PREMIER PSYCHIATRY

PSYCHIATRIC AND BEHAVIORAL HEALTH SERVICES

10745 165th Street
Orland Park, IL 60467

P: 708-799-8384 F: 708-799-1305
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**

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

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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: _____

Medical / Psychiatric History

Allergies

Substance Use

Alcohol: ☐ None ☐ Occasional ☐ Regular

Tobacco: ☐ None ☐ Yes

Other: _____

Safety

☐ No thoughts of self-harm

☐ Thoughts of self-harm (explain):

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: _____

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