SAGINAW
Psychological
SERVICES

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

# Notice of Privacy Practices Acknowledgement And Receipt of Client Orientation

**Client Information:**

| | |
|---|---|
| Last Name: | First Name: |
| Today's Date: | Date of Birth: |
| Current Address: | |
| Current Phone Number: | |
| Additional Phone Numbers: | |
| Current Email Address: | |

I understand that, under the Health Insurance Portability Act of 1998 (HIPAA) 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 Notice of Privacy Practices Acknowledgement:**

| | |
|---|---|
| Client/Guardian Signature | Date |
| Witness Signature | Date |

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## 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 |

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**Insurance Two:**

| | |
|---|---|
| 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 |

I understand that any portion of my medical bills that are not covered by insurance will be billed to me at the address I have provided. If I do not receive a bill, I understand I may request one by contacting SPSI. I understand it is my responsibility to inform SPSI when my address changes or my insurance policy changes. Non-compliance or defaulting on payments may result in denial of service and/or legal claim against me for non-payment.

**Signatures Attesting to My Financial Responsibility & Service Agreement:**

| | |
|---|---|
| Client/Guardian Signature | Date |
| Witness Signature | Date |

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## Consent to Release Medical Records Information

**Client Information:**

| | |
|---|---|
| Last Name: | First Name: |
| Today's Date: | Date of Birth: |

I authorize SPSI to release and/or obtain medical and/or mental health information contained in my records as specified below and to provide access to or provide such photocopies as may be requested of the person or organization and to the extent and nature listed below, subject to the conditions listed below.

**I authorize SPSI to provide information to the following Person(s)/Organization(s)**

| |
|---|
| Printed Name |
| Address |
| Telephone Number |
| Fax Number |
| Covering Date of Service Range |

Place a "x" next to information to provide:

| | | | | | |
|---|---|---|---|---|---|
| | Psychological Evaluation | | Treatment Summary | | Medication Review(s) |
| | Psychiatric Evaluation | | Discharge Summary | | Discharge Instructions |
| | Lab Work Results | | Clinical Psychotherapy Note(s) | | |
| | Other (specify) | | | | |

Identified information should be disclosed:

| | | | |
|---|---|---|---|
| | Verbally | | Hard Copy |

Place a "x" next to purpose of disclosure:

| | | | | | |
|---|---|---|---|---|---|
| | Employer Request | | Vocational Rehabilitation | | Attorney Inquiry |
| | Insurance Claim | | Social Security | | Disability Certification |
| | Continuation of Care | | Consultation | | Insurance Application |
| | Social Service | | Worker's Comp | | |
| | Other (specify) | | | | |

Place a "x" to authorize disclosure of records/information/notes related to:

| | | | |
|---|---|---|---|
| | HIV/AIDS | | Substance Abuse |

**I authorize SPSI to obtain information from the following Person(s)/Organization(s)**

| |
|---|
| Printed Name |
| Address |
| Telephone Number |
| Fax Number |
| Covering Date of Service Range |

Place a "x" next to information to provide:

| | | | | | |
|---|---|---|---|---|---|
| | Psychological Evaluation | | Treatment Summary | | Medication Review(s) |
| | Psychiatric Evaluation | | Discharge Summary | | Discharge Instructions |
| | Lab Work Results | | Clinical Psychotherapy Note(s) | | |
| | Other (specify) | | | | |

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**I authorize SPSI to obtain information from the following Person(s)/Organization(s)** ***Continued***

| Identified information should be disclosed: | | Verbally | | Hard Copy |
|---|---|---|---|---|

Place a "x" next to purpose of disclosure:

| | | | | | |
|---|---|---|---|---|---|
| | Employer Request | | Vocational Rehabilitation | | Attorney Inquiry |
| | Insurance Claim | | Social Security | | Disability Certification |
| | Continuation of Care | | Consultation | | Insurance Application |
| | Social Service | | Worker's Comp | | |
| | Other (specify) | | | | |

Place a "x" to authorize disclosure of records/information/notes related to:

| | | | |
|---|---|---|---|
| | HIV/AIDS | | Substance Abuse |

I understand that my records are protected by Federal and State Confidentiality Laws, and cannot be further disclosed without my written authorization, unless release is required by other State or Federal regulations. I understand that there is a possibility the information may be re-disclosed by the recipient of the information and will no longer be protected by the Privacy Rules.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I understand that I may inspect or copy any information released under this authorization.

I understand this authorization will expire upon termination of services, or one year from the date of signature. I further understand that, per the Privacy Notice, I may revoke this authorization at any time by notifying Saginaw Psychological Services, Inc in writing, but that previously disclosed information would be subject to may revocation request.

**Signatures Attesting to My Consent to Release of Information:**

Client/Guardian Signature Date

Witness Signature Date

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# Consent to Treatment

**Client Information:**

| | |
|---|---|
| Last Name: | First Name: |
| Today's Date: | Date of Birth: |

The following is to be read, completed and signed by the client or the client's parent/guardian. If guardian, please provide a copy of the court paperwork (true copy, copy) for our records, legally stating guardian award.

I agree to attend psychotherapy and/or case management on an individual, family or group as determined with a therapist or examiner. I have the Client Handbook, which includes the SPSI Code of Ethics and my Rights. Questions which arose were answered satisfactorily.

The following pertains only to client seeking SPSI services. 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.

**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: SCCMHA; BABHA; MSHN, TBHS
- Medicaid Clients

I have received a copy of the following supplemental booklets and/or pamphlets. Question which arose were answered satisfactorily.

- Notice of Privacy Practice - containing "Your Rights" booklet information.
- Community Mental Health specific brochures and handbooks
  - Includes but not limited to: SCCMHA; BABHA; MSHN, TBHS
- Person Centered planning brochure

**Signatures Attesting to Receipt of the Above Documents:**

| | |
|---|---|
| Client/Guardian Signature | Date |
| Witness Signature | Date |

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## Consent to TeleMedicine Services

TeleMedicine 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 may be used for diagnosis, therapy, follow up and/or education. While our best efforts are made to safeguard privacy and confidentiality, there is inherent risk in this modality.

**Client Information**

| | |
|---|---|
| Last Name: | First Name: |
| Today's Date: | Date of Birth: |

I am providing my consent to engage in TeleMedicine with SPSI as a part of psychological services. I understand that TeleMedicine psychotherapy may include: mental health evaluation, assessment, consultation, treatment planning and therapy. TeleMedicine will occur primarily through interactive audio, video and telephone.

By signing this form, I understand and consent to the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to TeleMedicine; this means that no information obtained in the use of TeleMedicine 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 TeleMedicine; 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 TeleMedicine in the course of my care at any time without affecting my right to future care or treatment.
4. I understand that TeleMedicine 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 the use of TeleMedicine.
7. I understand that in rare cases, information transmitted may be insufficient 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 TeleMedicine, he/she may require the remainder of said services to be carried out in person.
10. I understand that I may expect the anticipated benefits from the use of TeleMedicine in my care, but that no results can be guaranteed or assured.
11. I acknowledge that I have been made aware of the above information regarding TeleMedicine and have reached out to SPSI to answer any questions or concerns I have. I hereby give my informed consent for the use of TeleMedicine with SPSI.

**Signatures Attesting to My Informed TeleMedicine Consent for Services:**

| | |
|---|---|
| Client/Guardian Signature | Date |
| Witness Signature | Date |

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## Consent to Discharge Agreement

**Client Information:**

| | |
|---|---|
| Last Name: | First Name: |
| Today's Date: | Date of Birth: |

**Discharge Policy:** Under certain circumstances, clients may be discharged for cause from treatment or participation in services at Saginaw Psychological Services Inc. Conditions that may precipitate involuntary discharge are as follows:

- Acts of violence against either staff or other clients of the agency.
- Threats of violence against either staff or other clients of the agency.
- Failure to maintain scheduled appointments.
- Failure to remain in regular contact with SPSI for more than thirty (30) days.
- Failure to work toward treatment plan objectives.
- Failure to adhere to these SPSI agreements and policies
    - Financial Responsibility
    - Coordination of Care
    - TeleMedicine Services

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.

**Signatures Attesting to My Agreement:**

| | |
|---|---|
| Client/Guardian Signature | Date |
| Witness Signature | Date |

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# 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

Primary Care Fax Number

I O do / O do not authorize SPSI, my behavioral health care provider and my primary care physician (identified and named above) to exchange information regarding my mental health/substance abuse treatment, medical health, psychiatric and therapy records for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care, psychiatric care or substance abuse care and/or treatment (as protected under 42 CFR Part) 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 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 SPSI. 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:_____

---

Behavior Health Provider Information (to be completed by provider)

Treating Provider:_____ Address: Saginaw Psychological Services Inc.
2100 Hemmeter Rd. Saginaw, MI 48603

DSM V Diagnosis Code and Name: _____

Treatment Modalities:
Psychotherapy-O Individual O Group O Family Frequency of Visits:_____

Notes:_____

Medication Management By:_____
(Physician's name, phone, fax number)

Medications prescribed for behavioral health

Date:_____ Medication:_____ Dosage:_____ Discontinued Date:_____
Date:_____ Medication:_____ Dosage:_____ Discontinued Date:_____
Date:_____ Medication:_____ Dosage:_____ Discontinued Date:_____

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

Sent_____ Sent by:_____ Method: O Fax O Mailed

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2100 Hemmeter Road
Saginaw, MI 48603

615 S Euclid
Bay City, MI 48706

1000 N Johnson
Bay City, MI 48708

5912/5914 Eastman Avenue
Midland, MI 48640

**Date: _____ Staff who filled this out with client:_____**

**Initial in each section**

| Yes | No | N/A Telehealth | Client Orientation Checklist |
|---|---|---|---|
| | | | Staff introduced |
| | | | Arrival/departure procedure & hours of operation as well as after hour services |
| | | | Security procedures including evacuation plan |
| | | | Weapons & illegal drugs prohibited in facility |
| | | | Potential substance of misuse including medication brought onsite |
| | | | Cell phone use in facility limitations reviewed |
| | | | Locations of Restroom, exits, smoking area, first aid, fire alarm/extinguishers, and suggestion boxes |
| | | | Parking or Transportation options reviewed |
| | | | Consents you signed included, rights and responsibilities, complaint and appeals procedure, confidentiality policies, intent/consent to treat, discharge criteria, handbook (available on website and paper copy), standards of professional conduct and financial responsibilities |
| | | | Ways in which input can be given |
| | | | Behavioral expectations and consequences and how to regain privileges from consequences |
| | | | Transition criteria and procedures |
| | | | Response to identification of potential risk |
| | | | Requirements for reporting and follow-up for the mandated treatment, regardless of discharge outcome |
| | | | SPSI is a non-seclusion or restraint facility |
| | | | Education was done on advance directives, assessment process, person-centered plan development including goals, course of treatment and expectations regarding appointments and family involvement |
| | | | Identification of the person(s) responsible for service coordination |
| | | | Applicable rules or restriction based on program |

_____ _____

**Print Client/Guardian Name** **Signature of Client/Guardian**