Phone: (630) 217-9911
2132 Deep Water Ln, #240
Naperville, IL 60564
Fax: (630) 596-8636
www.greenpathclinic.com

Patient Information

Name: Last _____ First _____ Middle _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Nickname: _____

Social Security Number: _____ Marital Status: _____

Mailing Address: _____

_____

Phone and Email Consents

By providing an email and/or phone number below that allows texting, I hereby acknowledge and consent to the following:

- I am 18 years old or older, or the email and/or phone number provided is authorized to use by my legal guardian
- I understand that emails/texts may be viewed by unattended persons as they are not sent by way of encryption
- Emails/Texts may be seen or received by other GreenPath Clinic staff if necessary to facilitate the communication
- Emails/Texts are not intended for clinical purposes or as a replacement to therapy, but used as a simple adjunct to therapy or for administrative purposes
- Emails/Texts are not intended to handle emergencies and responding to them is a courtesy and not obligation of my doctor
- I release and hold harmless GreenPath Clinic staff for any claims that I may have, past, present, and future, arising from the use of email or texting
- This consent will remain in force during my treatment at GreenPath Clinic, until all account activity has been completed or upon receipt of my written revocation

As email is the primary method for billing (including invoices, receipts, and communications), an email address is required for all patients.

(Required) Email Address: _____

Phones: Cell (_____) _____ Home / Work (_____) _____

Contacts Information

Guarantor/Financially Responsible Party *(Skip if it is the patient)*

Name: _____ Relationship to Patient: _____

Mailing Address: _____

_____

Phones: Cell (____) _____ Home / Work (____) _____ Email Address: _____

Secondary Contact Information

Please list any other person (i.e. parent, spouse, etc.) who can be contacted should we fail to reach you. Initial next to the reasons they can be contacted.

Name: _____ Relationship to Patient: _____

Phones: Cell (____) _____ Email Address: _____

_____ *Regarding Scheduling* _____ *Regarding Billing* _____ *In case of emergency*

Insurance Information

Primary Insurance Company: _____ Phone Number: (____) _____

Subscriber: _____ Employer: _____

Member ID: _____ Group #: _____

Secondary Insurance Company: _____ Phone Number: (____) _____

Subscriber: _____ Employer: _____

Member ID: _____ Group #: _____

Credit Card on File

By providing a credit card on file, I hereby acknowledge and consent to the following:

- I authorize GreenPath Clinic to charge my card on file for any outstanding copays, co-insurances, deductibles, or other charges
- A receipt will be sent to the email address provided with a date of service at time of charge
- I release and hold harmless GreenPath Clinic staff for any claims that I may have, past, present, and future, arising from the use of my card on file
- This consent will remain in force throughout my treatment at GreenPath Clinic, until my account balance is cleared, or upon receipt of my written revocation

Card Number: _____

Expiration: _____ / _____ CVV Code: _____ Billing Zip Code: _____

Signature of card holder: _____ Date: _____

General Acknowledgements

By signing below, I acknowledge the following:

- I have been offered the "Notice of Privacy Policies and Client Rights" (posted on www.greenpathclinic.com)
- I have consented to the treatment provided by GreenPath Clinic and its personnel, as appropriate to my treatment needs
- My health information will be used for diagnosing and provision of treatment, and for authorizing treatments and claiming reimbursements from my insurance company
- My treatment record is the property of GreenPath Clinic and is treated as confidential and cannot be released without my written consent or as provided by the law of Illinois

- I take responsibility for the amount due for the services rendered, including co-pays, co-insurance, deductible, and services not covered or denied by my insurance. In the case of non-payments, my appointments may be refused, and my account may be turned over to collections
- I understand that co-pays, co-insurance, deductible, and all other payments are **due at time of service**
- I understand that the verification of benefits is an office courtesy and not a guarantee of payment by my insurance company
- If I need to cancel or reschedule an appointment, I will provide a **minimum 24-hour notice**, or I am subject to the **$150 Missed Appointment/Same Day Cancellation Fee**, not billable to insurance and for which I am responsible for payment in full. I understand that for psychological testing, this fee may be higher depending on the number of hours set aside. I understand that the balance for this fee must be cleared within **7 days**, after **60 days account may be turned over to collections**

- I understand that the court testimony, letters, and forms beyond scope of treatment are NOT covered by insurance, and I am responsible for payment for these services in full
- I understand that in case of returned check, I am responsible to pay the original check amount, a $12 Returned Check Fee, and administrative cost of $25 per month; after the three-month period, the entire balance would be submitted to collections

- I understand that **GreenPath Clinic is not a 24/7 care facility** and that I am responsible for seeking care at my nearest emergency center or through another provider of my choice when my doctor is not available

- The information that I provided above is true and accurate

Patient Signature: _____ Date: _____

(If accepting this Consent Form on behalf of a child who is under the age of 12:)

Parent/Guardian Signature: _____ Date: _____

Parent Name: _____

Therapist's Name: _____