SAGINAW Psychological SERVICES

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

Welcome to Saginaw Psychological Services Inc. (SPSI)

Client Information:

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

Thank you for choosing SPSI. We are a member of the Bay-Arenac Behavioral Health Authority (BABHA), Saginaw Community Mental Health Authority (SCCMHA) Provider Network, as well as many other contract providers. Our purpose is to provide the highest quality behavioral health and substance use treatment in a safe and positive environment. All persons served and visitors are asked to refrain from using vulgar language in common areas of the building and are expected to treat SPSI staff and other persons in the building with respect.

Here are some facts and expectations regarding your services

- You will meet with a therapist, psychologist, or case manager and will receive a comprehensive assessment to understand your needs and help us determine which of our programs is the right program for you.
- Your worker may make a referral to either our medical provider for a psychiatric evaluation and medication management services or BABHA/SCCMHA, if that is appropriate.
- Your worker will help you develop a person-centered plan, which is based upon your needs. A person-centered plan must be completed for you to receive services, including medication management.

We look forward to your full cooperation in services. Failure to participate in the program may result in your services ending, including medication services. You will be notified in advance if you are at risk of services ending. If your services end because of lack of participation, there is a grievance and appeals process available through the BABHA/SCCMHA customer service department.

If you are involved in medication management services and you have fully participated in your program, and you are 18 years old or older, you may be able to graduate to the medication only service with your assigned medication provider. This will occur only if your assigned SPSI worker recommends this and the treating medical provider gives their approval. In order to fully comply with this program standard, you would still need to sign appropriate consents once a year. SPSI reserves the right to take you out of this program and switch you into traditional services at any time the prescriber deems necessary. Examples of such circumstances could include psychiatric hospitalization SUD rehabilitation, overall functioning decreases and/or other situations that indicate necessity for a higher level of care.

- All legally prescribed medications brought into our facility must be in their original containers with the original labels attached.
- Any person entering the building possessing a weapon and/or illegal drugs, or behaving in a threatening manner will be asked to leave and may return when he/she no longer has a weapon, has illegal drugs on his/her person, and/or can demonstrate they have regained control of their behavior enough to attend a meeting. If at any time a person is, or becomes, a threat to himself/herself and/or to others, local authorities will be contacted for immediate assistance.

In the event of an emergency, it is the responsibility of SPSI staff to ensure the safety of all persons served and visitors. Your worker is familiar with the building, including the location of emergency exits and first aid kits. In the event of an emergency, you will be directed and escorted to the appropriate safe area. If physical emergency care is necessary, arrangements for treatment will be made.
Thank you for choosing SPSI to address your recovery needs. Your cooperation with our program rules and expectation is greatly appreciated. We look forward to assisting you with your goals. Feel free to discuss any questions or concerns with your worker or their supervisor.

Signatures Attesting to Responsibility & Service Agreement:

Client/Guardian Signature	Date
Witness Signature	Date

SAGINAW Psychological SERVICES

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

Consent to Financial Responsibility and Service Agreement

Client Information:

Last Name:	First Name:
Today's Date:	Email Address:

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 paying all co-payment, co-insurance, deductibles, and non-covered services at the time of the services and not to extend beyond **30 days** of the date of service.
- Failure to pay your portion of services rendered will be reported to your insurance carrier and/or a collection agency.
- The fees listed below must be paid at the time of service:
    - Forms Completion: Disability, insurance, travel, release from work, that are not required by most insurance plans or employers.
        - If you require a member of your care team to complete one of these forms or write a letter, there will be a **$25** charge in addition to your office visit charge.
    - Medical Records: We will provide to you, upon written request, a copy of your medical records.
        - We charge a base fee of **$31.54** as well **$1.58** for the first 20 pages**, $0.79** per pages 21-50 and **$0.32** per pages 51+
    - There is a **$40** fee if your appointment is not canceled within 24 hours prior to the appointment.
    - Late fees: balances not paid within 60 days will result in a **$10** late fee per month.

Assignment of Benefits-Financial Agreement:
I hereby give lifetime authorization for the payment of insurance benefits to be made directly to Saginaw Psychological Services Inc. (SPSI) for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

Insurance Status Agreement
I hereby further agree that at all times during my treatment at SPSI I will provide all updated insurance coverage information. I understand that if I fail to give SPSI information regarding other primary or secondary insurances I have that I will be fully financially responsible for all monies SPSI is unable to collect from Medicaid, Medicare and/or BABHA/SCCMHA directly.

Primary Insurance Company: Name of Insurance Company _____
Subscriber ID# _____ Group # _____
Policyholder Full Name: _____ Date of Birth: _____
Relationship to You: Self Spouse Child Other: _____
Secondary Insurance Company: Name of Insurance Company _____
Subscriber ID # _____ Group # _____
Policyholder Full Name: _____ Date of Birth: _____
Relationship to You: Self Spouse Child Other: _____

I understand that any portion of my medical bills that are not covered by insurance will be billed to me at the email/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 email/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. I further agree that a photocopy of this agreement shall be as valid as the original.

Signatures Attesting to My Financial Responsibility & Service Agreement:

Client/Guardian Signature	Date
Witness Signature	Date

SAGINAW Psychological SERVICES

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

Consent to Treatment and Discharge

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 you are a guardian, please provide a copy of the court paperwork (true copy) for our records, legally stating guardianship award.

I agree to attend psychotherapy and/or case management on an individual, family or group basis, as determined with a therapist or examiner. I have read, reviewed, and understand information provided in the Client Handbook, which includes the SPSI Code of Ethics and my Rights. Any questions I may have had, have been answered satisfactorily.

Throughout the course of my/my family's treatment at SPSI I agree to abide by the following policies:

- I may not leave my minor children unattended in the waiting room.
- I may not leave the building while my child is in a session with their worker.
- I may not bring children into adult therapy sessions.
- I am responsible for making childcare arrangements in advance in order to avoid violating any of the above policies.

Regarding attendance, I understand and agree to the following (limited and reasonable exceptions can be made at the discretion of your worker or with supervisor approval):

- I am expected to cancel all appointments 24 hours in advance of my appointment.
- If I cancel three consecutive appointments my case may be closed.
- Failure to attend two consecutive appointments, without notice, may result in case closure.
- If I arrive 10 minutes late this will result in the appointment being considered a no show.
- Failure to have contact with the agency for 30 days may result in case closure.
- At no time will I be able to have prescriptions phoned in or written for me (or my children) without a face-to-face meeting with an SPSI prescriber. I understand any exceptions to this rule must come directly from my assigned prescriber.
- Failure to work toward person centered plan objectives may result in discharge
- I will be considered for immediate discharge if I engage in any acts or threats of violence or aggression toward staff or other person served.

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 officer.

The following pertains to both Community Mental Health and Medicaid Clients. I have received a copy of the following supplemental booklets and/or pamphlets.

- Notice of Privacy Practice – containing "Your Rights" booklet information
- Community Mental Health specific brochures and handbooks
- Person Centered Planning brochure

Signatures Attesting to Consent to Provide Treatment and Receipt of the Above Documents:

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date:_____

Reviewed & Updated January 2026

Saginaw Psychological Services
Controlled Substance Agreement

Client Name: _____ Date of Birth: _____

The purpose of this contract is to prevent misunderstandings about the medications you are prescribed by Saginaw Psychological Services, Inc.

You may be prescribed a controlled substance for the treatment of your psychiatric illness(es). It is important that you understand the risks and responsibilities that accompany this treatment. You are ultimately responsible for your physical and emotional health.

This agreement will help you and your prescriber to comply with the law(s) regarding controlled pharmaceuticals.

MAPS (Michigan Automated Prescription System) is a database operated by the State of Michigan that requires all pharmacies to report any controlled substances that they dispense to a patient. This report lists all controlled substances that you pick up from any pharmacy in Michigan and will be monitored to help ensure compliance with this contract.

- I agree not to sell, share or give any medications to another individual.
- I understand that any mishandling of my medications is a violation of this agreement and will result in treatment being terminated (this includes any attempt to alter a prescription).
- I understand that any medical treatment is initially a trial and that continued prescription is based on evidence of benefit. I understand that if my symptoms are not improved or my ability to function is not improved with the medication prescribed, it may be stopped or changed. I will work with my therapist and/or case manager and/or prescriber to maintain realistic expectations of what medication can do for my illness(es). I am agreeable to therapy as a treatment option and know I am responsible to make and keep scheduled appointments.
- I will not attempt to obtain any anti-anxiety medications, sleeping pills or stimulants from another prescriber.
- I will safeguard my medications from loss or theft. I understand that any lost, stolen, or destroyed prescriptions for controlled substances will **NOT** be replaced even with a police report. I will not call the office to report medication lost, stolen or destroyed in effort to obtain refills or additional prescriptions.
- I agree to submit to a urine drug screen if requested by my prescriber.
- I will not use recreational drugs, street drugs or alcohol.
- I understand that if I become pregnant I must notify my prescriber as soon as possible.
- I will report all medications that I am taking (including, but not limited to Methadone, Medical Marijuana, Suboxone and pain medication) to my Saginaw Psychological Services provider. I also agree to sign releases for my prescriber to communicate with all other healthcare providers that are prescribing medications(s) for me.
- I understand that running out of medication early, needing early refills, taking more than prescribed and losing prescriptions may be signs of misuse of the medications and may be reasons for my prescriber to discontinue the medications I have been prescribed.

If you have any questions regarding this information, please request clarification before signing.

Client/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Name: _____ ID # _____ Date: _____

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event?
Yes No

If no, screen total = 0. Please stop here.
If yes, please answer the questions below.

In the past month, have you …

1. had nightmares about the event(s) or thought about the event(s) when you did not want to? Yes No

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? Yes No

3. Been constantly on guard, watchful, or easily startled? Yes No

4. Felt numb or detached from people, activities, or your surroundings? Yes No

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? Yes No

PC-PTSD-5 (2015)

National Center for PTSD

*If this screen has any answers of "Yes" then fill out PCL-5

Transportation Informed Consent

Client Name: _____ **Case Number:** _____

Under certain circumstances a consumer of Saginaw Psychological Services, Inc (SPSI) may utilize transportation services. This may occur in an employee's personal vehicle or the company vehicle.

I understand that agreeing to and utilizing SPSI's transportation services means the following:

1. Other consumers may be present in the vehicle during the same trip.
2. Other consumers may see where you live and may witness other people who are present when you are picked up or dropped off. This information is generally considered Protected Health Care Information (PHI). SPSI will never reveal any PHI without your written consent.
3. By signing below, you acknowledge that this information may be revealed and consented to.
4. The main SPSI transporter is an integral part of the case management team and may have access to your PHI. Additionally, if the driver is your case manager, he/she would have access to your PHI. SPSI employees cannot discuss any aspect of your case in front of another consumer or any other individual without your expressed written consent. Therefore, please do not engage the driver in any discussions about your case. It is SPSI's policy that consumers are encouraged not to discuss any personal information about themselves or their treatment during transportation.
5. You are to immediately, or as soon as reasonable possible, inform the driver, your case manager, therapist, or administrator regarding any concerns you have about how transportation is being provided or any aspect of your transport.
6. You agree to: 1) act in a respectful manner to all passengers 2) stay seated 3) not distract the driver 4) adhere to all laws while in the vehicle and not engage in any illegal activities 5) no smoking of cigarettes/e-cigarettes while in the vehicle etc.
7. You acknowledge any illegal behavior during transport will be reported to the proper authorities.
8. If your child requires any special accommodations during transport such as a car seat/booster seat, you are responsible for providing that item at the time of transport, otherwise we will have to cancel the transportation.
9. We will never provide transportation to your child without your informed consent.

Client Signature_____ Date _____

Witness Signature _____ Date _____

SAGINAW
Psychological
SERVICES

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

HEALTH HISTORY FORM

SmartCare ID: _____ Date: _____

Legal name for insurance purposes: _____

Name (if different than legal): _____

Pronouns: _____

Gender Identity: _____

Sex Assigned at Birth: Male __ Female __ Intersex __

Significant relationship:

____ single
____ married
____ monogamous
____ polyamorous
____ life partnership

Family Doctor's name: _____ phone number: _____
Preferred pharmacy name: _____ phone number: _____
In case of emergency, please contact: _____ phone number: _____
Additional emergency contact: _____ phone number: _____

Who do you want to release information to: _____
Language(s) spoken at home: _____

Are you pregnant: Yes _____ No_____

Are you receiving prenatal care: Yes _____ No_____

Most recent hospitalization: _____ Why: _____

CURRENT MEDICATIONS	**HOW WELL DO THEY WORK ON A SCALE OF 0 TO 10 (0=did not work at all—10=worked very well)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICATIONS	**HOW WELL DID THEY WORK ON A SCALE OF 0 TO 10 (0=did not work at all—10=worked very well)**
_____	_____
_____	_____
_____	_____

Reviewed & Updated January 2026

SAGINAW
Psychological
SERVICES

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

Do you have any allergies or adverse reactions to medications? If yes, please list the medication and the reaction below:

_____ _____
_____ _____
_____ _____
_____ _____

Do you use any substances? Yes __ No__

If Yes, What? _____

Do you have any current or past health conditions? Yes __ No___

If Yes, What? _____

_____

Any surgical procedures: Yes__ No ___

If Yes, What? _____

Research has shown that, in many cases, complimentary approaches to mental health can help increase well-being, ease symptoms of depression, reduce anxiety, and/or aid relaxation. Do you use any of the following to help manage your symptoms?

Meditation: Yes_____ No_____ Art Therapy: Yes ____ No_____

Yoga: Yes_____ No_____ Dance: Yes_____ No_____

Acupuncture: Yes_____ No_____ Tai Chi: Yes_____ No_____

Massage therapy: Yes _____ No_____

Spirituality: Yes ____ No _____

Other: _____

We at SPSI want to make sure that all the information we share with you and present to you is clear and understandable. For this purpose, it is important for us to know if you are able to read all your paperwork, or if you need support in this area. What is your best estimate of your reading grade level?

_____ grade level

_____
Client signature

_____
Witness Signature

SAGINAW Psychological SERVICES

BABH Recovery Assessment Scale

Name: _____ **Case #:** _____ **Date:** _____

○ Initial ○ Periodic Review ○ Annual ○ Discharge ○ Decline

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I have a desire to succeed					
I have my own plan for how to stay or become well.					
I have goals in life that I want to reach					
I believe I can meet my current personal goals.					
I have a purpose in life.					
Even when I don't care about myself, other people do.					
I can handle what happens in my life.					
I like myself.					
If people really knew me, they would like me.					
Something good will eventually happen.					
	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I'm hopeful about my future.					
Coping with my mental illness is no longer the main focus of my life.					
My symptoms interfere less and less with my life.					
My symptoms seem to be a problem for shorter periods of time each time they occur.					
I know when to ask for help.					
I am willing to ask for help.					
I ask for help, when I need it.					
I have people I can count on.					
Even when I don't believe in myself, other people do.					
It is important to have a variety of friends.					