CLIENT INFORMATION

CLIENT INFORMATION

Client Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: ___/___/___ Gender: ❑Male ❑Female Marital Status: _____

Home Phone: _____ May I leave a message? ❑ Yes ❑ No

Cell Phone: _____ May I leave a message? ❑ Yes ❑ No

Email: _____

Emergency Contact In the event of an Emergency, who do you give us permission to call?

Name: _____ Relationship: _____ Phone #: _____

Signature: _____ Date: _____

If Child/Senior/Guardian:

Parent/Guardian's/POA's Name: _____

Relationship to: _____ Phone #: _____

INSURANCE INFORMATION

Insurance Company Name:_____ Phone Number:_____

Insurance Company Address:_____

Contract/ID Number:_____ Group Number:_____

Subscriber Name:_____ Birthdate:_____ Relationship to Subscriber: _____

SECONDARY INSURANCE

Insurance Company Name:_____ Phone Number:_____

Insurance Company Address:_____

Contract/ID Number:_____ Group Number:_____

Subscriber Name:_____ Birthdate:_____ Relationship to Subscriber: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the clinician and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billings, we request that your copay amount be paid at the conclusion of each visit.

I hereby assign all mental/behavioral health benefits for which I am entitled including private insurance and other health plans to: Michigan Institute for Behavioral Health LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information to secure the payment, including copies of portions of the client's records.

Signature: _____ Date: _____

37504 Seven Mile Rd., Livonia, MI 48152 Phone: 734.744.5171 Fax: 734.744.8035

MICHIGAN INSTITUTE FOR
BEHAVIORAL HEALTH, LLC

Consent for Treatment

I, _____, (Client name) voluntarily consent to participate in behavioral health services offered and provided by Michigan Institute for Behavioral Health, LLC (MIBH) and its staff.

I understand that I shall have the opportunity to discuss any treatments or testing with the therapist and/or their assistants and designees participating in my case. I understand that in emergency situations, it may be necessary or advisable for the therapist/counselor to extend services beyond those contemplated at the beginning of treatment.

I understand that the therapist/counselor or designees may perform psychological assessments upon me and I will be informed of the purpose. The results of any assessment(s) will be treated confidentially, but may be disclosed as necessary to personnel that will care, authorize service, or insure care and services to me.

I understand that the practice of therapy/counseling is not an exact science. No guarantees or promises have been made to me regarding the results of any therapeutic treatment.

I understand that if I am not compliant with treatment or miss two consecutive sessions in a row, my treatment will be terminated. I understand that if I do not cancel my scheduled appointment within 24 hours, I will be charged with a $50.00 no show or late cancellation fee.

I authorize the clinic to release any and all information contained in my medical records, including information protected under Michigan Public Act 174 of 1989 as amended, substance abuse information, if any, and social and psychological services information to (a) any third party payer, insurance agencies or carriers responsible in whole or in part for paying any expenses associated with my treatment; and/or (b) any health care facility used by the therapist/counselor for the purpose of facilitating continuing care and treatment.

I assign and authorize direct payment of all health care benefits and other forms of payment of any kind that relates to the care provided to me by the clinics staff for application to my bill. I assume full financial responsibility for payment of all expenses associated with my care and treatment. It is my responsibility to pay any deductible amount, co-insurance fee, or any other balance not paid by my insurance provider. In order to control the cost of billing, I understand that the request of charges for office visits must be paid at the conclusion of each visit.

I understand that the clinic is not liable for the loss or damage of any personal property.

I certify that I have read this form(s) or that they have been read to me. I understand its contents and accept its terms unless otherwise indicated on this form. If the signer is not the client, the signer certifies that he/she is the patient's legally authorized representative and consents for treatment on behalf of the individual. A photocopy of this consent is to be considered as valid as an original.

_____	_____	_____
Client Name	Client/Guardian Signature	Date

_____	_____
Witness Signature	Date

MICHIGAN INSTITUTE FOR
BEHAVIORAL HEALTH, LLC

Primary Care Physician Notification Form

Attention Primary Care Physician: Your patient is being seen at the **Michigan Institute for Behavioral Health LLC (MIBH)** at 37504 Seven Mile Rd., Livonia, MI 48152. Phone: 734.744.5171 Fax: 734.744.8035

With patient authorization, we herein provide diagnoses and treatment information. *Please retain for your records.*

Patient Name: _____ **DOB**:_____

DSM-5 Diagnoses (Including Codes):

_____

_____

Treatment Information:

_____

_____

_____

Therapist Signature _____

PRINT NAME AND CREDENTIALS

TO THE PATIENT: If you **do wish** us to notify your primary care/family doctor that you are receiving services, please provide the complete name and address of your Primary Care Physician:

Primary Care Physician: _____ Phone: _____

Clinic Name (if any): _____Fax: _____

Address: _____ City: _____ State: _____ Zip:_____

Please read and complete the following:

I, (print name here) _____ hereby authorize the Michigan Institute for Behavioral Health, LLC (MIBH) to exchange information regarding my/my child's (circle one) mental health and/or substance abuse treatment and medical health care for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect throughout the course of this treatment. I understand that I may revoke this authorization at any time by written notice to the behavioral health care provider indicated herein. I also understand that it is my responsibility to notify my behavioral health care provider if I choose to change my primary care physician.

If you **do not wish** to authorize us to notify your primary care/family doctor, please complete the section below:

☐ I don't have a primary care/family doctor.

☐ I don't want my primary care/family doctor to know I'm receiving services at this time.

☐ I just don't want to.

_____ _____

Client Signature or Parent/Guardian Signature if client is a minor Date

_____ _____

Witness Date

MICHIGAN INSTITUTE FOR BEHAVIORAL HEALTH, LLC

ADOLESCENT INTAKE ASSESSMENT

Parents: Please complete this form to help your clinician as he/she works with your child. Please not the information is important for your child's care. If you are unsure about the answer to any of these questions, please discuss them with your clinician. All information provided is confidential.

CLIENT INFORMATION

Child's Name: _____ Today's Date: _____

Nick Name: _____ Birth Date: _____ Age: _____ Grade Level: _____

MOTHER'S INFORMATION

Mother's Name: _____ Phone #: _____ Age: _____

Occupation(s): _____ Employer(s): _____

Marital Status: ❑Married ❑Unmarried ❑Divorced ❑Separated ❑Living Together ❑Widowed

FATHER'S INFORMATION

Father's Name: _____ Phone #: _____ Age: _____

Occupation(s): _____ Employer(s): _____

Marital Status: ❑Married ❑Unmarried ❑Divorced ❑Separated ❑Living Together ❑Widowed

**If parents are living apart, then please fill in the address blanks below:

Mother's Address: _____ City: _____ State: ____ Zip: _____

Father's Address: _____ City: _____ State: ____ Zip: _____

Current Family/Support System

Who has legal guardianship of your adolescent? _____

Who does your adolescent currently live with? _____

Household Members (Name)	Relationship to Child	Age	Quality of Relationship
Others Significant to Child	**Relationship to Child**	**Age**	**Quality of Relationship**

Does anyone in the adolescent's family use currently (or in the past) any type of drug, tobacco, or alcohol? ❑Yes ❑No If yes, please describe:

Basic Information:

Briefly describe the problem for which your adolescent is seeking counseling?

What would you like to see happen as a result of counseling?

What is most concerning right now?

Medical History Please note past/present services below:

Has your adolescent received any counseling or psychiatric care?

Facility/Counselor Name	Month/Year Seen	Reason Seen	Helpful?
_____	_____	_____	❑No ❑Yes
_____	_____	_____	❑No ❑Yes

Has anyone in your family received any counseling or psychiatric care?

Family Member	Facility/Counselor Name	Reason Seen	Month/Year Seen
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Adolescent's Primary Care Physician: _____

Address: _____ Phone: _____

Date of Last Medical Exam: ____/____/____ Please rate your child's health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Is your adolescent taking any medications?:

Name of Medication	Dosage	Medication Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your adolescent experienced any of the following medical problems/physical disabilities?:

❑Serious accident ❑Hospitalization ❑Surgery ❑Asthma ❑Head Injury ❑High fever ❑Convulsions/seizures

❑Eye/ear problems ❑Meningitis ❑Hearing problems ❑Allergies ❑Loss of consciousness

❑Other: _____

Child Development:

Were there any complications with the pregnancy or delivery of your adolescent? ❑ Yes ❑ No ❑ Uncertain

If yes, please describe: _____

Did your adolescent have health problems at birth? ❑ Yes ❑ No ❑ Uncertain

If yes, please describe: _____

Did your adolescent experience any developmental delays (i.e. toilet training, walking, talking)? ❑ Yes ❑ No ❑ Uncertain

If yes, please describe: _____

Did your child have any unusual behaviors or problems prior to age 5? ❑ Yes ❑ No ❑ Uncertain

If yes, please describe: _____

Family History:

Has the family/home been disrupted by serious illness/ accident/ death/ divorce? ❑ No ❑ Yes

If yes, please describe: _____

Has your adolescent experienced any emotion, physical, or sexual abuse? ❑ No ❑ Yes

If yes, please describe: _____

Please check any family concerns that your family is currently experiencing:

❑ Verbal Fights	❑ Feeling Distant	❑ Loss of Fun
❑ Physical Fights	❑ Financial Problems	❑ Death of Family Member
❑ Feeling Unsafe	❑ Job Loss/ Change	❑ Lack of Honesty
❑ Disagreeing about Relatives	❑ Threatening Behavior	❑ Abuse/Neglect
❑ Disagreeing about Friends	❑ Alcohol Use	❑ Drug Use
❑ Divorce/Separation	❑ Remarriage	❑ Birth of a sibling
❑ Other _____	❑ Other _____	

Education History:

What school does your adolescent attend? _____

Address: _____ Phone: _____

Teacher's Name _____ Current Grade: _____

Has your adolescent experienced any of the following problems at school?: (Please check all that apply)

❑ Fighting ❑ Lack of friends ❑ Drugs/alcohol ❑ Detention ❑Suspension ❑ Poor attendance ❑ Poor grades

❑ Gang Influence ❑ Incomplete homework ❑ Behavioral problems ❑ Learning Disabilities

❑Other: _____

Chemical History:

Do you have any concerns with your adolescent's use of alcohol or drugs? ❑ Yes ❑ No

If yes, please describe: _____

Internet/ Electronic Communication Usage:

Do you have any concerns with your adolescent's use of the internet or electronic communication such as facebook, Snapchat, Twitter, texting, etc.? ❑ Yes ❑ No

If yes, please describe: _____

Legal Issues

Please list any legal issues that are affecting you or your family, son or daughter at present, or have had a significant effect in the past? _____

Other History

Has your adolescent ever made statements of wanting to hurt him/her self or seriously hurt anyone else? ❑ Yes ❑ No

Has your child ever purposely hurt himself or another? ❑ Yes ❑ No ❑ Uncertain

If yes, please describe: _____

Strengths

What activities do you feel your adolescent is successful when he/she tries?:

_____

What personal qualities would you say your adolescent has?

_____

Who are some of the influential people (and/or what activities or beliefs) that are important in your adolescent's life?

_____

Concerns What are some of the individual concerns you notice regarding your son or daughter? Place an "X" where needed:

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Hyperactivity					Indecisiveness				
Binging/Purging					Low Energy				
Unresolved Grief					Excessive Worry				
Loneliness					Low Self-Esteem				
Irritability					Anger Issues				
Impulsivity					Spiritual Concerns				
Nausea/Indigestion					Hallucinations				
Social Anxiety					Racing Thoughts				
Self Mutilation					Restlessness				
Cutting					Drug Use				
Nightmares					Suicidal Thoughts				
Hopelessness					Past Suicide Attempt				
Elevated Mood					Panic Attacks				
Mood Swings					Feeling Anxious				
Disorganized					Feeling Panicky				
Anorexia					Obsessive Thoughts				
Grief					Alcohol Use				
Phobias					Trauma Flashbacks				
Headaches					Easily Distracted				
Unplanned Weight Changes					Other				

Is there anything else you would like us to know?

MICHIGAN INSTITUTE FOR BEHAVIORAL HEALTH, LLC

ADOLESCENT INTAKE ASSESSMENT

Please complete this form to help your clinician as he/she works with you regarding your reasons for seeking therapy. If you are unsure about the answer to any of these questions, please discuss them with your clinician. All information provided is confidential.

CLIENT INFORMATION

Name: _____ Today's Date: _____

Nick Name: _____ Birth Date: _____ Age: _____

Phone (cell): _____ Messages okay? _____ Text reminders okay? _____

School: _____ Grade Level: _____

Please share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

_____

Do your parents have access to your electronic communication? ❑Yes ❑No

Do they have any issues with your use of phone, text, electronic communication? ❑Yes ❑No

Personal Strengths

What activities do you enjoy and feel you are successful when you try?

Who are some of the influential and supportive people in your life? (Please describe)

Current Reason for Seeking Counseling

Briefly describe the problem(s) for which you are seeking counseling?

What would you like to see happen as a result of counseling?

Have you previously seen a counselor? ☐Yes ☐No

If yes, what did you find most helpful in therapy?

_____

If yes, what did you find least helpful in therapy?

_____

Family History

1. Are your parents married or divorced? _____

2. Do you think their relationship is good? ❑ Yes ❑ No ❑ Unsure

3. If your parents are divorced, whom do you primarily live with? _____

4. How often do you see each parent? Mom_____% Dad _____%.

5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home?

Please describe as much as you feel comfortable.

Please check any family concerns that your family is currently experiencing

❑ Verbal Fights	❑ Feeling Distant	❑ Loss of Fun
❑ Physical Fights	❑ Financial Problems	❑ Death of Family Member
❑ Feeling Unsafe	❑ Job Loss/ Change	❑ Lack of Honesty
❑ Disagreeing about Relatives	❑ Threatening Behavior	❑ Abuse/Neglect
❑ Disagreeing about Friends	❑ Alcohol Use	❑ Drug Use
❑ Divorce/Separation	❑ Remarriage	❑ Birth of a sibling
❑ Other _____	❑ Other _____	

Substance Use History

Do you currently use alcohol? ❑ Yes ❑ No

If yes, how often do you drink? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Rarely

If yes, how much do you drink? _____ (#) per time.

Do you currently use Tobacco? ❑ Yes ❑ No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? ❑ Yes ❑ No

If yes, what drugs do you use? _____

If yes, how often do you use? ❑ Daily ❑ Weekly ❑ Occasionally ❑ Rarely

1. Have you ever used more than 1 chemical (drug) at the same time to get high? ❑ Yes ❑ No

2. Do you avoid family activities so you can use? ❑ Yes ❑ No

3. Do you have a group of friends who also use? ❑ Yes ❑ No

4. Do you use to improve your emotions such as when you feel sad or depressed? ❑ Yes ❑ No

Have you received any previous treatment for chemical use? ❑ Yes ❑ No

If so, where did you go?_____ ❑ Inpatient ❑ Outpatient

Legal Issues

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

Peer Relations

1. How do you consider yourself socially? ❑ Outgoing ❑ Shy ❑ Depends on the situation
2. Are you happy with the amount of friends you have? ❑ Yes ❑ No
3. Have you ever been bullied? ❑ Yes ❑ No
4. Are your parents happy with your friends? ❑ Yes ❑ No
5. Are involved in any organized social activities (e.g. sports, scouts, music)? Please List:

School History

1. Do you like school? ❑ Yes ❑ No
2. Do you attend school regularly? ❑ Yes ❑ No
3. What are your current grades? ❑ Mostly A's ❑ Mostly B's ❑ Mostly C's ❑ D's & Below GPA: _____
4. Do you feel you are doing the best you can at school? ❑ Yes ❑ No

Individual Concerns

Do you have thoughts now or recently of wishing you were dead? ❑ No ❑ Yes

Have you ever attempted suicide or attempted to seriously harm yourself? ❑ No ❑ Yes

If yes, please explain (when, how many times, method used): _____

Do you have any thoughts now or recently of harming others? ❑ No ❑ Yes

Place an "X" in the category of symptoms listed below:

Symptom	None	Mild	Moderate	Severe	Symptom	None	Mild	Moderate	Severe
Hyperactivity					Indecisiveness				
Binging/Purging					Low Energy				
Unresolved Grief					Excessive Worry				
Loneliness					Low Self-Esteem				
Irritability					Anger Issues				
Impulsivity					Spiritual Concerns				
Nausea/Indigestion					Hallucinations				
Social Anxiety					Racing Thoughts				
Self Mutilation					Restlessness				
Cutting					Drug Use				
Nightmares					Phobias				
Hopelessness					Headaches				
Elevated Mood					Panic Attacks				
Mood Swings					Feeling Anxious				
Disorganized					Feeling Panicky				
Anorexia					Obsessive Thoughts				
Grief					Alcohol Use				
Easily Distracted					Trauma Flashbacks				
Unplanned Weight Changes					Other				

** We look forward to meeting you and want you to know that we respect your privacy and hope to create an environment that is comfortable for sharing.**

THERAPIST-CLIENT SERVICES AGREEMENT

Instructions: Please read, initial each page and sign document.

Welcome. This document contains important information about this practice and its business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law designed to protect your privacy and your rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with the attached Notice of Privacy Practices that explains HIPAA and how it affects you. The law also requires that we obtain your signature acknowledging that you have received this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can address any questions you have about the procedures before your next session. When you sign this document, it will also represent an agreement between you and your therapist and Michigan Institute for Behavioral Health, LLC. You may revoke this Agreement in writing at any time. That revocation will be binding except for information already disclosed; obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

GETTING STARTED

Services vary depending on your needs and your therapist's approaches. Aside from treatment with medications, there are many different methods used to deal with the issues that you hope to address. Your initial session(s) will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions. You should evaluate this information along with your own impression of whether you feel comfortable working with your therapist. If you have questions about procedures, please feel free to discuss them whenever they arise. If your doubts persist, your provider will be happy to help you set up a meeting with another professional for a second opinion (at your expense).

MEETINGS

Standard psychotherapy sessions include 45 minutes face-to-face time and 15 minutes for documentation by your therapist. Request for shortened or longer sessions should be discussed with your therapist. When an appointment time is scheduled, you will be responsible to attend the **appointment unless you provide at least 24 hours advance notice of cancellation or need to reschedule**. This cancellation should be made by phone to ensure your therapist receives notice in a timely manner. You are financially responsible for the time you reserve. **You may be charged $50.00 for late cancellations.** Please note that insurance companies do NOT provide reimbursement for cancelled sessions.

PROFESSIONAL FEES AND PAYMENT

Your provider has a fee schedule for out-of-network services. In-network- services will be provided according to your insurance plan fee schedule. If there are questions, please discuss this during your visit. If you want to set up a payment plan, you may also discuss this during your visit. You will be expected to pay for each session at the time it is held, preferably at the beginning of the session, unless another schedule is agreed upon or unless you have insurance coverage. If we file your insurance, you are expected to meet your deductable and make your co-pay at each visit. Payment schedules for other professional services (such as report writing, extended telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, or legal testimony) will be agreed to when they are requested. We accept cash, credit and personal checks. **There will be a $25 service charge for returned checks**.

Initial_____

If your account has not been paid for more than 60 days and you have not made arrangements for payment or worked out a payment plan with your provider, we have the option of using legal means to secure the payment. This may include collection agency or small claims court which will require disclosing otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

INSURANCE REIMBURSEMENT

In order for you to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Your provider will fill out required forms and provide you with assistance in receiving the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of your bill.

If your coverage changes, it is your responsibility to notify your provider and to comply with your new policy. You should also be aware that your contract with your health insurance company requires that we provide a clinical diagnosis and information about the services provided to you. Sometimes your therapist must provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, every effort will be made to release only the minimum information about you that is necessary for the purpose requested.

Once we have all of the information about your insurance coverage, your therapist will discuss what you can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself.

CONTACTING YOUR THERAPIST

Your therapist may not be immediately available by phone because they are usually with clients during working hours. Calls received by voice mail will regularly be checked and every effort to return your call within 24 hours will be made, or by the next business day if you call on weekends or on holidays. If you are difficult to reach, please leave information about times when you will be available. **In emergencies, you need to call 911.** Generally, if your therapist is unavailable for an extended time such as during a vacation, you will be provided with the name and telephone number of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and therapist. Several types of communications and the consent they require are discussed below.

1) Generally, information about your treatment can be released to others only if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA.

2) There are other situations, however, that require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, every effort is made to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. You will not be told about these consultations unless your therapist feels that it is important to your work together.
- If your therapist employs other mental health professionals or administrative staff in many cases, some protected information may be shared with these individuals for both clinical and administrative

purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members would be given training about protecting your privacy and would agree not to release any information outside of the practice without the permission of a professional staff member.

- MIBH has contracts with other vendors such as software providers and an accountant. Typically no protected health information would be shared with them. As required by HIPAA, we have a formal business associate contract with any of these other businesses, in which they promise to maintain the confidentiality of any such data except as specifically allowed in the contract or otherwise required by law. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If your therapist believes that a client presents an imminent danger to his/her health or safety, they may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

3) There also are some situations where therapists are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that are provided to you, such information is protected by the therapist-patient privilege law. Information cannot be provided without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a client files a complaint or lawsuit against a therapist, that therapist may disclose relevant information regarding that client in order to defend him/herself.

- If a client files a worker's compensation claim, and services are being compensated through workers compensation benefits, a provider must, upon appropriate request, provide a copy of the client's record to the client's employer or requesting agency.

4) In addition, there are some situations in which we are legally obligated to take actions, which are necessary to attempt to protect others from harm and which may require revealing some information about a client's treatment. These situations are unusual in this practice. They include the following:

- If there is cause to suspect that a child under 18 is abused or neglected, or reasonable cause to believe that a disabled or elderly adult is in need of protective services, the law requires that a report be filed with the County Department of Human Services. Once such a report is filed, additional information may be required.

- If there is reason to believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

Initial _____

If such a situation arises, staff will make every effort to fully discuss it with you before taking any action and will limit disclosure to only what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that any questions or concerns that you may have now or in the future be discussed. The laws governing confidentiality can be quite complex. In rare situations where specific advice is required, formal legal advice may be needed.

E-MAIL, CELL PHONE, TEXTING AND FAX COMMUNICATION

It is very important to be aware that e-mail and cell phone (also cordless phone) communication can be relatively easily accessed by unauthorized people and, hence, the privacy and confidentiality of such communication can be easily compromised. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please notify your therapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use email or faxes in emergency situations.

PLEASE DO NOT RETURN FILLED FORMS BY EMAIL, but bring them to your session or fax them to the office. If there would be a need to discuss clinical matters in between session, please use the phone (a landline is the most confidential means of communication).

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, your therapist may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, medications prescribed, type of therapy approach provided, the goals that are set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records received from other psychiatrists/psychologists/therapists, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and your therapist believes that access is reasonably likely to cause substantial harm to such other person or to yourself, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with your therapist, or have them forwarded to another mental health professional so you can discuss the contents. (There may be a charge for copying records). The exceptions to this policy are contained in the attached Privacy Notice. If your request for access to your records is refused, you have a right of review, which will be discussed with you upon request.

In addition, your therapist may also keep a set of Psychotherapy Notes. These Notes are for your therapist's use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations with your therapist, an analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to your therapist that is not required to be included in your Clinical Record and information revealed to your therapist confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without a separate written, signed Authorization.

Initial _____

LITIGATION LIMITATION
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

MINORS & PARENTS
Children over the age of eighteen have the right to independently consent to and receive mental health treatment without parental consent and, in that situation, information about that treatment cannot be disclosed to anyone without the child's agreement. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents. It is our policy only to share information that is considered necessary with his/her parents. This includes general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless the psychiatrist/therapist feels that the child/adolescent is in danger or is a danger to someone else, in which case, the parents will be notified of this concern. Before giving parents any information, this will be discussed with the child/adolescent, if possible, and an attempt will be made to handle any objections he/she may have. Children under 18 must be accompanied by their parent or legal guardian to therapy appointments.

ID-THEFT PREVENTION According to the ID-Theft prevention policies of Michigan Institute of Behavioral Health, LLC you will be required to bring a picture ID and your insurance card to your initial session.

YOUR INITIALS AND SIGNATURE INDICATE THAT YOU HAVE:

1) BEEN GIVEN THIS AGREEMENT,
2) READ AND AGREE TO ITS TERMS.

IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA PRIVACY NOTICE FORM and the NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.

_____ _____
Patient Name Date

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR PATIENT HEALTH INFORMATION

This notice describes how psychological information about you may be used and disclosed, and how you can get access to this information as governed by HIPAA. Please review it carefully.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:

Michigan Institute for Behavioral Health, LLC (MIBH) may use or disclose your Protected Health Information (PHI) for treatment, payment and health care operations purposes with your consent to help clarify these terms, here are some definitions: **"PHI"** refers to information in your health record that could identify you. **"TREATMENT"** is when the MIBH clinician provides, coordinates or manages your health care and other services related to your health care. An example; when the clinician consults with another health care provider such as your family physician or another mental health provider.

"PAYMENT" is when MIBH obtains reimbursement for your healthcare. An example; when MIBH discloses your PHI to your health insurer to obtain payment reimbursement for your health care or to determine eligibility and/ or coverage.

"HEALTH CARE OPERATIONS" are activities that relate to the performance and operation of this practice. An example; quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination.

"USE" applies only to activities within MIBH such as sharing, employing, applying, utilizing examining, and analyzing information that identifies you.

"DISCLOSURE" applies to activities outside of the office such as releasing, transferring or providing access to information about you to other parties.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

MIBH may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An **"AUTHORIZATION"** is written permission above and beyond the general consent that permits only specific disclosures. In those instances when MIBH is asked for information for purposes outside of treatment, payment or health care operations, MIBH will obtain an authorization from you before releasing this information. MIBH will also need to obtain an authorization before releasing your Psychotherapy Notes**.**

"PSYCHOTHERAPY NOTES" are notes the MIBH clinician have made about your conversation during a private, joint or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent:

- MIBH has relied on that authorization or
- If the authorization was obtained as condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

MIBH may use or disclose PHI without your consent or authorization in the following circumstances:

CHILD ABUSE - If MIBH has reasonable cause or suspicion to suspect child abuse or neglect, it must be reported to the appropriate authorities as required by law.

ADULT AND DOMESTIC ABUSE - If MIBH has reasonable cause or suspicion to suspect you have been criminally abuse, it must be reported to the appropriate authorities as required by law.

TREATMENT OVERVIEW ACTIVITIES - If MIBH receives a subpoena or other lawful requests from the Department of Health or the Michigan Board of Psychology, PHI information must be disclosed pursuant to that subpoena or request.

JUDICIAL OR ADMINISTRATIVE PROCEEDINGS - If you are involved in a court proceeding and a request is made for information about the diagnosis and treatment thereof¸ such information is privileged under state law and will not be released without your written authorization or a court order.

SERIOUS THREAT TO HEALTH OR SAFETY - If you communicate a threat of physical violence against a reasonably identifiable third person, and you have the apparent intent and ability to carry out that threat if the forcible future, MIBH may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If MIBH believes that there is an imminent risk that you will inflict serious physical harm on yourself, MIBH may disclose information in order to protect you.
WORKMAN'S COMPENSATION - MIBH may disclose PHI regarding you only to the extent necessary to comply with laws related to Workman's Compensation or other similar programs as established by law, that provides benefits for work-related injuries or illnesses without regard to fault.

IV. PATIENT'S RIGHTS AND MIBH CLINICIAN DUTIES

RIGHT TO REQUEST RESTRICTIONS - You have the right to request restrictions on certain uses and disclosures of PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare or not disclosed to family members or friends who may be involved in yours and care. Your request must state the specific restriction requested and to whom you want the restriction to apply. However, MIBH is not required to agree to a restriction you may request. If MIBH believes it is in your best interest to use and disclose your PHI, your information will not be restricted.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being treated, you may be request that your bills be sent to a different address.)

RIGHT TO INSPECT AND COPY - You have the right to inspect or obtain a copy of PHI in MIBH's health and billing records used to make decisions about your care for as long as your information is maintained in your records. MIBH may deny access to your PHI under certain circumstances but you may request that this decision be reviewed. On your request, I will discuss with you the details of the request and denial process.

RIGHT TO AMEND - You have the right to request an amendment of your PHI for as long as the PHI is maintained in the record. Your request may be denied; however, MIBH will discuss the details of this amendment process.

RIGHT TO AN ACCOUNTING - You generally have the right to receive an accounting of disclosures of PHI. On your request, MIBH will discuss with you the details on the accounting process.

RIGHT TO A PAPER COPY - You have the right to obtain a paper copy of the notice from MIBH upon request, even if you have agreed to receive the notice electronically.

MIBH'S DUTIES
MIBH is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

MIBH reserves the right to change the privacy policies and practices described in this notice. MIBH will notify you of any such changes but will continue to abide by the terms currently in effect.

If MIBH revises these policies and procedures, MIBH will provide you with these changes in person or by mail.

V. COMPLAINTS

If you are concerned by MIBH has violated your privacy rights or you disagree with a decision made about access to your records, please let MIBH know personally. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. MIBH will be able to provide you with the appropriate address upon request.

VI. EFFECTIVE DATE, RESTRICTIONS AND CHANGES TO PRIVACY POLICY

This notice will go into effect on January 1, 2014.

MIBH reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that MIBH maintains. MIBH will provide you with a revised notice either in person or by mail.

HIPPA & PRIVACY NOTICE

I have received and reviewed a copy of the HIPPA Privacy Notice Form and the Notice of Privacy Practices outlines in my Service Agreement.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Effective 11/1/17

37504 Seven Mile Rd., Livonia, MI 48152 Phone: 734.744.5171 Fax: 734.744.8035