AGREEMENT AND INFORMATION

We would like to welcome you to our office. Please review this Agreement and Information sheet to assist you in understanding our office policies. Our therapists are private practitioners. NKGS acts as their agent for the purposes of billing and collection. As their agent NKGS follows the procedures described below.

Our rate for a full session, lasting 45 to 50 minutes is $135.00, with the initial session $200.00. If you have insurance coverage, you are responsible for any co-pay and securing authorization as needed. (Non-authorized sessions are billable to the client.) Our office maintains a cancellation list of clients who are waiting for appointment times to become available. To accommodate waiting clients, we will need 24 hour notice of any cancellations of appointment times. If this notice is not given, a full charge will be made. Please note that insurances do not pay for missed appointments. If you need to cancel an appointment over a weekend, please call our office and leave a message on our answering machine. Calls that are emergency in nature should be made to our answering service at 242-4932. Evening and weekend calls that are not considered emergencies by the therapist will be billed to the client as well as any non-emergency calls during business hours that last more than five minutes.

We are happy to bill your insurance company for you. *We do however, want you to understand that you are ultimately responsible for all charges incurred at North Kent Guidance Services. We cannot be responsible for changes in coverage, deductibles or loss of insurance coverage*. It is your responsibility to verify coverage and get authorization when needed. If you have any questions, we will be happy to help. Please also know that any required psychological testing will be an additional fee to the therapy session.

Unless you request otherwise, please be aware that we may be contacting you by mail after discharge for follow-up purposes.

We also ask that you pay for all copays and deductible amounts at the time of service. If you feel that you need a special payment plan arranged, please work this out with your therapist at the first session. Accounts running 60 days with no payment will be charged a $10.00 statement fee.

It is sometimes necessary to send delinquent accounts to either our attorney or collection agency for collection. Any costs incurred in this process will be passed on to you. We also have a $20.00 charge for any check returned from the bank unpaid.

We hope that your contact with our office is a pleasant one. If you have any questions, please feel free to discuss them with us.

By signing this agreement, you are acknowledging that you have read and understand the agreement and are willing to agree to its terms. Your signature also indicates that you have been given both your recipient rights and a copy of the Michigan Notice of Privacy Practices (HIPAA).

X _____

SIGNATURE - (client, parent or guardian) DATE

I authorize the release of any medical information necessary to process my insurance claim.

X _____

SIGNATURE DATE

I authorize payment of medical benefits to my therapist at North Kent Guidance Services.

X _____

SIGNATURE DATE

_____

THERAPIST'S SIGNATURE DATE

EMERGENCY CONTACT

AUTHORIZATION FOR RELEASE OF INFORMATION

Client: _____ Birthdate: _____

I hereby give consent and authorize (therapist name)_____

to release___ or exchange _X_ information to: **(list emergency contact name and phone here)**

_____

Specific TYPE OF INFORMATION to be disclosed is limited to emergency situations and rescheduling information.

This authorization will remain in effect for one year or until termination of treatment, whichever occurs first.

The specific PURPOSE AND NEED for such disclosure would be in the case of emergency or to reschedule or change and appointment when client is not available.

I understand that my records are protected under the Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical, mental and/or emotional illness, including treatment of psychiatric, alcohol or chemical dependency for any admission; diagnosis, prognosis, testing for and/or treatment for HIV infection, Acquired Immunodeficiency Syndrome (AIDS) or Acquired Immunodeficiency Syndrome Related Complex (ARC).

I understand that this consent may be revoked at any time by submitting a written and dated notice of revocation to the agency releasing this information. (Unless release of information has taken place.)

X_____ _____

Client (or personal representative)
(please state relationship to client)

Date

_____ _____

Witness (can be clinician)

Date

Further release of information disclosed by the above authorization is prohibited by the Michigan Mental Health Code and the Federal regulations governing disclosure of Substance Abuse records. This means that the release of information may not be copied, shared or released except as consistent with the authorization purpose stated above and any such re-disclosure by the recipient of your information is no longer protected by the HIPAA Privacy Rule. This release is in compliance with Title 42 of the Code of Federal Regulations, Part II which also prohibits re-disclosure.

NORTH KENT GUIDANCE SERVICES
HEALTH QUESTIONNAIRE

Name: _____ Case # _____

Have you ever had, or been treated by a physician for any of the following? (Check if applies)

		YES			YES
1.	Abnormal Fatigue	___	24.	Hepatitis	___
2.	Allergy	___	25.	Hemorrhoid	___
3.	Seizures	___	26.	High Blood Pressure	___
4.	Anemia	___	27.	Impaired Vision	___
5.	Arthritis	___	28.	Indigestion (chronic)	___
6.	Asthma/Hay Fever	___	29.	Jaundice	___
7.	Back Injury/Pain	___	30.	Mononucleosis	___
8.	Bladder/Kidney Difficulties	___	31.	Nervousness or Depression	___
9.	Blood Clots	___	32.	Chest Pain	___
10.	Blood Spitting	___	33.	Rheumatic Fever	___
11.	Chronic Cough	___	34.	Shakes or DT's	___
12.	Cirrhosis of Liver or Pancreatitis	___	35.	Shortness of Breath	___
13.	Dental Disease	___	36.	Sickle Cell Anemia	___
14.	Diabetes	___	37.	Stomach Difficulties	___
15.	Diarrhea (chronic)	___	38.	Thyroid Problems	___
16.	Discharge from Ears	___	39.	Tuberculosis	___
				Date of last skin test_____	
17.	Dizziness	___	40.	Tumors or Cancer	___
18.	Epilepsy	___	41.	Ulcers	___
19.	Fainting Spells	___	42.	Sexually Transmitted Infections	___
20.	Frequent Headaches	___	43.	Vomiting (persistent)	___
21.	Frequent Sore Throat	___	44.	Irregular Heartbeat	___
22.	Gall Bladder/Liver Disease	___	45.	Other: specify_____	___
23.	Heart Disease	___		* Do not disclose HIV status	

NORTH KENT GUIDANCE SERVICES

If any of the preceding questions were answered yes, explain your answers showing the corresponding number:_____

_____

Are you aware of any additional medical problems? Yes__ No__ If yes, please explain:

_____

_____

Any recent hospitalizations or surgeries? Yes__ No__ If yes, please explain:

_____

Are you aware, or do you believe that any of your past or present physical problems are associated with your chemical use? Yes__ No__ If yes, please explain:

_____

Describe your eating/meal habits:_____

Describe your exercise habits:_____

Date of last physical:_____If more than 2 yrs. ago (6 mos. if substance abuse case) clinician verbally recommended physical:Yes___NA___

Date of last consultation with a physician:_____Who:_____

Why:_____

List any medications (including birth control pills, vitamins, psychotropic or anticonvulsant) you have <u>previously</u> or are <u>currently</u> taking (specify current or past med, <u>dosage and frequency, Dr.prescribing)</u> and if they were helpful. _____

_____

List any medication allergies:_____

I certify that the above information is true, complete and correct.

X Patient's Signature:_____ _____
Date

_____ _____
Clinician Reviewer Signature (North Kent Personnel Only) Date
(See Medical Section of Psychosocial history)

NORTH KENT GUIDANCE SERVICES
INITIAL TREATMENT AGREEMENT

_____ Case#_____
Name (please print)

What brings you to North Kent Guidance Services and what do you expect from treatment?

_____

_____

Please list any physical, geographical, time, or other personal restrictions we need to be aware of:

_____

_____

I agree to:

a) Attend all scheduled appointments. Exceptions would include emergency situations or timely notification.
b) Follow through with assigned tasks as agreed upon between myself and my therapist (i.e., reading literature, attending a support group..).
c) Inform my therapist of any changes such as address, phone number, insurance carrier, job status, or treatment needs/concerns.
d) Participate in mental health and/or substance abuse counseling at NKGS.

I understand:

a) I may be asked to evaluate the program and that no personal information will be included in any reporting.
b) That my case may be reviewed in supervision as required by law and agency policy.
c) Other therapists in this practice will have access to my case information (written and verbal) as warranted by "internal agency confidentiality".
d) North Kent Guidance Services agrees to address concerns in the most appropriate and professional way and to make referrals to other services as needed or requested.

I have received:

a) Recipient Rights information and have access to Client Feedback Forms
b) The program's rules and policies about discharge.

X _____ _____
Signature Date

_____ _____
Witness (can be clinician) Date

Acct #_____ PATIENT REGISTRATION DX:_____

Patient's Name:_____Today's Date_____

Patient's Address:_____City:_____State:_____Zip:_____

Telephone: home:_____work:_____cell:_____May we leave a message_____

Patient's SSN:_____Date of Birth:_____Male_____Female_____

Email:_____Ethnicity (optional)_____

If patient is a minor, name, address and SSN of person financially responsible:_____

_____

Patient's marital status: Single_____Married_____Separated_____Divorced_____Other_____

Patient's Employer:_____Occupation_____

Contact person in case of emergency:_____Telephone:_____(Sign release)

Address:_____City:_____State:_____Zip:_____Relationship:_____

Referred to North Kent Guidance by:_____

May we send an acknowledgement letter to your referral source? yes_____no_____

Name of primary care physician:_____

Physician's address:_____telephone:_____

INSURANCE INFORMATION

Primary Insurance Company:_____Telephone:_____

Billing address:_____City:_____State:_____Zip:_____

Policyholder's Name:_____DOB:_____Employer:_____

Relationship to patient:_____Address(if different from above):_____

Policyholder's SSN:_____Contract #:_____Group #:_____

Secondary Insurance Company:_____Telephone:_____

Policyholder's Name:_____Employer:_____

Policyholder's SSN:_____Relationship:_____Contract#:_____Group #:_____

North Kent Guidance Services
5250 Northland Drive NE, Ste. A
Grand Rapids, MI 49525

Primary Care Physician (PCP) Communication Form
Client Consent to Exchange Information

Client:_____ Birthdate:_____

I _____ Authorize /Do Not Authorize (please circle one)
(Client, parent or guardian)
My behavioral health provider_____

and my primary care physician, Dr._____ Phone#_____fax#_____
Address:_____
_____
to exchange information regarding my mental health/substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral health care provider. I also understand that it is my responsibility to notify my behavioral health care provider if I choose to change my primary care physician.

Signature:_____Date:_____

Signature of parent/
guardian_____Date:_____

Witness:_____Date:_____

Provider Information
(To be completed by behavioral health provider)

Provider:_____

DSM IV Diagnosis code &
name:_____
Treatment Plan: Type_____Frequency_____Est. length of TX_____
Comments:_____

_____

_____

Signed:_____Date:_____
(If need to communicate an urgent or emergency situation, please call PCP in addition to sending form.)
Conclusion of mental health/substance treatment:_____
Date of last session:_____Treatment completed: Yes_____ No_____

COPY OF THIS FORM SHOULD BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE CLIENT RECORD.