Oakland Psychological Clinic

2550 S. Telegraph Rd., Ste. 250
Bloomfield Hills, MI 48302

2222 S. Linden Rd., Ste. J
Flint, MI 48532

16664 15 Mile Rd.
Fraser, MI 48026

10785 S. Saginaw St., Bldg. E, Ste. A
Grand Blanc, MI 48439

1455 S. Lapeer Rd., Ste. 175
Lake Orion, MI 48360

33300 Five Mile Rd., Ste. 208
Livonia, MI 48154

1800 N. Milford Rd., Ste. 100
Milford, MI 48381

17352 W. 12 Mile Rd., Ste. 100
Southfield, MI 48076

Consent to Treatment, Privacy Practices, and Payment Policies Agreement

Client Name (please print): _____ Date of Birth: _____ Chart #: _____

If not self, state relationship to client: _____

I am voluntarily choosing to enter in to treatment at Oakland Psychological Clinic, hereafter referred to as the Organization, and hereby acknowledge that I am over eighteen (18) years of age or am the parent/legal guardian of the child/individual, of sound mind and competent to consent to treatment. Furthermore, I consent to have treatment provided by a contractual psychiatrist, psychologist, social worker, counselor, therapist, or intern in collaboration with the Organization's Medical Director. 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 Organization.

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 regulations do not protect any information about a crime committed by a client either at the Organization, or against any person who works for the Organization or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities. Healthcare professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Organization's duty to warn any potential victim, when a threat of harm has been made.

Understanding the Cancellation of Appointments Policy

I understand that I may cancel an appointment by phoning my clinic 24 hours a day. I am required to cancel at least 24 hours in advance. If I do not cancel 24 hours in advance, or do not keep my appointment, I, not my insurance company or third-party, will be charged $75 for a session with a clinician and full-fee of appointment for prescribers.

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 Organization.
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 the Organization.
5. If I do not make payments or payment arrangements in a timely manner.
6. If I am referred to a higher level of care (hospitalization, day hospital, etc.) or are incarcerated. I may request to re-engage in treatment once I have completed the other services.

I understand that I will be notified of non-voluntary discharge by letter, 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 Organization 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 client lose decision-making capacity. Advance directives may include a living will, durable power of attorney, or similar documents portraying the client's preferences.

Understanding Psychiatry Services

I understand during treatment at the Organization, if psychiatric services become part of my treatment, it is required that I continue seeing an Organization therapist. In other words, I must see my therapist <u>at least</u> every two weeks in order to receive psychiatric services with the Organization. If I choose to discontinue seeing a therapist, my case will be closed and I will accept a referral for physician services elsewhere.

Understanding Recipient's Rights

I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

_____ _____
Client Initials Parent Initials

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 Organization and request information regarding clients' treatment in order to verify the Organization'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 the Organization to provide information to such other party necessary for billing and payment purposes.

If I have insurance coverage for treatment, the Organization may accept payment from the insurance company, but the Organization does not guarantee coverage or benefit amounts and holds me ultimately responsible for payment. If the Organization bills a third party, (for example: a divorced spouse, or other third person) at my request and that third party fails to make payment within 120 days, I understand that I am ultimately responsible for payment. Payment is expected at the time services are rendered. I understand that failure to provide required documents, such as an insurance card, will result in my being charged.

I, the undersigned, agree and acknowledge that I am responsible for the full payment, including deductibles, co-payments, and/or rejected insurance or third-party payer claims 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, the Organization may report the status of my account to a credit-reporting agency or agencies. I also understand that I am responsible for verifying my insurance benefits for services not provided by the Organization. If I am referred outside of the Organization for services, such as a psychiatrist or blood work I will be billed by that provider for those services.

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. Federal and/or State laws and regulations protect the confidentiality of client records maintained by the Organization. We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. We have a designated Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations The Privacy Officer will also take your complaints and can give you information about how to file a complaint. You can contact the Privacy Officer at 248-322-0003.

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. (See 42 U.S.C. 290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records.)

- **For treatment**: We may disclose your protected health information to other mental health care practitioners within the Organization 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 the Organization.
- **For operations**: We may use/disclose your protected health information in the course of operating the Organization. *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.*

Client Initials _____ Parent Initials _____

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. Parents of a non-emancipated minor have certain rights to protected health information. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's record. 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:

- 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 healthcare 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 client commits or threatens to commit a crime either at the Organization or against any person who works for the Organization.

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.

- **Emergency contact and/or those directly involved in your care**: We may disclose information to the person listed as your emergency contact on your Screening Information form and/or those directly involved in your care, as deemed medically necessary.

INDIVIDUAL RIGHTS

The Organization is dedicated to providing quality services. It is our policy that each client, defined as an individual who receives services 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

- All civil rights guaranteed by state and federal law.
- The right to reasonable access to treatment care and services.
- The right to be treated with personal dignity.
- The right to treatment, care and services that are considerate and respectful of individual personal values and beliefs.
- The right to receive treatment via telehealth methods; These services would be provided by technology (including but not limited to video, phone, text, and email) and do not involve direct, face to face communication. There may be limitations and potential risks related to the use of this electronic communication. I understand that the use of electronic communication means that my confidentiality cannot be guaranteed according to HIPAA regulations.
- 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.

- Freedom from abuse and neglect.
- The right not to be fingerprinted, photographed, audiotaped, videotaped, or viewed through a one-way glass unless the client or client's legal representative agree in writing.
- The right to treatment in a place that is clean and safe.
- 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. The Organization expects that children 10 years or older will participate in the treatment planning process.
- 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.
- The right of the individual served and their family to be informed of their rights in a language that they understand.
- Each client 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.
- SUBSTANCE ABUSE CLIENTS 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, the Organization will not, in any way, inhibit the recipient. Upon admission, each substance abuse client is provided with a brochure summarizing recipient rights specific to substance abuse clients entitled, "Know Your Rights." For additional information, clients 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 clients or other concerned individuals may report quality of care or safety concerns to CARF, our accrediting body (1-888-281-6531 or online complaint at www.carf.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 permit a copy of this authorization to be used in the place of the original.

I am aware that I may obtain more information about my rights from the Recipients Rights Advisor at 2550 S. Telegraph Road, Suite 250, Bloomfield Hills, MI 48302 (248-322-0003).

I have read, agree with and consent to treatment and agree to abide by the above stated policies and agreements with the Organization.

Client Signature: _____ **Date:** _____

Client Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Witnessed by: _____ **Date:** _____

Dear Client/Guarantor:

Oakland Psychological Clinics, like many other healthcare offices, implemented a credit card on file policy. You will be asked for a credit card number at the time of your first appointment. It can only be a credit card, NOT A DEBIT CARD that requires a PIN. Cards must be run as credit. The information will be held securely to be used to pay balances on your account, such as deductibles, copays, insurance rejections and no show/late cancellation fees. Payment is due at the time services are rendered.

This will be an advantage to you, since you will no longer have to remember to bring your payment with you at each session. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and mail. This will be a benefit to everyone in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company regarding how they processed your claim.

If you choose not to participate, you must maintain a zero account balance. If you make a payment with cash, debit or check on the day of your appointment your credit card will not be charged. All insurance rejections and no show/late cancellation fees will be charged to your credit card within 30 days if you have an unpaid balance on the account.

If you have any questions, please do not hesitate to speak with clinic management. We are working diligently to be stewards of all resources and attempting to keep your costs to a minimum.

Sincerely,

OAKLAND PSYCHOLOGICAL CLINICS

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Client Name: _____ Date: _____

Date of Birth: _____ Case Number: _____
(for office use only)

Name of the Person who is Responsible for Payment: _____

Relationship to Client: _____

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☐ I AUTHORIZE Oakland Psychological Clinics to charge outstanding balances on my account to the following credit card:

☐ VISA ☐ MASTERCARD ☐ AMEX

Account Number: _____ Exp Date: _____ Security Code: _____

Name on Card (please print): _____

Billing Address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

☐ Please send me a credit card receipt when my credit card has been charged.

☐ I DO NOT authorize Oakland Psychological Clinics to charge my credit card. I understand that payment must be made in full at each session and that I must maintain a zero balance on the account.