treating patients and are asking us to demonstrate how effective our clinicians are in treating conditions.

#### WHAT THIS MEANS FOR OUR PATIENTS

For our patients this means in the beginning of your session your clinician may ask you to take a brief computerized test to determine how well your condition is doing on a standardized test. In addition, it means that there will be a charge associated with the test. Typically the test is paid for by your insurance company and you may have a small copayment for the test. If the test is not covered by the insurance company, please call our billing department and we will investigate this and assist you. The charge for the testing goes to pay for the cost of the technology and implementation of state of the art care in our practice.

The testing is not optional as we have to be able to know objectively how well we are caring for you.

Sincerely,

Ronald Wuest MD

Medical Director

The Institute for Personal Development

# INSTITUTE FOR PERSONAL DEVELOPMENT

## MEDICAID/ILLINOIS PUBLIC AID ACKNOWLEDGEMENT

1401 Lakewood Drive, Suite A  
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Joliet, IL 60435  
(815) 725-6511

I, \_\_\_\_\_, understand that the Institute for Personal Development is not accepting Medicaid/Illinois Public Aid Insurance for **primary or secondary** insurance. If Medicaid/Illinois Public Aid insurance is needed to be obtained during treatment here at I.P.D., I understand that I will be accepted as a cash patient and agree to pay my account in full at time of service. \*\*

\_\_\_\_\_  
Signature of Patient (or Legal Guardian)

\_\_\_\_\_  
Date

\*\* In the event that services are not paid in full and we must pursue legal action, all attorneys' fees, court costs and filing fees will be the responsibility of the patient/guarantor. \*\*



Note: ALL MENTAL HEALTH INFORMATION IS PRIVILEGED AND HIGHLY CONFIDENTIAL. The information you share is STRICTLY BETWEEN YOU AND YOUR CHILD'S DOCTOR OR THERAPIST! No information will ever be released without your written permission!



**Institute for Personal Development**  
**Child Form**  
**(Age 12 and Under)**

**INSTRUCTIONS:**

Please fill out this form completely. If you are the parent/guardian of the patient, please ask the patient any questions that he/she is able to answer according to his/her age. Otherwise, answer the questions below to the best of your knowledge of the patient. The answers to these questions are very important in allowing us to care for the patient. Some of these questions we ask may seem silly or that they don't apply to you. Regardless, answer all questions to the best of your ability.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male/Female Date: \_\_\_\_\_

Name of Individual Completing this form for the patient listed above:

Relation to Patient: \_\_\_\_\_

What are the child's current problems for which you are here?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**PAST PSYCHIATRIC/ PSYCHOLOGICAL HISTORY:**

Has your child ever seen a psychiatrist, psychologist or therapist in the past? Yes/No

If yes, who? \_\_\_\_\_

Was your child ever prescribed a medication to help his/her mood, anxiety, or thinking? Yes/No

If yes, what medications? \_\_\_\_\_

Which medications were helpful? \_\_\_\_\_

Has your child ever had a bad reaction to medication? Yes/No

If yes, which ones? \_\_\_\_\_

Has your child ever been hospitalized for psychiatric reasons? Yes/No

If yes, where and when? \_\_\_\_\_

Has your child ever tried to take his/her life? Yes/No

If yes, when and what did he/she attempt to do? \_\_\_\_\_

Has your child ever tried to hurt himself/herself? Yes/ No

If yes, how did he/she try to hurt himself/herself? \_\_\_\_\_

When? \_\_\_\_\_ How Often? \_\_\_\_\_

Who is your child's primary care physician? \_\_\_\_\_

In the event that you request we contact your child's primary care physician to coordinate his/her care, please give us his/her general doctor's phone number. (\_\_\_\_\_) \_\_\_\_\_

**\* Please make sure to sign an IPD Release of Information Form**

Does your child have any medical problems? Yes/No      If yes, please list them:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Has your child had any surgeries? Yes/No      If yes, please list them with dates:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list all medications your child currently takes -- with dosages:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Please list any allergies or sensitivities to medications your child has:

\_\_\_\_\_

Has your child ever been hospitalized other than for the above surgeries? \_\_\_\_\_

Has your child ever seriously hit his/her head or lost consciousness? \_\_\_\_\_

**PAST SUBSTANCE USE HISTORY:**

Has your child ever used alcohol? Yes/No/NA      If yes, please answer the following questions:

What type of alcohol did he/she drink? \_\_\_\_\_

How long has he/she been drinking and how much? \_\_\_\_\_

Does your child use street drugs? Yes/No/NA      If yes, please answer the following questions:

What different drugs does he/she use? (For each drug, please list how many days per week, and how many uses per day)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Does your child smoke cigarettes? Yes/No/NA

If yes, how many packs per day? \_\_\_\_\_

How many years has he/she smoked? \_\_\_\_\_

**FAMILY HISTORY:**

Does anyone in your child's family have any psychiatric problems? Yes/No

If yes, who and what type of psychiatric problems & what relation is this person to him/her?

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Does anyone in your child's family have any serious medical problems? Yes/No

If yes, who and what type of medical problems & what relation is this person to him/her?

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Does anyone in your child's family have a serious drug and/or alcohol problem? Yes/No

If yes, who and what type of drug or alcohol problem & what relation is this person to him/her?

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**SOCIAL/DEVELOPMENTAL HISTORY:**

At what (approximate) age did your child:

Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_

Talk? \_\_\_\_\_ Toilet Train? \_\_\_\_\_

Was your child born with any developmental delays? Yes/ No

If yes, please list any diagnosis that your child has been given since birth: \_\_\_\_\_

---

Does your child live with his/her biological parent(s)? Yes / No

(Please list if your child lives with only one parent- Mother or Father) \_\_\_\_\_

If No, who does your child live with and who is his/her legal guardian? \_\_\_\_\_

---

Has your child or his/her family been under a lot of stress lately? Yes/No

If yes, please list what events have been stressful: \_\_\_\_\_

---

Has your child suffered from physical, emotional, or sexual abuse? Yes/No

If yes, please explain: \_\_\_\_\_

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Has your child ever been in trouble with the law? Yes/No/NA

If yes, please explain: \_\_\_\_\_

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Is there anything we did not ask that your child or his/her loved ones feel is important or we should know?

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**GOALS:**

Many times people come to the Institute for Personal Development to feel better or to manage a crisis. In addition, however, life enhancement is also something we may be able to help your child with. For example: overcoming past painful events, improving self-esteem or self-understanding, losing weight, not worrying as much, improving self-confidence, etc.

What additional goals does your child (or his/her family) have that he/she would like to accomplish?

1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
-

## Review of Symptoms

**THE FOLLOWING IS A LIST OF SYMPTOMS THAT MAY OCCUR IN YOUR CHILD AS THE RESULT OF HIGH LEVELS OF STRESS OR BRAIN CHEMISTRY PROBLEMS. PLEASE CIRCLE "Yes" or "No" TO THE FOLLOWING SYMPTOMS:**

Sad, blue or blah feelings	NO	YES
Low energy	NO	YES
Difficulty with concentration	NO	YES
Low motivation	NO	YES
Difficulty with memory	NO	YES
Change in appetite	NO	YES
Low self-esteem/ Poor thoughts of self?	NO	YES
Sense of hopelessness	NO	YES
Sense of loss of control	NO	YES
Waking up at night	NO	YES
Sleeping too much	NO	YES
Changes in mood for no reason	NO	YES
Thoughts of not wanting to go on	NO	YES
Thoughts of ending his/her life	NO	YES
Plans to follow through on taking his/her life	NO	YES
Feeling nervous	NO	YES
Worrying a lot	NO	YES
Difficulty controlling the worry	NO	YES
Low energy during the day	NO	YES
Muscles tight in upper back and neck	NO	YES

**PLEASE ANSWER THE FOLLOWING TO WHETHER YOUR CHILD HAD A SUDDEN ONSET OF ANY OF THE FOLLOWING SYMPTOMS:**

Onset of nervousness for no expected reason	NO	YES
Pounding heart or chest pains	NO	YES
Shortness of breath	NO	YES
Dizziness or unsteadiness	NO	YES
Upset stomach or vomit when nervous	NO	YES
Feelings of "going out of his/her mind"	NO	YES
Feelings like he/she might die	NO	YES
Feelings like he/she is outside of his/her body	NO	YES
Feelings like things are not real	NO	YES

**SOMETIMES UNDER UNUSUAL STRESS, INDIVIDUALS MIGHT HAVE THOUGHTS THAT THEY ORDINARILY MIGHT NOT HAVE HAD. HAS YOUR CHILD EVER:**

Seriously hurt someone else	NO	YES
Heard a voice when no one was there	NO	YES
Thought others might be out to hurt him/her	NO	YES
Thought something which he/she were not sure was true or not	NO	YES
Noticed a change in his/her personality/ The way that he/she acts toward others	NO	YES
Had weakness or numbness in any part of his/her body	NO	YES
Had new onset of headaches	NO	YES
Felt like he/she has to do something over and over again for no reason	NO	YES
Had a thought in his/her mind which he/she could not get out of his/her head	NO	YES
Does your child have any problems with his/her relationships?	NO	YES
Does your child have any fears that interfere with his/her life?	NO	YES

**Please check the frequency which best answers the following questions about your child:**

	Never	Occasionally	Often	Very Often
Does your child fail to give attention to details or make careless mistakes?				
Does your child have difficulty paying attention to tasks or activities?				
Does your child seem not to listen when directly spoken to?				
Does your child have difficulty following instructions and fail to finish assignments?				
Does your child have difficulty organizing assignments and activities?				
Does your child avoid doing tasks requiring mental effort (i.e., homework)?				
Does your child lose things necessary for assignments?				
Is your child easily distracted?				
Is your child forgetful in daily activities?				
Does your child fidget or squirm in his/her seat?				
Does your child have difficulty remaining seated?				
Does your child run or climb on things when asked not to?				
Does your child have difficulty playing quietly?				
Does your child talk excessively?				
Does your child blurt out answers to questions before they have been completed?				
Does your child have difficulty awaiting his/her turn?				
Does your child interrupt people or interrupt other children's work?				
Does your child lose his/her temper?				
Does your child argue with adults?				
Does your child refuse to do what you tell him/her to do?				
Does your child do things that he/she knows will annoy others?				
Does your child blame others for his/her own misbehavior?				
Is your child easily annoyed by others?				
Is your child angry and resentful?				
Does your child take his/her anger out on others?				
Is your child truant from school?				
Does your child lie to avoid responsibility?				
Does your child intimidate, bully or threaten others?				
Does your child start physical fights?				
Has your child stolen items?				
Has your child deliberately destroyed the property of others?				
Has your child used physical force to steal items?				
Has your child used a weapon when fighting?				
Does your child show excessive fear (heights, insects, storms, etc.)?				
Does your child have trouble getting worrisome thoughts out of his/her mind?				
Does your child feel compelled to perform ritualistic habits (checking locks, washing hands, etc.)?				
Has your child experienced a traumatizing event and continues to let it bother him/her?				
Does your child have unusual movements (twitching, blinking, etc.)?				
Does your child have an unusual way of relating to others (odd gestures, avoiding eye contact, etc.)?				
Does your child have problems playing or relating well with other children?				
Is your child uninterested in making friends?				
Does your child have no interest in the feelings of other people?				
Has your child had a significant language development problem?				
Does your child struggle to make conversation that is socially appropriate?				
Does your child talk in a strange way (uses odd words or phrases, repeats what others say, etc.)?				
Is your child unable to use his/her imagination when playing?				

	Never	Occasionally	Often	Very Often
Does your child show excessive preoccupation with a certain topic?				
Does your child become very upset when he/she experiences a change in his/her routine or environment?				
Does your child make strange repetitive motions?				
Does your child have a strange preoccupation for parts of objects?				
Is your child abnormally shy?				
Is your child unusually shy with his/her peers?				
Is your child generally outgoing and friendly with familiar adults?				
Does your child avoid or withdraw from social situations in which he/she feels uncomfortable?				

# Institute for Personal Development

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P: 815-725-6511  
F: 815-725-7166

*Also Serving: Aurora & Ottawa*

## Authorization to Release Information

\_\_\_\_\_ I authorize Institute for Personal Development to request records from the following office:

\_\_\_\_\_ I authorize Institute for Personal Development to release records to the following office:

\_\_\_\_\_  
(Name of Facility or Clinician)/Nature or Relationship to Patient

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Phone Number)

\_\_\_\_\_  
(Fax Number)

The following information on \_\_\_\_\_

(Patient's Name)

(Date of Birth)

Please release the following information (or specify):

- |  |   |
|--|---|
| <input type="checkbox"/> Verbal Information          | <input type="checkbox"/> ALL INFORMATION                                  |
| <input type="checkbox"/> Medical Records             | <input type="checkbox"/> Lab Results                                      |
| <input type="checkbox"/> Medical History/Physical    | <input type="checkbox"/> Treatment Plan/Patient Progress                  |
| <input type="checkbox"/> Psychologist Evaluation     | <input type="checkbox"/> Discharge Summary                                |
| <input type="checkbox"/> Social History              | <input type="checkbox"/> Results of Drug and Alcohol Treatment or Testing |
| <input type="checkbox"/> Prescription/Sample Pick-Up | <input type="checkbox"/> Mental Health Records                            |
| <input type="checkbox"/> Other (specify) _____       |   |

For the Purpose of: Coordination of Care

Approximate Dates of Service: \_\_\_\_\_

Release Expiration Date: \_\_\_\_\_ *Not to exceed 90 days* (Consent subject to revocation at any time.)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.

\_\_\_\_\_  
Signature of Patient / Responsible Party if Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Clinician #1

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Clinician #2

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Clinician #3

\_\_\_\_\_  
Date

**\*\*\* There is a standard processing fee of \$30.00 for any medical records that are released.  
All patients 12 years of age or older need to sign this authorization to release.\*\*\***

Updated: 12/2014