711 PLEASANT STREET
ST. JOSEPH, MI 49085
269.408.8474

Confidential Client Information
Children & Adolescents (17 & under)

Welcome to THRIVE Psychology. We want to make the most of each appointment you have with us. One way of doing this is for you to provide the following information in advance of your first appointment. *Complete the information that is applicable to you. If you have concerns about the relevance of any information and wish to leave it out, feel free to do so.* This information is confidential.

Client's full name _____

Client's preferred name _____

Date of Birth _____/_____/_____ Age _____ Gender M / F / T Preferred gender pronoun_____

Adult Information (relationship) Father Mother Stepparent Other_____

Name_____

Address_____

EMAIL_____

Phone (H)_____ Phone (W)_____ Phone (Cell)_____

Employer _____

Other adult Information (relationship) Father Mother Step-parent

Name_____

Address_____

EMAIL_____

Phone (H)_____ Phone (W)_____ Phone (Cell)_____

Employer _____

Emergency Contact: Please circle - MOTHER FATHER OTHER

If OTHER - NAME: _____ Phone_____

Relationship to child _____

Child's Medical Care:

Child's physician _____ Phone _____

Practice name or address _____

How often does this child see a physician? _____ Date of last visit _____

Is your child on any medications? ____ Yes ____ No

If yes, indicate type, dosage and reason _____

_____

Does your child have any history of the following (check all that apply)

___ hospitalizations ___ surgeries ___ high fevers ___ serious accidents ___ allergies ____ seizures

___ eye, ear, nose & throat issues ___ digestive issues ___ head injuries ___ serious/chronic illness

Were there notable circumstances of your child's birth and/or early development that would be helpful for us to know (low birth weight, premature, foster care, adoption, early trauma, met or didn't meet milestones in development, etc.)?

_____

_____

Child's interests and activities:

Describe some of your child's strengths and positive characteristics _____

_____

Describe activities your child enjoys and participates in _____

_____

Reason for seeking treatment at this time:

Briefly describe the challenges your child is having at this time_____

_____

When did your child begin experiencing this problem, how often does the problem occur, how long does it last?

_____

Has your child ever had previous counseling of any kind ___ No ___ Yes

If yes, for how long and when _____

Was the experience helpful and what was addressed? _____

Has your child been hospitalized for emotional/behavioral problems? ___ No ___ Yes

If so, when and where was this?_____

Has your child been prescribed medications to control emotional/behavioral problems? ___ No ___ Yes

Medication/s and dosage _____

To your knowledge, has your child experimented with alcohol/drugs? ___ No ___ Yes

Describe _____

Family:

Has your child experienced parental separation, divorce or death? ___ No ___ Yes

If parents are divorced, who has custody? _____

What are the living arrangements? _____

Identify siblings of your child, their ages and how often he/she sees them:

_____

_____

Other information you consider important to our understanding your child but hasn't been asked for above

_____

_____

_____

_____

INFORMED CONSENT FOR TREATMENT

I _____, parent/legal guardian of _____

(agree and consent to have this child participate in behavioral health care services offered and provided by **THRIVE**

Psychology and _____(name of your clinician), a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above clinician is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of the license, certification and training of the behavioral health care providers directly supervising the services received by the patient. As this patient is under the age of 18, I attest I have legal custody of this individual and am authorized to initiate and consent for treatment.

Signature: _____ Date:_____

Relationship to Patient: _____

HIPAA NOTIFICATION

Your signature below indicates that you have read the Psychotherapist-Patient Service Agreement, the Michigan Notice Form (Notice of Psychologist's Policy & Practices to Protect the Privacy of your Patient Health Information), Received the HIPAA Notice AND agree to abide by all terms during our professional relationship.

_____

Patient Name (Please Print)

_____ _____

Patient's/Parent or Guardian Signature **Date**

TELEPHONE NOTIFICATION CONSENT

Patient confidentiality is a top priority at **THRIVE Psychology.** In order to meet your needs in this area, we are requesting that you sign a release allowing us to contact you by phone and leave a message identifying that the call is from your healthcare provider.

_____ YES, I give permission for **THRIVE Psychology** to leave me a detailed information *regarding my child/legal guardians appointment or general information* regarding business with this office.

In the event you cannot reach me I authorize you to contact the following people:

Contact Person	**Relationship**	**Contact Number:**
_____	_____	_____
_____	_____	_____

_____ NO, I do not wish to give permission to leave detailed information to anyone, *including myself*.

Therapist / Client Service Agreement

Congratulations on your decision to begin the therapy process! The choice to begin to move toward positive change is highly respected. The relationship between therapist and client is a meaningful, unique, and powerful connection through which restoration, forward movement, and measurable positive change are achieved. We understand this commitment includes a financial, emotional, and time investment. This document contains important information about the professional services and policies. Please take time to review our payment and attendance policy as follows:

Professional Fees, Payment, and Billing:

Your insurance will be billed as a courtesy. Please be aware that your plan may require a copay or deductible that is assigned as patient responsibility.

Initial Diagnostic Session: $350.00
45-55 min Psychotherapy: $200.00
Private Pay: $150.00

In addition, there is a charge for other professional services requested, such as phone calls over 15 minutes, legal activities, preparation of records or treatment summaries, correspondence to other professionals, evaluations, etc.

Cancellations*:*
If the need arises to cancel your scheduled appointment, please call the office at 269.408.8474 at least 24 hours prior. Scheduling changes not made within the 24 hour policy will result in a **$100.00** late cancelation fee.

Confidentiality*:*
The information you disclose during a therapy session is confidential. Information will not be released to anyone without your written consent. The limits to confidentiality arise in the case that an individual expresses intention to harm him or herself or someone else, or do not appear suitable to perform safety-sensitive duties. In such cases, we may be required to break confidentiality to assess the health and safety of all concerned. In addition, we are mandated by law, to report to the appropriate state authority any information regarding child and elder abuse or neglect. Finally, information presented during therapy may need to be disclosed in the case of a court order or medical emergency.

If you are having difficulty consistently managing the balance on your account, and arrangements for payment have not been agreed upon, we will discuss the barriers around payment with you and develop a plan to address the balance in a reasonable amount of time.

By signing the Therapist/Client Agreement document, you indicate that you have read and agree to follow the policies and procedures as written. If at any time you have concerns about this agreement, available alternatives will be discussed. Your signature also serves as an acknowledgment that you have received the HIPAA Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information.

The adult accompanying a minor to the appointment is responsible for payment.

Your signature grants us permission to bill your insurance company and receive reimbursement (if applicable). For clients between the ages of 18-26 who remain on their parents'/guardians' insurance plan, this signature grants permission to share financial information (including statements) with parents/guardians.

_____ _____

Client Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

REV 3.10.20

THRIVE Psychology Financial Agreement

Thank you for choosing THRIVE Psychology as your mental health provider. There are many aspects of supporting a successful outcome for you, including your financial responsibility regarding treatment. Following is our financial policy.

Indicate your understanding and agreement with each of the following statements by signing your initials at the left of each statement.

_____ **Payment/Copayment is due at the time of service.** Cash, personal check, money order, MasterCard, Visa, Discover, and HSA cards are accepted. If you do not pay by cash or check, we may ask that you keep a credit card on file to be charged after every visit.

_____ Billing statements will be emailed directly to you using the email address provided on page 1.

_____ **Private Pay/Self Pay**. Our practice offers a cash rate for those who do not have insurance coverage or choose not to use insurance. Payment is required at time of service. We may ask you to keep a credit card on file to be charged after your visits.

_____ A $100.00 fee will be charged for missed appointments as well as appointments cancelled or rescheduled without 24-hour notice: *Note:* These costs cannot be submitted to your insurance company for reimbursement and you are fully responsible.

_____ We will inform you of your expected copay/deductible responsibility, and that amount will be collected at the time of your visit. Your insurance policy is a contract made between you and the insurance company. THRIVE Psychology is not a part of the contractual agreement. You are encouraged to contact your insurance company to confirm your benefits. **You are responsible for any and all charges that your insurance does not pay.**

_____THRIVE Psychology charges a processing fee of $50 for release of medical records, completion of disability forms and/or other miscellaneous forms. This fee will be charged for each subsequent set of forms that are completed.

_____THRIVE Psychology will charge a fee of $50 per quarter hour for phone-calls, emails, etc that are made on your behalf as part of your treatment plan.

_____THRIVE Psychology does not participate with Medicaid Health Insurance.

_____Unpaid fees of any type may indicate a break not only in this agreement, but in the therapeutic process as well. THRIVE Psychology reserves the right to review your treatment. As we strive to increase your ability to manage all areas of life, we will not increase your financial stress by enabling a large debt to accrue.

By initialing each item above and signing below, you confirmed you have read and understood this financial policy. Further, your initials and signature indicate your agreement to adhere to the policy outlined in this agreement.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

_____ _____

PRINTED CLIENT NAME OR RESPONSIBLE PARTY **DATE**

Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

• All Mental Health records for children age 16 or older.

• All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.

• Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.

- You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.

- In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.

- Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental well being, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

_____ _____

Signature of Responsible Party Date

_____

Printed name of patient or responsible party