



PsychSystems, P.C. (734) 729-PSYC (7792)

35640 Michigan Ave West
Wayne MI 48184

Fax (734) 729-7938
psychsystemsonline.com

PLEASE REVIEW THIS PACKET. PLEASE COMPLETE THE PATIENT HISTORY FORM (PAGES 8-11) AND BRING THE COMPLETED FORM TO YOUR FIRST APPOINTMENT. PLEASE SIGN AND RETURN THE LAST PAGE OF THIS PACKET WHEN YOU ARRIVE AT THE OFFICE FOR THE FIRST APPOINTMENT

Welcome to PsychSystems

Thank you for choosing PsychSystems P.C. as your behavioral health provider. We strive to do everything in our power to make your treatment experience as valuable for you while we help you achieve your personal goals.

You will see the attached HIPAA notice. This describes our privacy policies and how they effect you and your personal health information. Please take a moment to read this handout, but to summarize, your personal information is safe with us. We will not release any information about you unless we have your prior written permission. We also keep your chart and other records locked up or password protected so that no one can see them unless they have a need to know. If you have any questions, please ask your therapist.

We ask that you be on time for your appointments- our therapists usually have another person coming in right after your appointment. We pledge to be on time as well. If unforeseen circumstances occur, and you will need to be late or you need to reschedule, we ask for 24 hours notice. IN some cases, we may charge you for a missed appointment or one canceled with less than 24 hours notice. Please speak to your therapist about the way they will handle such cases.

As you probably expect, we cannot tolerate violence or anything that might promote violence, such as possession of weapons while on the premises. Such acts are cause for dismissal from the program. The attached Discharge Criteria form also details reasons that we may ask you to leave the program. If you have any concerns about your safety, please speak to your therapist or a program administrator.

Fees are determined by your insurance company, your MCPN agency or by a personal agreement between you and a program administrator. We have a fee scale that is used to help people who need services, but do not have sufficient income to pay our full fee. These fee agreements require that you pay your fee at the time of the appointment. We also ask that you pay your co-pay or deductible at the time of your appointment. We accept checks and we offer a PayPal option for those who would like to use a credit card. We also offer payment plans for people who may need such a service. Please contact a program administrator for more details.

We want your experience here to be a positive one. If you have a complaint or would like to see a different therapist, please contact either Gary Carone or Alison Donigan (734) 729-7792, 401 or 402) program administrators with your concern. We will do our best to resolve your complaint here at our program.. If you do not feel that your complaint has been resolved adequately, you may have additional rights. Members of the MCPN system in Wayne or Oakland counties, you can appeal through the agency in which you belong, or to the MCPN directly. If you are a WCHO member, you can file a complaint directly with the WCHO customer service department..

Thanks for choosing PsychSystems.

General Consent to Treatment

1. Release of Information

I authorize the Facility to release information from my medical record, including:

- Information about communicable diseases and serious communicable diseases and infections as defined by statute and Michigan Department of Public Health Rules, which include venereal disease “VD”, tuberculosis “TB”, human immunodeficiency virus “HIV”, acquired immunodeficiency syndromes “AIDS”, and AIDS related complex “ARC”.
- Substance abuse treatment information protected by 42 Code of Federal Regulations Part 2.
- psychological and social services information including communications made by me to a psychologist or social worker to
 - a. any third party payor or insurance company (including Medicare, Medicaid, maternal and infant health, Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, workers’ disability compensation insurers, health maintenance organizations, preferred provider organization, and managed care plans) which are responsible in whole or in part for paying my health care bill so that the Facility may be paid for its services;
 - b. any healthcare facility or physician to which I am referred or transferred for continuity of care~ and
 - c. any independent auditors or reviewers retained by the Facility, any third party payor, private health insurer or any employee providing health insurance benefits to me so that these independent auditors can analyze Facility utilization and/or charges.
 - d. my current potential employer, if the purpose of the medical examination and/or treatment arises from or pertains to my current or prospective employment, e.g., an employment physical or care and treatment arising from a workplace injury.

This release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. With respect to substance abuse information (if any), this consent may be revoked at any earlier time unless the Facility has already released information in reliance upon it.

2. No Guarantees or Assurances

This facility has made no guarantee or assurances about the results of my hospitalization or healthcare. I understand that a patient will receive the usual and ordinary care rendered in this community, and that no other contract, written or implied, is made.

** Facility: The term “Facility” is just a convenient description and does not suggest or create any relationships between the above listed entities.

Payment Provisions

Note: The term “health care benefits” in the following paragraphs mean Medicare, Medicaid, maternal and infant health, Blue/Cross Blue Shield, commercial health insurance benefits, automobile no-fault benefits, workers’ disability compensation benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

3. I understand that, except in limited circumstances, separate billings will be issued for services of the Facility and services of physicians, and that neither charges are included in the billings of the other.
4. I request payment on my behalf of all health care benefits for services provided by the Facility and by physicians for whom the Facility is authorized to bill.
5. I assign and transfer to the Facility all health care benefits applicable to my care, including those health care benefits listed on the first page of my medical record. I authorize and direct that all such health care benefits be

paid directly to the Facility.

6. I agree personally to pay for any Facility or physician charges not covered by or collected from any applicable health care benefits program, including any deductibles and coinsurance amounts.

Note: Please advise that the Facility may perform an HIV test upon a patient without any special written consent if a health professional, health facility employee, police officer, fire fighter, medical first responder, emergency medical technician, emergency medical technician specialist, or paramedic who sustains in the health facility, while treating the patient before transport to the health facility, or while transporting the patient to the health facility, a percutaneous, mucous membrane, or open wound exposure to the patient's blood or other bodily fluids or the HIV test is performed pursuant to a request under MCL 33.20191 (2).

Client Notice of Confidentiality

The confidentiality of mental health or alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a client attends the program, or disclose any information identifying a client as an alcohol, drug abuse, or mental health services recipient UNLESS:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audits, or program evaluation.

Violation of these Federal laws and regulations by any program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a client either at the program or against any person who works for the program or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspect child abuse or neglect from being reported under State law to appropriate State or local authorities.

Client Acknowledgement

By my signature, I confirm that I have been informed of program practices, policies, and procedures as listed below:

1. Program goals and objectives, hours of operation, and fees charged.
2. I have received a copy of my recipient rights and notice of confidentiality and I understand them. I understand I will participate in the development of my treatment plan. I have also received a copy of program policies which may restrict certain rights.
3. I have been informed of and have received a copy of program discharge policies.
4. At my request I have had an opportunity to review a listing of services which I may receive through referral to other agencies.
5. I understand that I must request any written progress reports at least one week in advance of when needed.
6. I understand that I am liable for payment of the fees for therapy/treatment, regardless of my insurance coverage. It is my responsibility to determine what portion of the fees are covered by my insurance, and the duration of the coverage of my insurance. I have received a copy of the fees for services schedule, or have been informed

of all outpatient rates.

7. I will be charged a “no show” fee for any appointments that are not kept or canceled at least 24 (twenty-four) hours prior to the appointment. Furthermore, I understand that third party insurance’s do not cover “no show” and “late cancellation” fees and I am fully responsible for these fees.

Discharge Policy

Discharge from Outpatient Mental Health, Chemical Dependency treatment may occur for any of the following reasons:

1. Completion of prescribed treatment and progress toward achievement of goals.
2. Inability to comply with the structure of the program including:
 - a. non-compliance with program rules.
 - b. habitual non-compliance with treatment plan
 - c. possession of alcohol or drugs
 - d. threat or action of physical violence
 - e. unauthorized weapons
 - f. inconsistent attendance as evidenced by:
 1. failure to show for four (4) scheduled appointments.
 2. canceling more than $\frac{1}{2}$ of the scheduled appointments in a six (6) week period.
3. No response to calls from the therapist or the office staff, or no response to correspondence from the office indicating our intent to close the case.

PsychSystems P.C.
35640 Michigan Ave. West
Wayne, MI 48184-0159

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

PLEASE REVIEW THIS INFORMATION CAREFULLY

NOTICE OF PRIVACY PRACTICES

As a provider of Mental Health services, PsychSystems is required to protect your privacy and provide you with this notice of the steps we take to assure that your personal health information is kept confidential.

This Notice describes your rights and our obligations regarding the use and disclosure of your health information. Over time we may revise this Notice however, if we do, we are required to inform you of our new privacy policy by making a revised Notice available to you. Copies of the Notice can be obtained in our office. All persons who receive services will be asked to sign or re-sign a "Consent for Treatment", which will serve as your acknowledgement of this Notice.

When you come to PSYCHSYSTEMS, a record of your treatment is started. This record contains "demographic information" (such as name, address, telephone number, social security number, birth date and health insurance information) as well as other information including why you have come to our program, how you say you feel, what health problems you have, treatments you may have received, observations by health care providers, diagnosis and plan of care. This information is known as Protected Health Information, or **PHI**, and is used for a number of purposes that are explained in more detail in this Notice. We do not sell your **PHI** and we take steps to protect your **PHI** from people who do not need or have the legal right to see it.

TREATMENT, PAYMENT AND OPERATIONS

We may use your **PHI** for treatment, payment purposes, or for agency operations making reasonable efforts to limit the use and disclosure of PHI to the minimum amount necessary to accomplish the intended purpose. This is covered when you sign the "Consent for Treatment" form at intake. All current service partners will sign a revised "Consent for Treatment" form upon receipt of this Notice. Your signed "Consent for Treatment" form will be your Authorization for the use and disclosure of your **PHI** for treatment, payment purposes, or for agency operations according to the following definitions.

Treatment: Your **PHI** will be used to provide, coordinate, or manage your care and related services. This includes the coordination or management of your treatment with another person like a doctor or therapist.

Payment: Your **PHI** will be used and disclosed to obtain payment for the services we have provided. This may include communications to your health insurer to obtain approval for treatment. or may include statistical reports to agencies making funds available to us for your benefit.

Operations: We may use your **PHI** within our agency in order to maintain or improve services. This can include quality assessment, accreditation, licensing or business management and general administrative activities.

Other uses and disclosures covered by your treatment, payment and operations Authorization include:

- Calls to remind you of an appointment and messages left on answering machines if you do not answer the telephone.
- To inform you of potential treatment options.
- To inform you of health benefits or services that may be of interest to you.

- To provide training to health professional students who are working in our agency.

Notice of Privacy Practices continued

- For research purposes if the study is approved by our Board of Directors and also meets the requirements of Federal and State law and regulation.
- To assist with or to avert a serious threat to the health and safety of you or the public.
- To report disease, injury, disability or death as required by law.
- To alert State or local authorities if we believe someone is a victim of child abuse, neglect or domestic violence.
- To alert authorities or medical personnel if we believe someone is at risk of injury by means of violence.
- To health oversight agencies for such purposes as audits, civil or administrative reviews, inspections and licensing activities.
- When required by federal, state or local law i.e. reporting laws, public health activities, national security, and intelligence activities.
- To a law enforcement official for law enforcement purposes such as responding to a court order, identifying a suspect or missing person, providing information about a crime victim or to report a criminal conduct.

At times, either PsychSystems or you may wish to use your **PHI** for a reason not identified above. In those cases, a special Authorization will be needed. If your **PHI** is requested for a use that requires a special Authorization, you will be told why your information is requested, who is asking for the information, and what information is requested. You will also be told how you may cancel your Authorization. If we have already acted on an Authorization you gave us earlier, your cancellation will affect information release for the future.

YOUR INFORMATION RIGHTS

In addition to the Authorizations already discussed, you have specific rights related to you Protected Health Information (**PHI**). These are:

- Right to Request Restriction of Uses and Disclosures: You may request limitations on the uses of your **PHI**. For example, you can ask that your information not be shared with certain family members. We are not always able to comply with these requests however, if we are unable or do not agree to your request, we will let you know. If we do agree to a restriction, and the restricted information is needed for your emergency care, we may still use or disclose the information as we think appropriate.
- Right to Request Alternate Methods of Communication: You may request an alternate method of receiving confidential mailings and other communications of your health information. For instance, you may request that your health information be sent to your office or to a post office box rather than to your home address. You may also request that calls be made to a certain telephone number. We do not require that you state a reason for your request.
- Right to Access PHI: You may request to review your **PHI** and obtain a copy. This request is made in writing to your counselor. If your request is accepted, we will arrange a mutually agreeable time for you to look at your health information. We may deny your request to review and copy in a few limited circumstances however, if your request is denied, you may ask for a review of that denial by contacting the Clinical Supervisor. A reasonable fee may be required for copies of health information. We will let you know what the fee will be before any copies are made.
- Right to Request an Amendment to Your PHI: You may request an Amendment to your health information if you think it is incorrect or incomplete. We will ask that the request be in writing and state the reasons for the amendment. We will notify you to let you know if we agree or disagree with your request. If we do not agree, we will provide you with information on why we disagree and what options you have. To request an amendment, please contact our privacy officers at the location where you receive services.

Notice of Privacy Practices continued

- Right to an Accounting of Disclosures of PHI. You have the right to request a periodic accounting of the disclosures of your health information so that you will be aware of who has had access to your information. Your request may specify a time period up to six years. We are not required to provide an accounting for disclosures prior to April 14, 2003 and not every disclosure included in an accounting. Disclosures you authorized in writing, routine internal disclosures such as those made to agency personnel in the course of providing you services, and/or disclosures made in connection with payment are all examples of things not included in the accounting. The accounting will state the time of the disclosure, the purpose for which it was disclosed and a description of the information disclosed. If there is any fee for the accounting, we will let you know what it is before the accounting is done.
- Right to Receive a Copy of this Notice: You will be offered a copy of this Notice during intake and additional copies will be available upon request at PsychSystems.

COMPLAINTS

If you have questions, would like additional information or feel that we have violated your privacy rights, you may contact our Privacy Officer at 734-729-7792 or in writing at:

Privacy Officer
PsychSystems, P.C.
35640 Michigan Ave. West
Wayne, MI 48184-0159

Or by filing a written complaint with the:

Secretary of the U.S. Department of Health and Human Services.
200 Independence Avenue SW
Washington DC 20201

We will not retaliate against you or any person for filing a complaint or exercising your rights under the privacy regulations.

This notice is provided in accordance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996 effective April 14, 2003

PsychSystems P.C.
Patient History

I. Identifying Information:

Date: _____ Who is filling out this form? _____ relationship? _____

Patient Name: _____ Telephone Number: _____

Address: _____

D.O.B. _____ Age: _____ Sex _____ Race _____ ID# or SS # _____

Marital Status (circle one): Single Married Partnered Separated Divorced Widowed
(Years? _____)

Education _____ Religion _____

College Attended _____ Major _____ Minor _____

Occupation: Present _____ Previous _____

Height _____ Weight _____

II. History of Present Problem:

In your own words, tell us why you think you were referred for this evaluation.

What questions were you hoping we will be able to answer with this evaluation?

When did your problem begin? (Stroke, seizure,
whatever) _____

What medications are you taking now?

What medications have you taken in the past (for at least a month)?

Have you in the past or presently had any problems with:

- 1) Loss of consciousness _____
- 2) Memory _____
- 3) Numbness or tingling in limbs (paralysis) _____
- 4) Vision _____

- 5) Hearing _____
- 6) Other sensory changes (taste, smell, touch) _____
- 7) Learning problems while in school (specifically: reading, spelling, writing, arithmetic, drawing) _____
- 8) Work problems _____
- 9) Coordination difficulties or change _____
- 10) Abnormally high fever _____
- 11) Seizures (type, duration, frequency) _____
- 12) Allergies (to meds) _____
- 13) Head trauma _____
- 14) Broken bones _____
- 15) Injuries to arms, hands, and/or fingers _____
- 16) Headaches _____
- 17) Do you think your personality has changed in the past few years? Explain how. _____

Have you had any of the following:

- Polio _____ Meningitis _____ Huntington's Chorea _____
- Diabetes _____ Encephalitis _____ High Blood Pressure _____
- Fainting _____ Syphilis or Gonorrhea _____ Rheumatic or Scarlet Fever _____

Other medical problems which are a part of your history:

Other hospitalizations (give dates, reasons):

Have you ever had shock treatments? _____ When? _____

III. Family History

Members of household:

Handedness (Right/Left)	Family Member	Age	Health Problems	Yrs. Of Education	Occupation
	1) Spouse or Significant Other				
	2) Mother				
	3) Father				
	4) Children				
	a.				
	b.				
	c.				

	d.				
	e.				
	5) Siblings (in order of birth)				
	a.				
	b.				
	c.				
	d.				
	e.				
	f.				

Is there any history of emotional or neurological problems in you family? (Alcoholism, psychiatric hospitalizations, neurological problems?)

IV. Social History

Smoking Yes _____ No _____ Packages/day x _____ years

Drinking Yes _____ No _____ If yes, amount: _____

Drugs (Yes or No to the following):

Sleeping Pills _____

Phenobarbital _____

Marijuana _____

Morphine _____

Heroin _____

Others _____

V. Additional Information: (use the back side of this page)

Intake information & Signature page- Please complete this form and the patient history form and bring to your first appointment

Last name: _____ **First name:** _____ **Date:** _____

DOB _____ **Home Phone #** _____ **Cell #** _____

E-mail _____ **May we leave a message (circle) Yes No**

Emergency Contact person : _____ **Phone:** _____

Primary Care physician name _____ **Phone** _____

How did you find out about us? _____

Certification of receipt and understanding of information packet

I certify that I have read this packet and that I understand it and consent to it. Please initial each section in this packet that indicates that you read and understand that section:

_____ General Consent to Treatment

_____ Confidentiality

_____ Discharge Policy

_____ HIPAA policy

_____ Payment Provisions

_____ I have completed a patient history form _____ (therapist initials indicating completion)

_____ I am willing to allow PsychSystems P.C. to send me information about new services or other announcements by e-mail. What is your preferred e-mail address? _____

I certify that I have read this packet and that I understand it and consent to it. If the signer is not the patient, the signer certifies that he is the patient's legally authorized representative, or, if a minor, his or her parent.

In consideration of the Facility and professional services provided or be provided to the patient, I guarantee payment of any Facility or physician charges which are not covered by or collected from any applicable health care benefit program, including deductibles and coinsurance amounts.

Signature of Patient or Legal representative or parent

Date

Witness

Date
