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

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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 and Accountability Act of 1996 (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 my treatment directly and/or 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 provides 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 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

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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)**
_____	_____
_____	_____
_____	_____

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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 COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

OFFICE USE ONLY

Return Application by: _____

Date Application Rec'd: _____

Received by Staff (initial): _____

Ability to Pay/Sliding Fee Scale Application

Consumer Information

Last Name, First Name, Middle Initial:			Case #:
Mailing/Street Address:	City:	State:	Zip Code:
Phone #:	DOB:	Number of people in your household, including yourself:	
If minor responsible party name: _____ DOB: _____ Phone #: _____			

Insurance Information (attach copy of Medicare and Commercial insurance card(s)–front/back)

Please list all current insurance policies, including Medicaid, Medicare, and Commercial Coverage.

Insurance Company Name	Contract/Policy #	Group #	Effective Date	Policy Holder Name/Date of Birth

If you have active Medicaid, your Ability to Pay/Sliding Fee Scale amount is $0 (zero), please skip the following household and income questions, and sign/date.

Household Information (uninsured/non-Medicaid only)

Please list all people in your household, related by blood, marriage, or adoption, and financially legally responsible for each other. Eligible household members will be included in your application.

Last Name	First Name	DOB	Relationship to Applicant

Consumer Name	Case #

Types of Income Received by Household (uninsured/non-Medicaid only)

Please place a check (√) in the columns below to indicate *all* sources of income:				
Source of Income	Applicant	Spouse/ Partner	Other	Amount of Annual Income * attach proof
Salary/Wages				
Self-Employment				
Unemployment				
Social Security/Disability				
Pension/Investment (i.e., 401K, IRA, etc.)				
Alimony/Other				

I hereby certify that the information provided on this application is accurate and I authorize Saginaw County Community Mental Health Authority to verify any of the information above.

(REQUIRED) Signature of Applicant,
Parent, and/or Legal Guardian:_____ Date:_____

RETURN COMPLETED APPLICATION, PROOF OF HOUSEHOLD INCOME (non-Medicaid)
and copy of insurance card(s) TO:
Saginaw County Community Mental Health
Entitlements Office
500 Hancock
Saginaw MI 48602

***********For Office Use Only***********

Action		**Notes**
Active Medicaid	Yes No If no, Date of Application:	If MA denied, reason:
Total Household Income (if non-MA)		
Total Number in Household (if non-MA)		
Sliding Fee Amount Per Visit/Day	**Start Date**	**End Date**
Verified by:	**Date:**	

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:

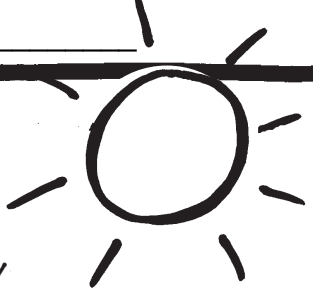
1. Other consumers may be present in the vehicle during the same trip.
2. Other consumers may see where you live and may witness other people who are present when you are picked up or dropped off. This information is generally considered Protected Health Care Information (PHI). SPSI will never reveal 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 _____

Reviewed & Updated January 2026

Date: _____ Name: _____



Good day

What does a good day look like?

Bad day

What does a bad day look like?

What will it take to have more good days and less bad days?

Signature: _____