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: O Single O Married O Widowed O Separated O 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:

O Cash O Check O Credit Card O 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:

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 O Individual, O Family, and/or O 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 heareby 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 O do / O 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, Inc. 2100 Hemmeter, Saginaw, MI 48603

Phone: (989) 799-2100 Fax: (989) 799-2637

DSM V Diagnosis Code and name: ____________________

Treatment Modalities:

Psychotherapy - O Individual O Group O Family Frequency of visits: ____________

O Inpatient O Partial Hospitalization Dates: ____________

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

O 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: O Fax O Mail

PLEASE RETAIN ORIGINAL FORM IN PATIENT'S RECORD

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

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS INFORMATION

Client Name (printed): ______________________ Date of Birth: ______________

Address: ______________________ Client ID#: ______________

______________________ Social Security #: ______________

I authorize Saginaw Psychological Services, Inc. (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 specified below:

1. I authorize SPSI to ***provide*** information to the following Person(s)/Organization(s), Please indicate name(s) and address(es) below:

   ____

   ____

2. I authorize SPSI to ***obtain*** information from the following Person(s)/Organization(s), Please indicate name(s) and address(es) below:

   ____

   ____

3. Specific type of information to be disclosed, covering dates from __________ to __________:
   O Psychological Evaluation O Treatment Summary O Discharge Summary O Discharge Instructions
   O Psychiatric Evaluation O Medication Review(s) O Lab Work O Other (specify below)

   ____

4. The identified information should be exchanged: O Verbally O Hard Copy

5. Purpose of disclosure:
   O Employer Request O Vocational Rehabilitation O Attorney Inquiry O Insurance Claim
   O Social Security O Disability Certification O Continuation of Care O Consultation
   O Insurance Application O Social Service O Worker's Comp O Other (specify below)

   ____

6. I authorize disclosure of records/information related to: Substance Abuse O Yes O No
   HIV/AIDS O Yes O No

7. 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 the possibility the information may be re-disclosed by the recipient of the information and will no longer be protected by the Privacy Rules.

8. 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.

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

10. 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 not be subject to my revocation request.

______________________________________ ______________________________________
Client or Guardian Signature Date Witness Signature Date

Notice: This disclosure represents a true and exact copy of original information. Any further release of this information is prohibited by law, and person(s) receiving this information are so advised. This release is in accordance with section 748 of Act 258, Public Acts 1974, as amended and is compliance with Title 42 CPR, Part II. This information is protected by the Mental Health Code 330.1748 and further disclosure is subject to the restrictions therein.

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

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	5914 Eastman Ave
Saginaw, MI 48603	Bay City, MI 48706	Bay City, MI 48708	Midland, MI 48640
Phone (989) 799-2100	Phone (989) 439-1513	Phone (989)895-8666	Phone (989)799-2100
Fax: (989) 79902637	Fax (989) 439-1512	Fax (989)778-3317	Fax (989)799-2637