The Behavioral Change Clinic, PLLC
with Dominic C. Moceri, PhD
200 East Big Beaver Road, Troy, MI 48083
Phone: 248.564.1183 | Fax: 248.458.4578
www.BehavioralChangeClinic.com

CHILD & ADOLESCENT INTAKE FORM

If you need more space, you may use additional paper.

Demographic Info

Child's Name: _____ | **Date Completing Form:** _____
Legal Name *(if different)*: _____
Date of Birth: _____ | **Age:** _____ | **Gender:** _____ | **Marital Status:** _____
Race/Ethnicity *(optional)*: _____ |**Spirituality/Religion** *(optional)*: _____
Home Address *(Street, City, Zip)*: _____
School Name: _____ | **Education Level:** _____ *(Current/Completed)*
Phone* *(Adolescent)*: _____ *(Mobile)* | **Permission to leave a message** ☐ Yes ☐ No
Email* *(Adolescent)*: _____ | **Permission to leave a message** ☐ Yes ☐ No

** Please, only provide phone and email if your child will be driving themselves to therapy and/or if there is another important treatment coordination reason. This should be discussed in session and agreed upon by all parties. The default position of the Clinic is to coordinate care with parent(s)/guardian(s) directly. See "COMMUNICATION POLICY FORM" for important privacy information about emails.*

Parent/Guardian A

Parent/Guardian A's Name: _____
Date of Birth: _____ | **Age:** _____ | **Gender:** _____ | **Marital Status:** _____
Home Address *(Street, City, Zip) (if different)*: _____
Names & Ages of People Living Here: _____
_____
Phone 1: _____ *(Mobile/Home/Work)* | **Permission to leave a message** ☐ Yes ☐ No
Phone 2: _____ *(Mobile/Home/Work)* | **Permission to leave a message** ☐ Yes ☐ No
Email:** _____ | **Permission to leave a message** ☐ Yes ☐ No
Name of Employer and/or School *(if any)*: _____
Occupation: _____ | **Education Level:** _____ *(Current/Completed)*

**** If you use a school/employee email, the school/employer may have a legal right to read the email. Please, see *"COMMUNICATION POLICY FORM" for additional important privacy information.*

Parent/Guardian B

Parent/Guardian B's Name: _____
Date of Birth: _____ | **Age:** _____ | **Gender:** _____ | **Marital Status:** _____
Home Address *(Street, City, Zip) (if different)*: _____
Names & Ages of People Living Here: _____
_____
Phone 1: _____ *(Mobile/Home/Work)* | **Permission to leave a message** ☐ Yes ☐ No
Phone 2: _____ *(Mobile/Home/Work)* | **Permission to leave a message** ☐ Yes ☐ No
Email:** _____ | **Permission to leave a message** ☐ Yes ☐ No
Name of Employer and/or School *(if any)*: _____
Occupation: _____ | **Education Level:** _____ *(Current/Completed)*

**** See *"COMMUNICATION POLICY FORM" for important privacy information about emails.*

Treatment Targets

Why are you seeking psychotherapy? What do you want to accomplish in psychotherapy? What are your roadblocks? _____

_____

_____

_____

_____

_____

_____

When did the problem(s) start? _____

_____

_____

Current stressors: _____

_____

_____

What are your child's strengths? _____

_____

_____

What are your child's most important values *(i.e., What's most important to them)***?** _____

_____

_____

Mental Health History

Emotions (0-10): *Please rate the below emotions, where 0 is an absence and 10 is an abundance.*
Happiness: _____ |**Sadness:** _____ |**Anxiety/Fear:** _____ | **Anger/Outbursts:** _____ | **Pain:** _____
Family History: *Please summarize any known/suspected genetic history, including who and what type (e.g., depression, anxiety, OCD, Tourette's/tics, ADHD, learning disabilities, alcohol/drugs, suicide, death).* _____

_____

_____

_____

_____

Previous Psychotherapy: *Please summarize any previous experience(s), including therapist names, dates, why you started, why you stopped, what you found (un)helpful, etc.* _____

_____

_____

_____

_____

_____

Mind-Body Connection

Diagnoses & Medications: *Please list all relevant mental and physical problems.*

Diagnosis	Current Provider	Current Medication	Dosage

Physical Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor | **Last Exam by a Medical Professional:** _____
Overall Health: *Please summarize any concerns that you have had (e.g., physical issues; hospitalizations, surgeries; serious accidents, injuries, or seizures; traumatic brain injury; anxiety regarding illnesses, needles, vomit; frustration with not being understood by professionals).* _____
_____
_____
_____

Developmental History: *Please summarize any complications during pregnancy; alcohol, marijuana, or drug use during pregnancy; complications at birth; problems during infancy; delays in developmental milestones, such as walking and talking; and any abuse or neglect.* _____
_____
_____

Sleep Hygiene: *Please summarize when your child typically goes to sleep, wakes up, total hours of sleep, what your child does the last hour before going to bed.* _____
_____
_____

Exercise: *Please summarize what your child does for physical activity, its frequency, and time of day it occurs.* _____
_____

Eating: *Please summarize any issues/concerns with dietary restrictions, snacks, overeating, anxiety, etc.*
_____
_____

Social Environment

Please summarize the impact of the following on your child's quality of life (past and present). Include ***unique*** *circumstances and relevant* ***cultural*** *attitudes, experiences, and values.*
Home: _____
_____

Friendships & Romantic Relationships: _____
_____

Education/School *(e.g., Grades/GPA; Relationships with Teachers & Students; Bullying?; Detentions?; Suspensions?)***:** _____
_____
_____

Chores/Extracurriculars/Employment: _____
_____

Additional Concerns

Please summarize any concerns that you or anyone close to you have had (past and present) with…
Trauma History *(e.g., Abuse, Neglect, Accidents)***:** _____
_____

Substances *(e.g., Alcohol, Marijuana, Drugs, Prescription Medications, Smoking, Vaping)***:** _____
_____

Excessive Behaviors *(e.g., Internet, Video Games, Spending Money, Food, Sex)***:** _____
_____
_____

Safety *(e.g., Self-Injury, Suicidal Thoughts and/or Attempts, Violent Plans and/or Actions)***:** _____
_____
_____

COMMUNICATION POLICY FORM

RESPONDING TO MESSAGES: Please, allow your Therapist two business days to return your message. If you need a rapid response, please specify this in your message and your Therapist will do their best to accommodate. If your Therapist will be unavailable for an extended period of time (e.g, family medical issue; vacation), you will be notified and provided with contact information for another Therapist, if desired.

EMERGENCIES: If you are experiencing an emergency, please dial 988 for the Suicide and Crisis Lifeline; dial 911 for Emergency Assistance; or go to the nearest emergency room. After you have arrived, call the Clinic line (248.564.1183) and sign a Release Form from my Forms webpage to coordinate care.

PHONE, EMAILS, AND TEXTING: Mobile phones, emails, and texting are not considered secure methods of communication as information can potentially be intercepted in transit. Messages should be limited to scheduling and sharing important files rather than sharing detailed personal information due to the inherent risks associated with transmitting personal information over the internet and via mobile networks.

- ***Texting*** is a particularly vulnerable form of communication as messages are typically transmitted and stored without encryption or password protection.
- ***Emails*** sent from The Clinic will be encrypted in a HIPAA secure manner. If you reply to an encrypted email sent by your Therapist using that program, the message should be encrypted on its trip to the Therapist. If you use a school/employee email, the school/employer may have a legal right to store and read the email.

I have read the Communication Policy Form and agree to its terms.

Parent or Guardian Signature	**Date**	**Clinician Signature**	**Date**

Emergency Contact

In the case of an emergency, please provide the following. You may list a parent or other legal guardian. You may provide additional emergency contacts below, if desired.

Emergency Contact Name: _____ | **Relationship:** _____
Emergency Contact Phone Number: _____

Parent or Guardian Signature	**Date**	**Clinician Signature**	**Date**

FINANCIAL POLICY FORM

PAYMENTS: Payments are expected **at the start** of each session, unless you have a credit card on file (see "*PREAUTHORIZATION FORM"*). The Clinic will provide receipts upon request.

- **TYPES OF PAYMENTS:** The Clinic currently accepts cash, checks, Visa, Mastercard, Discover, American Express, PIN Debit, and Health Savings Account (HSA) transactions. The Clinic may change the payment options at any time. Checks should be made out to "The Behavioral Change Clinic, PLLC." If any charges are billed to the clinic due to insufficient funds, you will owe the balance to the Clinic. If this happens multiple times, there may be a $20 surcharge each time.
- **OVERDUE BALANCES:** In the event of a balance being over 30 days overdue, a late fee of 2% will be charged each month. In the event that a balance is over 60 days overdue, The Clinic reserves the right to pursue legal methods to obtain payment, such as using a collection agency or small claims. In such an event, the bare minimum amount of information will be released to obtain payment (which includes at least the Client's name, contact information, the amount due, and the name of The Clinic). At least three phone calls and three letters across two months will be made by The Clinic before legal methods are employed.
- **JOINT MEDICAL CUSTODY:** The parent/guardian who brings the client to the clinic for the appointment will be legally responsible for all payments on that day. If the courts have indicated that someone else is responsible for the final payment, the person who brings the client must secure the payment from that individual in advance to pay the clinic at the time of service (unless there is a credit card on file). If there is any ambiguity about who brought the client, the person signing this document is legally responsible.
- **ANOTHER PAYER:** If a non-parent/non-guardian (aka the Payer) is making payments directly to the Clinic for your child's treatment (e.g., using a credit card for copays, coinsurance, deductible, private pay), the Clinic reserves the right to verify their identity (e.g., photo ID) and to verify that they are consenting to paying, which may include them briefly coming to the Clinic in person once or another non-obtrusive method agreed upon by the Clinic. The Clinic reserves the right to require that a "RELEASE FORM" for this person (aka the Payer) for the sole purposes of discussing payments. Both the parent/guardian of the child and the Payer will need to sign the "PREAUTHORIZATION FORM" if the Payer is using their credit card.

INSURANCE: Parent(s)/Guardian(s) are responsible for all deductibles, copays, and/or co-insurances that are outlined in the insurance policy for behavioral health. Any information provided by The Clinic is a quote, not a guarantee. If the insurance company refuses to pay for any reason, you will be responsible for the private pay amount outlined below. If required by your insurance company, you are responsible for obtaining a referral (e.g., from your primary care physician or pediatrician). By using insurance and signing this document, you are authorizing the release of information necessary for transactions and assignment of benefits for claims (usually name, date of birth, date of service, procedure code, diagnosis codes, and subscriber's name and date of birth). If you have both primary and secondary insurance, The Clinic will submit bills according to applicable laws and regulations.

- **IN-NETWORK (IN):** The Clinic and/or your Therapist is currently in-network for the following insurances. The Clinic will bill your insurance company directly if you are in-network.
    - **Aetna:** Active Aetna networks include *First Health/Cofinity* and *Coventry Health Care*.
    - **Blue Cross Blue Shield (BCBS):** The following *BCBS of Michigan (BCBSM)* networks are currently active: *Traditional, PPO TRUST, and Medicare Plus Blue PPO*. Blue Care Network (BCN) is **NOT** an active network and does not usually provide out-of-network benefits.

- **Medicare:** Michigan Medicare Part B is in-network. However, most Medicare Advantage plans (aka Medicare Part C) are **NOT** active networks and may not provide out-of-network benefits. Medicare Plus Blue PPO (through BCBS) is an exception.

- **OUT-OF-NETWORK (OON):** If the insurance company allows out-of-network benefits AND the reimbursement rates are comparable to the Private Pay rate, The Clinic will attempt to bill the insurance company. You will still be responsible for any deductibles, copay, or co-insurance, as outlined in your insurance policy for behavioral health. The Clinic will not agree to a Single Case Agreement (SCA) under most circumstances.

PRIVATE PAY (PP): If your insurance is not accepted at The Clinic, or the insurance company rejects the bill (and attempts to resolve it were unsuccessful), the below fee schedule applies. The Clinic reserves the right to alter and update the Fee Schedule. Whenever possible, The Clinic will provide you with at least a 90-day advance notice. An absolute minimum of 30-days will be provided before any fee increases. Review of the fee schedule will likely occur at least annually.

MISSED APPOINTMENTS: Missed appointments include both failing to show up for a scheduled appointment (i.e., No Show) as well as cancelling or rescheduling with less than 24 hours (as determined by the time stamp of the voicemail or email). Insurance will not pay for any part of this fee, and you will be charged the full amount listed in the fee schedule below for a full session.

- *On a case by case basis, the missed appointment fee may be **waived** under extenuating circumstances (e.g., contagious illness; medical emergency; flat tire; your work shift being rescheduled against your will; an adult having to stay home with a sick child; significant weather advisory/warning/watch). Notes ("proof") will NOT be required. If this occurs too frequently, this will be discussed, and the fee is unlikely to be waived for the following incident(s).*
- *Fees will **not be waived** for preventable circumstances (e.g., forgetting another medical appointment was scheduled at that time; a child having homework, a project, or a quiz/test the next day; normal traffic; lack of coordination of automobiles with another household member).*

FEE SCHEDULE: This table provides the standard fees for the Clinic.

PSYCHOTHERAPY SERVICES	**CPT Code**	**Fee**
***Initial Evaluation** *(first appointment)*	**90791**	**$250**
***Full Session** *(53-60 minutes)*	**90837**	**$210**
Three-Quarter Session *(38-52 minutes)*	90834	$175
Half-Session *(16-37 minutes)*	90832	$125
Family Session with Client Present *(26-60 minutes)*	90847	$210
***Parent/Family Session without Client Present** *(26-60 minutes)*	**90846**	**$210**
Crisis Session *(30-74 minutes)*	90839	$250
Additional Time for Crisis *(per additional 30 minutes above 60 minutes)*	90840	$150
Intensive ERP per hour *(may not be covered through insurance)*		$210
OTHER FEES[1]		
***Forms & Letters** *(per 15 minutes)*	**N/A**	**$50**

***Missed Appointments** *(No Shows; Cancelling or Rescheduling with less than 24-hours per the voicemail or email timestamp)*	**N/A**	**$210**
Travel Time to non-Clinic sites		
First 30 minutes *(minimum)*	N/A	$125
Each additional 15 minutes	N/A	$50

** Most common billing codes used at The Clinic.*

[1] "OTHER FEES" are not reimbursable by insurance and are separate from intake/session deductibles, coinsurance, and copays. Short phone calls, short emails, and brief letters (e.g., early dismissal from school) have no fees. Long phone calls may be billed to insurance as a session, if allowed, or charged a prorated private pay fee. Long emails, longer letters, and detailed forms (e.g., disability letter for university accommodations) are subject to prorated fees in 15-minute units. Phone/email should not be used as a replacement for therapy sessions or parent sessions.

COURT APPEARANCES: In general, The Clinic discourages involving The Clinic and your therapist in court appearances and testimonies. Complicated ethical and legal issues often arise regarding the confidentiality of treatment that are often unforeseen (see "NOTICE OF PRIVACY PRACTICES & HIPAA INFORMATION FORM"). As the law views fact witnesses and expert witnesses as distinct entities, your Therapist may be restricted in what can be said (e.g., diagnosis, course of treatment, and progress) and unable to provide the testimony that you desire (e.g., make custody recommendations; testifying that a divorce or work situation harmed you). If you believe special circumstance applies and the risks are worth it, you are encouraged to discuss the issue with your Therapist directly in advance. If you decide to proceed, you will be charged for eight times the full session rate plus travel time (as outlined in the "FEE SCHEDULE") for each day of court. This is due to court appearances often requiring the Therapist to cancel an entire day of sessions in addition to preparation time. Additional fees might apply.

WAIVER OF JURY TRIAL (LANDLORD): According to the lease of The Behavioral Change Clinic, PLLC, all clients, family members, guests, and invitees are bound by the following agreement. By signing this document you are waiving your right to a trial by jury of any action or equity brought against the Landlord (i.e., AmeriCenter of Troy, LP) or Landlord's agents or employees, arising out of, or in any way connected to its premises.

I have read the Financial Policy Form and agree to its terms. If I am using insurance, I authorize the release of information necessary for transactions and assignment of benefits for claims. If I miss a session or cancel with less than 24-hours notification, I understand that I will be charged the full amount of the session (e.g., copay and what insurance typically pays) and that insurance will not pay for this. I understand that knowingly providing false or misleading information for payments (private or insurance) may be subject to criminal and civil penalties. If any part of this agreement is deemed unenforceable, then that part shall be omitted but such omission will not affect the rest of the agreement herein.

Parent or Guardian Signature **Date** **Clinician Signature** **Date**

Insurance Information

If you are using insurance to pay for any portion of treatment, please complete the below information.

Insurance Company: _____ **State Insurance is Purchased** *(e.g., MI)***:** _____

Enrollee/Member ID: _____ |**Group Plan ID:** _____
Subscriber's Name: _____ |**Subscriber's Date of Birth:** _____
Subscriber's Home Address *(If different from Client)***:** _____
Subscribed Through *(e.g., Subscriber's Employer)***:** _____

The Behavioral Change Clinic, PLLC
200 East Big Beaver Road, Troy, MI 48083; 248.564.1183

PREAUTHORIZATION FORM

As a courtesy The Clinic accepts automatic payments for those who keep a payment number on file. The clinic currently accepts cash, checks, Visa, Mastercard, Discover, American Express, PIN Debit, Health Savings Account (HSA) transactions, and Flexible Spending Account (FSA) transactions. The Clinic may change the payment type that it accepts at any time, in which case another payment type must be used.

CHARGES: Automatic payments on file will be billed sometime between the end of that session and 30 days thereafter, whenever possible. The **full balance due** will be charged at that time.

EXTRA PRIVACY AND SECURITY: If you should desire extra privacy and security, you may put a card on file two additional ways. **One**, you may write "**** [insert last 4 digits] given during [insert date] session" on the "Credit Card Number Line." You will then provide your Therapist with the number during that session, who will manually enter it in the system. **Two**, you may write "Activate my TherapyPortal." You will be then be sent a message to your primary email on file, where you will be asked to enter the information online securely. After you sign the online form, the credit card number will be redacted from the view of The Clinic and your Therapist, except for the last four digits. **If you choose either of these options, you must still sign and complete the remainder this form.**

HSA/FSA LIMITATIONS: HSA and FSA can only be charged for psychotherapy services provided. They **cannot** be charged for missed appointments or other fees arranged with The Clinic. If you put an HSA/FSA card on file, please complete a **second version** of this form, which will be used if/when your HSS/FSA is ineligible (e.g., too low of a balance; fees).

Client's Legal Name: _____
Name of Individual on Credit Card: _____
Relationship to Client *(Self/Parent/Guardian/Spouse/Other)***:** _____
Credit Card Number: _____
Card Security Code (CSC): _____ | **Expiration Date:** _____
Type of Card: ☐ Credit Card ☐ Debit Card ☐ HSA Card ☐ FSA Card
Billing Address of Cardholder *(Street, City, Zip)***:** _____
Billing Phone Number of Cardholder: _____ *(Mobile/Home/Work)* |
Permission to leave a message ☐ Yes ☐ No

I have read the Preauthorization Form and agree to its terms. The full balance due will be charged. If I miss a session or cancel with less than 24-hours notification, I understand that I will be charged the full amount of the session (e.g., copay and what insurance typically pays) and that insurance will not pay for this. I understand that knowingly providing false or misleading information for payments (private or insurance) may be subject to criminal and civil penalties.

_____ _____
Parent or Guardian Signature **Date** **Clinician Signature** **Date**

_____
Cardholder's Signature **Date**
(necessary if different from Parent or Guardian Signature)

INITIATING TREATMENT FORM

Your Choice: You are consenting for your child to begin assessment and/or treatment at The Behavioral Change Clinic, PLLC. You and your child will be expected to be an active participant throughout the psychotherapeutic process, including identifying challenges, setting goals/objectives, and making concrete changes in your life. Your Therapist can help you with this process. You are encouraged to ask your Therapist questions and are able to revise your goals/objectives throughout treatment.

Behavioral Tasks: Your and your child will very likely be asked to attempt **behavioral tasks during and between sessions**. You and your child might initially think that these tasks are daunting or anxiety-provoking, but your child's Therapist will work with You and your to accomplish these tasks step by step. You and your child will never be asked to do something against your child's will or something that is actually dangerous. You and your child will always have a choice.

Regular Attendance: In order to make meaningful progress in psychotherapy, most people require weekly psychotherapy appointments. In order to help prevent irregular attendance, your child will likely be assigned an ongoing appointment time (e.g., Wednesdays at 3pm) that you are expected to attend each week (except for unusual events, such as illnesses or Holiday vacations). If you reduce the frequency of attendance due to improvement, you may be asked to change the day/time to a timeslot where another person is alternating their weeks.

- In order to be fair to the many people still seeking treatment, The Clinic has established the following polices:
- **Irregular Attendance:** If your child's attendance is irregular, The Clinic may assign that timeslot to another person. The new timeslot may be at a different time of day and/or a different day of the week. If irregular attendance becomes a concern, your Therapist will discuss this with you. Missing four ongoing appointment times in a row automatically counts as irregular attendance.
- **Default Closing:** If your child do not attend a session for six weeks, The Clinic may close the chart. Under special circumstances (e.g., visiting relatives in another country; surgery), exceptions can be made if they are discussed with the Therapist. Your child's chart can be reopened if you call your Therapist and the Therapist agrees; but there is no guarantee that the previous ongoing appointment time will still be available. If you are planning on terminating treatment, you should discuss this with your Therapist in advance rather than enact this policy.

I have read the Initiating Treatment Form and agree to its terms. I have been given opportunities to ask questions and help design my treatment plan. And, I reserve the right to do so at any time in the future.

Parent or Guardian Signature	**Date**	**Clinician Signature**	**Date**

AUTOMATIC APPOINTMENT REMINDER FORM

As a courtesy The Clinic offers the **option** to enroll you in automatic appointment reminders via text and/or email. There is no charge to you. You may opt-out at any time by following the instructions provided by the practice management software or by notifying your Therapist in writing.

TIME FRAME: Text (SMS) messages to mobile devices are typically sent 2-28 hours in advance. Emails are typically sent 24-60 hours in advance.

RECIPIENTS: You may list mobile phone numbers or emails for yourself and/or others. The Clinic reserves the right to require that a "RELEASE FORM" is signed for anyone that is not the designated client (or parent/guardian of the client) for the sole purposes of discussing appointment attendance and reminders. The Clinic reserves the right to limit the recipients, if deemed clinically important.

DISCLAIMERS: The automatic reminders are sent by the Clinic's practice management software (which is currently "TherapyNotes," and may be changed at any time with or without notification). The Behavioral Change Clinic, PLLC and your Therapist hold zero liability for the security and privacy of the sending and storage of these messages. See "COMMUNICATION POLICY FORM" for important privacy information about texting and emails. **If you use a school/employee email and/or phone number, the school/employer may have a legal right to store and read the email and/or text message.** If for whatever reason, the automatic reminders are not sent, **you are still responsible** for attending your session. See "FINANCIAL POLICY FORM" and "INITIATING TREATMENT FORM" for details.

I have read the Automatic Appointment Reminder Form and agree to its terms. I understand that this form is completely optional and that includes certain benefits and risks. I understand that I may list zero, one, or multiple phone numbers and/or emails.

Mobile Phone Numbers (if any): _____
_____
_____

Emails (if any): _____
_____
_____

_____ _____

Parent or Guardian Signature **Date** **Clinician Signature** **Date**

The Behavioral Change Clinic, PLLC
200 East Big Beaver Road, Troy, MI 48083; 248.564.1183

LEGAL GUARDIANSHIP FORM

ALL PARENTS/GUARDIANS MUST COMPLETE THIS FORM to attest that they have the legal authority to initiate and continue psychotherapy treatment for the person listed below.

Child's Legal Name **Child's Date of Birth**

Please, **initial** the appropriate option for your child after reading all of the options.

_____ *(initials)* My child lives with **BOTH legal parents/guardians** (e.g., biological parents; adoptive parents) and there is **NOT** a legal custody agreement in place.

_____ *(initials)* I am the **Sole Legal Custodial Parent** of my child and there is **NOT** a custody arrangement in place.

_____ *(initials)* I am the **Sole Legal Parent/Guardian** of my child and there **IS** a custody arrangement in place.

_____ *(initials)* I am the **Joint Legal Parent/Guardian** of my child and there **IS** a custody arrangement in place.

_____ *(initials)* I am the **Joint Legal Parent/Guardian** of my child and there is **NOT** a custody arrangement in place.

Complete only if your child lives in more than one home:
Please specify which days/times the child is at each home as well as each person who live in each home. If there are any special circumstances regarding legal custody, please specify.

_____
_____
_____
_____
_____

---

*I have provided truthful and complete information on the Legal Guardianship Form. I have **legal authority** to enter this child into psychotherapy and sign papers on the child's behalf. I understand that if there is joint legal custody with another person, that person **may also be involved** in the child's therapy and/or may receive communication from the Therapist. I will **provide** The Clinic with a copy of any Legal Custody Agreements in place regarding the child.*

Parent or Guardian Signature **Date** **Clinician Signature** **Date**

NOTICE OF PRIVACY PRACTICES & HIPAA INFORMATION FORM

CONFIDENTIALITY: The Behavioral Change Clinic, PLLC is committed to safeguarding your child's information regarding your child's physical health, mental health, and personal history. The Clinic keeps records of your services in order to provide you with quality care, meet ethical guidelines, comply with legal requirements. Federal and state laws, such as HIPAA, protect your right to privacy between a client (aka patient) and Therapist (aka psychotherapist, clinician, behavioral health provider). The Therapist is prohibited from sharing protected health information (PHI) about your child with others, unless certain circumstances are met. If you ever have any concerns about your privacy or safety, please express them to The Clinic as soon as possible, so that your concerns can be addressed as soon as possible.

RISK TO SELF: If the Therapist assesses that the client is an imminent danger to oneself, hospitalization of the client may be required. And/or, family members or others may need to become involved to help ensure safety.

RISK TO OTHERS: If the Therapist assesses that the client is an imminent danger to the health or safety of another, the law requires that protective actions are taken, such as hospitalization, calling the police, and/or warning the potential victim.

ABUSE/NEGLECT OF PROTECTED POPULATIONS: If the Therapist has reasonable suspicion that a member of a special population is being abused or neglected, the law requires that a report is filed with the appropriate agency. Additional actions may be required to ensure safety of the person. Special populations include children under 18, disabled adults, and the elderly.

OTHERWISE REQUIRED BY LAW: If the law requires information to be released, then the Therapist will comply with the law to the extent necessary. The Therapist will make efforts to protect sensitive information as much as legally and ethically possible. These situations are usually rare, but often involve court cases. Please be aware that releasing any information about your child's treatment in a courtroom (such as a letter) may trigger a process that allows your entire record to be admissible in court. If you suspect that your child's records may be subpoenaed, please consult with a legal expert who is familiar with HIPAA and psychotherapy laws.

UNDER 18: A strong alliance between the Therapist and the parent(s) [or legal guardian(s)] is often necessary for successful treatment of a child under 18 years old. Thus, the Therapist will share with the parent(s) general information about treatment progress and impediments. However, some of the details may be withheld in order to demonstrate to the child that therapy is a safe place to share information that they might normally keep to themselves. Before sharing information with parent(s), the Therapist will discuss this with the child first, when possible. If the child is ever at-risk of serious consequences, the parent(s) will be informed as soon as possible, even if the child objects.

TURNING 18: Once your child turns 18 years old, they are legally an adult and any information shared in session cannot be disclosed to parents, even if the child is still attending high school, living at home, or under their parent(s)'s insurance. If your child signs a release, then your Therapist will be legally allowed to share information as indicated on the form.

SIGNED RELEASE FORM: If you sign a release form, your Therapist receives legal authorization to coordinate your child's care with whoever is designated on the form. Release forms are often used to allow communication with physicians, psychiatrists, previous psychotherapists, school counselors, teachers, significant others, or family members. However, they can be written to authorize communication to anyone you believe would be beneficial. There typically are no fees associated with your Therapist communicating with the person designated on the release form, unless otherwise discussed ahead of time. The type of information to be shared will be discussed when you sign the form. Release forms can be revoked at any time in writing, which is effective as soon as the communication is received by your Therapist.

At the behest of some insurance companies, your **Therapist requests that you grant permission** for your Therapist to communicate **with (a) your child's pediatrician or primary medical practitioner (PCP) and (b) other behavioral health specialists (e.g., psychiatrist).** If you consent, please complete a "Release Form" for each provider. If you choose to complete the form(s), you may limit the type of information to be shared by selecting or skipping the options provided. When your Therapist can openly communicate with your child's psychiatric medication prescriber (if applicable), both treatments are often enhanced. However, you **may decline** to submit a "Release Form" for any reason without your treatment at The Clinic being limited under the vast majority of circumstances.

INSURANCE INFO SHARED: By using insurance and signing this document, you are authorizing the release of information necessary for transactions and assignment of benefits for claims (usually name, date of birth, date of service, procedure code, diagnosis codes, and subscriber's name and date of birth). The insurance company is not usually informed about the details of your child's diagnosis(es) or personal history. However, the insurance company reserves the right to audit your child's file (e.g., to investigate insurance fraud). Historically, insurance audits have been rare. If you are concerned about this, you may contact your insurance company, discuss it with your Therapist, and/or sign a form indicating that you are voluntarily choosing to pay privately. You may choose whatever option is best for you, but the vast majority of in-network clients use their insurance.

PUBLIC SPACES: Like many clinics, The Behavioral Change Clinic, PLLC is currently located in a building with several other businesses. In order to secure your attention, you and your child's name may be used in public areas (e.g., the waiting room and hallways); but your Therapist will not initiative conversations about your private information in these public spaces. If a manager or front desk staff of the building interact with you or your family, you may simply state that you are waiting to meet your Therapist, and they will respect your privacy. Likewise, The Clinic strongly requests that you respect other clients' privacy if you happen to see someone in a public area.

SOCIAL MEDIA POLICY: Social media interactions with your Therapist or The Clinic are prohibited. Social media does meet ethical and legal guidelines for confidentiality and privacy. Additionally, it introduces elements of multiple relationships (aka dual relationships), which can interfere with current and future assessment and treatment. Neither your Therapist nor The Clinic will accept or respond to messages or contact requests from current, former, or prospective clients (or family members) on any social networking sites (e.g., Facebook, LinkedIn). The Clinic encourages caution with allowing your social media websites and apps to upload your contacts lists, as you may accidentally send a friend/contact message or invite. If you have questions about this policy, please address them with your Therapist.

CONSUMER REVIEW SITES: Therapists and Staff of the Clinic will not solicit or request testimonials or consumer reviews. The Clinic does not have any ownership or relationship with review sites for

professionals (e.g., Healthgrades, WebMD, Yelp). The Clinic discourages leaving consumer reviews online as it will likely compromise your confidentiality. Instead, you are strongly encouraged to attempt to resolve any complaints or concerns with your Therapist directly.

BUSINESS ASSOCIATES: The Clinic contracts with several third-party business associates for services. Current examples include website hosting; digital communication (i.e., email, phone, and fax); electronic health records (EHR); and credit card billing. A signed Business Associate Agreements (BAA) that is HIPAA compliant is obtained whenever PHI is involved (e.g., digital communication; EHR) and other privacy methods are secured for non-PHI business activities. These BAAs and other methods legally protect your child's personal and medical (mental and physical) information. Your child's information will never be sold for marketing purposes.

HIPAA RIGHTS: The Health Insurance Portability and Accountability Act (HIPAA) provides you with six fundamental rights. You have the right

1. to receive a notice about your privacy policies (i.e., this form);
2. to access the medical information The Clinic maintains about your child;
3. to limit the uses and disclosure of medical information;
4. to request amendments to the medical record;
5. to revoke or limit authorization; and
6. to an accounting of disclosures of PHI.

Any requests to view or amend your records must be made in writing. A fee may be charged to cover expenses for copying, printing, mailing, or any other activities that require direct costs. Under limited circumstances, requests about your records can be denied. At your written request, the denial can be appealed and reviewed by an independent Therapist chosen by The Clinic. **You are strongly encouraged to attempt to resolve any complaints or concerns with your Therapist directly.** Concerns and dissatisfaction can be resolved verbally but all official complaints must be submitted in writing. If the situation cannot be resolved in a satisfactory manner, you may contact the HIPAA Privacy Officer at "Risk Management 2100 Pontiac Lake Road, Waterford, MI 48328, Phone: 248-858-1000" and ask to speak with the Rights Officer of the Day. **You will not be penalized or retaliated against for filing a complaint.** Additional guidance materials about your rights under HIPAA can be found on the website of the U.S. Department of Health & Human Services: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

RIGHT TO PAPER COPIES: If you make a written request, The Clinic will provide you with any signed documents that you have completed.

CHANGES TO THIS NOTICE & POLICIES: The Clinic reserves the right to revise and update the Privacy Notice and all other documentation. You will be updated of any changes to policies that substantially affect you. The Clinic will notify you and obtain your signature before implementing any changes to fees.

I have read the Notice of Privacy Practices & HIPAA Information Form and agree to its terms.

Parent or Guardian Signature	**Date**	**Clinician Signature**	**Date**

REFERRAL SOURCE FORM

Please, check the box that best indicates how you discovered The Clinic or your Therapist. Then, list the name of the person or organization that led you to The Clinic on the line below. Please, do not list the name if the person was another client/patient.

☐ www.IOCDF.org
☐ Internet Search (e.g., Google)
☐ a psychotherapist/clinician (e.g., PhD, MA, MSW, LMFT, LPC)
☐ a psychiatrist (e.g., MD, DO)
☐ another medical professional (e.g., physician, pediatrician, nurse, internist)
☐ a school professional (e.g., teacher, school counselor)
☐ another client/patient (do NOT list a name below)
☐ Other (Please, specify below)

Name of Person/Organization: _____
Address of Person/Organization: _____
Phone of Person/Organization: _____