MICHIGAN MODERN PSYCHOLOGY

Client Information Form

please print clearly

Client Name: _____ **Client DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone:_____ **Home Phone:** _____

E-mail: _____ □ Voicemail & Text □ Voicemail □ Text

Gender: □ Male □ Female **Marital Status**: □ Single □ Married □ Divorced □ Widowed

Primary Language Spoken:_____ **Home Language:**_____

Employer: _____ **Phone:** _____

Emergency Contact: _____ **Phone:** _____

Relation to client: _____

Referral Source: _____ **Client Social Security #:** _____

If client is under 17, list legal guardian(s): _____

Primary Health Insurance: _____ **Ins. Phone:** _____

Contract #: _____ **Group #:** _____

☐ **Check if same as client, if not…**

Primary Insurance Card Holder: _____

Relationship to Client: _____ **Primary Card Holder's DOB:** _____

Primary Card Holder's Address: _____ ☐ **Check if same as client**

City: _____ **State:** _____ **Zip:** _____

Primary Card Holder's Cell Phone: _____ **Home Phone:** _____

Primary Card Holder's Social Security Number: _____

Employer: _____ **Phone:** _____

Secondary Health Insurance: _____ **Ins. Phone:** _____

Contract #: _____ **Group #:** _____

☐ **Check if same as client, if not…**

Secondary Insurance Card Holder: _____

Relationship to Client: _____ **Secondary Card Holder's DOB:** _____

Secondary Card Holder's Address: _____ ☐ **Check if same as client**

Secondary Card Holder's Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Phone:** _____

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CONSENT FOR TREATMENT

I, _____, voluntarily consent to and authorize all psychological care including routine testing procedures as deemed necessary or advisable by the psychologist, their assistants or designees, and employees of the facility participating in my care.

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

In keeping with ethical standards of our profession as well as state and federal law, all services provided by the clinician, their assistants or designees kept confidential except as noted below. All information shared with the clinicians at MMP is confidential. No information will be released without your consent. MMP treatment records are electronic and stored on a secure server as part of your treatment records. Access to records by MMP providers is done only on a need to know basis for purposes of collaborative care (e.g., referral for medication, evaluations, etc.). In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. There are specific and limited exceptions to this confidentiality which include the following:

- When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child, disabled person or elderly individual is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the vulnerable party, and to inform the proper authorities.
- When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that if I am unable to make decisions about care, treatment of services, or I choose to delegate decision making to another individual, the organization involves the surrogate decision-maker in making these decisions. In these events, the surrogate decision-maker may give informed consent.

I understand that the psychologist or designees may perform psychological testing upon me and I will be informed of the purpose. The results of any test(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 psychology is not an exact science. NO GUARANTEES OR PROMISES have been made to me regarding the results of any psychological treatment.

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: and substance abuse information, if any, protected

under Federal Government Regulations. Part 2: and social and psychological services information, if any, including communication made to a social worker or psychologist, 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 {b} any health care facility used by the psychologist 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 clinic staff for application to my bill. I assume full FINANCIAL RESPONSIBILITY FOR PAYMENT of all expenses associated with my care and treatment, including any portion of charges not covered by insurances, worker's compensation, or social agencies. I agree to pay the same at the time of discharge or on an interim basis while in treatment.

***Please note, our office does not participate with ANY Medicaid plans, including straight Medicaid or any commercial Medicaid plans, be advised if for any reason your insurance changes to a Medicaid plan, you will be responsible for the bill.

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

I CERTIFY THAT I HAVE READ THIS FORM OR THAT IT HAS BEEN READ TO ME. I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS UNLESS OTHERWISE INDICATED ON THIS FORM. IF THE SIGNER IS NOT THE PATIENT, THE SIGNER CERTIFIES THAT HE OR SHE IS THE PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE.

_____ _____

Signature of patient, parent, or legal guardian Date

_____ _____

Therapist Date

ADVANCED PSYCHIATRIC DIRECTIVE

Do you have an advanced directive for psychiatric services? Yes____ No_____

Are you interested in receiving information about advanced directives for psychiatric needs?
Yes_____ No_____

******Clinician Use Only******
If pt requested information about advanced directives, did you provide information?
Yes_____ No_____

Clinician Signature_____Date:_____

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NOTICE OF PRIVACY PRACTICE

Uses and Disclosures of PHI: Michigan Modern Psychology may use PHI for the purposes of treatment, payment, and health care operations without your written permission. The following are examples of our use of your PHI.
- For treatment: This includes any information received from you, other medical personnel, or other medical facilities pertaining to your medical condition and treatment. It also includes information we give to other health care personnel to whom we transfer your care and treatment.
- For payment: This includes any activities, filing claims, medical necessity reviews, and collection of outstanding accounts.
- For health care operations: This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fund raising, and certain marketing activities.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:
The right to access, copy, or inspect your PHI. This means you may come to our office within 30 days and inspect and copy most of the medical information about you that we maintain, for a reasonable fee. In limited circumstances, we may deny you access to your medical information and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer.

The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We will either amend your information within 60 days of your request, or as permitted by law, deny your request to amend your medical information only in certain circumstances, such as when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact the privacy officer. You have the right to appeal a denial, and we will provide the appropriate appeal form.

The right to request an accounting of our use and disclosure of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment, or health care operations.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment, or health care operations, or to restrict information that is provided to family, friends and other individuals involved in your health care. Michigan Modern Psychology is not required to agree to any restrictions you request, but any restrictions agreed to by Michigan Modern Psychology are binding.

Your Legal Rights and Complaints: You also have the right to complain to us, Michigan Modern Psychology, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments, or complaints, you may direct all inquiries to the privacy officer.

Revisions to the Notice of Privacy Practice: Michigan Modern Psychology reserves the right to change the terms of this Notice at any time. The changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to this Notice will be promptly posted in our facilities.

I hereby acknowledge that I am entitled to receive a copy of Michigan Modern Psychology's Notice of Privacy Practices upon request.

_____ _____
Patient signature Date

Please Print:

Patient Name: _____

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ATTENDANCE & COVERAGE POLICY

Dear Patients,

Due to the heavy volume of last minute cancellations, we are being forced to enforce our 24-Hour No Show Policy. If you find that you need to miss a scheduled appointment, please call and cancel at least 24 hours prior to the appointment or you will incur a "No Show" fee of $70.00.

In addition, due to the constant changes in insurance policies, it is no longer possible to interpret each individual's insurance policy. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, *the insured*. Although we try our best to stay aware of the changes, insurance policies change daily with no warning. Please keep in mind that your insurance policy is between *you and your insurance company* and **NOT** between the insurance company and the doctor's office. IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. Any portions of claims that are not covered become the responsibility of the insured.

By signing this document, I agree, in order for Michigan Modern Psychology to service my account or to collect any amounts I may owe, Michigan Modern Psychology and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, if applicable.

***Please note, our office does not participate with ANY Medicaid plans, including straight Medicaid or any commercial Medicaid plans, be advised if for any reason your insurance changes to a Medicaid plan, you will be responsible for the bill.

I/We have read this disclosure and authorize express consent that Michigan Modern Psychology, its affiliates, and third party service providers may contact me/us as described above.

Patient Name:_____ Date:_____

Patient Signature:_____ Date:_____

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CONSENT TO INFORM PCP OF CURRENT TREATMENT

If you would like us to send a letter to your Primary Care Physician informing them that you are receiving services here, please provide your PCP's name and address and your signature which will indicate that you grant permission for the release of this info. The letter will inform your PCP of your initial date of service and your diagnosis at this agency. A letter will not be sent if an address is not provided on this form. You may also choose to decline to have a letter sent if you do not feel it is necessary. Please choose one of the options below:

- ❑ **Yes, please send a letter to my PCP**

PCP NAME _____

PCP ADDRESS _____

CLIENT NAME _____

CLIENT SIGNATURE (PARENT/GUARDIAN) _____

-OR-

- ❑ **No, I decline to have a letter sent to my PCP**

CLIENT NAME _____

CLIENT SIGNATURE (PARENT/GUARDIAN) _____

****

CELL PHONE/CONTACT POLICY

Your therapist may choose to provide you with a cellular phone number to reach him or her directly. MMP therapists are not "on call" and may not be able to respond immediately to calls or texts. If your therapist provides you with such a number, please understand that it is not to be used in case of crisis or emergency. In the case of emergency, go to your nearest emergency room, dial 911, or contact the hotline on the Crisis Resource Form provided to you today.

Patient signature/acknowledgement:_____Date_____

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HEALTH, PAIN & NUTRITION SCREENING TOOL

Section I: Health and Medical Status

- Name of primary health care doctor: _____
- Have you had a physical exam within the last 12 months? ☐ **Yes** ☐ **No***
- Are you currently experiencing any of the following health problems? ☐ **Yes** ☐ **No**

- o Diabetes
- o Heart problems
- o High blood pressure
- o Seizures
- o Hearing problems
- o Vision problems
- o Speech problems
- o Muscle or joint problems
- o Nausea or vomiting
- o Other medical conditions (If yes, explain) _____ _____

- If you are experiencing any of the health problems listed above, are you being treated by a primary health care provider for this problem? ☐ **Yes** ☐ **No***
- Do you have any allergies? If yes, please list_____

Section II: Pain Screening

- Are you experiencing any ongoing physical pain? ☐ **Yes** ☐ **No**

(If "No", please skip down to Section III: Nutrition Screening)

If "Yes", where is the pain located? _____

- How would you rate the intensity of the pain **on a scale from 1 to 10** with 10 being the worst possible pain you could imagine? _____
- Are you currently being treated for this pain? ☐ **Yes** ☐ **No**
- Is the treatment effective? ☐ **Yes** ☐ **No**

Section III: Nutrition Screening

- Have you experienced an unintentional weight loss or gain of 10 pounds or more within the last *month*? ☐ **Yes** ☐ **No**
- Has a doctor or other medical professional placed you on a special diet? ☐ **Yes** ☐ **No**

If yes, are you compliant with that diet? ☐ **Yes** ☐ **No**

- Do you have chronic chewing, swallowing or gastric difficulties that interfere with eating sufficient food? ☐ **Yes** ☐ **No**

****CONTINUE TO NEXT PAGE - THIS PAGE TO BE COMPLETED BY CLINICIAN AND/OR MEDICAL PROFESSIONAL****

Section IV: Review and Recommendations

Instructions: *<u>*Asterisked items*</u>* (on page 1) indicate that a recommendation should be given to the client to seek treatment from a primary health care provider.

Section I: Health and Medical Status (Recommend that client seek treatment from primary health care provider if,)

- Client has not had a physical exam within the past 12 months.
  Recommendation:

  _____

AND/OR

- Client has an acute/ chronic health problem that is not being treated by a primary health care provider
  Recommendation:

  _____

Section II: Pain Screening (Recommend that client seek treatment from primary health care provider if,)

- Client is experiencing significant physical pain that is not being treated by a primary health care provider or the treatment is not effective.
  Recommendation:

  _____

Section III: Nutrition Screening (Recommend that client seek treatment from primary health care provider if,)

- Client has experienced an unintentional weight loss/ gain of 10 pounds or more within the last *month*.
  Recommendation:

  _____

AND/OR

- Client is non-compliant with a prescribed special diet.
  Recommendation:

  _____

AND/OR

- Client has chronic chewing, swallowing or gastric difficulties that interfere with eating sufficient food.
  Recommendation:

  _____

Review and Recommendations completed by:

<u>Clinician</u>:
Signature: _____

Name: _____ Date _____

Client Name:_____**Date:**_____

SUICIDAL IDEATION

1. Are you suicidal? ☐ **Yes, continue to 1a** ☐ **No, continue to 2**
   a. Do you have a plan for how you would attempt suicide? Explain

   b. Do you have the means or can easily access the means to complete your plan?

   c. Would you actually go through with your plan?

2. Have you ever attempted suicide before? ☐ **Yes, continue to 2a** ☐ **No, continue to 3**
   a. How did you do it?

   b. Did you receive treatment for any of these prior attempts?

3. If there is a plan, means and/or intent, what interventions were taken? (i.e., verbal contract, resources given, etc)

HOMICIDAL IDEATION

1. Do you feel like hurting anyone else? ☐ **Yes, continue to 1a** ☐ **No, continue to 2**
   a. Do you have a plan for how you would hurt someone else? Explain.

   b. Would you actually go through with your plan?

2. Have you ever attempted to injure another before? ☐ **Yes, continue to 2a** ☐ **No, continue to 3**
   a. Did you experience any consequences? (i.e., legal consequences, treatment, etc)

3. If there is a plan, means and/or intent, what interventions were taken? (i.e., verbal contract, resources given, etc)

PSYCHOSIS

1. Do you hear or see things that aren't really there? ☐ **Yes, continue to 1a** ☐ **No, next page**
   a. Do you have difficulty distinguishing what is real and what is not real?

   b. Do your voices command you to complete certain actions?

   c. Are you able to control impulses related to what you hear or see?

****If any <u>yes</u> box was checked, Therapist must complete a Higher Level of Care Form****

Clinician Name:_____**Clinician Signature:**_____

Patient Name:_____

SUBSTANCE ABUSE SCREENER

Alcohol

Age of First Use: _____
Duration of Use: _____
Frequency of Use: _____
Date of last use:_____
Amount of alcohol consumed on a typical episode of use:_____
Pattern (circle one): episodic continuous binge

Substance: _____

Age of First Use: _____
Duration of Use: _____
Frequency of Use: _____
Amount of Use: _____
Date of last use:_____
Pattern (circle one): episodic continuous binge

Tobacco

__ Cigarettes/Cigars ___Chewing Tobacco
Age of First Use: _____
Duration of Use: _____
Amount of Use: _____(ppd)
Date of last use:_____
Pattern (circle one): episodic continuous binge

Substance: _____

Age of First Use: _____
Duration of Use: _____
Frequency of Use: _____
Amount of Use: _____
Date of last use:_____
Pattern (circle one): episodic continuous binge

Substance: _____

Age of First Use: _____
Duration of Use: _____
Amount of Use: _____
Frequency of Use: _____
Date of last use:_____
Pattern (circle one): episodic continuous binge

Substance: _____

Age of First Use: _____
Duration of Use: _____
Frequency of Use: _____
Amount of Use: _____
Date of last use:_____
Pattern (circle one): episodic continuous binge

Please list any emotional, behavioral, legal and/or social consequences of substance use:

_____

_____

Please list any physical problems associated with substance use:

_____

_____

Have you ever received previous care, treatment or services for substance use including detox, counseling and/or AA/NA? If yes, please give approximate dates, length of treatment, and indicate your response to treatment:

_____

_____

Please describe relapse history, if any:

_____

_____

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally; (b) you *witnessed it* happen to someone else; (c) you *learned about it* happening to a close family member or close friend; (d) you were exposed to it as *part of your job* (for example, paramedic, police, military, or other first responder); (e) you're *not sure* if it fits; or (f) it *doesn't apply* to you. Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to Me	Witnessed it	Learned about it	Part of my job	Not Sure	Doesn't apply
1. Natural Disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substances (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (i.e., homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm or death you caused to someone else						
17. Any other very stressful event or experience						

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Crisis Resource Form

Michigan Modern Psychology, an outpatient care clinic, is dedicated to the safety of all clients. There may be times, however, when a person feels that they need immediate care. If this is the case, look into the following:

If you are experiencing a **crisis**

Go to the Emergency Room

- The primary resource for maintaining safety
- Go if you believe that you may hurt yourself or another person
- Evaluation is typically needed before going to other forms of care

Contact 911

- Beneficial if you cannot get to the emergency room on your own

Call a Suicide Prevention Hotline

- Free and confidential support for people in distress; availiable 24/7
- National Number: **1-800-273-8255**

Forms of Mental Health Care

Outpatient Clinics

- Therapy in a confidential enviornment
- Flexible scheduling based on client and therapist availiabiltiy
- Varies from twice per week to "as needed" based on client need and therapist recommendation

Intentisve Outpatient Program

- Provide therapy for several hours per day, several days per week
- Utilizes several modalities and typically includes group therapy

Partial Hospitalization Program

- Provides a full day of therapy for at least 5 days per week
- Utilizes several modalities and typically includes group therapy
- Clients may meet with a psychiatrist

Inpatient Hospitalization

- Provides 24 hour care in a safe, secure enviornment
- Typically includes medication management