Name of client: ______________________________________________

## Michigan Psychological Care

Michigan Psychological Care strives to provide you with the highest level of care possible. Psychotherapy is very dependent on the client-therapist relationship- the stronger the connection is, the better your results will be. It is for this reason that it is important that you find a therapist that matches well with you, that you feel comfortable, and that you can be provided with a positive relationship to help you on your journey.

Here at Michigan Psychological Care if you feel that your connection with your therapist is not as strong as you would like, we encourage you to switch to a therapist that will fit your needs better. If you find that you would like to try a different relationship, please contact our front desk and speak with our receptionist staff. The receptionist staff is there to ensure that your experience is the best that it can be, and to connect you with the therapist and the resources that you require, receptionists are available through our front desk, which is reached at our main number of 989-292-3572.

Please sign this form indicating that you understand that each therapist has a different style and that you agree to try a different therapist if the one you have been assigned does not mesh well with you.

Signature:___________________________________ Date:____________

**AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT BENEFITS**

I understand that as part of my health care, this organization originated and maintains health records describing my health, history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that my psychological records may be maintained as a part of my overall medical record or maintained as one chart that the clinical staffs at both this organization and the partnering medical facilities are able to access for my overall physical and mental health maintenance.

I authorize Michigan Psychological Care to bill and release to private insurance carriers such information from my patient records as is required in order to receive reimbursement for any billings for services. This includes alcohol and drug abuse and mental health treatment information protected under the relations in title 42 or code of Federal Regulations Part II. Information about human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS) and AIDS related complex (ARC) as defined by the Department of Public Health rules Act 174 1989 and Act 368 Public Act 1978.

I request that payment of authorized benefits (if billed by the office) be paid directly to Michigan Psychological Care on my behalf. This is an authorization agreement, until such times as revoked by me and a yearly update is required. I understand that I am responsible for/hereby accept responsibility for the payment to Michigan Psychological Care for whatsoever sums of money shall become due and payable for services received, I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and I

Name of client: ______________________________________________

personally will be active in the resolution of claims delay or unjustified reductions or denials, I certify that all statements made on this application are true.

I authorize Michigan Psychological Care staff to discuss my medical and billing information with the following person(s): (This may include family members, friends, neighbors, or anyone else you designate):

| Name & Phone number (if possible) | Relationship to patient | Info to be released (Please circle) |
|---|---|---|
| | | Financial, Medical, Mental Health, or all |
| | | Financial, Medical, Mental Health, or all |
| | | Financial, Medical, Mental Health, or all |

_______________________________________________________________________________

Signature of Patient or Legal Representative Date Initials of Witness

**REQUEST AND CONSENT FOR TREATMENT OF MINOR CHILDREN**
**(IN THE ABSENCE OF PARENT OR GUARDIAN)**

As a parent or guardian I, ____________________________________________, hereby request and give my full consent for medical care, treatment and or surgery, and authorize hospital admission, as the treating provider may deem medically necessary; or my child during my absence. This is a lifetime authorization agreement, until such time as revoked by me. However, a yearly update is required.

Listed below are the individual(s) that have authorized to make medical decisions and bring my child in for medical treatment in my absence, (You may use the back of this form as well)

| Name | Phone | Relationship |
|---|---|---|
| | | |
| | | |

_______________________________________________________________________________

Signature of Patient or Legal Representative Date Initials of Witness

Name of client: ______________________________________________________

**HIPAA NOTICE ACKNOWLEDGMENT**

I acknowledge that I have been advised of the Notice of Privacy Practices at Michigan Psychological Care and that a copy of this policy is available to me.

Date:_________________________________________________

Patient's Name (Please Print): ___________________________________________________

Patient or Representative Signature: ______________________________________________

Representative's Relationship to Patient: ___________________________________________

Clinic Representative: __________________________________________________________

Name of client: ___________________________________________

**Michigan Psychological Care  Personal History Form**

Client Name:_______________________________________________________________
DOB:_____________________
Address:___________________________________________________________________
Phone Number: (___) ____________________  Email: ________________________________
Social Security Number (of parent, if identified client is a minor child): _________________________
Employer (of parent, if identified client is a minor child): ___________________________________
Emergency Contact: (name) ______________________________________________________
(phone number) __________________________ (relationship) ______________________________
Who referred you? _____________________________________________________________
Briefly describe why you are here: _________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Employment Status:
( ) Employed  ( ) Unemployed  ( ) Student  ( ) Disabled  ( ) Other

Educational Status:
Currently Enrolled? Y( ) N ( ) If Y, where? ____________________Current Grade ________
Special Education? Y( ) N ( ) Highest level of education:_____________________________

Family Status:
( ) Married ( ) Single ( ) Divorced (divorce in process) ( ) LTP (Live Together Partner)
( ) Widowed ( ) Separated

Individual/ Family Support (Who lives in the home? Childcare providers?)

| NAME | RELATIONSHIP | LIVING IN HOME? | AGE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Medical History: List health problems, health diagnoses, and health concern
___________________________________________________________________________
___________________________________________________________________________

| Current medications: | Dosage/Frequency: | Purpose: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Primary Care Physician: ___________________________Fax:__________________________

___________________________________________________________________________
Signature **(By signing I authorize communication between Michigan Psychological Care and my PCP)**

Name of client: ____________________________________________________

**Appointment Reminders and Online Appointment Scheduling**

You can receive an appointment reminder to your email address, your cell phone (via text message), or your home phone (via a computer generated voice message) the day before your scheduled appointment.
****PLEASE SPEAK WITH A MEMBER OF RECEPTION IF YOU WISH TO HAVE THE ABILITY TO SCHEDULE APPOINTMENTS ONLINE****

Your Home Phone Number: ____________________________________________

Your Cell Phone Number: ____________________________________________

Where would you like to receive appointment reminders? **(Check One)**
______Via a text message on my cell phone ( normal text message rates will apply)
______Via an email message to address listed above
______Via an automated telephone message to my home phone
______None of the above, I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA, By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above

_____________________________________________ _________________________
Signature Date

**Fee, Cancellation, and No-Show Agreement**

**THERAPY SERVICES**

The established fees for THERAPY SERVICES are due at the time services are provided. Cancellations must be made at least 24 hours in advance of appointment time. Appointments canceled on our answering machine will be treated according to the time that call was made. The charge for late or no-call/no-show cancellations will be $50.00. This fee must be paid before the next appointment.

**VIOLATION OF THE 24 HOUR CANCELLATION POLICY WILL RESULT IN SUSPENSION OR TERMINATION OF TREATMENT.**

I understand that my case will be terminated or suspended due to noncompliance if I violate the cancellation policy TWO (2) sessions in a row, or THREE (3) times within a 90 day period.

Client Signature_____________________________________________________ Date: _______________

**Fee, Cancellation, and No-Show Agreement**

Name of client: ____________________________________________________

**PSYCHOLOGICAL ASSESSMENTS**

The established fees for PSYCHOLOGICAL ASSESSMENTS are due at the time services are provided. Cancellations must be made at least **48** hours in advance of the scheduled appointment. Appointments canceled on our answering machine will be based on the time the call was made. The charge for late cancellations or no-call/no-show will be $50.00 PER SCHEDULED HOUR. The fee must be paid before the next appointment.

Additionally, each form given to the client by the psychologist that is lost or requires a replacement for any reason will result in a $10.00 replacement fee.

BY SIGNING THIS AGREEMENT, I AGREE TO THE ABOVE FEES AND UNDERSTAND I MAY BE TERMINATED OR SUSPENDED IF I DO NOT SHOW UP FOR APPOINTMENTS OR CANCEL WITHIN 48 HOURS.

Client Signature: ______________________________________________________Date: ___________

**MICHIGAN PSYCHOLOGICAL CARE**
**NOTIFICATION OF MEDICAL & PSYCHOLOGICAL MEDICAL RECORDS**

Patient's Name: __________________________________________________

I understand that as part of my health care, this organization originates and maintains health records describing my health history both medical and psychological, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this organization participates in joint activities with the primary care agencies listed in the Notice of Privacy Practices under an arrangement known as an "organized health care arrangement."

I understand that my psychological records are maintained as a part of my overall medical record and are maintained as one chart that the clinical staffs at both this organization and the Medical Center are able to access for my overall physical and mental health maintenance.

| ________________________________________ | ____________ | ______________ |
|---|---|---|
| Signature of Patient or Legal Representative | Date | Initials of Witness |

**NON-COVERED BENEFITS:**

Name of client: ____________________________________________

This serves to indicate that the following services, when not covered by insurance, will be held as patient responsibility:

Individual Sessions: $150.00
Group Sessions: $35.00
Psychological Evaluations: $500.00 - $1500.00 (depending on type)
Intern Visits: $20.00
Driver's License/Substance Abuse Evaluations: $200.00

These fees will be imposed in the event that your insurance coverage lapses or terminates and you will be responsible for paying for them in full at the time of service or through an appropriately arranged payment plan. Financial hardship forms are available and may be able to reduce these costs. These fees may also be incurred if our facility is non-participating with your insurance and you have no out-of-network coverage. Our facility is non-participating with straight Medicaid.

Should you elect not to use your insurance coverage for a service, these fees will be expected at time of service.

By signing below, you understand our fees and the times that you would be expected to pay them.

__________________________________________ ___________
Signature of Client or Responsible Party Date

__________________________________________________
Print Name of Client

Name of client: ___________________________________________

Your signature below forms a binding agreement between Michigan Psychological Care (MPC – the provider of psychological services) and the patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). The Responsible Party is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at time of services.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the Responsible Party, you are responsible if your insurance company declines to pay for any reason. While our staff will try to aid you in working with your insurance company, ultimately it is your responsibility to check with your insurance.

The person signing on behalf of the client as the Responsible Party must:

Inform MPC of the current address and phone number for the patient and the responsible party
Present all current insurance cards prior to each office visit
Verify at each visit that the information is current by signing our data sheet
Pay any required co-pay at the time of the visit
Pay any additional amount owing within 30 days of receiving a statement from our office

NON-PAYMENT ON ACCOUNT: Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party understands that MPC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% ARP, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to those terms

______________________________
Patient's Name (please print)

______________________________ ________________
Patient's Signature Date

______________________________
Responsible Party Name (please print)

______________________________ ________________
Responsible Party Signature Date

**EXPERT WITNESS FEES**

Name of client: ___________________________________________________

Your relationship with your therapist is professional in nature. Therefore, if your therapist is called to testify in relation to your case; they MUST be called on as an Expert Witness.

Michigan Psychological Care has the following policy and fees regarding testifying as an Expert Witness:

FEES:

The fee is $200 PER HOUR with a minimum of FOUR HOURS for a doctorate level therapist.

The fee is $150 PER HOUR with a minimum of FOUR HOURS for a master's level therapist.

Clients must give THIRTY (30) DAYS notice prior to the trial date for adequate preparation time.

A NONREFUNDABLE DEPOSIT $400 IS DUE AT LEAST SEVEN (7) DAYS PRIOR TO TRIAL DATE.
In the event that you do not need your therapist to testify, seven (7) days notice must be provided or you will still be held responsible for the Expert Witness fees.
Therapists will not appear for testimony without a subpoena being issued to the physical location of your therapist.

____________________________________________________ ____________
Patient Signature Date

**INFORMED CONSENT**

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, they will be provided with only general information about our work together, unless there is a high risk that you will seriously harm yourself or someone else.

I ________________________________________________ hereby understand the risks and benefits of psychotherapy and authorize Midland Psychological Services to provide psychotherapeutic treatment to me or my child.

Client Name: ___________________________________________________

Client or Guardian Signature: ____________________________________________

Date: ______________________