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CLIENT INFORMATION

Client Name:		
Client Date of Birth:		
Address:		
City:	**State:**	**Zip:**
Phone Number:	**Preference : ☐ Voicemail & Text ☐ Voicemail ☐ Text**	
Email:		
Sex:	**☐ Male ☐ Female**	
(Optional) Preferred Pronouns:	**☐ He ☐ She ☐ They ☐ No preference ☐ Other**	
Marital Status:	**☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed**	
Race/Ethnicity:		
Preferred Language Spoken:		
IF CLIENT IS UNDER 17, LIST LEGAL GUARDIAN(S):		

EMERGENCY CONTACT INFORMATION

Emergency Contact:	
Relation to Client:	
Phone Number:	**Preference : ☐ Voicemail & Text ☐ Voicemail ☐ Text**
Email:	

Emergency Contact:	
Relation to Client:	
Phone Number:	**Preference : ☐ Voicemail & Text ☐ Voicemail ☐ Text**
Email:	

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CLIENT INSURANCE INFORMATION

NOTE: IF YOU ARE UNCERTAIN IF WE ACCEPT YOUR INSURANCE, PLEASE ASK OUR FRONT DESK STAFF.

Primary Health Insurance:	
Subscriber ID Number:	**Group ID Number:**
Insurance Phone Number:	

☐ **Please check this box if the following information is the same as the client information. If not, please fill out the information below.**

Primary Insurance Card Holder's Name:		
Primary Insured's Date of Birth:		
Primary Insured's Address:		
City:	**State:**	**Zip:**
Primary Insured's Relation to Client:		
Primary Insured's Phone Number:		

If you do not have secondary insurance, please proceed to the next page.

Secondary Health Insurance:	
Subscriber ID Number:	**Group ID Number:**
Insurance Phone Number:	

☐ **Please check this box if the following information is the same as the client information. If not, please fill out the information below.**

Secondary Insurance Card Holder's Name:		
Secondary Insured's Date of Birth:		
Secondary Insured's Address:		
City:	**State:**	**Zip:**
Secondary Insured's Relation to Client:		
Secondary Insured's Phone Number:		

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CONSENT FOR TREATMENT

I, _____, voluntarily consent to and authorize all psychological care including routine testing procedures as deemed necessary or advisable by the clinician, their assistants or designees, and employees of the facility participating in my care.

I understand that I shall have the opportunity to discuss any treatments or testing with the clinician and/or their assistants and designees participating in my case. I understand that in certain situations, it may be necessary or advisable for the clinician to extend services beyond those contemplated at the beginning of treatment.

While clinicians strive to uphold the strictest of confidentialities, practitioners reserve the right to alter treatment at their own discretion if boundaries become compromised. This may include, but is not limited to, amending or terminating treatment and/or disclosing the least amount of information possible to the appropriate agencies in order to maintain safe boundaries.

In keeping with ethical standards of our profession as well as state and federal law, all services provided by the clinician, their assistants or designees will be kept confidential except as noted below. All information shared with the clinicians at MMP is confidential, no information will be released without your consent. MMP treatment records are stored on a secure electronic server as part of your treatment records. Access to records by MMP providers is done only on a need to know basis for purposes of collaborative care (e.g., referral for medication, evaluations, etc.). In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. There are specific and limited exceptions to this confidentiality which include the following:

- When there is a risk of imminent danger to the client or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child, disabled person or elderly individual is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the vulnerable party, and to inform the proper authorities.
- When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I authorize the clinic to release any and all information contained in my medical records, including information protected under Michigan Public Act 174 of 1989 as amended: and substance abuse information, if any, protected under Federal Government Regulations. Part 2: and social and psychological services information, if any, including communication made to a social worker or psychologist, to {a} any third party payer, insurance agencies or carriers responsible in whole or in part for paying any expenses associated with my treatment; and {b} any health care facility used by the psychologist for the purpose of facilitating continuing care and treatment.

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CONSENT FOR TREATMENT (CONTINUED)

I assign and authorize direct payment of all health care benefits and other forms of payment of any kind that relates to the care provided to me by the clinic staff for application to my bill. I assume **FULL FINANCIAL RESPONSIBILITY FOR PAYMENT** of all expenses associated with my care and treatment, including any portion of charges not covered by insurances or other social agencies. I agree to pay the same at the time of discharge or on an interim basis while in treatment.

I understand that if I am unable to make decisions about care, treatment of services, or I choose to delegate decision making to another individual, the organization will involve the surrogate decision-maker in these decisions. In this event, the surrogate decision-maker may give informed consent on behalf of myself.

I understand that the clinician or designees may perform psychological testing upon me if deemed necessary, and I will be informed of the purpose of said testing. The results of any testing will be treated confidentially, but may be disclosed as necessary to personnel that will care, authorize service, or insure care and services to me.

I understand that the practice of psychology is not an exact science. NO GUARANTEES OR PROMISES have been made to me regarding the results of any psychological treatment.

PLEASE NOTE THE FOLLOWING:

- **Our office does not participate with ANY Medicaid plans, including straight Medicaid or any commercial Medicaid plans. Please be advised if for any reason your insurance changes to a Medicaid plan, you will be responsible for the bill.**
- **Additionally, if the therapy pertains to social security disability or FMLA, Michigan Modern Psychology will not fill out requested or additional paperwork.**
- **The clinic shall not be liable for the loss or damage of any personal property.**
- **I understand that if I do not attend an appointment for 2 months, my chart will be closed and my case will be terminated.**

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ THIS FORM OR THAT IT HAS BEEN READ TO ME. I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS UNLESS OTHERWISE INDICATED ON THIS FORM. IF THE SIGNER IS NOT THE PATIENT, THE SIGNER CERTIFIES THAT THIS SIGNER IS THE PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE.

Client, parent, or legal guardians' signature:	**Date:**

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NOTICE OF PRIVACY PRACTICE

Uses and Disclosures of PHI: Michigan Modern Psychology may use your Protected Health Information, hereon noted as PHI, for the purposes of treatment, payment, and health care operations without your written permission. The following are examples of our use of your PHI.

- **For treatment:** This includes any information received from you, other medical personnel, or other medical facilities pertaining to your medical condition and treatment. It also includes information we give to other health care personnel to whom we transfer your care and treatment.
- **For payment:** This includes any activities, filing claims, medical necessity reviews, and collection of outstanding accounts.
- **For health care operations:** This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fund raising, and certain marketing activities.

Client Rights: As a client, you have a number of rights with respect to the protection of your PHI, including the following.

- **The right to access, copy, or inspect your PHI:** This means you may come to our office within 30 days and inspect and copy most of the medical information about you that we maintain, for a reasonable fee. In limited circumstances, we may deny you access to your medical information and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer.
- **The right to amend your PHI:** You have the right to ask us to amend written medical information that we may have about you. We will either amend your information within 60 days of your request, or as permitted by law, deny your request to amend your medical information only in certain circumstances, such as when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact the privacy officer. You have the right to appeal a denial, and we will provide the appropriate appeal form.
- **The right to request an accounting of our use and disclosure of your PHI:** You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment, or health care operations.
- **The right to request that we restrict the uses and disclosures of your PHI**: You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment, or health care operations, or to restrict information that is provided to family, friends and other individuals involved in your health care. Michigan Modern Psychology is not required to agree to any restrictions you request, but any restrictions agreed to by Michigan Modern Psychology are binding.

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NOTICE OF PRIVACY PRACTICE (CONTINUED)

Your Legal Rights and Complaints: You also have the right to complain to us, Michigan Modern Psychology, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments, or complaints, you may direct all inquiries to the privacy officer.

Revisions to the Notice of Privacy Practice: Michigan Modern Psychology reserves the right to change the terms of this Notice at any time. The changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to this Notice will be promptly posted in our facilities.

I hereby acknowledge that I have read to and consent to the terms of the form, and acknowledge that I am entitled to receive a copy of Michigan Modern Psychology's Notice of Privacy Practices upon request.

Client, parent, or legal guardians' signature:	**Date:**

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CELL PHONE CONTACT POLICY AND COMMUNICATION PREFERENCES

Your therapist may choose to provide you with a cellular phone number to reach them directly. MMP therapists are not "on call" and may not be able to respond immediately to calls or texts. If your therapist provides you with such a number, please understand that it is not to be used in case of crisis or emergency. **In the event of an emergency, go to your nearest emergency room or dial 911.**

By signing below, I acknowledge the above information.

Client, parent, or legal guardians' signature:	**Date:**

Michigan Modern Psychology values our clients' privacy. Please indicate how you would like to be contacted and how others may be able to manage your accounts/appointments. *Be aware that this form does not allow others access to your personal medical information or clinical information*.

☐ I would like to receive text reminders of my appointment at the number below.

Phone Number:

☐ I would like someone to be able to discuss the following information for me.

Client Representative's Name:	
Relation to Client:	
Representative's Phone Number:	
Representative's Email:	
This person can make appointments for me:	**☐ Yes ☐ No**
This person can make payments to my account:	**☐ Yes ☐ No**
This person can discuss billing of my claims/my account balance:	**☐ Yes ☐ No**

By signing this form, I authorize the above to be able to communicate with the Michigan Modern Psychology staff as indicated.

Client, parent, or legal guardians' signature:	**Date:**

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ATTENDANCE & INSURANCE COVERAGE POLICY

DUE TO THE HEAVY VOLUME OF LAST-MINUTE CANCELLATIONS, WE HAVE IMPLEMENTED OUR 24-HOUR NO SHOW POLICY.

IF YOU FIND THAT YOU NEED TO MISS A SCHEDULED APPOINTMENT, PLEASE CALL AND CANCEL AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT OR YOU WILL INCUR A "NO SHOW" FEE OF $100.00.

In addition, due to the constant changes in insurance policies it is not feasible to interpret each individual's insurance policy. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, *the insured*. Although we try our best to stay aware of the changes, insurance policies change daily with no warning given to us.

Please keep in mind that your insurance policy is between you and your insurance company and **NOT** between the insurance company and the doctor's office. **It is your responsibility to know your individual coverage.** Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. Any portions of claims that are not covered become the responsibility of the insured.

Furthermore, it is the client's responsibility to report any changes in insurance or coverage to Michigan Modern Psychology. If changes to a client's policy or insurance coverage are not reported to Michigan Modern Psychology within 30 days of when the change is effective, Michigan Modern Psychology will not rebill and the client is responsible for the payment.

As a final note, payment for the services rendered is due at time of service. It is the client's responsibility to monitor their balance and make timely payments of any outstanding balance. Michigan Modern Psychology will send a monthly statement of any outstanding balance. If no payment is received for three consecutive months, we will send the outstanding balance to debt collections. **If a balance on an account exceeds $500, that account will be locked and the client will not be able to be seen until the balance is below $300.**

By signing this document, I agree to the following. In order for Michigan Modern Psychology to service my account or to collect any amounts I may owe, Michigan Modern Psychology and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide for this purpose. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, if applicable.

I have read this disclosure and authorize express consent that Michigan Modern Psychology, its affiliates, and third-party service providers may contact me as described above for the purpose stated above.

Client, parent, or legal guardians' signature:	**Date:**

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CONSENT TO INFORM PCP OF CURRENT TREATMENT

If you would like us to send a letter to your Primary Care Physician (PCP) informing them that you are receiving services here, please provide the PCP's name and address, and your signature. This will indicate that you grant permission for the release of this information. The letter we send will inform your PCP of your initial date of service, as well as your diagnosis at this agency. A letter will not be sent if an address is not provided on this form. You may also choose to decline to have a letter sent if you do not feel it is necessary.

ANY CLIENT WHO HAS BLUE CARE NETWORK MUST CHOOSE YES AND PROVIDE THE INFORMATION, IT IS REQUIRED BY YOUR INSURANCE POLICY.

Please fill out the boxes and sign below if you would like us to send a letter to your PCP.

PCP Name:	
PCP Address:	
Client, parent, or legal guardians' signature:	**Date:**

OR

Please sign below if you would not like a letter sent to your PCP.

Client, parent, or legal guardians' signature:	**Date:**

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HEALTH, PAIN, AND NUTRITION SCREENING

Health Concern	Currently being treated?	Year Diagnosed
Acute Pain	☐ Yes ☐ No	
Cancer (and type):	☐ Yes ☐ No	
Chronic Pain	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Hearing or Vision Problems	☐ Yes ☐ No	
Heart Problems	☐ Yes ☐ No	
High blood pressure	☐ Yes ☐ No	
Hyperthyroidism	☐ Yes ☐ No	
Hypothyroidism	☐ Yes ☐ No	
Migraines	☐ Yes ☐ No	
Muscle or joint problems	☐ Yes ☐ No	
Nausea or vomiting	☐ Yes ☐ No	
Seizures	☐ Yes ☐ No	
Any other relevant conditions:	☐ Yes ☐ No	

Health and Medical Status

Name of your primary health care doctor:
Have you had a physical exam within the last 12 months? ☐ Yes ☐ No
Have you experienced an unintentional weight gain or loss of 10 pounds or more within the last month? ☐ Yes ☐ No
Do you have any allergies? ☐ Yes ☐ No
If yes, please list the allergies:
Do you take any medications? ☐ Yes ☐ No
If yes, please medications including dosage:

By signing below, I acknowledge the above information as correct to the best of my understanding.

Client, parent, or legal guardians' signature:	Date:

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SECONDARY SCREENER

IF THE FOLLOWING DOES NOT APPLY TO YOU, PLEASE CHECK NO ON THE FIRST BOX OF EACH SECTION AND PROCEED TO THE NEXT PAGE.

1. SUICIDAL IDEATION

Are you currently suicidal?	☐ **Yes, continue to 1A** ☐ **No, continue to the next section**
1A. Do you have a plan for how you would attempt suicide?	☐ **Yes** ☐ **No**
If yes, please explain:	
1B. Do you have the means or easy access to the means to complete your plan?	☐ **Yes** ☐ **No**
1C. Would you actually go through with your plan?	☐ **Yes** ☐ **No**
1D. Have you ever attempted suicide before?	☐ **Yes** ☐ **No, continue to the next section**
If yes, how did you do it?	
1E. Did you receive treatment for any of these prior attempts?	☐ **Yes** ☐ **No**

2. HOMICIDAL IDEATION

Do you currently want to hurt anyone else?	☐ **Yes, continue to 2A** ☐ **No, continue to the next section**
2A. Do you have a plan for how you would hurt someone else?	☐ **Yes** ☐ **No**
If yes, please explain:	
2B. Would you actually go through with your plan?	☐ **Yes** ☐ **No**
2C. Have you ever attempted to injure another before?	☐ **Yes** ☐ **No**
2D. Did you experience any consequences?	☐ **Yes** ☐ **No**
If yes, please explain (ex: legal consequences, treatment, etc.):	

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SECONDARY SCREENER (CONTINUED)

IF THE FOLLOWING DOES NOT APPLY TO YOU, PLEASE CHECK NO ON THE FIRST BOX OF EACH SECTION, SIGN BELOW, AND PROCEED TO THE NEXT PAGE.

3. PSYCHOSIS

Do you hear or see things that aren't actually there?	☐ **Yes, continue to 3A** ☐ **No, continue to the next section**
3A. Do you have difficulty distinguishing what is real and what is not real?	☐ **Yes** ☐ **No**
3B. Do your voices command you to complete certain actions?	☐ **Yes** ☐ **No**
3C. Are you able to control impulses related to what you hear or see?	☐ **Yes** ☐ **No**

People sometimes go through life-threatening or otherwise stressful events. Please briefly list any instances where you have experienced significant stress or trauma.

By signing below, I acknowledge the above information as correct to the best of my understanding.

Client, parent, or legal guardians' signature:	**Date:**
Clinicians' signature:	**Date:**

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SUBSTANCE USE SCREENER

IF THE FOLLOWING DOES NOT APPLY TO YOU, PLEASE WRITE "N/A", SIGN BELOW, AND PROCEED TO THE NEXT PAGE.

Type of Substance:	Alcohol	Marijuana	Tobacco	Other:
Age of first use:				
Duration of use:				
Frequency of use:				
Amount consumed during use:				
Date of last use:				
Pattern: Episodic, Continuous, or Binge?				
Have you tried to quit?				
If yes, what method have you tried?				

Please list any emotional, behavioral, legal, and/or social consequences of substance use:

Have you ever received previous care, treatment, or services for substance use?

This can include detox, counseling, and/or AA/NA.

If yes, please explain:

Please describe any relapse history:

By signing below, I acknowledge the above information as correct to the best of my understanding.

Client, parent, or legal guardians' signature:	Date:

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PAYMENT AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

EFFECTIVE DATE: 11/05/2026

At Michigan Modern Psychology, we strive to make the billing process as simple and transparent as possible. To help avoid missed payments and reduce the need for follow-up billing, **we require all clients to maintain a secure credit or debit card on file.** It is our preferred payment method and helps ensure timely processing of client financial responsibility and reduces the likelihood of large outstanding balances.

INSURANCE AND CLIENT RESPONSIBILITY

As a courtesy, MMP will verify insurance benefits and eligibility and submit claims to your insurance carrier. Please be advised that your insurance coverage is a contract between you and your insurance company. You are ultimately responsible for all amounts not paid by your insurance plan, including but not limited to:

- Copayments
- Coinsurance
- Deductible amounts
- Non-covered services
- Any balance determined to be client responsibility after insurance processing

Providing an insurance estimate does not guarantee your final financial responsibility. Final client responsibility is determined only after your insurance carrier has processed your claims.

PAYMENT POLICY

Payment will be collected on your date of service for any known balances, such as copays, deductible, etc. If your insurance processes your claim after your appointment and determines additional client responsibility, any remaining balance will become due once your claim has been processed. This form authorizes the practice to securely charge your card for client responsibility amounts as described in this agreement.

STATEMENTS

If your account carries a balance, you will receive an itemized statement monthly. If your account remains unpaid after two consecutive monthly statements, a final notice will be sent during the third month. **If payment is not received by the deadline stated in the final notice, your account will be referred to a third-party collection agency.** Outstanding balances may also result in suspension of scheduling future non-emergency appointments and, when clinically appropriate and in accordance with applicable laws and professional standards, termination of services. Once an account has been placed with collections, payments must be made directly to the collection agency unless otherwise authorized by MMP.

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PAYMENT AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT (CONTINUED)

UPDATING A CARD ON FILE

Failure to update payment information does not relieve the client of responsibility for any outstanding balance. Clients are responsible for maintaining current payment information. Payment information may be updated by calling or visiting our front desk or by completing a new payment authorization form through the secure patient portal.

CARD ON FILE AUTHORIZATION

I authorize the practice to charge my card for the following:

- Copayments or coinsurances due at the time of service
- Deductible amounts due at the time of service, whenever known
- Any remaining client responsibility due after insurance processing
- Charges for self-pay or non-covered services

I understand the following:

- My payment information will be stored using industry-standard secure payment processing
- My full card number will not be accessible to office staff
- I may update or replace my payment method at any time
- I may request an itemized statement or receipt for any processed payment
- This authorization remains in effect until I provide updated payment information

I have read and understand that I remain responsible for all client balances. Payment is expected at the time of service whenever the amount is known. Any remaining balance after my insurance plan has processed my claim is due upon notification. Failure to maintain a current method o payment to keep the balance at $0.00 may result in delayed scheduling of future non-emergency appointments or other actions permitted under the practice's financial policies, including termination of services.

I understand that authorization to charge my card does not waive my right to dispute charges that I believe were made in error. Questions regarding charges should be directed to the practice promptly upon receipt of a statement.

By signing below, I acknowledge that I have read, understand, and agree to the terms of this form.

Client, parent, or legal guardians' signature:	**Date:**

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CLINICIAN ACKNOWLEDGEMENT

By signing below, I acknowledge that I have discussed the relevant portions with the client, and that the packet has been filled out in full.

Clinician Signature:	**Date:**