DISCLOSURE STATEMENT AND CONSENT TO TREATMENT
~ Perspectives Therapy Services LLC ~

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.

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

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

Child History and Symptom Questionnaire

Basic Background Information

Child's name:_____ Birthdate:_____ Present age:_____

Name of person completing form:_____ Today's Date:_____

Relationship to Child: ☐ Biological or Adoptive Parent ☐ Guardian ☐ Other (Specify) _____

Biological Parent Information

Relationship status: ☐ Married ☐ Divorced ☐ Never married ☐ Separated ☐ Widowed

Child's age at time of divorce:_____ Child's age at time of parent death:_____

Living environment: ☐ Same home ☐ Different homes

Legal custody arrangement:_____

Physical custody arrangement:_____

☐ Child resides with neither parent Please explain:_____

Quality of biological parents' relationship: (check all that apply)

☐ Effective co-parenting team ☐ Usually on the same page ☐ Different parenting styles ☐ Poor communication

☐ Similar goals for parenting ☐ High degree of mutual respect ☐ Low levels of respect noted ☐ No contact

Parent A employment: ☐ Employed – FT or PT ☐ Unemployed ☐ Social Security ☐ Not seeking employment

☐ Enrolled in School ☐ Retired ☐ Self-employed ☐ Stay at home parent

Parent B employment: ☐ Employed – FT or PT ☐ Unemployed ☐ Social Security ☐ Not seeking employment

☐ Enrolled in School ☐ Retired ☐ Self-employed ☐ Stay at home parent

Was your pregnancy with this child: planned or unplanned (circle one)

School History

Current grade of your child:_____ Current school your child attends:_____

Has your child not passed a grade or been held back? ☐ Yes ☐ No

If yes, what grade(s) and why?_____

Does your child experience problems in the following areas? (check all that apply)

☐ Reading ☐ Math ☐ Spelling ☐ Emotional regulation ☐ Paying attention

☐ Attendance ☐ Obeying rules ☐ Making friends ☐ Following directions ☐ Fighting ☐ Teacher relationships

Is your child utilizing or being considered for special resources/services? ☐ Yes ☐ No

Has your child been tested for learning problems? ☐ Yes ☐ No If yes, when tested?_____ By who?_____

Does your child currently work with a school counselor or social worker? ☐ Yes ☐ No If yes, who?_____

Please describe any concerns or problems you have about your child's school performance:_____

_____

Please describe any concerns that your child's teachers have about your child: _____

_____

Strengths

☐ bright	☐ loving	☐ motivated	☐ good leader	☐ optimistic	☐ sense of humor	☐ open-minded
☐ creative	☐ has friends	☐ can calm self	☐ resourceful	☐ responsible	☐ adaptable	☐ compassionate/kind
☐ can ask for help	☐ establishes boundaries	☐ active	☐ good solve problems	☐ grateful	☐ patient	☐ willing to try new things
☐ able to forgive	☐ can express feelings	☐ persistent	☐ brave/courageous	☐ hopeful	☐ good listener	☐ able to say "no"

Current Concerns

- ☐ Difficulty maintaining attention or easily distracted
- ☐ Seems not to listen when spoken to directly
- ☐ Fidgets with hands or squirms in seat
- ☐ Bullies, threatens or intimidates others
- ☐ Has engaged in fire-setting
- ☐ Defies adult requests or rules
- ☐ Deliberately destroys property
- ☐ Often argues with adults and others in authority
- ☐ Seems angry or resentful
- ☐ Worries something bad will happen to parent(s)
- ☐ Toileting problems (including bed wetting)
- ☐ Anxiety in social situations
- ☐ Issues with low self-esteem
- ☐ Persistent feelings of sadness
- ☐ Has been bullied by peer(s)
- ☐ Loss, grief or separation from loved one
- ☐ Seems to engage in attention-seeking behaviors
- ☐ Unhealthy eating habits
- ☐ Experimentation with substance(s)
- ☐ Recent break-up with girlfriend or boyfriend
- ☐ Strained parent-child relationship
- ☐ Sensitive to noises, fabrics, lights, temperatures, etc.
- ☐ Often loses things
- ☐ Verbally or physically aggressive
- ☐ Has been cruel to animals or people
- ☐ Difficulty maintaining friendships
- ☐ Has stolen items from others or stores
- ☐ Actively defies rules or refuses to comply
- ☐ Blames others for his/her mistakes or misbehavior
- ☐ Specific, repetitive behaviors
- ☐ Issues with impulsivity
- ☐ Issues separating from a loved one
- ☐ Difficulty when routine is disrupted/issues transitioning
- ☐ Engages in self-harm behaviors
- ☐ Withdrawal from previously enjoyed activities
- ☐ Feelings of hopelessness
- ☐ Suicidal attempt
- ☐ People pleasing behaviors
- ☐ Desires to change weight
- ☐ Excessive use of electronics
- ☐ Sexual orientation questions
- ☐ Homocidal thoughts
- ☐ Difficulty organizing tasks
- ☐ Forgetful
- ☐ Often loses temper
- ☐ Starts fights
- ☐ Often lies
- ☐ Deliberately annoys people
- ☐ Issues w/ school attendance
- ☐ Seems easily annoyed
- ☐ Excessive worry
- ☐ Sleep difficulties
- ☐ Refuses to go to school
- ☐ Repeated nightmares
- ☐ Irritable
- ☐ Cries often
- ☐ Suicidal thoughts
- ☐ Perfectionistic tendencies
- ☐ Poor body image
- ☐ Low energy/fatigue
- ☐ Sexual abuse/molestation
- ☐ Gender identity questions
- ☐ Intrusive thoughts

Has your child witnessed any traumatic event(s)? ☐ Yes ☐ No If yes, please explain:_____

_____

Has your child experienced any significant loss(es)? If yes, please explain:_____

_____

Is your child currently having suicidal thoughts? ☐ Yes ☐ No

Has your child had suicidal thoughts in the past? ☐ Yes ☐ No If yes, when?_____

Has your child ever been hospitalized for mental health related concerns? ☐ Yes ☐ No If yes, when and where?_____

How would you describe the quality of the parent-child relationships?_____

_____

Please identify biological family members and their relationship to your child who have a history of mental health/substance abuse problems, or suicidal thoughts/attempts:

_____ _____
Family member/relationship to child — Psychiatric concern/diagnosis

_____ _____
Family member/relationship to child — Psychiatric concern/diagnosis

_____ _____
Family member/relationship to child — Psychiatric concern/diagnosis

~ 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:** _____

~ Perspectives Therapy Services, LLC ~

School 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 child's school support system. In creating a comprehensive care team to address needs and treatment goals, it is often helpful for us to connect with school social workers, school counselors, and teachers.

Please read & check the appropriate box. If you do want information to go to the school system, then check the "**YES"** box and sign below. If you do not want information to go to the school system, then check the **"NO**" box and sign below.

Yes **No** I do hereby authorize/give my permission to exchange information with school personnel listed below regarding my child's mental health treatment and medical healthcare for coordination of care purposes. 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 school support system 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 our support team changes within the school (new teachers, social worker or counselor assigned).

School professional's name: _____ **Position:**_____

School name:_____ Phone number:_____ Fax number:_____

School address:_____

_____

School professional's name: _____ **Position:**_____

School name:_____ Phone number:_____ Fax number:_____

School address:_____

Client Signature (if over 12): _____ **Date:** _____

Parent/Legal Guardian Signature (if client is 17 or younger):

_____ **Date:** _____

Staff Witness Signature: _____ **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: