Relationship Intake Packet

Hello there,

You should have received two of these Relationship Intake Packets via email. As you navigate relational therapy, it will be helpful for your therapist to have a sense of what both partners are currently experiencing. Each partner should take some time and space individually to complete and submit one packet. "Client" refers to the person completing the packet.

Please fill out this questionnaire and all attached documents. Your answers will be saved as you go, so no need to finish it all in one sitting. For best outcomes, it is important that we receive your thoroughly completed form at least 48 hours prior to your first appointment. Thank you, and we look forward to working with you!

-PTS Team

CLIENT PROFILE INFORMATION

1. CLIENT CONTACT INFORMATION

First Name: _____ Middle Initials: _____ Last Name: _____

Social Security #: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Home Phone: _____ Work Phone: _____ Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. Date of Birth: _____ Birth/Biological Sex: ○ Female ○ Male Racial/Cultural Identity: _____

Gender: _____ Gender Pronouns (ex: she/her/hers, they/them/theirs, etc.): _____

Marital Status: _____ Religious affiliation: _____

Military history: _____ Employment status: _____

Job title: _____ Company name: _____

Education: Highest Grade Completed/Degree earned/Vocational program: _____

3.

	Household Member Name	Date of Birth	Relationship to You
1			
2			
3			
4			
5			

4. Emergency Contact Name: Emergency Contact Relationship:

Emergency Contact Phone #:

REFERRAL INFORMATION

5. 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
- ☐ Psychology Today
- ☐ Perspectives' Website
- ☐ Instagram
- ☐ Other

If other, please specify:

6. May we send a thank-you?
○ Yes ○ No

If yes, where should this be sent?

BILLING INFORMATION

7. Responsible Party Name (who pays for services): Social Security Number:

Responsible Party Address:

8. Primary Insurance

Primary Insurance Company: Member ID / Policy #: Group Number:

Client Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name: Insured Phone #: Insured Date of Birth: Insured Biological Sex:
○ Female ○ Male

Insured Street Address: | Insured City: | Insured State: | Zip Code:

9. Secondary Insurance

Secondary Insurance Company: | Member ID / Policy #: | Group Number:

Client Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name: | Insured Phone #: | Insured Date of Birth: | Insured Biological Sex:
○ Female ○ Male

Insured Street Address: | Insured City: | Insured State: | Zip Code:

PREVIOUS THERAPY EXPERIENCE

10. 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?

Describe what brings you to therapy:

MEDICAL CARE BACKGROUND

11. Primary Care Physician: | Phone Number:

Name of Medical Practice: | Fax Number:

Address:

12. Please list medications you are currently taking.

	Medication	Dosage	Reason for Taking?
1			
2			
3			

13. Have you ever been hospitalized for reasons relevant to your attending therapy?

○ Yes ○ No

If yes, please describe

_____

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

- ☐ Diabetes
- ☐ Depression
- ☐ High/Low Blood Pressure
- ☐ Auto-Immune Disorders
- ☐ Lung Disease
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Attention Deficit Disorder
- ☐ Substance Abuse
- ☐ Psychotic Disorder (such as schizophrenia)
- ☐ Asthma
- ☐ Bi-polar Disorder
- ☐ Cancer
- ☐ Personality Disorder
- ☐ Migraines
- ☐ Learning Disorder
- ☐ Thyroid Disease
- ☐ Eating Disorder
- ☐ AIDS/HIV
- ☐ Sexually Transmitted Infection
- ☐ Seizures
- ☐ Ulcer
- ☐ Traumatic Brain Injury
- ☐ Colitis/IBS
- ☐ Cirrhosis
- ☐ Heart Disease
- ☐ Muscular Disorder
- ☐ Low Blood Pressure
- ☐ Nerve Disorder
- ☐ Other

If other, please specify:

_____

15. Please identify any relatives that have experienced a mental health or substance abuse related problem:

	Family member/relationship to you	Psychiatric concern/diagnosis
1		
2		
3		

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

_____

Current Concerns/Symptoms

17.

- ☐ Issues with low self esteem
- ☐ Suicidal ideation
- ☐ Sleep Disturbance
- ☐ Sexual abuse
- ☐ Withdrawn/avoids others
- ☐ Forgetful
- ☐ Racial trauma
- ☐ Homicidal thoughts
- ☐ Intrusive/obsessive thoughts
- ☐ Difficulty concentrating
- ☐ Body image issues
- ☐ Racing thoughts
- ☐ Quick to anger
- ☐ Wanting to run away
- ☐ Persistent Worrying
- ☐ Weight loss
- ☐ Poor work performance
- ☐ Overambitious
- ☐ Mood swings
- ☐ Pregnancy
- ☐ Sexual Assault
- ☐ Gender identity
- ☐ Low self worth
- ☐ Relational conflict
- ☐ Life cycle transition
- ☐ Termination of pregnancy
- ☐ Difficulty when routine is disrupted
- ☐ Sensitive to noises, fabrics, lights, etc.
- ☐ Grief/loss or separation from loved one
- ☐ Overuse of prescription medications
- ☐ Pornography seeking behaviors
- ☐ Issues with impulsivity
- ☐ Excessive use of electronics
- ☐ Irritable
- ☐ Xenophobia
- ☐ People pleasing behaviors
- ☐ Lying behaviors
- ☐ Restless/fidgety
- ☐ Excessive worry
- ☐ Nervousness
- ☐ Loss of interest in sex
- ☐ Heart Palpitations
- ☐ Anxiety
- ☐ Difficulty making decisions
- ☐ Restrict food
- ☐ Lack of motivation
- ☐ Weight gain
- ☐ Panic attacks
- ☐ Exercise excessively
- ☐ Boundary issues
- ☐ Gambling
- ☐ Trauma
- ☐ Parenting issues
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Fertility issues
- ☐ Legal involvement
- ☐ Repeated nightmares/flashbacks
- ☐ Experimentation with substances
- ☐ Specific common repetitive behaviors
- ☐ Stomach trouble/bowel disturbances
- ☐ Spouse or significant other conflict
- ☐ Engage in self harm behaviors
- ☐ Difficulty organizing tasks
- ☐ Perfectionistic tendencies
- ☐ Persistent feelings of sadness
- ☐ LGBTQ+ experience
- ☐ Frequent crying episodes
- ☐ Feelings of hopelessness
- ☐ Low energy/fatigue
- ☐ Uneasy in social situations
- ☐ Dizziness/headaches
- ☐ Lonely
- ☐ Excessive sweating
- ☐ Overeat/binge
- ☐ Body tension
- ☐ Unable to relax
- ☐ Self critical
- ☐ Teeth grinding
- ☐ Loss of interest in activities
- ☐ Paranoia
- ☐ Stress
- ☐ Employment concerns
- ☐ Financial problems
- ☐ Phobia (specific fear)
- ☐ Violent behaviors
- ☐ School problems
- ☐ Difficulty maintaining relationships
- ☐ Defy rules and refuse to comply
- ☐ Engage in attention seeking behaviors
- ☐ Residual childhood experiences
- ☐ Difficulty maintaining attention or easily distracted
- ☐ Blame others for mistakes or behavior

Self-care

18. Check all the following areas of support that you use:

- ☐ Nuclear family
- ☐ Church/mosque/temple
- ☐ Extended family
- ☐ Spouse/intimate partner
- ☐ Group of friends
- ☐ 12-step or similar program
- ☐ Service system
- ☐ Close friend

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

- ☐ Plenty of sleep
- ☐ Meditate
- ☐ Journal/write
- ☐ Take time to laugh
- ☐ Balanced nutrition
- ☐ Pray
- ☐ Listen to or play music
- ☐ Block out time for self
- ☐ Watch television or movies
- ☐ Go to therapy
- ☐ Use social media
- ☐ Engage socially
- ☐ Read
- ☐ Positive self-talk (affirmations)
- ☐ Exercise/Movement (yoga)
- ☐ Artistic expression (draw,paint)
- ☐ Other

If other, please specify:

_____

Strengths

20.

- ☐ Bright
- ☐ Can ask for help
- ☐ Able to forgive
- ☐ Sense of humor
- ☐ Stable employment
- ☐ Insightful
- ☐ Have friends
- ☐ Keep my boundaries
- ☐ Can express feelings
- ☐ Compassionate/kind
- ☐ Able to say “no”
- ☐ Motivated
- ☐ Can calm myself
- ☐ Morally ethical
- ☐ Financially wise
- ☐ Patient
- ☐ Active
- ☐ Creative
- ☐ Good leader
- ☐ Resourceful
- ☐ Can solve problems
- ☐ Brave/courageous
- ☐ Good listener
- ☐ Optimistic
- ☐ Responsible
- ☐ Grateful
- ☐ Hopeful
- ☐ Open-minded
- ☐ Persistent
- ☐ Able to self-regulate emotions
- ☐ Willing to try new attitudes & behaviors

Risk Assessment

21. Substance Use

Caffeine consumption:
○ None ○ Occasional ○ Social ○ Regular ○ Heavy consumption ○ Trying to limit/reduce consumption
○ Currently abstaining

Tobacco/Nicotine use:
○ None ○ Occasional ○ Social ○ Regular ○ Heave use ○ Trying to limit/reduce use
○ Currently abstaining

Recreational drug use:
○ None ○ Occasional ○ Social ○ Regular ○ Heave use ○ Trying to limit/reduce use
○ Currently abstaining

Alcohol consumption:
○ None ○ Occasional ○ Social ○ Regular ○ Heave use ○ Trying to limit/reduce use
○ Currently abstaining

22. Sucidal Ideation

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

Relationship History and Symptom Questionnaire

23. Basic Background Information

Name of person completing this form: _____ Date of Birth: _____

Partner's name: _____ Date of Birth: _____

24. Relationship Status:
○ Married ○ Separated ○ Divorced ○ Dating ○ Engaged ○ Living together ○ Living apart

Length of time in current relationship? _____

Do you have children together?
○ Yes ○ No

If yes, what are the children's names and ages?

25. How many times have you been married?
○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

Duration(s) of previous marriage(s):

Do you have children from previous relationships?
○ Yes ○ No

If yes, what are the children's names and ages?

Quality of Current Intimate Relationship

26. How would you rate the present state of your relationship in the following areas? (1=Very Poor, 5=Excellent)

	1	2	3	4	5
1. Affection					
2. Emotional Closeness					
3. Commitment					
4. Communication					
5. Child-rearing agreement					
6. Financial security					
7. Honesty					
8. Housework shared					
9. Physical attraction					
10. Religious commitment					
11. Respect					
12. Social life together					
13. Time together					
14. Trust					
15. Decision-making					
16. Sexual fulfillment/enjoyment					
17. Sexual frequency					

27. How would you rate your own desire or need for the following areas? (1=Not important to me, 5=Extremely important to me)

	1	2	3	4	5
1. Affection					
2. Emotional Closeness					
3. Commitment					
4. Communication					
5. Child-rearing agreement					
6. Financial security					
7. Honesty					
8. Housework shared					
9. Physical attraction					
10. Religious commitment					
11. Respect					
12. Social life together					
13. Time together					
14. Trust					
15. Decision-making					
16. Sexual fulfillment/enjoyment					
17. Sexual frequency					

28. How would you rate your partner's desire or need for the following areas? (1=Not important to me, 5=Extremely important to me)

	1	2	3	4	5
1. Affection					
2. Emotional Closeness					
3. Commitment					
4. Communication					
5. Child-rearing agreement					
6. Financial security					
7. Honesty					
8. Housework shared					
9. Physical attraction					
10. Religious commitment					
11. Respect					
12. Social life together					
13. Time together					
14. Trust					
15. Decision-making					
16. Sexual fulfillment/enjoyment					
17. Sexual frequency					

29. How often do I personally demonstrate the following behaviors during conflict with my partner?

	Never	Rarely	Sometimes	Frequently	Always
1. Apologize					
2. Become silent					
3. Bring up the past					
4. Criticize					
5. Make cruel accusations					
6. Cry					
7. Destroy property					
8. Leave the house					
9. Make peace					
10. Namecall					
11. Light-hearted joke					

12. Not listen/Ignore					
13. Hit, push, kick					
14. Make physical threats					
15. Use sarcasm					
16. Yell					
17. Slam doors					
18. Become defensive					
19. Asks clarifying questions					
20. Use validation					
21. Express emotions					
22. Invite dialogue					
23. Speak calmly					
24. Escalate					
25. Threaten breaking up					
26. Use tender touch					
27. Caretaking					
28. Threaten to take kids					
29. Throw things					
30. Verbally attack					
31. Roll eyes					
32. Threaten to hurt self					
33. Take time out to calm					
34. Use alcohol or drugs					
35. Threaten to hurt others					

30. How often do I observe my partner demonstrating the following behaviors during conflict with me?

	Never	Rarely	Sometimes	Frequently	Always
1. Apologies					
2. Become silent					
3. Bring up the past					
4. Criticize					
5. Cruel accusations					
6. Cry					

7. Destroy property					
8. Leave the house					
9. Make peace					
10. Namecall					
11. Light-hearted joke					
12. Not listen					
13. Hit, push, kick					
14. Physical threats					
15. Sarcasm					
16. Yell					
17. Slam doors					
18. Defensive					
19. Ask clarifying ?s					
20. Validating responses					
21. Express emotions					
22. Invite dialogue					
23. Speak calmly					
24. Escalate					
25. Threaten breaking up					
26. Tender touch					
27. Caretaking					
28. Threaten to take kids					
29. Throw things					
30. Verbal attack					
31. Eye rolling					
32. Threaten to hurt self					
33. Take time out to calm					
34. Use alcohol or drugs					
35. Threaten to hurt other					

31. Please upload: 1. Front and back of your insurance card. 2. Drivers license. *If preferred, you can send a photo or scan of these required items to (810) 214-0760*

Relationship Symptom Questionnaire (For Partner)

Relationship History and Symptom Questionnaire

1. Basic Background Information

Name of person completing this form: _____ Date of Birth: _____

Partner's name: _____ Date of Birth: _____

2. Relationship Status:
○ Married ○ Separated ○ Divorced ○ Dating ○ Engaged ○ Living together ○ Living apart

Length of time in current relationship? _____

Do you have children together?
○ Yes ○ No

If yes, what are the children's names and ages?

_____

_____

3. How many times have you been married?
○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

Duration(s) of previous marriage(s): _____

Do you have children from previous relationships?
○ Yes ○ No

If yes, what are the children's names and ages?

_____

_____

Quality of Current Intimate Relationship

4. How would you rate the present state of your relationship in the following areas? (1=Very Poor, 5=Excellent)

	1	2	3	4	5
1. Affection					
2. Emotional Closeness					
3. Commitment					
4. Communication					
5. Child-rearing agreement					
6. Financial security					
7. Honesty					
8. Housework shared					
9. Physical attraction					
10. Religious commitment					
11. Respect					
12. Social life together					
13. Time together					
14. Trust					
15. Decision-making					
16. Sexual fulfillment/enjoyment					
17. Sexual frequency					

5. How would you rate your own desire or need for the following areas? (1=Not important to me, 5=Extremely important to me)

	1	2	3	4	5
1. Affection					
2. Emotional Closeness					
3. Commitment					
4. Communication					
5. Child-rearing agreement					
6. Financial security					
7. Honesty					
8. Housework shared					
9. Physical attraction					
10. Religious commitment					
11. Respect					
12. Social life together					
13. Time together					
14. Trust					
15. Decision-making					
16. Sexual fulfillment/enjoyment					
17. Sexual frequency					

6. How would you rate your partner's desire or need for the following areas? (1=Not important to me, 5=Extremely important to me)

	1	2	3	4	5
1. Affection					
2. Emotional Closeness					
3. Commitment					
4. Communication					
5. Child-rearing agreement					
6. Financial security					
7. Honesty					
8. Housework shared					
9. Physical attraction					
10. Religious commitment					
11. Respect					
12. Social life together					
13. Time together					
14. Trust					
15. Decision-making					
16. Sexual fulfillment/enjoyment					
17. Sexual frequency					

7. How often do I personally demonstrate the following behaviors during conflict with my partner?

	Never	Rarely	Sometimes	Frequently	Always
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4. Criticize					
5. Make cruel accusations					
6. Cry					
7. Destroy property					
8. Leave the house					
9. Make peace					
10. Namecall					
11. Light-hearted joke					

12. Not listen/Ignore					
13. Hit, push, kick					
14. Make physical threats					
15. Use sarcasm					
16. Yell					
17. Slam doors					
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19. Asks clarifying questions					
20. Use validation					
21. Express emotions					
22. Invite dialogue					
23. Speak calmly					
24. Escalate					
25. Threaten breaking up					
26. Use tender touch					
27. Caretaking					
28. Threaten to take kids					
29. Throw things					
30. Verbally attack					
31. Roll eyes					
32. Threaten to hurt self					
33. Take time out to calm					
34. Use alcohol or drugs					
35. Threaten to hurt others					

8. How often do I observe my partner demonstrating the following behaviors during conflict with me?

	Never	Rarely	Sometimes	Frequently	Always
1. Apologies					
2. Become silent					
3. Bring up the past					
4. Criticize					
5. Cruel accusations					
6. Cry					

7. Destroy property					
8. Leave the house					
9. Make peace					
10. Namecall					
11. Light-hearted joke					
12. Not listen					
13. Hit, push, kick					
14. Physical threats					
15. Sarcasm					
16. Yell					
17. Slam doors					
18. Defensive					
19. Ask clarifying ?s					
20. Validating responses					
21. Express emotions					
22. Invite dialogue					
23. Speak calmly					
24. Escalate					
25. Threaten breaking up					
26. Tender touch					
27. Caretaking					
28. Threaten to take kids					
29. Throw things					
30. Verbal attack					
31. Eye rolling					
32. Threaten to hurt self					
33. Take time out to calm					
34. Use alcohol or drugs					
35. Threaten to hurt other					

Disclosure Statement and Consent to Treatment

THERAPIST TRAINING AND CREDENTIALS:

Thank you for choosing *Perspectives Therapy Services* LLC for your emotional, mental, and relationship needs. Your therapist with Perspectives has received an advanced degree in one or more of the following fields: marriage, family therapy, social work, or professional counseling. 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 fo both the problem and its solutions.

The initial assessment meeting for therapy is charged at **$225**. Subsequent therapy sessions are charged based on time: **45-minute** sessions are billed at **$150** and **55-minute** sessions are **$185**. 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, or family systems
- Initial and ongoing assessment, and treatment planning
- Time spent in consultation with other professional

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.

COURT INVOLVEMENT AND FEES

Your therapist is trained to be a mental health provider, operating in a confidential space on behalf of the best interest of their clients. Your therapist is not trained, nor positioned to serve in an evaluative role for legal or court purposes. They will not make any recommendations or predictions that would be outside of

their scope of practice. Therefore, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your Perspectives Therapy Services provider to testify in court or at any other proceeding. Additionally, you agree that psychotherapy records, which are an extension of the privileged relationship between a client and therapist, will not be requested.

I agree to not subpoena or court order my therapist to appear in court for any reason. I agree my therapist will not appear as a witness (either fact or expert) in court on my behalf.

In the event that a therapist is called to participate in a legal proceeding, including but not limited to testifying through deposition or court appearance, responding to a subpoena or court order, supplying case file information or a written report, or conversations with an attorney, a retainer of $2500 is required and must be paid by you at least 7 days before participation in any legal proceeding. This fee will be charged to the card on file. The retainer fee is non-refundable once a therapist's schedule is blocked. Additional charges will be incurred at the rate of $300 per hour (charged in 15 minute increments) + the allowable IRS mileage reimbursement rate. It is noted that these charges are not made for the testimony itself, as fact witnesses are paid a nominal stipend for their time and a treating therapist would not ethically serve as an expert in a case. Rather, these charges are to compensate the therapist for a loss of income that would be incurred from not being able to see clients, as well as for preparation time and paperwork related matters.

Additionally, we do not complete evaluations for disability applications and, rather, advise that a medical doctor or psychiatrist be consulted for this need.

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 $85 for a missed therapy session. 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.

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.

_____ **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.

Communication between Therapist and Client

Providers at Perspectives Therapy Services use a HIPAA secure, third-party phone service, which includes both phone calls and text messages. Please note that communication in-between appointment times is primarily used for scheduling purposes. If details regarding treatment are discussed via phone, the client will be charged for time spent. Often, concerns brought up in a text message or left as a voicemail are better addressed in the therapy session. Providers will respond to phone or text messages as time permits, usually within 24 hours. Please respect normal business hours when calling or texting your provider. The phone number given to you by your provider in no way indicates 24-hour access to their 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
Ingham County: (517) 346-8200
Oakland County: (800) 231-1127
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.

_____ _____
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.

*The card entered in your client portal 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.

Client Name:_____

Client Signature:_____

Authorization to Disclose Protected Health Information

As the person who is the subject of the protected health information, I request and authorize:

Perspectives Therapy Services, LLC

to disclose to and/or obtain information from:

_____ _____
Name of person or organization Phone

_____ _____
Address Fax

Description of Information to be Disclosed (Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____Psychotherapy Notes*
_____Dates of Service with Corresponding Charges
_____Financial balances
_____Other_____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to my provider at the respective office where I render services. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on this authorization.

Expiration
Unless revoked earlier, this authorization expires 365 days from the date of signature.

Conditions
I understand that my signature on this authorization has no relationship to my ability to receive treatment, payment, enrollment or eligibility for benefits.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

A copy of this authorization will be provided to you upon request.

_____ _____
Print Name of Client Date of Birth

_____ _____
Signature of Client Date

_____ _____
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

_____ _____
Signature of Staff Witness Date

Supervision Disclosure

In an effort to provide you with the most comprehensive mental health care possible, your therapist will be working closely with a clinical supervisory team. These supervisors are fully licensed mental health providers that are available to consult and plan with your therapist to achieve the very best treatment results. The extraordinary care model that we utilize at Perspectives Therapy Services embraces a collaborative process, while still prioritizing client confidentiality.

Your therapist may consult with our Clinical Director, Tara Freni, LPC, LMFT, and one of the following senior-level therapists who serve on our clinical leadership team:

Abby Usher, LMSW, IMH-E

Beth Kennedy, LMSW

Brittney Briggs, PsyD, LP

Deborah Adams, LMSW

Dr. Kate McKee, PhD, LMFT

Melanie Zentz, LPC

Angela Spranger, LMSW

If you have any questions, please feel free to talk with your therapist.

_____ _____

Client Signature Date

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, PTS employees and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

• You will only keep your in-person appointment if you are symptom free. _____

• You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you cancel for this reason, we can instead meet via teletherapy. _____

• You will wait in your car or outside until I text you that I am ready for our session to begin. For the current time being, our waiting room is off-limits_____

• You will wash your hands or use alcohol-based hand sanitizer when you enter the building. _____

• You will adhere to the safe distancing precautions of at least 6 feet that is required in all parts of our building. _____

• You will wear a mask in all common areas of the building. _____

• You will respect that there is no physical contact allowed (e.g. shaking hands, hugs, etc.) with me or any PTS employee. _____

• You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. _____

• You will cough or sneeze into your elbow and both of us will sanitize immediately following this action (hands, air, etc.).

• If you are bringing your child for services, you will make sure that your child follows all of these sanitation and distancing protocols. _____

• You will take steps between appointments to minimize your exposure to COVID. _____

• If you are exposed to other people who are infected, you will immediately let me know. _____

• If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth. _____

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

Our Commitment to Minimize Exposure

Perspectives Therapy Services has taken steps to reduce the risk of spreading the coronavirus within the office. Below is a list of precautions and protocol that we are following to protect our team and clients.

• Our waiting room is temporarily closed. Clients are asked to wait in their vehicle or outside until their therapist contacts them through text or phone that the session is ready to begin.

• PTS staff wear masks.

• PTS staff maintains safe distancing of at least 6 feet, in all areas of the building.

• Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.

• Hand sanitizer that contains at least 60% alcohol is available in the therapy rooms, the waiting room and at the reception counter.

• Pens, tissue boxes, door handles, and countertops that are commonly touched are sanitized multiple times per day.

• Physical contact is not permitted, including shaking hands and hugs.

• Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.

• Common areas are thoroughly disinfected at the end of each day.

If You or I Are Sick

You understand that I am committed to keeping you, me, PTS employees and all of our families safe from the spread of this virus. If you show up for an appointment and I or our PTS team believe that you are exhibiting COVID-19 related symptoms, or believe you have been exposed, I will have to require you leave the office immediately. We can follow up with services by telehealth, as appropriate.

If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start, or re-initiation of our in-person work together.

Your signature below shows that you agree to these terms and conditions.

Client Signature	Date

Medical Provider Coordination of Care

Client Name: _____ Date of Birth: _____

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 payers.

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: _____

Parent/Guardian

_____ _____

Client Signature Date

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?

- ○ 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

_____ _____

Patient Signature Date

Telehealth Reference Guide

Perspectives Therapy Services is pleased to be able to offer telehealth services for situations that may prevent an in-person therapy session. Circumstances that may lead to engaging in telehealth services include, but are not limited to:

- illness or health-related barriers
- inclement weather
- and geographic distance due to travel

Telehealth services provide a convenient and effective way to stay engaged in treatment, lending to symptom relief and successful outcomes. We care about your privacy and confidentiality and therefore have chosen a platform called Doxy.me to connect with you using video-conferencing on-line. This system is HIPAA compliant and secure (encrypted).

Step-by-step of what to expect:

Step 1: Talk about the possibility of telehealth services with your mental health provider

Step 2: Complete the telehealth consent form

Step 3: Schedule an on-line session. Your provider will send you an invite via email. The email will include a link to doxy.me

Step 4: A few minutes before your scheduled session time, click on link emailed to you by your therapist to enter the online "waiting room"

What you will need:

Chances are, you already have all the equipment you need to engage in a telehealth visit.

Here are the basics:

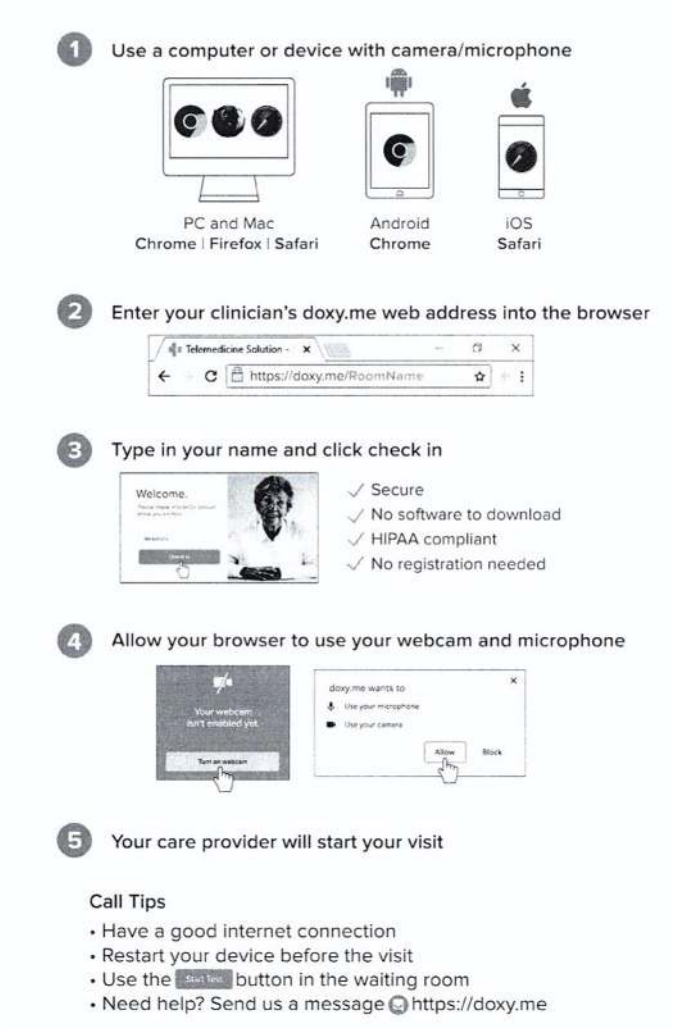
- Computer or smartphone or tablet
- Microphone (if not included in the mobile device or computer)
- Webcam (if not included in the mobile device or computer)
- Email address to receive the invite with link

6 Tips for a Great Telehealth Experience:

- **Restart your computer before a call.** Other software might be using computer power or interfere with your video or microphone. Restarting your computer will assure your computer is ready for video.
- **Use fast internet.** Video quality adapts to internet speed, so the faster your internet connection, the better the video quality you will experience. Ethernet cable often provides the best results, however, wi-fi connection will suffice.
- **Use a newer computer with plenty of speed.** Sending and receiving video takes a lot of computer power. Old or slow computers will have a harder time processing the video, which can cause choppiness.
- **Use low resolution.** If you are experience poor quality, try lowering the resolution. By doing this it requires less bandwidth and computer power, resulting in less choppiness during your call.
- **Use headphones.** Typically, your computer will automatically eliminate echo or audio feedback so you don't hear yourself talking. But if it happens, have headphones on standby and ready to use.
- **Design your space.** Create a space that is therapeutic.

- Consider sound — a quiet and private environment is important both therapist and client can speak openly and freely. Close the door and put a "do not disturb" sign on it if possible.
- Front lighting is helpful to see one another easily (avoid sitting in front of a window — no backlight)
- Supply yourself with a drink and a tissue box
- If using a smart phone to connect, consider getting a stand so that you don't have to hold it for the entire session. Your arm getting tired may be an annoyance and distraction to doing great therapeutic work as well as it can dampen the intimacy of therapy.
- Try to look at each other and not the screen. This creates real connection. Consider putting a post-it note over your face so you are not distracted by your own image. (People tend to want to look at themselves.)

How to check in for your video visit



Informed Consent for Telemental Health

The following information is provided to clients opting for telemental health therapy as part of their service delivery of mental health treatment provided by Perspectives Therapy Services. This document covers your rights, risks and benefits associated with receiving telehealth services, our policies, and your authorization. You are asked to initial after each section to indicate that you have read and understand the content. Please ask questions and get clarification if needed, prior to signing this document.

Telemental health defined:

Telemental health refers to mental health services that are delivered remotely, using technology-assisted media. The technology devices may include, but are not limited to, a telephone, video, internet. a smartphone. tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. PTS utilizes a HIPAA secure platform called Doxy for live video-conferencing (referred by as "synchronous") as our preferred method of telemental health delivery.

_____

Limitations of Telemental Health Service Delivery

While Telemental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy, and thus involves some disadvantages and limitations worth noting.

Technology is not flawless and can come with interruptions to clear communication. For example, there may be a disruption to the service (e.g. the video drops or is "glitchy"). This can be frustrating and interrupt the normal flow of a personal interaction. The risk of misunderstanding one another when communication lacks clear visual or auditory cues that would be present in face-to-face interactions. For example, if video quality is lacking, your therapist might not see details such as facial expressions to be able to accurately interpret a reaction or emotional response. Or, if audio quality is lacking, your therapist may not hear differences in your tone of voice that they could easily pick up in you were in their physical office.

Additionally, the physical therapy office decreases the likelihood of disruptions to the session. However, together we will work to minimize these so that you will experience the intention of a therapy session to "hold space" for you and your thoughts and feelings. Our goal together will be to maximize privacy and achieve a high level of effectiveness through this, or another form of therapy service delivery we choose together. As the therapist, I will take every precaution to insure technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private, quiet location where the sessions may be conducted. Consider using a "do not disturb" sign/note on the door. Virtual sessions should be conducted using a secure (not public) wifi connection for the best results, to minimize disruption and maximize privacy. _____

In Case of Technology

Failure I understand that during a telemental health session, we could encounter a technological failure. Difficulties with hardware, software, equipment, wi-fi connectivity, and /or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call your therapist to continue/complete the session by phone. We may also mutually decide to reschedule if technology fails us. _____

Structure and Cost of Sessions

Face-to-face therapy in our physical clinic location is the primary means of service delivery through Perspectives Therapy Services. Sometimes, special circumstances warrant an alternative means of service delivery, such as telemental health, so that care is not interrupted (i.e. illness/health-related circumstances, inclement weather, travel out of the geographic area, etc.). Please be aware that your insurance company may or may not cover telemental health sessions. We strongly recommend that you contact your insurance provider to verify coverage via telemental health. The structure and cost of telemental health sessions are the same as in-person sessions described in the general consent form that you initially sign with PTS. Texting and emails (other than just setting up appointments) are billed at an hourly rate for the time spent reading and responding. These out-of-session services are not billable to insurance. As standard at PTS, we require a credit card to remain on file for ease of billing and will charge the card at the beginning of each session for any balance due including copays or deductible amounts. You will need to sign a Credit Card Authorization to keep on file. _____

Email and Text Messaging

PTS uses the companies Enguard and iPlum as HIPAA secure technology communication systems when it comes to connecting via email or text. Although these systems have been chosen because they take extra precautions to protect privacy, email or text are not preferred methods of communication as they have the potential to compromise your confidentiality. Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email or text to prevent compromising your confidentiality. We strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, do not communicate this to your therapist via email or text as they may not see it in a timely manner. Instead, please see the "Emergency Management Plan" below.

_____

Social Media

If you choose to follow Perspectives Therapy Services on social media, please do not reference our work together as it may compromise your confidentiality and blur the boundaries of our relationship. If this occurs, we may make the decision to block you from our social media sites as your confidentiality is a top priority for us. Please only follow our Facebook page if you are comfortable with the general public being aware of the fact that your name is attached to Perspectives Therapy Services, a known mental health practice. Please refrain from making contact with PTS using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not monitor them closely. Our social media presence has nothing to do with our mental health services (live or tele), and rather, is intended to be a general tool for communicating positive, inspiring, and validating mental health and wellness information (of a non-clinical nature) to the general public. _____

Cancellation Policy

Our cancellation policy is the same for in-person therapy or telemental health and is outlined in our general consent form that you initially sign with PTS. Unless a session is cancelled 24 hours in advance, you will be responsible to remit payment of $75 for a missed therapy session. 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. The credit card on file will be automatically charged for this fee when applicable. In cases of excessive absences, it will be your therapist's discretion to terminate services at PTS and refer your care elsewhere. _____

Emergency Management Plan

We are not available for emergency or crisis services, and advise that in these cases, you follow any part of this plan:

1. Reach out to your Emergency Contact Person for support, transportation or monitoring

Emergency Contact Person Name: _____ Relationship: _____

Phone number: _____

*This information must be completed to participate in telemental health services.

2. Go to your local Community Mental Health agency

3. Go to your local emergency room/medical center/hospital

4. Call 911

5. Call Lifeline at (800) 273-8255 (National Crisis Line)

CONSENT TO TREATMENT

☐ I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand that I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

☐ I understand that there will be no recording or archive of our electronic exchange and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

☐ I, voluntarily agree to participate in online mental health therapy services for assessment, continued care, treatment, or other services and authorize my therapist within Perspectives Therapy Services. LLC to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may withdraw consent for such care, treatment, or services that I receive through PTS at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client Signature Date

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") and regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, therapist or staff review activities, licensing, and conducting or arranging for other business activities. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to received reports of child or elder abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical

personnel only in order to prevent serious harm.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent (verbal OR written permission) or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena, court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from the U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State of medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or less the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constituted a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Office at our central business office at 120 Flint Road, Brighton, MI 48116.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you, if the

information is contained in separately maintained psychotherapy notes or if your treatment involved more than one person in the therapeutic environment and a signed release is not obtained by the other party or parties. Our office will charge a reasonable, cost-based fee for copies. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you believe that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care items or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Dr. Tianna Rooney or with the Secretary of the Health and Human Services Department at 200 Independence Avenue S.W., Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is August 1, 2015