

# Notice of Privacy Practices Acknowledgement And Receipt of Client Orientation

Client Information:		
Last Name:	First Name:	
Today's Date:	Date of Birth:	
Primary Care Printed Name		
Primary Care Address		
Primary Care Telephone Number		
Primary Care Fax Number		

I understand that, under the Health Insurance Portability Act of 1998 (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 SPSI's Notice of Privacy Practices, which provide a more complete description of the uses and disclosures of my health information. I understand that SPSI has the right to change its Notice of Privacy Practices from time to time and that I may contact SPSI at any time to obtain a current copy of the Notice of Privacy Practices.

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

Signatures Attesting to My Request for Coordination of Care:			
Client/Guardian Signature	Date		
Witness Signature	Date		



# Consent to Financial Responsibility and Service Agreement

Client Information:		
Last Name:	First Name:	
Today's Date:	Date of Birth:	

**Financial Policy:** All insurance policies, third party insurance administrator and court order payment documents are contracts and / or orders between you and the party listed on those documents. SPSI will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, co-insurance, covered charges, secondary insurances, usual and customary charges etc. other than to supply information as necessary. You are ultimately responsible for the timely payment of your account. Timely payment is within 30 days of the service rendered date.

**Authorization to Bill Insurance:** I hereby certify and attest that I have sought evaluation, treatment, or medical advice from SPSI. I authorize the medical staff, clinical provider and administrative personnel to release my, or my minor child's medical information to the insurance company(ies) named below for the purpose of determining and receiving benefits for medical billings.

I understand and acknowledge that the SPSI medical provider, clinical provider and/or administrative staff will submit my claim to the insurance company(ies) named below. I further understand that I will be held responsible for any amount of my medical bill that is not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, copayments, coinsurance, and uncovered charges I incur through using services at SPSI.

**Insurance Waivers:** I understand that insurance payers may waive copay or coinsurance from time to time. I further understand that SPSI will consider these waivers as part of the ongoing calculation of the client balance due to SPSI. SPSI will update the SPSI billing system when the insurance payer sends payment to SPSI.

**Health Savings Accounts (HSA) & Employee Assistance Programs (EAP):** I understand that if I have a third-party payer such as an HSA or EAP it will be reviewed by SPSI for consideration as a claim's payer, but there is no guarantee it can be approved for use as a SPSI claims payer. I understand that SPSI can take credit card payments which are linked to my HSA credit account. I understand that SPSI will not bill HSA third party administrators, unless I have received confirmation from SPSI directly. Lastly, I understand that I am responsible to work with my respective HSA, or EAP payer as necessary.

**Adult Children on their Parent(s)/Guardian Insurance Plans:** I understand that I am responsible for my insurance deductibles, fees, copayments, coinsurances, and uncovered charges incurred while using services at SPSI. I understand that I cannot assign my financial responsibility to my parent or guardian without their written consent.

### Insurance One:

Name of Insurance as Written on Insurance Card	Insured ID on Card	
Insured Group Number on Card	Provider Contact Telephone Number on Card	
Subscriber Name	Subscriber DOB	
Subscriber Relation to You	Subscriber Sex	



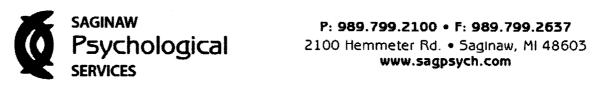
Name of Insurance as Written on Insurance Card	Insured ID on Card
Insured Group Number on Card	Provider Contact Telephone Number on Card
Subscriber Name	Subscriber DOB
Subscriber Relation to You	Subscriber Sex
at the address I have provided. If I do not receiv	that are not covered by insurance will be billed to me re a bill, I understand I may request one by contacting rm SPSI when my address changes or my insurance

legal claim against me for non-payment.

Signatures Attesting to My Financial Responsibility & Service Agreement:

Client/Guardian Signature	Date
Witness Signature	Date

policy changes. Non-compliance or defaulting on payments may result in denial of service and/or



Consent to	Treatment
Client Information.	
Client Information:  Last Name: Fi	rot Nama
	rst Name:
Today's Date: Da	ate of Birth:
The following is to be read, completed and parent/guardian. If guardian, please provid copy, copy) for our records, legally stating	de a copy of the court paperwork (true
I agree to attend psychotherapy and/or cas group as determined with a therapist or ex- which includes the SPSI Code of Ethics an answered satisfactorily.	aminer. I have the Client Handbook,
The following pertains only to client seekin and understand the "know your rights" boo questions I may have had, have been answ	klet for substance abuse clients. Any
Signatures Attesting to Consent to Provide	Treatment:
Client/Guardian Signature	Date
Witness Signature	Date
The following pertains only to:  • Community Mental Health Clients  • Includes but not limited to: So  • Medicaid Clients	CCMHA; BABHA; MSHN, TBHS
I have received a copy of the following sup Question which arose were answered satis  Notice of Privacy Practice - containing  Community Mental Health specific by Includes but not limited to: So	sfactorily.  ng "Your Rights" booklet information.  prochures and handbooks  CCMHA; BABHA; MSHN, TBHS
Signatures Attesting to Receipt of the Above	ve Documents:
Client/Guardian Signature	Date
Witness Signature	Date



Consent to Discharge Agreement		
Client Information:		
Last Name:	First Name:	
Today's Date:	Date of Birth:	
<b>Discharge Policy:</b> Up or participation in se involuntary discharge	nder certain circumstances, clients may be discharged for cause from treatment rvices at Saginaw Psychological Services Inc. Conditions that may precipitate e are as follows:	
<ul> <li>Threats of v</li> <li>Failure to m</li> <li>Failure to re</li> <li>Failure to w</li> <li>Failure to ac</li> <li>Fina</li> <li>Coo</li> </ul>	nce against either staff or other clients of the agency. iolence against either staff or other clients of the agency. aintain scheduled appointments. main in regular contact with SPSI for more than thirty (30) days. ork toward treatment plan objectives. Ihere to these SPSI agreements and policies ancial Responsibility ordination of Care shealth Services	
Client discharge dec	isions are made by the SPSI clinical program director in consultation with your	

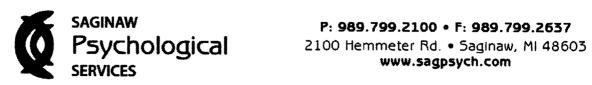
Client discharge decisions are made by the SPSI clinical program director in consultation with your primary clinician. Acts or threats of violence may result in immediate discharge by the clinical staff present at the time of such act.

I understand that in the instance of involuntary discharge, I have the right to appeal the discharge to the clinical program director and recipient rights personnel.

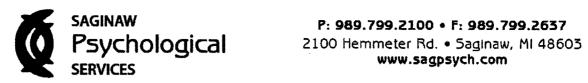
If I am being considered for involuntary discharge, I will be notified of this in writing. In cases of acts or threats of violence, written discharge is not provided, rather a verbal discharge at the time of the incident is provided.

I have reviewed and understand the criteria for discharge described above.

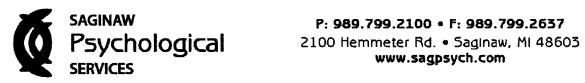
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Client/Guardian Signature	Date
	-
Vitness Signature	Date



Consent to Coordination of Care		
Client Information:		
Last Name:	First Name:	
Today's Date:	Date of Birth:	
Primary Care Printed Name		
Primary Care Address		
Primary Care Telephone Number	r	
Primary Care Fax Number		
(identified and named above) to enhealth/substance abuse treatment purposes as may be necessary for coverage. The information exchanges are or substance abuse care and such as diagnosis and treatment regarding the presence or absence shall remain in effect for one year course of this treatment, whichever authorization at any time by written responsibility to notify this provides	realth care provider and my primary care physician exchange information regarding my mental and medical health care for coordination of care or the administration and provision of my healthcare inged may include information on mental health d/or treatment (as protected under 42 CFR Part) plan and medical information, including information of From the date of my signature below, or for the ear is longer. I understand that I may revoke this en notice to SPSI. I further understand that it is my ear if I choose to change my primary care physician.	
1.		
2.		
3.		
Signatures Attesting to My Reque	st for Coordination of Care:	
Client/Guardian Signature	Date	
Witness Signature	Date	



authorize SPSI to release and/or obtain medical a ecords as specified below and to provide access to equested of the person or organization and to the conditions listed below.  authorize SPSI to provide information to the follow Printed Name Address Telephone Number Fax Number Covering Date of Service Range  Place a "x" next to information to provide:  Psychological Evaluation Treatment	to or provide such ph extent and nature lis	hotocopies as may be sted below, subject to the
Last Name: Da  Today's Date: Da  authorize SPSI to release and/or obtain medical a ecords as specified below and to provide access to equested of the person or organization and to the conditions listed below.  authorize SPSI to provide information to the follow  Printed Name  Address  Telephone Number  Fax Number  Covering Date of Service Range  Place a "x" next to information to provide:  Psychological Evaluation Treatment	ate of Birth: and/or mental health to or provide such ph extent and nature lis	hotocopies as may be sted below, subject to the
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Printed Name Address Telephone Number Fax Number Covering Date of Service Range  Place a "x" next to information to provide: Psychological Evaluation Treatment	wing i Grading	an izzauch ((3)
Address Telephone Number Fax Number Covering Date of Service Range  Place a "x" next to information to provide: Psychological Evaluation Treatment		
Telephone Number  Fax Number  Covering Date of Service Range  Place a "x" next to information to provide:  Psychological Evaluation Treatment		
Fax Number Covering Date of Service Range  Place a "x" next to information to provide:  Psychological Evaluation Treatment		
Covering Date of Service Range  Place a "x" next to information to provide:  Psychological Evaluation Treatment	1 2 2 2 2 2	
Place a "x" next to information to provide:    Psychological Evaluation   Treatment		
Psychological Evaluation Treatment		W-12-
Psychological Evaluation Treatment		
	Summary	Medication Review(s)
Psychiatric Evaluation Discharge		
	Discharge Summary Discharge Instruct Clinical Psychotherapy Note(s)	
Other (specify)	yonounciapy motors	
Place a "x" next to purpose of disclosure:		Hard Copy
	Rehabilitation	Attorney Inquiry
Insurance Claim Social Sec		Disability Certification
Continuation of Care Consultation		Insurance Application
Social Service Worker's C	Comp	<u> </u>
Other (specify)		
Place a "x" to authorize disclosure of records/info		. ما دم.
HIV/AIDS Substance		u to.
TilV/AiD3   Substance	Abuse	
authorize SPSI to obtain information from the folk	owing Person(s)/Org	ganization(s)
Printed Name		
Address		
Telephone Number Fax Number	<del></del>	
Covering Date of Service Range		
COVERING Date of Service Paricie		
Place a "x" next to information to provide:	Summon	Modication Devisors/a
Place a "x" next to information to provide:  Psychological Evaluation Treatment		Medication Review(s)
Place a "x" next to information to provide:  Psychological Evaluation Treatment Psychiatric Evaluation Discharge		Discharge Instructions



I authorize SPSI to obtain informa	tion from the fo	illowing Person(s)/Orga	nization(s) <i>Continued</i>
Identified information should be	disclosed:	Verbally	Hard Copy
Place a "x" next to purpose of dis	sclosure:		
Employer Request		Vocational Rehabilitation Attorney Inquiry	
Insurance Claim	Social So	Social Security Disability Certification	
Continuation of Care	Consulta	Consultation Insurance Application	
Social Service	Worker's	Worker's Comp	
Other (specify)	• • • • • • • • • • • • • • • • • • • •		
Place a "x" to authorize disclosur	re of records/in	formation/notes related	to:
HIV/AIDS		ce Abuse	
regulations. I understand that the recipient of the information and will understand that I may refuse to sability to obtain treatment, payment understand that I may inspect or I understand this authorization will signature. I further understand that time by notifying Saginaw Psycholinformation would be subject to m	sign this authorint, or my eligibition copy any informal expire upon teat, per the Privalogical Service any revocation resignation.	protected by the Privac ization, and that my refulity for benefits. mation released under the ermination of services, of acy Notice, I may revokes, Inc in writing, but that equest.	y Rules.  usal to sign will not affect my  this authorization.  or one year from the date of e this authorization at any t previously disclosed
Client/Guardian Signature			Date
With and Cinner and			Dete
Witness Signature			Date



Witness Signature

P: 989.799.2100 • F: 989.799.2637 2100 Hemmeter Rd. • Saginaw, MI 48603 www.sagpsych.com

Date

## Consent to Telehealth Services

Telehealth involves the use of electronic communication to enable health care and mental health

	ers at locations different from their consumers to en il information for the purpose of maintaining and im	
for diag	pnosis, therapy, follow up and/or education. While o	our best efforts are made to safeguard
privacy	and confidentiality, there is inherent risk in this mo	daiity.
	nformation	
Last N		
	r's Date: Date of Bi	
underst	oviding my consent to engage in telehealth with SP tand that telehealth psychotherapy may include: me	ental health evaluation, assessment,
consulta audio, v	ation, treatment planning and therapy. Telehealth video and telephone.	will occur primarily through interactive
By signi	ing this form, I understand and consent to the follow	wing:
1.	I understand that the laws that protect privacy and also apply to telehealth; this means that no information identifies me will be disclosed to researchers or ot consent.	the confidentiality of medical information ation obtained in the use of telehealth which her entities without my expressed written
2.	I understand that the limits of confidentiality that at these include a mandated reporting of child and vu harm to oneself or others, or as a part of legal prova a court of law.	ulnerable adult abuse, expressed imminent
3.	I understand that I have the right to withhold or wit in the course of my care at any time without affecti	hdraw my consent to the use of telehealth
4.	I understand that telehealth may involve electronic information (PHI) to other medical practitioners when the state of the	communication of my protected health
5.	I understand that it is my duty to inform my treatmeregarding my care that I may have with other healt	ent provider of electronic interactions
6.	I understand that security protocols can fail. Mean health information cannot be guaranteed with the	ing privacy and confidentiality of protected
7.	I understand that in rare cases, information transmappropriate medical decisions (e.g., poor resolutio	nitted may be insufficient to allow for
8.	I understand that delays of treatment may occur de	ue to deficiencies of equipment.
	I understand that if my provider deems the service through telehealth, he/she may require the remain	, he/she is providing to be inappropriate der of said services to be carried out in
	person.	
10.	I understand that I may expect the anticipated ben but that no results can be guaranteed or assured.	efits from the use of telehealth in my care,
11.	I acknowledge that I have been made aware of the	above information regarding telehealth
	and have reached out to SPSI to answer any ques informed consent for the use of telehealth with SPSI.	tions or concerns I have. I hereby give my
Signatu	ires Attesting to My Informed Telehealth Consent fo	or Services:
Client/6	Guardian Signature	Date
		Date