OAKLAND PSYCHOLOGICAL CLINIC, P.C.

Please read this form carefully. It provides important information about your consent to treatment, a statement of your rights as a recipient of substance abuse or mental health services and a statement of privacy regarding your protected health information.

CONSENT TO TREATMENT

Patient Name (please print): _____

If not self, state relationship to patient:_____

I am voluntarily choosing to have psychological and/or psychiatric treatment and hereby acknowledge that I am over eighteen (18) years of age, of sound mind and competent to consent to treatment. I hereby certify that I understand the services that the patient (who is myself or a child/individual for whom I have legal custody or guardianship) will receive at Oakland Psychological Clinic, P.C. The risks, benefits and alternatives to treatment have been explained to my satisfaction and I understand that the result of such treatment cannot be warranted or guaranteed. I understand that I will be responsible for participating in the development of my own treatment plan.

I may terminate or request a change in the professional treating me at any time. I understand that it is my right and responsibility to voice any concerns, objections or doubts I may have regarding the course of treatment to the professionals with whom I am in treatment or the director of the clinic.

Violation of federal law and regulation by a clinic is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations. Federal law and regulation does not protect any information about a crime committed by a patient either at the clinic or against any person who works for the clinic or about any threat to commit such a crime. Federal law and regulation does not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Understandings Regarding Termination from Treatment

I understand that I may be terminated from treatment non-voluntarily for the following reasons:

1. If I exhibit physical violence, verbal abuse, carry weapons, or engage in illegal acts at the clinic.
2. If I refuse to comply with stipulated program case protocol or refuse to comply with treatment recommendations.
3. If I am unable to schedule or attend appointments at assigned times.
4. If I am judged to have symptoms that cannot be adequately treated with the resources available at Oakland Psychological Clinic, P.C.

I understand that I will be notified of non-voluntary discharge by my therapist, but that this is seen as a last resort when other, less drastic measures have proven ineffective. I may appeal this decision with the director of the clinic or request to re-apply for service at a later date.

Understanding Regarding Advance Directives

I understand that I have the right to formulate advance directives should I become unable to direct my own care due to severe illness or mental incapacity. An advance directive is a legal document allowing a person to give directions about future medical care or to designate another person to make medical decisions should the patient lose decision-making capacity. Advance directives may include a living will, durable power of attorney or similar documents portraying the patient's preferences.

Payment Understandings

I understand that my insurance company, third party payer, or managed care representative may request such information or records as is necessary in order to process and verify billing claims or authorize treatment. From time to time, governmental agencies and accrediting bodies may survey the clinic and request information regarding patients' treatment in order to verify the clinic's adherence to standards. I give permission for the release of such information and records to my insurance company, governmental agencies, collection agencies, accrediting agencies or courts for the purpose of billing and/or receiving payment for services or accreditation purposes. In some instances, the payor of services may require copies of progress notes from the medical record before making payment. A signed Authorization of Release of Confidential Information signed by me will not be necessary for Oakland Psychological Clinic, P.C. to provide information to such other party necessary for billing and payment purposes.

_____ Patient Initials

_____ Parents Initials

If I have insurance coverage for treatment, Oakland Psychological Clinic, P.C. may accept payment from the insurance company, but Oakland Psychological Clinic, P.C. does not guarantee coverage or benefit amounts and holds me ultimately responsible for payment. If Oakland Psychological Clinic, P.C. bills a third party, i.e., a divorced spouse or other third person at my request and that third party fails to make timely payment, I understand that I am ultimately responsible for payment. I understand that failure to provide required documents, such as an insurance card, will result in my being charged.

I am aware of the charges for treatment services and understand that I am the financially responsible party for payment of services rendered as well as any late fees or costs arising from any court action should my account become delinquent. I understand that if my account becomes delinquent, Oakland Psychological Clinic, P.C. may report the status of my account to a credit-reporting agency or agencies. I cannot assign my financial responsibility to any other individual unless Oakland Psychological Clinic, P.C. is provided with written consent by such other party. A form entitled "Acknowledgment of Financial Responsibility" provided by the clinic or other form providing the same information may be used for this purpose.

Other Understandings

- I understand that I may be contacted by telephone or mail for purposes of scheduling, billing, or other reasons. If there are any restrictions placed on contacting me or where bills may be sent, I will inform the office in writing.

- I understand that I may be contacted after completion of my treatment as a follow up to services provided.

- I understand that my medical record may be kept for several years and that in time it will be shredded or otherwise disposed of in such a manner that confidentiality will be maintained.

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED MENTAL HEALTH INFORMATION

We use and disclose protected health information for a variety of reasons. For most uses/disclosures, we must obtain your consent. However, the law provides that we are permitted to make some uses/disclosures without your consent. The following offers more description and examples of our potential uses/disclosures of your protected health information.

- **For treatment**: We may disclose your protected health information to other mental heath care practitioners within Oakland Psychological Clinic, P.C. who are involved in providing your mental health care. However, a release of information is required to disclose your protected health information to mental health care practitioners outside of Oakland Psychological Clinic, P.C.
- **For operations**: We may use/disclose your protected health information in the course of operating our clinic. *For example, we may use your protected health information in evaluating the quality of services provided, creating reports that do not individually identify you, or disclose your protected health information to our accountant or attorney for audit purposes. We may disclose your protected health information to designated staff in the clinic where you are seen, and our administrative offices.*
- **Payment:** We may disclose your protected health information to insurance companies and managed care entities, when necessary, to obtain reimbursement.
- **Exceptions:** Although your consent is usually required for the use/disclosure of your protected health information, the law allows us to use/disclose your protected health information without your consent in certain situations. *For example, we may disclose your protected health information if needed for emergency treatment if it is not reasonably possible to obtain your consent prior to the disclosure and we think that you would give consent if able.*

Uses and Disclosures Requiring Authorization: For uses and disclosures beyond treatment, payment, and operations purposes we are required to have your written authorization (signed permission), unless the use or disclosure falls within one of the exceptions described below. Like consents, authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already acted upon your authorization.

Uses and Disclosures Not Requiring Consent or Authorization: The law provides that we may use/disclose your protected health information without consent or authorization in the following circumstances:

When required by law: We may disclose protected health information when a law requires that we report information about:

_____ Patient Initials _____ Parents Initials

- Suspected abuse or neglect of a minor child or vulnerable adult
- Duty to warn or protect you or others from harm
- In response to a court order
- To Protective Services during an investigation

We must also disclose protected health information to authorities who monitor compliance with these privacy requirements.

- **For health oversight activities**: We may disclose protected health information for audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) to oversee the health care system.
- **To avert threat to health or safety**: In order to avoid a serious threat to health or safety, we may disclose protected health information as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm. *For example, a plan to commit suicide or a homicidal act*.
- **For specific government functions**: We may disclose protected health information of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.
- **For law enforcement**: When a patient commits or threatens to commit a crime either at the clinic or against any person who works for the clinic.

Uses and Disclosure Requiring You to Have an Opportunity to Object: In the following situations, we may disclose your protected health information if we inform you about the disclosure in advance and you do not object. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

- **To families, friends or others involved in your care**: We may share with these people information directly related to your family's, friend's or other person's involvement in your care. We may also share protected health information with these people to notify them about your location or general condition. *For example, parents of a minor have certain rights to protected health information. Also, we may have to locate family members to inform them of the location of a patient who was hospitalized after being diagnosed as severely depressed.*

INDIVIDUAL RIGHTS

Oakland Psychological Clinic, P.C. is dedicated to providing quality services. It is our policy that each patient, defined as an individual who receives services from Oakland Psychological Clinic, P.C. and who meets admission criteria, be treated with dignity and respect regardless of race, color, national origin, religion, sex, ethnicity, age, disability, marital status, sexual preference or political beliefs.

In most cases you have the right to look at or get a copy of your health information. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe information in your record is incorrect or that important information is missing, you have the right to request that we correct the existing information or add the missing information. You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it. To make requests related to your health records or for more information about our privacy practices, you may contact the Recipient Rights Advisor.

OTHER IMPORTANT RIGHTS

1. All civil rights guaranteed by state and federal law.
2. The right to reasonable access to treatment care and services.
3. The right to be treated with personal dignity.
4. The right to treatment, care and services that are considerate and respectful of individual personal values and beliefs.
5. The right to refuse treatment or services. Should you (or your legally responsible party) refuse services, we may seek appropriate alternatives, such as orders of involuntary treatment. Should you consent to treatment but refuse specific services that are recommended for you, we may terminate the relationship with you upon reasonable notice and make a referral to another provider.
6. Freedom from abuse and neglect.
7. The right not to be fingerprinted, photographed, audiotaped, videotaped, or viewed through a one-way glass unless the patient or patient's legal representative agree in writing.
8. The right to treatment in a place that is clean and safe.

_____ Patient Initials _____ Parents Initials

9. The right to informed participation in decisions regarding treatment, care, and services. This right is applied to children as appropriate to their age, maturity and clinical condition, and the right of the family of individuals served to participate in such planning. Oakland Psychological Clinic, P.C. expects that children 10 years or older will participate in the treatment planning process.
10. The right to individualized treatment, care and services, including a) adequate and humane services regardless of the source of financial support; b) provision of services within the least restrictive environment possible; c) an individualized treatment plan, d) periodic review of the treatment plan and e) an adequate number of competent, qualified, and experienced staff to supervise and carry out the treatment plan.
11. The right of the individual served and their family to be informed of their rights in a language that they understand.
12. Each patient has the right to request a second opinion, a consult (at his or her expense), or to request an in-house review of the treatment plan. Such a request should be made to the Patient Rights Advisor.
13. SUBSTANCE ABUSE PATIENTS may present grievances or suggested changes in program policies and services to the program staff, to governmental officials, or to another person within or outside the program in accordance with the promulgated administrative rules of the Office of Substance Abuse Service. In this process, OPC will not, in any way, inhibit the recipient. Upon admission, each substance abuse patient is provided with a brochure summarizing recipient rights specific to substance abuse patients entitled, "Know Your Rights." For additional information, patients may contact the Program Rights Advisor or the Michigan Department of Public Health in Lansing, MI.

OUR LEGAL DUTIES

We are required by law to protect the privacy of your information, provide this notice about our information practices and follow the information practices that are described in this notice. We may change our policies at any time. Before we make a significant change in our policies, we will change this notice and post the new notice in public areas of the agency. You can also request a copy of our notice any time.

COMPLAINTS

If you are concerned that we have violated any of your rights, you may contact our Recipients Rights Advisor. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint. All patients or other concerned individuals may report quality of care or safety concerns to The Joint Commission, our accrediting body (1-800-994-6610 or online complaint at www.jointcommission.org).

CONTACT INFORMATION

Recipient Rights Advisor, 2550 S. Telegraph Road, Suite 250, Bloomfield Hills, MI 48302 Phone: 248-322-0003
Department of Health and Human Services, Office of the Secretary, 200 Independence Avenue, SW, Washington, DC 20201

I acknowledge that I have been provided with a copy of this form, which includes my Consent for Treatment, Notice of Privacy, and Statement of Patient Rights.
I am aware that I may obtain more information about my rights from the Patient Rights Advisor, 2550 S. Telegraph Road, Suite 250, Bloomfield Hills, MI 48302 (248-322-0003).

Patient Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Printed Name: _____

Witnessed by: _____ **Date:** _____

Admin/Forms/Clin(6/10;7/14;1/18)

_____ Patient Initials _____ Parents Initials