MICHIGAN
MODERN
PSYCHOLOGY

CLIENT DEMOGRAPHICS FORM

please print clearly

Client Name: _____ **Client DOB:** _____

Address: _____

City:_____ **State:** _____ **Zip:** _____

Preferred Phone Number: _____ □ Voicemail & Text □ Voicemail □ Text

Preferred Email: _____

Gender ID: □ Male □ Female □**Other:** _____

Preferred Pronouns: □ **He** □ **She** □ **They** □**No preference** □ **Other:** _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partner **Employer:** _____

Emergency Contact: _____ **Phone:**_____

Relation to Client: _____

Preferred Language Spoken: _____ **Race/Ethnicity:** _____

If client is under 17, list legal guardian(s): _____

Primary Health Insurance: _____ **Ins. Phone:** _____

Contract #: _____ **Group #:** _____

☐ **Check if same as client, if not…**

Primary Insurance Card Holder: _____

Insured's Relationship to Client: _____ **Primary Card Holder's DOB:** _____

Primary Card Holder's Address: _____ ☐ **Check if same as client**

City:_____ **State:**_____**Zip:** _____

Primary Card Holder's Preferred Phone: _____

Employer: _____

Secondary Health Insurance: _____**Ins. Phone:** _____

Contract #: _____ **Group #:** _____

☐ **Check if same as client, if not…**

Secondary Insurance Card Holder: _____

Insured's Relationship to Client: _____**Secondary Card Holder's DOB:** _____

Secondary Card Holder's Address: _____ ☐ **Check if same as client**

Secondary Card Holder's Preferred Phone: _____

Employer: _____

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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 emergency situations, it may be necessary or advisable for the clinician to extend services beyond those contemplated at the beginning of treatment.

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 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 electronic and stored on a secure 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 myself 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 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 involves the surrogate decision-maker in making these decisions. In these events, the surrogate decision-maker may give informed consent.

I understand that the clinician or designees may perform psychological testing upon me and I will be informed of the purpose. The results of any test(s) 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.

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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.

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, worker's compensation, or other social agencies. I agree to pay the same at the time of discharge or on an interim basis while in treatment.

***Please note, our office does not participate with ANY Medicaid plans, including straight Medicaid or any commercial Medicaid plans, 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.

I understand that 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.

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 HE OR SHE IS THE PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE.

_____ _____

Signature of client, parent, or legal guardian Date

_____ _____

Clinician Signature Date

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NOTICE OF PRIVACY PRACTICE

Uses and Disclosures of PHI: Michigan Modern Psychology may use 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.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:
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.

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 am entitled to receive a copy of Michigan Modern Psychology's Notice of Privacy Practices upon request.

Patient Name (Printed): _____

Patient Signature: _____ Date:_____

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ATTENDANCE & COVERAGE POLICY

Dear Patients,

Due to the heavy volume of last minute cancellations, we are being forced to enforce 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 $80.00.

In addition, due to the constant changes in insurance policies, it is no longer possible 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. 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. Further, 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 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. 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, 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. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, if applicable.

***Please note, our office does not participate with ANY Medicaid plans, including straight Medicaid or any commercial Medicaid plans, be advised if for any reason your insurance changes to a Medicaid plan, you will be responsible for the bill.

I/We have read this disclosure and authorize express consent that Michigan Modern Psychology, its affiliates, and third party service providers may contact me/us as described above.

Patient Name:_____ Date:_____

Patient 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 your PCP's name and address and your signature which will indicate that you grant permission for the release of this information. The letter will inform your PCP of your initial date of service and 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. Some insurance companies require them. Please choose one of the options below:

- ❑ **Yes, please send a letter to my PCP (BLUE CARE NETWORK MEMBERS MUST CHOOSE THIS OPTION).**

PCP Name:_____

PCP Address: _____

_____

Client Name: _____

Client Signature (Parent/Guardian): _____

-OR-

- ❑ **No, I decline to have a letter sent to my PCP**

Client Name: _____

Client Signature (Parent/Guardian): _____

****

CELL PHONE/CONTACT POLICY

Your therapist may choose to provide you with a cellular phone number to reach him or her 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 case of an emergency, go to your nearest emergency room or dial 911.

Client signature/acknowledgement: _____ Date: _____

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Communication Preferences

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.*

Client Name: _____ Date of Birth: _____

☐ **Yes**, I do want to receive text reminders 24 hours before my appointment sent to this number: _____

☐ **Yes**, I do want to receive an email reminder 48 hours before my appointment sent to this email address: _____

☐ **Yes, I do want someone to be able to make appointments for me**.

Person(s) allowed to make appointments on my behalf:_____

This person is my_____

☐ **Yes, someone can make payments to my account.**

Person(s) allowed to make payments to my account:_____

This person is my_____

☐ **Yes, someone can discuss billing of my claims/account.**

Person(s) allowed to discuss my billing account:_____

This person is my_____

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

Client or Parent/Guardian Signature: _____Date:_____

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Health, Pain, and Nutrition Screening

Health and Medical Status

- Name of primary health care doctor: _____
- Have you had a physical exam within the last 12 months? ☐ **Yes** ☐ **No**
- Have you experienced an unintentional weight loss or gain of **10 pounds or more** within the last *month*? ☐ **Yes** ☐ **No**
- Please indicate if you have experienced any of the health concerns outlined below:

Health Concern	**Currently being treated?**	**Year Diagnosed**		**Health Concern**	**Currently being treated?**	**Year Diagnosed**
Acute Pain				Hypothyroidism		
Chronic Pain				Migraines		
Diabetes				Muscle or joint problems		
Hearing or Vision Problems				Nausea or vomiting		
Heart Problems				Seizures		
High blood pressure				Cancer (and type):		
Hyperthyroidism				Other:		

Do you have any allergies? If yes, please list: _____

List any current medications, including dosage:

_____

_____

_____

Client Name:_____**Date:**_____

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1, SUICIDAL IDEATION

1. Are you currently suicidal? ☐ **Yes, continue to 1a**** ☐ **No, continue to #2**
   a. Do you have a plan for how you would attempt suicide? Explain

   b. Do you have the means or can easily access the means to complete your plan?

   c. Would you actually go through with your plan?

2. Have you ever attempted suicide before? ☐ **Yes, continue to 2a** ☐ **No, continue to #3**
   a. How did you do it?

   b. Did you receive treatment for any of these prior attempts?

2. HOMICIDAL IDEATION

1. Do you currently want to hurt anyone else? ☐ **Yes, continue to 1a**** ☐ **No, continue to #2**
   a. Do you have a plan for how you would hurt someone else? Explain.

   b. Would you actually go through with your plan?

2. Have you ever attempted to injure another before? ☐ **Yes, continue to 2a** ☐ **No, continue to #3**
   a. Did you experience any consequences? (i.e., legal consequences, treatment, etc)

3. PSYCHOSIS

1. Do you hear or see things that aren't really there? ☐ **Yes, continue to 1a**** ☐ **No, next page**
   a. Do you have difficulty distinguishing what is real and what is not real?

   b. Do your voices command you to complete certain actions?

   c. Are you able to control impulses related to what you hear or see?

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

_____

_____

_____

Clinician Name:_____ **Clinician Signature:**_____

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SUBSTANCE USE SCREENER

Client Name: _____ **Date:** _____

***** Please fill out if you have used any of the following substances at any time in your life.***

Alcohol
Age of First Use: _____
Duration of Use: _____
Frequency of Use: _____
Date of last use:_____
Amount of alcohol typically consumed during episode of use:_____
Pattern: ⬜ episodic ⬜ continuous ⬜ binge
Have you tried to quit? ⬜ yes ⬜ no
If yes, which method? _____

Marijuana
Age of First Use: _____
Duration of Use: _____
Frequency of Use: _____
Amount of Use: _____
Date of last use:_____
Pattern: ⬜ episodic ⬜ continuous ⬜ binge
Have you tried to quit? ⬜ yes ⬜ no
If yes, which method? _____

Tobacco
__ Cigarettes/Cigars ___Chewing Tobacco
Age of First Use: _____
Duration of Use: _____
Amount of Use: _____(ppd)
Date of last use:_____
Pattern: ⬜ episodic ⬜ continuous ⬜ binge
Have you tried to quit? ⬜ yes ⬜ no
If yes, which method? _____

Substance: _____
Age of First Use: _____
Duration of Use: _____
Frequency of Use: _____
Amount of Use: _____
Date of last use:_____
Pattern: ⬜ episodic ⬜ continuous ⬜ binge
Have you tried to quit? ⬜ yes ⬜ no
If yes, which method? _____

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 including detox, counseling and/or AA/NA? If yes, please give approximate dates, length of treatment, and indicate your response to treatment:

_____

_____

Please describe relapse history, if any:

_____

_____