

## DISCLOSURE STATEMENT AND CONSENT TO TREATMENT

~ *Perspectives Therapy Services LLC* ~

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### **THERAPIST TRAINING AND CREDENTIALS:**

Thank you for choosing *Perspectives Therapy Services LLC* for your emotional, mental, relationship and psychiatry needs. Your therapist with Perspectives has received an advanced degree in one or more of the following fields: marriage, family therapy, social work, professional counseling, or psychiatry. S/he is licensed through the state of Michigan. If s/he holds a limited license or it is required by the particular insurance company, s/he will be supervised by a fully licensed clinician in the practice.

Therapeutically our staff is trained to work with individuals, couples, and families. We make up a group practice of licensed professionals, not affiliated with any medical center or hospital. We are not available for emergency services, and advise that in these cases, your local Community Mental Health agency or your nearest medical center/hospital be contacted. Therapists are not physicians and do not prescribe medications or perform medical procedures, however, with written consent, we look forward to collaborating with medical providers.

### **THERAPY SPECIFICS:**

Therapy sessions last 45-60 minutes beginning on the hour. Sessions are typically held one time per week. Initial sessions are dedicated to assessment, which involves gathering information about you, your family and the problem bringing you to therapy. To gain the full benefits of therapy it is strongly encouraged that you fully participate in the sessions through regular attendance and willingness to try alternative perspectives for both the problem and its solutions.

The initial assessment meeting for therapy is charged at **\$200**. A Psychiatric Evaluation is **\$250** for **60-minutes** and the Medication Review is **\$175** for **30-minutes**. Subsequent therapy sessions are charged based on time: **45-minute** sessions are billed at **\$150** and **55-minute** sessions are **\$175**. Obligation for payment is understood not to be dependent upon the client's receiving third party reimbursement from insurance coverage. While the practice certainly supports and encourages clients to pursue the maximum amount of financial reimbursement from third party payers (such as health insurance agencies), it is ultimately the client's responsibility to insure that s/he receives all third party payments for which s/he may be eligible. Perspectives will submit all insurance billing for health insurance companies that we are networked with. **All co-payments are due at the time of service.** There is a returned check fee of **\$20**. It is our practice policy to keep a credit card on file for all clients in the practice. You may still choose to pay for your balances using another form of payment.

Session fees cover the following professional services:

- Therapy for the individual, couple, family system or psychiatric services
- Initial and ongoing assessment, and treatment planning
- Time spent in consultation with other professionals

Phone contact, other than to schedule appointments, is considered a consultation and billed at \$30 per 15 minutes. Report writing is charged at a rate of \$150 per hour for therapists.

The therapists at PTS do not provide custody evaluations or appear in court. Additionally, evaluations for disability applications are also not completed.

### **CLIENT RIGHTS AND RESPONSIBILITIES:**

Although you may choose to end treatment at any time, you are responsible to attend scheduled sessions. Unless a session is cancelled 24 hours in advance, you will be responsible to remit payment of \$75 for a missed therapy session and \$90 for a missed medication review. This is a strict policy with no exceptions. Please remember that if you are using insurance, charges cannot be submitted for missed sessions and you will be held responsible for the charges as specified above. In cases of excessive absences it will be your therapist's discretion to terminate services at PTS and refer your care elsewhere. If a client owes on their account, payment is expected during each visit in order to continue scheduling. If a balance exists whereby no payments have been made in 30 days, PTS will attempt to contact you. If no payments are made as a result of these attempts, PTS contracts with an external collections service that will then pursue settling the amount due.

Information disclosed during treatment will be kept confidential within the bounds of Perspectives Therapy Services practice and its employees. Protected Health Information will not be revealed to any other person or agency without your written permission. However, there are exceptional circumstances that require your therapist to share information obtained in a therapy session without your permission. These exceptional situations include: 1) If you threaten serious bodily harm to yourself or another person, your therapist is required by law to inform the intended victim and/or the appropriate law enforcement agency; 2) If your therapist is subpoenaed by a court of law to provide specific information, s/he is obligated to comply; and 3) If you reveal information to your therapist about child abuse and/or neglect, s/he is required by law to report this information to the appropriate authority.

After you have carefully read this information and have received satisfactory answers to any questions that may have surfaced, please sign this contract below. Anyone over age 18 must sign this form in order to be treated through Perspectives Therapy Services. Parents or legal guardians must sign for persons under 18 years old.

I have read and understand the information provided in this document and agree to the procedures and conditions outlined. I understand that I may terminate therapy at any time and will be financially responsible for those sessions already completed.

Patient name (please print): \_\_\_\_\_

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent signature for minor client)

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

At times there are persons who join the therapy process who are not identified as the “patient”, however are important to treatment. By signing below you acknowledge this is a health care setting. The protections in place through our practice’s HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or legal guardian must consent to this participation by signing below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ **Initial here to acknowledge that you have read the Notice of Privacy Practices and that a copy of the Notice has been provided to you upon your request.**

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**Insurance Consent**

By signing below I give permission Perspectives Therapy Services to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

\_\_\_\_\_  
Signature of insured Date

**Addendum to Consent to Treatment: Cell Phone Consent**

As a contractual therapist at Perspectives Therapy Services I offer you, the client and/or guardian of the client, the privilege and ability of contacting me via cell phone. This communication includes both phone calls as well as text messaging. Know that this information is indeed a privilege that can be revoked if the therapist deems the client to be abusing the privilege. This definition of abuse is left to the discretion of the therapist and may include, but is not limited to: excessive calls and texts despite the therapist addressing the concern or attempting to contact the therapist after normal business hours.

Please know that because you call or text does not mean you will get a reply immediately or at all. Some concerns brought up in a text message are better addressed in the therapy session. Please note that the intention of receiving this therapists' phone number is primarily for scheduling purposes and to increase efficiency of communication.

Providing this number in no way indicates 24-hour access to my services, nor should it be considered an emergency resource. If you are in crisis, you are still instructed to contact your local Community Mental Health agency (listed below), call 911 or go to your local Emergency Room.

Livingston County: (517) 548-0081  
Oakland County: (800) 231-1127

Ingham County: (517) 346-8200  
Genesee County: (810) 257-3740

Please respect normal business hours when calling or texting.

**HIPAA Privacy Disclosure:**

Please be advised that communication via cell phone is not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls or texts cannot be guaranteed.

**By signing below, I understand and accept the conditions above. Your care at Perspectives Therapy Services will not change should you decline to sign this section of the form. It is completely optional.**

\_\_\_\_\_  
Client Signature (or Parent/Legal Guardian Signature if client is a minor) Date

# REGISTRATION AND INTAKE FORM

## CLIENT CONTACT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_ Is it ok to leave a message? Yes No  
\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Is it ok to leave a message? Yes No  
\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_ Is it ok to leave a message? Yes No  
Email address: \_\_\_\_\_

## APPOINTMENT REMINDERS

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have requested below.

\*\*Missed appointment fees will still apply if the reminder message is not received.

Where would you like to receive an appointment reminder? (check one)

- Via text message on my cell phone (normal text message rates will apply according to your contract)  
 Via email message to the address listed above  
 Via automated telephone message to my home phone  
 None of the above. I'll remember my appointments on my own

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CLIENT PROFILE INFORMATION

Date of Birth: \_\_\_\_\_ Birth/Biological Sex: M F  
Gender:  Female  Male  Transgender (F to M)  Transgender (M to F)  Other \_\_\_\_\_  
Personal Gender Pronoun:  she/her/hers  he/him/his  they/them/theirs  other \_\_\_\_\_  
Relationship Status: Single \_\_\_\_\_ Partnered \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Other \_\_\_\_\_  
Household Member Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Relationship to you \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**\*\*Emergency contact:** \_\_\_\_\_  
Name Phone number Relationship

## REFERRAL INFORMATION

How did you find out about Perspectives Therapy Services?

- Friend(s)/Neighbors  Family Member  Physician/Family Doctor  Web Search/Internet  
 Social Service Agency  Court System  School System  Facebook  
 Other (please specify) \_\_\_\_\_ May we send a thank-you?  Yes  No

If yes, where should this be sent? \_\_\_\_\_

**BILLING INFORMATION**

Responsible Party Name (who pays for services): \_\_\_\_\_ SSN: \_\_\_\_\_

Responsible Party Address: \_\_\_\_\_  
Street City State Zip Code

Primary Insurance Company Name: \_\_\_\_\_

Subscriber/Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient relation to insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber birthdate: \_\_\_\_\_

Subscriber biological sex (as reported to the insurance company): Female Male

Secondary Insurance Company Name: \_\_\_\_\_

Subscriber/Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Patient relation to insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Subscriber birthdate: \_\_\_\_\_

**PREVIOUS THERAPY EXPERIENCE**

Have you received mental health services (counseling/therapy) in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes,.....When? \_\_\_\_\_ Where or with whom? \_\_\_\_\_

For what reason? \_\_\_\_\_

What was *most* helpful about this therapy experience? \_\_\_\_\_

What was *least* helpful about this previous therapy experience? \_\_\_\_\_

**MEDICAL CARE BACKGROUND**

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name of Medical Practice: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please list medications you are currently taking.

Medication _____	Dosage/Frequency _____	Reason for taking _____
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Medication _____	Dosage/Frequency _____	Reason for taking _____
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Medication _____	Dosage/Frequency _____	Reason for taking _____
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Have you ever been hospitalized for reasons relevant to your attending therapy?  Yes  No

If yes, please describe \_\_\_\_\_

Describe what brings you to therapy: \_\_\_\_\_

What would you like to see happen as a result of therapy? \_\_\_\_\_

# PERSPECTIVES THERAPY SERVICES LLC

## Adult History and Symptom Questionnaire

### Basic background information

First name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

What type of therapy are you seeking (check all that apply)?  Individual  Couple  Family

Marital status:  Married  Divorced  Single  Widowed  Separated

How many times have you been married? \_\_\_\_\_ How long in current marriage? \_\_\_\_\_

Religious affiliation: \_\_\_\_\_ Military history: \_\_\_\_\_

Employment Status:  Full-time  Part-time  Unemployed not looking for work  Unemployed looking for work  Self-employed  Retired

Job title: \_\_\_\_\_ Company name: \_\_\_\_\_

Education: Highest Grade Completed \_\_\_\_\_ Degree: \_\_\_\_\_ Other: \_\_\_\_\_

### Current concerns

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Loss of loved one through death    | <input type="checkbox"/> Separation from loved one      | <input type="checkbox"/> Divorce                             | <input type="checkbox"/> Trauma                    |
| <input type="checkbox"/> Care of elders/loved ones          | <input type="checkbox"/> Marriage difficulty            | <input type="checkbox"/> Lifecycle transition                | <input type="checkbox"/> Low self-worth            |
| <input type="checkbox"/> Change of jobs                     | <input type="checkbox"/> Employment concerns            | <input type="checkbox"/> Stress                              | <input type="checkbox"/> Abortion                  |
| <input type="checkbox"/> Spouse/significant other conflict  | <input type="checkbox"/> Family conflict                | <input type="checkbox"/> Parenting issues                    | <input type="checkbox"/> Co-dependency             |
| <input type="checkbox"/> Custody issues                     | <input type="checkbox"/> Pregnancy                      | <input type="checkbox"/> Fertility issues                    | <input type="checkbox"/> Victim of emotional abuse |
| <input type="checkbox"/> Behavior of adult children         | <input type="checkbox"/> Gender identity                | <input type="checkbox"/> Worry/anxiety interfering with life | <input type="checkbox"/> Suicidal thoughts         |
| <input type="checkbox"/> Health problems                    | <input type="checkbox"/> Victim of physical abuse       | <input type="checkbox"/> Financial problems                  | <input type="checkbox"/> Suicidal behaviors        |
| <input type="checkbox"/> Substance abuse                    | <input type="checkbox"/> Gambling                       | <input type="checkbox"/> Eating disorder                     | <input type="checkbox"/> Phobia (specific fear)    |
| <input type="checkbox"/> Excessive computer/electronics use | <input type="checkbox"/> Sexual orientation exploration | <input type="checkbox"/> Sexual assault/rape                 | <input type="checkbox"/> Legal problems            |
| <input type="checkbox"/> Pornography seeking behaviors      | <input type="checkbox"/> Violent/abusive behavior       | <input type="checkbox"/> Residual childhood experiences      | <input type="checkbox"/> Employment problems       |
| <input type="checkbox"/> Interpersonal problems             | <input type="checkbox"/> Unhappy, feeling depressed     | <input type="checkbox"/> School problems                     | <input type="checkbox"/> Other: _____              |

### Symptoms

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> nervousness                 | <input type="checkbox"/> dizziness/headaches         | <input type="checkbox"/> fainting spells     | <input type="checkbox"/> heart palpitations     | <input type="checkbox"/> stomach trouble                |
| <input type="checkbox"/> anxiety                     | <input type="checkbox"/> bowel disturbances          | <input type="checkbox"/> nightmares          | <input type="checkbox"/> feel tense             | <input type="checkbox"/> tremors                        |
| <input type="checkbox"/> unable to relax             | <input type="checkbox"/> shy with people             | <input type="checkbox"/> sleep difficulties  | <input type="checkbox"/> overambitious          | <input type="checkbox"/> unmotivated                    |
| <input type="checkbox"/> uneasy in social situations | <input type="checkbox"/> inferiority feelings        | <input type="checkbox"/> can't keep a job    | <input type="checkbox"/> lonely                 | <input type="checkbox"/> impulsivity                    |
| <input type="checkbox"/> excessive sweating          | <input type="checkbox"/> difficulty making decisions | <input type="checkbox"/> wanting to run away | <input type="checkbox"/> persistent worrying    | <input type="checkbox"/> indecisiveness                 |
| <input type="checkbox"/> weight loss (____ lbs.)     | <input type="checkbox"/> weight gain (____ lbs.)     | <input type="checkbox"/> panic attacks       | <input type="checkbox"/> memory problems        | <input type="checkbox"/> loss of interest in activities |
| <input type="checkbox"/> difficulty concentrating    | <input type="checkbox"/> withdrawn/avoid others      | <input type="checkbox"/> decreased energy    | <input type="checkbox"/> drink too much alcohol | <input type="checkbox"/> irritability                   |
| <input type="checkbox"/> quick to anger              | <input type="checkbox"/> overeat/binge               | <input type="checkbox"/> restrict food       | <input type="checkbox"/> self-harm behaviors    | <input type="checkbox"/> suicidal thoughts              |
| <input type="checkbox"/> abuse recreational drugs    | <input type="checkbox"/> abuse prescription meds     | <input type="checkbox"/> crying episodes     | <input type="checkbox"/> exercise excessively   | <input type="checkbox"/> mood swings                    |
| <input type="checkbox"/> loss of interest in sex     | <input type="checkbox"/> pornography addiction       | <input type="checkbox"/> negative body image | <input type="checkbox"/> poor boundary setting  | <input type="checkbox"/> racing thoughts                |
| <input type="checkbox"/> obsessive thoughts          | <input type="checkbox"/> inattention                 | <input type="checkbox"/> lack of focus       | <input type="checkbox"/> lack of motivation     | <input type="checkbox"/> easily distracted              |
| <input type="checkbox"/> self-critical               | <input type="checkbox"/> poor work performance       | <input type="checkbox"/> teeth grinding      | <input type="checkbox"/> aggressive behaviors   | <input type="checkbox"/> fatigue                        |

Other:  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_

## Self-care

Check all the following areas of support that you use:

Nuclear family

Church/mosque/temple

Spouse/intimate partner

Extended family

Group of friends

12-step or similar program

Service system

Close friend

Specifically what do you do (indicate now or in the past) to take care of yourself:

Plenty of sleep

Balanced nutrition

Watch television or movies

Use social media

Meditate

Pray

Exercise/Movement (yoga)

Engage socially

Journal/write

Listen to or play music

Positive self-talk (affirmations)

Artistic expression (draw, paint)

Take time to laugh

Block out time for self

Go to therapy ☺

Read

What else?:  \_\_\_\_\_

## Strengths

bright

insightful

motivated

good leader

optimistic

able to self-regulate emotions

have friends

can calm myself

resourceful

responsible

can ask for help

keep my boundaries

morally ethical

can solve problems

grateful

able to forgive

can express feelings

financially wise

brave/courageous

hopeful

sense of humor

compassionate/kind

patient

good listener

open-minded

stable employment

able to say "no"

active

creative

willing to try new attitudes & behaviors

persistent

## Medical/Psychiatric History

Please check any illness you currently have or have had in the past:

Diabetes

High/Low Blood Pressure

Lung Disease

Heart Disease

Low Blood Pressure

Asthma

Cancer

Any Sexually Transmitted Illness

Arthritis

Substance Abuse

Seizures

Traumatic Brain Injury

Migraines

Thyroid Disease

AIDS/HIV

Depression

Auto-Immune Disorders

Cirrhosis

Muscular Disorder

Nerve Disorder

Bi-polar Disorder

Personality Disorder

Anxiety Disorder

Attention Deficit Disorder

Psychotic Disorder (such as schizophrenia)

Ulcer

Colitis/IBS

Learning Disorder

Eating Disorder

Other (please describe) \_\_\_\_\_

Which relatives have experienced any mental health or substance abuse related problems?

\_\_\_\_\_  
Family member/relationship to you

\_\_\_\_\_  
Psychiatric concern/diagnosis

\_\_\_\_\_  
Family member/relationship to you

\_\_\_\_\_  
Psychiatric concern/diagnosis

\_\_\_\_\_  
Family member/relationship to you

\_\_\_\_\_  
Psychiatric concern/diagnosis

Is there anything else you would like me to know about your medical history?

## Risk Assessment

**Caffeine consumption:** What is your typical caffeinated drinks of choice? (circle one) Coffee Tea Soda \_\_\_\_\_ ounces/day

**Nicotine use:** Do you currently smoke cigarettes?  Yes  No **Recreation drug use?**  Yes  No

**Alcohol consumption:** What is your typical drink of choice? (circle one) Beer Wine Liquor

Estimated daily or weekly consumption: \_\_\_\_\_ cans/bottles/glasses, ounces/day or \_\_\_\_\_ cans/bottles/glasses, ounces/week

Are you currently having suicidal thoughts?  Yes  No

Have you ever made a suicide attempt?  Yes  No If yes, when and how? \_\_\_\_\_

Has anyone close to you made a suicide attempt?  Yes  No Has anyone close to you completed suicide?  Yes  No

~ *Perspectives Therapy Services, LLC* ~

**Medical Provider Coordination of Care**

(Authorization to Disclose Protected Health Information)

**Client name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

In order to provide you with the highest quality care, we ask your permission to communicate with your primary care physician (PCP) or psychiatrist. This is also a requirement of most health insurance companies and, therefore, part of our compliance contract with these payors.

Please read & check the appropriate box. If you do want information to go to your medical provider, then check the “YES” box, and sign below. If you do not want information to go to your medical provider, then check the “NO” box, and sign below.

**Yes**      **No**    I do hereby authorize/give my permission to exchange information with my medical provider listed below regarding my mental health treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health or substance abuse care and/or treatment such as diagnosis, estimated length of treatment, type of treatment to be provided, and the treatment plan. I also understand that my therapist will provide my medical provider with periodic status reports of my progress during the course of treatment.

I further understand that the authorization shall remain in effect for one (1) year from the date of my signature or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to my therapist at Perspectives Therapy Services. I also understand that it is my responsibility to notify my therapist if I choose to change my medical provider.

**Medical Provider name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Practice name:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

**Practice address:** \_\_\_\_\_  
\_\_\_\_\_

**Psychiatrist name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Practice name:** \_\_\_\_\_ **Fax number:** \_\_\_\_\_

**Practice address:** \_\_\_\_\_  
\_\_\_\_\_

**Client/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Credit Card Authorization

*Perspectives Therapy Services, LLC* uses an integrated electronic medical record-keeping system for client charts and billing. This form serves as an authorization to input your credit card information into our secure system and charge it when a balance on your account exists.

The following are examples of charges that will be charged to the credit card on file: co-payments, deductibles, document preparation/report-writing fees, costs for attendance at collaboration meetings, late cancel and no-show fees, and returned check fees.

Type of Card (check one):  MASTERCARD  VISA  AMERICAN EXPRESS  DISCOVER

Type of Card (circle one): CREDIT HSA/FSA DEBIT

Name of Cardholder: \_\_\_\_\_

Card No. \_\_\_\_\_

Expiration date: \_\_\_\_\_ CVV2 (security code): \_\_\_\_\_

Client address: \_\_\_\_\_  
Street City State Zip Code

Authorizing signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client name (printed): \_\_\_\_\_

\*This card will be used for any and all providers with whom a client receives services from through Perspectives Therapy Services. It is the client's responsibility to update credit card information with our practice as changes occur.

For Office Use Only: