Please provide the following information for Changes Counseling:

Client Name: _____

Name of parent/guardian (if under 18years):_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____ Therapist_____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Home Phone: (___)_____May we leave a message? □ Yes □ No

Cell/Other Phone: (___)_____May we leave a message? □ Yes □ No

E-mail: _____May we email you? □ Yes □ No

Please note: Email and phone correspondence are not considered to be a confidential medium of communication.

Are you currently taking any prescription medication? □ Yes □ No Please list:_____

Have you ever been prescribed psychiatric medication? □ Yes □ No- Please list and provide dates:_____

How would you rate your current physical health? (please circle) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

How would you rate your current sleeping habits? (please circle) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

How many times per week do you generally exercise? _____What types of exercise to you participate in_____

Please list any difficulties you experience with your appetite or eating patterns _____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes_____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes_____

Do you drink alcohol more than once a week? □ No □ Yes- If yes, how often? _____

How often do you engage in drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes- If yes, for how long? _____

What significant life changes or stressful events have you experienced recently:_____

In the section below identify if there is a **family history** of any of the following. Please Circle and List Family Member

Alcohol/Substance Abuse - yes □ no □ Anxiety- yes □ no □ Depression - yes □ no □

Domestic Violence - yes □ no □ Eating Disorders - yes □ no □ Obesity - yes □ no □

Obsessive Compulsive Behavior - yes □ no □ Schizophrenia - yes □ no □ Suicide Attempts - yes □ no □

Are you currently employed? □ No □ Yes – If yes, for how long?_____

Do you enjoy your work? Is there anything stressful about your current work? _____

What do you consider to be some of your strengths? _____

What do you consider to be some of your weaknesses? _____

What would you like to accomplish out of your time in therapy? _____

CLIENT/LEGAL REPRESENTATIVE DATE

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and **you will be billed for the entire cost of your missed appointment. Insurance does NOT pay this fee.**

A full session fee is charged for missed appointments or cancellations with **less than a 24-hour notice** unless it is due to illness or an emergency. Thank you for your consideration regarding this important matter.

************Insurance information************

For Client being seen

Relationship to subscriber:_____Full Name:_____

Date of birth:_____Address:_____City:_____State:_____Zip:_____

Phone number: (___)_____-_____Alternate number: (___)_____-_____Email address:_____

Insurance ID:_____Insurance group number:_____

For Subscriber of client being seen

Employer_____Full Name:_____

Date of birth:_____Address:_____City:_____State:_____Zip:_____

Phone number: (___)_____-_____Alternate number: (___)_____-_____Email address:_____

Insurance ID:_____Insurance group number:_____

****AUTHORIZATION TO KEEP AND BILL CREDIT CARD ON FILE****

*I authorize Changes Counseling, LLC to charge the client's credit card on file for any unpaid balances due to late cancellations, no show fees, and denied insurance coverage.
*I understand that if I have two insurances and do not present both cards at the time of service, I am responsible for any balance due.
*I hereby authorize Changes Counseling, LLC to release all information necessary to secure the payment of benefits.
**I authorize the use of this signature on all my insurance submissions and credit card charges:

Name on Card:_____

(Signature of Client or Guardian) _____(Date signed)_____

Credit Card # _____

Expiration Date:_____ CVC Code (3 or 4 digit number typically on back of card)_____

Please Initial Each:

_____ I have been given the opportunity to review the HIPAA regulations form.
_____ I have been given the opportunity to review the Professional Disclosure Statement
_____ I understand the limits to confidentiality, the cancellation fee and my rights as a client.
_____ If using insurance I agree to allow Changes Counseling, LLC to bill the policy on file
_____ **I acknowledge responsibility and will pay for any denied claims**.
_____ If my insurance changes I will let Changes Counseling know before my next session.
_____ I have reviewed the Fees Associated with Additional requests.
_____ My counselor/therapist addressed all of my questions.
_____ I authorize the use of this signature on all of my insurance submissions and credit card charges

_____

CLIENT/LEGAL REPRESENTATIVE DATE

_____

THERAPIST DATE

Addendum to Consent to Treatment: Cell Phone and Email Consent

As a contractual therapist at Changes Counseling I am willing to offer you, the client and/or guardian of the client, the privilege of contacting me via cell phone or through email. This privilege includes email, phone calls as well as text messaging. Know that this information is indeed a privilege that can be revoked if the therapist deems that you, the client, or guardian of the client, is abusing the privilege. This definition of abuse is to the discretion of the therapist and may include, but is not limited to: repeated calls and texts despite the therapist addressing the concern brought up by the client or guardian of the client; repeated calls or texts after the therapist asks the client or guardian of the client to desist emails, calls or texts.

Please know that because you email, call or text does not mean you will get a reply immediately or at all. Some concerns brought up in a text message or through email are better addressed in the therapy session. Please note that the intention of receiving this therapists' phone number or email is for scheduling purposes. This includes setting appointments, clarifying appointments, or rescheduling appointments. You will still need to give 24 hours' notice if you need to cancel or reschedule an appointment or you will be charged an $85 fee. You, the client or guardian of the client, are still welcome to contact this therapist at the office phone number at 810-475-2005. However, this cell phone privilege is being introduced so as to increase efficiency in communication.

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

Livingston County: (517) 548-0081
Ingham County: (517) 346-8200
Oakland County: (800) 231-1127

Further, please respect my normal business hours when calling or texting this phone. Specifically do not call or text this line before 8 AM or after 8 PM.

HIPAA Privacy Disclosure:
Please be advised that communication via cell phone and email are not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls, texts or emails cannot be guaranteed.

By signing below I understand and accept the conditions above. Your care at Changes Counseling will not change should you decline to sign this form. It is completely optional.

_____ _____
Client Signature Date

_____ _____
Client Guardian Signature (if client is a minor) Date

Changes Counseling, LLC
Disclosure Statement

Your Rights as a Counseling Client

- Attending counseling is your choice, you are not mandated to be here
- You have a right to terminate counseling at any time for any reason
- You have a right to work with a counselor who suites your needs and purposes
- You can ask about treatment plans at anytime

Risks to Counseling

- You might feel worse before you feel better
- Your current relationships might change
- Counseling doesn't work for everyone

What to Expect From Your Therapist

- A professional counselor, Psychologist, or Social Worker can help provide insight, help identify problem areas, work with you to come up with solutions, and support you through your changes. Counseling is tailored to the individual and to the successful attainment of your goals. Your therapist might draw from various styles of therapy in order to help you reach your goals including Family Systems Therapy, Person Centered, and Cognitive Behavioral Therapy. Your therapist may also highlight strengths and encourage exploration of solutions to help you maintain your changes long term while developing confidence in your ability to solve problems in the future.

What Is Expected Of You

- Achieving your goals will be based on several factors. Some of these include:
- Your willingness to work in session and outside of sessions towards achieving your goal
- Willingness to explore, problem solve, and try new skills
- Being honest in sessions
- Following through with treatment recommendations
- Attending sessions as recommended and starting on time
- Trust and connection with your counselor
- Focus and your goals or revision of goals if necessary
- Giving and receiving feedback about our time together, progress, goal evaluation, and attendance

Appointments

- Sessions are scheduled based on the recommendation of your therapist and your goals. A time slot will be selected by mutual availability. It is important that you commit to a time slot that works for you. Regular rescheduling or cancellation will be discussed in session with your therapist to determine if this relationship is effective. If you cancel an appointment with less than 24 hour notice or fail to show up for a scheduled session without notice you will be charged the full rate for the session as insurance cannot be billed. By signing this form you agree to this term.

Confidentiality and the Exceptions

- Everything we discuss in session is confidential with a few exceptions. Michigan Law requires your therapist to disclose the following types of communication to ensure your safety or safety of others: (please see HIPAA)
- Threatening to harm yourself or others
- Suspicion that you are abusing a person in a vulnerable population such as children, elderly, disabled, cognitively impaired.

Other Exceptions to Confidentiality

- If you are using insurance to pay for your sessions, identifying information will be disclosed to the medical biller to process your claims however the content of our sessions will not be shared
- Changes Counseling, LLC participates in coordination of care with other clinicians that belong to this practice. This means that your therapist might consult with other members of the team and utilize their experience or expertise to assist in determining best treatment strategies.

Contact Information

- There will be times where we need to communicate in between sessions. I will return your message within 2 business days. You are free to contact me the following ways:
- CC main phone number is 810-475-2005. Your call will be returned within 2 business days
- For emergencies go to your nearest ER
- Suicide Prevention Hotline 1-800-273-8255
- If you decide to communicate or subscribe to the CC's social media pages your confidentiality cannot be guaranteed. Please use these methods of contact sparingly and cautiously.

Education and Experience

- All clinicians at CC have a minimum of a Master's degree in their clinical field and hold a license through the State of Michigan. These licenses are in the office.

Fee Schedule

- Sessions range from $100-$225 per session, depending on the type or length of session, therapist, and insurance, etc.
- For your therapist to be involved in court matters that might include conversations with attorney's, letters, reports, court appearances, or any other sort of support for your legal matters, an advanced paid $1500 retainer is required prior to the delivery of any such services.
- Copies of records can be requested in writing to your therapist and will be provided after an administrative fee is paid along with a fee per page and postage.
- Individual letters for non-legal matters will be provided at your therapist's approval at their cash rate minimum for 30 minutes of time
- A more detailed explanation of retainer and copy costs can be requested from your therapist.

ANY APPOINTMENT THAT IS NOT CANCELLED 24 HOURS IN ADVANCE WILL BE BILLED AT THE FULL RATE.

By signing this form you are consenting to therapeutic treatment, understand your rights and responsibilities as a client, and the limitations of confidentiality.

_____

CLIENT/LEGAL REPRESENTATIVE DATE

_____

THERAPIST DATE

HIPAA STATEMENT

NOTICE OF PRIVACY PRACTICES

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

WE HAVE A LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU.

We are required by law to protect the privacy and confidentiality of health information about you, which we call "protected health information," or "PHI" for short. We are required to explain how we may use PHI about you and when we can give out PHI to others. You have rights regarding PHI about you as described in this Notice. We are required to follow the procedures in this Notice. We have the right to change our privacy practices and to make new Notice provisions effective for all PHI that we maintain by posting the revised notice at our location, making copies of the revised notice available upon request, and posting the revised notice on our website.

HOW WE USE OR DISCLOSE PROTECTED HEALTH INFORMATION.

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative).
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected. Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business, and for your treatment by your health care providers. For example, we may use your health information:

- To provide health care treatment to you.
- To obtain payment for services.
- For health care operations. We may use and disclose PHI in performing business activities that allow us to improve the quality of care we provide and reduce health care costs.
- We may use or disclose PHI without your permission in the following limited circumstances:
- When required by law.
- When necessary for public health activities.
- For reporting of victims of abuse, neglect or domestic violence.
- For health oversight activities.
- For judicial and administrative proceedings.
- For law enforcement purposes.
- When the use and/or disclosure relates to decedents.

MORE STRINGENT LAW

Highly Confidential Information. Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal and State law governing alcohol and drug abuse information as well as state laws that often protect information such as that dealing with HIV/AIDS.

YOU HAVE THE RIGHT TO OBJECT TO CERTAIN USES AND DISCLOSURES OF PHI AND, UNLESS YOU OBJECT, WE MAY USE OR DISCLOSE PHI IN THE FOLLOWING CIRCUMSTANCES.

We may share with a family member, relative, friend or other person identified by you, PHI directly related to that person's involvement in your care or payment for your care. We may share with a family member, personal representative or other person responsible for your care PHI necessary to notify such individuals of your location, general condition or death.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our office

ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION.

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

_____ _____

CLIENT/LEGAL REPRESENTATIVE DATE