



## PREMIER PSYCHIATRY

PSYCHIATRIC AND BEHAVIORAL  
HEALTH SERVICES

10745 165<sup>th</sup> Street  
Orland Park, IL 60467

P: 708-799-8384 F: 708-799-1305  
[www.premierpsychiatry.net](http://www.premierpsychiatry.net)

6833 Kingery Highway  
Willowbrook, IL 60527

## NEW PATIENT INTAKE PACKET

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### 1. PATIENT INFORMATION

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / ZIP: \_\_\_\_\_

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### 2. EMERGENCY CONTACT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

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### 3. INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_

Member ID: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy Holder (if different): \_\_\_\_\_

Secondary Insurance (if applicable): \_\_\_\_\_

Secondary Member ID: \_\_\_\_\_

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### 4. CONSENTS & POLICIES (PLEASE READ CAREFULLY)

By signing below, I acknowledge and agree to ALL of the following:

#### Privacy Practices

- I have received or been offered a copy of the Notice of Privacy Practices.
- Full notice available at: [www.premierpsychiatry.net](http://www.premierpsychiatry.net)

#### Communication Consent

- I consent to receive communication via phone, text message, email, and/or patient portal
- I understand messages may not be fully secure
- I may opt out at any time

#### Telehealth Consent

- I consent to participate in telehealth services
- I understand there may be privacy risks
- I agree to be in a private location during visits

#### Financial Policy

- Payment is due at time of service
- 48-hour cancellation required
- \$45 missed appointment fee applies
- I am responsible for co-pays, deductibles, and non-covered services

### Controlled Substance Policy (if applicable)

- I agree to take medications as prescribed
- No early refills for lost or stolen medications
- In-person visit required by 3rd visit and annually

### Release of Information (Optional)

I authorize Premier Psychiatry to share my information with:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

I do NOT authorize release of information

### Consent to Treatment

- I consent to psychiatric evaluation and treatment at Premier Psychiatry
- I understand treatment may include psychotropic medications
- My provider has explained the purpose, benefits, and potential risks of treatment
- I understand medication effects vary and may include side effects
- I agree to report side effects and follow treatment recommendations
- I agree to complete any recommended lab work
- I will discuss any desire to stop medication with my provider
- I have had the opportunity to ask questions and all questions have been answered

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## 5. CLINICAL INTAKE

Reason for Visit: \_\_\_\_\_

### Symptoms (check all that apply)

Depression  Anxiety  ADHD  Panic  Insomnia  PTSD  Mood Swings  Irritability  Substance Use

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## Current Medications

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

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## Medical / Psychiatric History

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## Allergies

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## Substance Use

Alcohol:  None  Occasional  Regular

Tobacco:  None  Yes

Other: \_\_\_\_\_

## 6. FINAL SIGNATURE

I confirm that I have read and agree to all policies and consents above and that the information provided is accurate and complete.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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*This form is intended for patients who are unable to complete digital intake.*