DR. TOYAH WILSON

Welcome to our office; Please take a moment to complete the following:

GENERAL INFORMATION (PLEASE PRINT) **Date** _____

Name_____ Social Security Number_____Sex_____

Date of Birth_____Place of Birth_____Height_____ft. _____inches Weight_____lbs.

Relationship

Phone # Home_____Work_____

Address_____

Street City State Zip Years at this address

Driver's License Number_____Insured Name_____

Insured Social Security Number_____Age_____ Occupation_____

Name and address of your employer_____

Who can we thank for referring you? _____

Marital Status (check one) ❒ Single ❒ Engaged ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

❒ Remarried (how many times?_____) ❒ Living with someone

Children / Step Children

Name	Age	Relationship	Living at Home Y/N

Do you have a family physician? ❒ Yes ❒ No

If yes, please give us his/her name(s) and telephone number(s)_____

DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your problem(s)_____

_____

_____

On the scale following please estimate the severity of your problem(s):

❒ Mildly upsetting ❒ Moderately upsetting ❒ Very severe ❒ Extremely severe ❒ Totally incapacitating

When did the problem(s) begin (give dates)_____

_____

Please describe significant event(s) occurring at that time, or since then, which may relate to the development or maintenance of the problem(s)_____

_____

_____

What solutions to your problem(s) have been most helpful?_____

_____

_____

Have you been in psychotherapy before or received any prior professional assistance for the problem(s)? If so, please give name(s), professional title(s), dates of treatments and results_____

_____

Your expectations regarding psychotherapy _____

_____

_____

In general, what do you think therapy is all about?_____

_____

How long do you think your therapy should last?_____

Check any of the following behaviors that apply to you:

❒ Overeat	❒ Impulsive reactions	❒ Concentration difficulties	❒ Take too many risks	❒ Nervous tics
❒ Smoke	❒ Sleep disturbance	❒ Aggressive behavior	❒ Eating problems	❒ Take Drugs
❒ Crying	❒ Outbursts of temper	❒ Odd behavior	❒ Work too hard	❒ Loss of control
❒ Lazy	❒ Drink too much	❒ Compulsions	❒ Suicide attempts	❒ Can't keep a job
❒ Vomiting	❒ Withdrawal	❒ Phobic avoidance	❒ Insomnia	❒ Panic attacks
			❒ Sexual Problems	❒ Procrastination

Are there any specific behaviors, actions, or habits that you would like to change?_____

What are some special talents or skills that you feel proud of?_____

What would you like to do more of?_____

What would you like to do less of?_____

What would you like to start doing?_____

What would you like to stop doing?_____

How is your free time spent?_____

Do you keep yourself compulsively busy doing an endless list of chores or meaningless activities?_____

Do you practice relaxation or meditation exercises regularly?_____

PHYSICAL SENSATIONS

Check any of the following that often apply to you:

- ❒ Headaches
- ❒ Dizziness
- ❒ Palpitations
- ❒ Muscle spasms
- ❒ Tension
- ❒ Sexual disturbances
- ❒ Unable to relax
- ❒ Bowel disturbances
- ❒ Tingling
- ❒ Numbness
- ❒ Stomach trouble
- ❒ Tics
- ❒ Fatigue
- ❒ Twitches
- ❒ Back pain
- ❒ Tremors
- ❒ Fainting spells
- ❒ Hear things
- ❒ Flushes
- ❒ Watery eyes
- ❒ Skin problems
- ❒ Dry mouth
- ❒ Burning or itchy skin
- ❒ Chest pains
- ❒ Rapid heart beat
- ❒ Don't like to be touched
- ❒ Blackouts
- ❒ Excessive sweating
- ❒ Visual disturbances
- ❒ Hearing problems

What sensations are especially:

Pleasant for you?_____

Unpleasant for you?_____

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health? Please specify_____

Please list any medicine(s) you are currently taking, or have taken during the past 6 months (including aspirin, birth control pills, or any medicine(s) that were prescribed or taken over the counter)_____

Check any of the following that apply to you or members of your family:

Family	Self		Family	Self		Family	Self		
❒	❒	Thyroid disease	❒	❒	Diabetes	❒	❒	Epilepsy	Other:_____
❒	❒	Kidney disease	❒	❒	Cancer	❒	❒	Heart disease	_____
❒	❒	Asthma	❒	❒	Gastrointestinal Disease	❒	❒	Glaucoma	_____
❒	❒	Neurological disease	❒	❒	Prostate problems	❒	❒	Infertility	_____
❒	❒	Infectious disease	❒	❒	High Blood Pressure	❒	❒	Arthritis	_____

Have you ever had any head injuries or loss of consciousness? Please give details_____

Please describe any surgery you have had (give dates)_____

Please describe any accidents or injuries you have suffered (give dates)_____

Do you eat three well-balanced meals each day? If not, please explain_____

Do you get regular physical exercise? If so, what type and how often?_____

Check any of the following that apply to you:

	Never	Rarely	Freq-uently	Very Often		Never	Rarely	Freq-uently	Very Often
Aspirin	❒	❒	❒	❒	Allergies	❒	❒	❒	❒
Alcohol	❒	❒	❒	❒	Diuretics	❒	❒	❒	❒
Coffee	❒	❒	❒	❒	Aches/pains	❒	❒	❒	❒
Cigarettes	❒	❒	❒	❒	Nausea	❒	❒	❒	❒
Painkillers	❒	❒	❒	❒	Vomiting	❒	❒	❒	❒
Tranquilizers	❒	❒	❒	❒	Insomnia	❒	❒	❒	❒
Sedatives	❒	❒	❒	❒	Headaches	❒	❒	❒	❒
Antidepressants	❒	❒	❒	❒	Backache	❒	❒	❒	❒
Depression	❒	❒	❒	❒	Early morning awakening	❒	❒	❒	❒
Anxiety	❒	❒	❒	❒	Fitful sleep	❒	❒	❒	❒
Sexual Dysfunction	❒	❒	❒	❒	Overeat	❒	❒	❒	❒
Stimulants/Diet Pills	❒	❒	❒	❒	Poor appetite	❒	❒	❒	❒
Diarrhea	❒	❒	❒	❒	Eat "junk foods"	❒	❒	❒	❒
Constipation	❒	❒	❒	❒					

DR. TOYAH WILSON

OFFICE USE ONLY	
DIAG. CODE	

PATIENT INFORMATION *(Please Print Clearly)*

☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

NAME: _____ SSN: _____
FIRST M.I. LAST

BIRTHDATE: ____/____/____ MALE ☐ FEMALE ☐ HOME PHONE: _____ MOBILE PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____

PATIENT'S EMPLOYER (PARENTS, IF MINOR): _____ WORK PHONE: _____

WORK ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SCHOOL/COLLEGE, IF PATIENT IS A STUDENT: _____ CITY: _____ STATE: _____

NAME OF SPOUSE (IF APPLICABLE): _____ SPOUSES EMPLOYER'S PHONE: _____

CONTACT IN CASE OF AN EMERGENCY?: _____ PHONE: _____

HOW WERE YOU REFERRED TO OUR OFFICE?: _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR ACCOUNT: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

EMPLOYER : _____ WORK PHONE: _____

DRIVER'S LICENSE #: _____ BIRTHDATE: ____/____/____ HOME PHONE: _____

WORK ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION - PRIMARY

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

SSN: _____ BIRTHDATE: ____/____/____ WORK PHONE: _____

EMPLOYER : _____ DATE EMPLOYED: ____/____/____

WORK ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE COMPANY: _____ INS. PHONE #: _____

INS. CO. ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURED'S ID#: _____ INSURED'S GROUP #: _____

HOW MUCH IS YOUR DEDUCTIBLE?: _____ AMOUNT USED: _____ MAXIMUM ANNUAL BENEFIT: _____

CO-PAYMENT AMOUNT: _____ CO-INSURANCE %: _____ IS PRECERTIFICATION REQUIRED?: ☐ YES ☐ NO

INSURANCE INFORMATION - SECONDARY *(If Applicable)*

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

SSN: _____ BIRTHDATE: ____/____/____ WORK PHONE: _____

EMPLOYER : _____ DATE EMPLOYED: ____/____/____

WORK ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE COMPANY: _____ INS. PHONE #: _____

INS. CO. ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

INSURED'S ID#: _____ INSURED'S GROUP #: _____

HOW MUCH IS YOUR DEDUCTIBLE?: _____ AMOUNT USED: _____ MAXIMUM ANNUAL BENEFIT: _____

CO-PAYMENT AMOUNT: _____ CO-INSURANCE %: _____ IS PRECERTIFICATION REQUIRED?: ☐ YES ☐ NO

PLEASE PROVIDE YOUR INSURANCE CARD

BILLING P0LICIES/LATE CHARGES

1) BY SIGNING THIS, YOU ARE CONSENTING TO TREATMENT PROVIDED BY ***Dr. Toyah Wilson***. YOU MAY TERMINATE TREATMENT WITH NO PENALTY TO YOU. ANY CONCERNS REGARDING TREATMENT SHOULD BE DISCUSSED WITH THE COUNSELOR/PSYCHOTHERAPIST.
2) FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION IS REQUIRED. IF CANCELLATION IS MADE AFTER THIS TIME, YOU WILL BE CHARGED FOR A FULL SESSION. IN THE CASE OF AN EMERGENCY, DEATH IN THE FAMILY, HOSPITALIZATION, ILLNESS, ETC., PLEASE SPEAK WITH YOUR THERAPIST REGARDING PAYMENT. IT IS UNDERSTOOD THAT TIME HAS BEEN RESERVED FOR YOU AND THE LACK OF ADEQUATE NOTICE PREVENTS SUFFICIENT TIME TO SCHEDULE OTHER PATIENTS WHO MAY BE IN NEED. IT IS ALSO UNDERSTOOD THAT YOUR INSURANCE COMPANY WILL NOT PAY FOR A FAILED APPOINTMENT AND THAT YOU WILL BE RESPONSIBLE FOR THE FULL FEE.
3) THE UNDERSIGNED AGRESS THAT IN CONSIDERATION OF THE SERVICES TO BE RENDERED TO THE PATIENT HE/SHE AGREES TO PAY DR. TOYAH WILSON IN ACCORDANCE WITH THE REGULAR RATES AND TERMS OUTLINED.
4) PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF USING INSURANCE BENEFITS, IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO DETERMINE YOUR PORTION DUE. YOUR BALANCE DUE IS YOUR FULL RESPONSIBILITY. OUR COMPANY REMITS CLAIMS AND ACCEPTS PAYMENTS FROM INSURANCE COMPANIES AS A COURTESY ONLY (FOR ALL NON-CONTRACTED CARRIERS).
5) SHOULD THE ACCOUNT BE REFERRED TO AN AGENCY OR ATTORNEY FOR COLLECTION, THE UNDERSIGNED WILL PAY REASONABLE ATTORNEY'S FEES AND COLLECTION EXPENSE. THE UNDERSIGNED SHALL ALSO BE RESPONSIBLE FOR ALL INTEREST, AFTER 60 DAYS, AT THE RATE OF 1.5% MONTHLY (18.0% ANNUAL) OF THE UNPAID MONTHLY BALANCE.
6) IF FAILURE TO COMPLY WITH THESE OBLIGATIONS, EACH CONSENTS TO THE DISCLOSURE OF THEIR IDENTITY AND OTHER NECESSARY INFORMATION RELATING TO SERVICES RENDERED TO THE PATIENT BY THE ATTENDING COUNSELOR, CLINIC, OR ATTORNEY FOR THE PURPOSE OF ENFORCING THE PATIENT'S OR GUARANTOR'S OBLIGATIONS TO THE ATTENDING COUNSELOR OR COLLECTION AGENCY OR ATTORNEY. SUCH DISCLOSURE OR REDISCLOSURE SHALL NOT BE DEEMED TO BE A BREACH OF THE PATIENT'S CONFIDENTIALITY BY THE ATTENDING COUNSELOR/PSYCHOTHERAPIST OR CLINIC PERSONNEL.

SIGNATURE

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND AGREE TO THESE CONDITIONS.

X _____ DATE: ____/____/____

SIGNATURE OF PATIENT OR PARENT, IF MINOR

AUTHORIZATION AND RELEASE

I AUTHORIZE ***Dr. Toyah Wilson*** TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO THE ABOVE NAMED PATIENT DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYOR'S FOR THE SOLE PURPOSE OF OBTAINING PAYMENT FOR SERVICES RENDERED TO THE PATIENT BY ***Dr. Toyah Wilson***.

I AUTHORIZE AND REQUEST THAT MY INSURANCE COMPANY PAY DIRECTLY TO ***Dr. Toyah Wilson*** INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE: ____/____/____

SIGNATURE OF PATIENT OR PARENT, IF MINOR

1305 Remington Road, Suite T
Schaumburg, IL 60173
(630) 723-9361
Fax (847) 519-9089
DrToyah@DrToyahWilson.com

Dr. Toyah Wilson

Patient Instructions

Please complete by signing and dating the **Patient's Acknowledgement** section below. Retain the **NOTICE OF PRIVACY POLICY** for your records.

RETURN ONLY THIS PAGE TO OUR OFFICE

Patient's Acknowledgement

I hereby acknowledge that I have been provided with the practice's **NOTICE OF PRIVACY POLICY** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

_____
Patient Name

_____ _____
Signature of Patient (or Legal Guardian/Representative) Date

_____
Witness Name

_____ _____
Signature of Witness Date

April 13, 2003 .
Notice Effective Date (See Page 1)

1305 Remington Road, Suite T
Schaumburg, IL 60173
(630) 723-9361
Fax (847) 519-9089
DrToyah@DrToyahWilson.com

Dr. Toyah Wilson

Thank you for being our patient

In order to give you a better understanding of our services & procedures, we would like to provide you with the following information.

- An hour session is based on a "clinical hour" in accordance with the Healthcare & Insurance industry. A clinical hour is between 45-50 minutes.

- Dr. Wilson uses an outside billing service. If, however, you should have any questions regarding your statement, please contact Dr. Wilson. If she is unable to assist you, she will contact the billing service directly.

- If you should change insurance carriers or have any other changes to your insurance, it is important that your clinician is notified of this change promptly & that your new insurance information is provided. Also, a copy (front & back) of your new or revised insurance card should be provided to our office promptly.

- We try to be understanding of our patient's busy schedules and lifestyles. Please note, however, that your clinician must receive (48) hours notice of cancellation or appointment change. Please understand that this time has been reserved for you. The lack of adequate notice prevents sufficient time to schedule other patients in need. Notice within (48) hours will be considered a "Failed" appointment. Failed appointments are not eligible for insurance benefits and you will be responsible for payment in full. Please discuss emergency situations with your clinician directly.

- Your appointment time slot has been reserved for you. If you arrive to your appointment late, please understand that your full session time generally cannot be provided. Abiding to the set schedule as arranged prevents disturbance to following appointments.

- Our office accepts payments from insurance companies as a courtesy to our patients. Please note that you are fully responsible for all charges and it is your responsibility to contact your insurance company to verify benefits, eligibility & coverage.

- Co-payments are due at the time of service. It is your responsibility to contact your insurance company to determine your portion due. Any amount due at the time of service is expected to be paid. Self payers (patients without insurance or not utilizing insurance) are responsible for paying their full session fee at the time of service.