

Welcome! Thank you for choosing SPSI for your healthcare needs. To help us help you, please fill out this form to the best of your ability. If you have any questions, our staff will be happy to help.

CLIENT INFORMATION

Name: _____ Date of Birth: _____ Soc Sec #: _____
Last First Middle

Gender: M F Race: _____ Marital Status: Single Married Widowed Separated Divorced

Phone Number: () _____ Alternate Phone: () _____ This is my () phone

Address: _____
Street Apt, Suite, etc. City, State ZIP

Employed By: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Who may we thank for referring you? How did you learn of our practice? _____

Where do you prefer to receive calls? _____ Any special instructions regarding telephone calls? _____

When is the best time to reach you? Days: _____ Times: _____

EMERGENCY CONTACT INFORMATION

Contact person: _____ Relation: _____ Home #: _____ Work #: _____

Name of Primary Physician: _____ Phone: _____ Hospital: _____

Date of Last Physical Exam: _____ Medical Conditions: _____

Allergies: _____

RESPONSIBLE PARTY

Responsible Party: _____ Relation: _____ Date of Birth: _____
Last First Middle

Driver's License #: _____ Soc Sec #: _____ Phone: _____

Employed by: _____ Occupation: _____ Work Phone: _____

INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance	Other Insurance
Effective Date			
Policy Holder			
Relation to Client			
Policy Holder Date of Birth			
Soc Sec #			
Employer			
Date Employed			
Occupation			
Ins. Company			
Group #			
Contract #			
Deductible Amount			

FINANCIAL ARRANGEMENTS

We ask payment in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer:

Cash Check Credit Card Payment Plan

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing, I realize a late charge of 1.5% on the balance then unpaid will be owed and will be assessed monthly. I realize that failure to keep the account current may result in you being unable to provide additional services, except for emergencies or where there is prepayment for additional services.

ASSIGNMENT AND RELEASE

AUTHORIZATION, ASSIGNMENT, AND RELEASE

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners or to persons designated as emergency contacts.

I assign directly to Saginaw Psychological Services, Inc. (SPSI) all medical benefits, if any, otherwise payable to me for services rendered. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, whether or not paid by insurance. I hereby authorize Saginaw Psychological Services, Inc. (SPSI) to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Saginaw Psychological Services, Inc. (SPSI) for any services furnished to me by SPSI. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date



Saginaw Psychological Services, Inc.

2100 Hemmeter Rd., Saginaw, MI 48603 • Phone: (989) 799-2100 • Fax: (989) 799-2637
Director: Mark Zaroff PhD, LP, LPC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: _____

Relationship to Client: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Saginaw Psychological Services, Inc.

FINANCIAL CONSENT AND SERVICE AGREEMENT

Client Name _____

Therapist ID No _____

Client Number _____

In relation to services rendered by Saginaw Psychological Services, Inc. (SPSI) to the client named above, I, the undersigned responsible person, hereby **AUTHORIZE**:

My signature will be retained in my file as authorization of the release of any information including diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and/or health practitioners or to the persons designated in my emergency contacts. This signature will be used in conjunction with all insurance submissions and the filing of insurance claims, including Medicare, for the reimbursement of such services.

I assign directly to SPSI all medical benefits, if any, otherwise payable to me for services rendered. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, whether or not paid by insurance. I hereby authorize SPSI to release all information necessary to secure the payment of my benefits.

I AGREE: To pay for services at the time provided, unless prior arrangements have been made. To pay interest on any balance over thirty (30) days at an annual rate of 18% (1.5% per month). That a monthly statement of services, charges, and payments is provided by mail and that any portion of the cost of services that is denied by a third-party payer or insurance company will be automatically billed to me and will be my responsibility due in thirty (30) days. That this financial relationship will continue in effect until all monies due SPSI are paid and/or SPSI has terminated this financial agreement. That SPSI may assign unpaid balances to collection agencies after written warning. That the total balance on my account is due at the termination of services.

THERAPEUTIC AND EVALUATION SERVICES: I agree to pay:

\$ _____ for a full session of therapy.

\$ _____ for a half session of therapy.

\$ _____ for group therapy per hour.

\$ _____ for psychological testing

\$ _____ for consultation services (attorneys, schools, etc.)

\$ _____ for records releases/reviews, insurance reports/forms completion, sick leave, disability papers, etc.

\$ _____ for missed appointments not cancelled at least 24 hours in advance, or missed without good cause

\$ _____ for copay, \$ _____ deductible, \$ _____ other (specify: _____)

I have read and/or have had the information above explained to me and agree to the terms.

Client/Guardian Signature _____

Date _____

Witness Signature _____

Date _____

Saginaw Psychological Services, Inc.

CONSENT TO TREATMENT

Client Name

Date

Client Number

The following is to be read, completed, and signed by the client or the client's parent/guardian:

I agree to attend psychotherapy and/or case management on an Individual, Family, and/or Group basis with a therapist or examiner. I have read the Client Handbook, which includes the Saginaw Psychological Services, Inc. Code of Ethics and my Rights. Questions which arose were answered satisfactorily.

The following pertains only to clients seeking services for a substance-related issue

I have read, reviewed, and understand the "know your rights" booklet for substance abuse clients. Any questions I may have had have been answered satisfactorily.

Client/Guardian Signature

Date

Witness Signature

Date

I authorize Saginaw Psychological Services, Inc. to contact me for follow up interviews at regular intervals through telephone contact or questionnaire. If I am not available, Saginaw Psychological Services, Inc. may communicate with the individual listed below to determine my status.

Name of Individual

at

Telephone Number

Client/Guardian Signature

Date

Witness Signature

Date

The following is to be read and signed by the Therapist/Examiner:

I have discussed and responded to client's questions. I hereby agree to engage in psychotherapy or psychological testing with the client as indicated by my signature;

Therapist Signature

Date

Saginaw Psychological Services, Inc.

INFORMED CONSENT TO DISCHARGE POLICY

Client Name _____

Date _____

Client Number _____

The following is to be read, completed, and signed by the client or the client's parent/guardian:

Under certain circumstances, clients may be discharged for cause from treatment or participation in services at Saginaw Psychological Services, Inc. Such conditions which may precipitate involuntary discharge are as follows:

Acts of violence or threats of violence against either staff or other clients of the agency.

Failure to maintain scheduled appointments or regular contact with this agency for more than thirty (30) days.

Failure to work toward treatment plan objectives.

Clients whose actions are consistent with those listed above may be discharged by decision of the program director in consultation with the primary clinician, or in the case of acts of violence or threats of same, may be discharged on the spot by the clinical staff member present at the time.

I understand that in the instance of involuntary discharge, I have the right to appeal the discharge to the program director.

If I am being considered for involuntary discharge, I will be notified of this in writing by the primary clinician in advance of discharge, unless the action is based upon threats or acts of violence.

I have reviewed the criteria for discharge and, by my signature, agree to the above.

Client/Guardian Signature _____

Date _____

Therapist Signature _____

Date _____

Saginaw Psychological Services, Inc.
CONFIDENTIAL BEHAVIORAL HEALTH SPECIALIST REPORT: FOR PHYSICIAN REVIEW
PATIENT CONSENT: COORDINATION OF CARE FORM
PRIMARY CARE PHYSICIAN (PCP) / BEHAVIORAL HEALTH (BH)

Client Name _____ Health Plan _____ Date of Birth _____

The following is to be read, completed, and signed by the client or the client's parent/guardian:

Primary Care Physician Name / Address (please print) _____

I do / do not authorize Saginaw Psychological Services, Inc., my behavioral health care provider and my above named primary care physician to exchange information regarding my mental health/substance abuse treatment and medical health care for coordination of care purposes as may be necessary or the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment (as protected under 42 CFR part 2) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one (1) year from the date of my signature below, or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to Saginaw Psychological Services, Inc. I further understand that it is my responsibility to notify this provider if I choose to change my primary care physician.

Client/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

Behavioral Health Provider Information: (to be completed by provider)

Treating Provider: _____ Address: Saginaw Psychological Services
615 S. Euclid Bay City, MI 48706
 Phone: 989-439-1513 Fax: 989-439-1512

DSM V Diagnosis Code and name: _____

Treatment Modalities:

Psychotherapy - Individual Group Family Frequency of visits: _____
 Inpatient Partial Hospitalization Dates: _____
 Medication Management By: _____
(Physician's name, phone, fax number)
 Other Specify: _____

Medications prescribed for behavioral health

Date	Medication	Dosage	Discontinued	Date	Medication	Dosage	Discontinued
/ /			/ /	/ /			/ /
/ /			/ /	/ /			/ /
/ /			/ /	/ /			/ /
/ /			/ /	/ /			/ /

Changes since last report: _____

If authorization is given, a copy of this form should be sent to the PCP.

Date sent to PCP: _____ Sent by: _____ Method: Fax Mail

PLEASE RETAIN ORIGINAL FORM IN PATIENT'S RECORD



Advance Directive Acknowledgement

Making choices is an important part of everyone's lives. Health care choices are some of the most important choices we make. Someday, you may not be able to communicate what your healthcare wishes are. Someone may have to make health care choices for you. An advanced directive is a way to describe the choices you want made for you in the future. There are three types of advance directives:

1. A **Durable Power of Attorney** lets you appoint a patient advocate. Your patient advocate will make healthcare choices for you if you are not able to make them for yourself. You can describe your choices in writing. Your patient advocate can make treatment and placement decisions for you based on your specific choices.
2. A **Do Not Resuscitate Order (DNR)** is a special kind of advance directive. A DNR describes the medical services you choose to receive when you are terminally ill and in the final stages of life.
3. A **Living Will** tells healthcare providers and the courts about your healthcare choices. Although courts will take living wills into consideration, they are not necessarily legally binding documents in the State of Michigan.

The choice to complete an advance directive is completely up to you. The services you receive will not be affected by your choice of whether or not to complete one. If you complete, or have completed, an advance directive, you should give a copy to all of your healthcare providers, including mental health and medical providers.

Please initial one choice:

____ I have read and understand this information and do not require additional information.

____ I would like more information and have received a brochure.

____ I have completed an advance directive, and will provide SPSI with a copy.

Client Name: _____

Relationship to Client: _____

Signature: _____

Date: _____

OFFICE USE ONLY

In my opinion, the client (or the client's guardian) named above is unable to understand the information about advance directives at this time. The primary clinician will follow-up on this material when the client is able to understand the content.

Signature

Date

Saginaw Psychological Services, Inc

Clinical Director: Nathalie Menendes, PsyD

C.E.O: Mark Zaroff, Ph.D

Website: <http://www.sagpsych.com/>

Telehealth Informed Consent

Telehealth involves the use of electronic communication to enable health care and mental health providers at locations different from their consumers to engage in therapeutic services or share medical information for the purpose of maintaining and improving care. The information be used for diagnosis, therapy, follow-up, and/or education. While our best efforts are made to safeguards privacy and confidentiality, we are unable to encrypt sessions at this time.

I _____, consent to engage in telehealth with Saginaw Psychological Services, Inc. as a part of my psychological services. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, and telephone.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth; this means that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my expressed written consent.
2. I understand that the limits of confidentiality that apply to treatment also apply to telehealth; these include a mandated reporting of child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that telehealth may involve electronic communication of my protected health information (PHI) to other medical practitioners who may be located in other areas
5. I understand that it is my duty to inform my treatment provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that security protocols can fail, meaning privacy and confidentiality of protected health information cannot be guaranteed with use of telehealth
7. I understand that in rare cases, information transmitted may not be sufficient to allow for appropriate medical decisions (e.g., poor resolution or sound quality)
8. I understand that delays of treatment may occur due to deficiencies of equipment
9. I understand that if my provider deems the service he/she is providing to be inappropriate through telehealth, he/she may require the remained of said services to be carried out in-person
10. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Consumer Consent to the Use of Telehealth:

By signing this form, I am acknowledging that I have been made aware of the above information regarding telehealth and have reached out to Saginaw Psychological Services, Inc. to answer any questions or concerns I have. I hereby give my informed consent for the use of telehealth with Saginaw Psychological Services.

My signature below shows that I understand and agree with all of these statements.

Client/Parent/Guardian Signature

Date

Printed name

Relationship to client

Signature of provider

Date

Copy accepted by client Copy declined by client Copy kept by therapist

Please mail this completed form to the location where you receive services at:

Saginaw Psychological Services, Inc.

Saginaw	Bay City	Midland
2100 Hemmeter Road	615 S. Euclid	1000 N. Johnson
Saginaw, MI 48603	Bay City, MI 48706	5914 Eastman Ave
Phone (989) 799-2100	Phone (989) 439-1513	Midland, MI 48640
Fax: (989) 79902637	Fax (989) 439-1512	Phone (989)799-2100
		Fax (989)799-2637