Please briefly state why this child was brought to the clinic. What are your concerns?

Has your child been seen by other persons for this problem? If yes, explain.

Education and School History

Please provide the following information for all schools that the child has attended:

School	Year started	Year stopped	Graduated?

What is your child's attitude about school? About the teacher(s)? About other students?

How would you describe your child's performance and behavior at school? Are there any problems?

Financial Status

Family's overall financial status (including gross annual income, major assets/liabilities, number of dependents, etc.)

Developmental History

How would you describe the pregnancy with this child?

Were there complications? If so, explain:

Birth weight:

Were there any difficulties in infancy with:

Feeding	Yes	No
Weight Gain	Yes	No
Sleeping	Yes	No
Weaning from breast or bottle	Yes	No
Crying	Yes	No

When did your child first (age):

- Sit:
- Walk:
- Say a word:
- Say simple sentences:

Describe and give age of any significant illnesses, including ear infections, high fevers, operations, and/or accidental injuries:

Describe any problem behaviors or personality difficulties as a preschooler:

Has your child had any traumatic or potentially traumatic experiences? If so, explain:

During the past year, have there been any significant events which might have had a negative effect on your child? If so, explain:

Legal Problems

Does your family have any pending legal problems? Yes No

Have you had prior legal problems in any way associated with your seeking treatment for your child at this time? Yes No

If yes to either of the above, please explain:

Culture, Ethic, and Religious Information

Does your family or your child currently, or have you or your child in the past, practiced a particular religion?
Yes No

If yes, please provide additional information about the religion, your current level of involvement, and your anticipated interest in this in the future:

Does your family identify with particular cultural or ethnic groups? Of what overall importance is this in your family's life?

Present Family Constellation

Siblings: Please indicate if any siblings reside in other than the child's residence.

Name	Age	Sex	Residence

Please list any other persons living with the family:

Have there been any significant separation, divorces, deaths, etc., in the child's life?

Activity Assessment

Approximately how much time does your child spend on play and leisure activities on a typical weekday?
Hours per day:

Approximately how much time does your child spend on play and leisure activities on a typical weekend (Saturday and Sunday)? Hours per day:

Is the amount of leisure time your child has available (check one):

Less than adequate Adequate More than adequate Much too much

With regards to the ways your child spends leisure time, would you say your child is (check one):

Very dissatisfied Less than satisfied Satisfied More than satisfied Very satisfied

Please list the activities in which your child is most active, starting with the activity in which he/she spends the most time? Include activities such as homework, individual or group play, chores, church activities, watching TV, computer, household projects, etc.

Activity	**Approximate number of hours per week**
1.	
2.	
3.	
4.	
5.	
6.	

Are there activities you would like to see your child involved in?

Are there activities your child has expressed interest in, but is not presently involved in?

Medical History

Name, address, and phone number of current or most recent medical doctor:

What was the date of your child's last physical examination?

Height: Weight:

Please list all current medications:

Name of medication	Dose	Frequency taken	How long taken	Who prescribes

Please check "yes" or "no" to indicate whether or not your child uses the following non-medical or non-prescribed drugs. For "yes" answers, please indicate usage:

	Yes	No	How much	How long
Cigarettes				
Sleeping pills				
Tobacco				
Alcohol				
Cocaine, crack				
Inhalants				
Stimulants ("uppers")				
Aspirin, other pain medication				
Cold remedies,cough medicine				
Coffee				
Tea				
Cola				
Other:				
Other:				

Does your child have physical pain? Yes No

If yes, rate the intensity of the pain: 1(mild) to 5 (severe):

If yes, where is the pain located:

If yes, how does it impact your child's functioning?

Does your child have any allergies, including food allergies? If yes, explain: **No**

Please check either "yes" or "no" to indicate whether or not the family has any of the following health problems. (Any unanswered questions will be considered a "no" response.)

	Child	**Mother**	**Father**	**Siblings**	**Extended family member**
Seizure disorder/epilepsy					
Glaucoma					
Emphysema					
Asthma					
Heart trouble					
High blood pressure					
Stomach trouble/ulcers					
Tuberculosis					
Thyroid disease					
Liver disease					
Gall bladder					
Hepatitis					
Diabetes					
Pancreatitis					
Cancer or tumor					
Arthritis or rheumatism					
Alcohol and/or drug abuse					
Stroke					
Anemia					
Depression					
Anxiety					
Mania or bipolar disorder					
Schizophrenia					
Learning disorder					
Attention deficit/hyperactivity disorder					
Other:					
Other:					

Is there any other medical, psychiatric, or substance abuse information that you feel we should know?

Is there anything else that you think we should know about your child or your family?

For electronic signature, print your name. Parent/Guardian Signature:	Date:

For therapist/psychiatric staff use only:

If it has been over a year since the patient's last physical, did you suggest that he/she have a physical?
Yes No Did the patient agree to this? Yes No

Therapist/Psychiatric Staff Signature: Date:

Child/Adolescent Symptom Checklist

Name: **Age:** **Date:**

Name of the person completing this form: **Relationship to child:**

Instructions: The questions below ask about things that might have bothered your child. For each word or phrase, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past 2 WEEKS.**

During the past **TWO (2) WEEKS,** how often has your child been bothered by:	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Hyperactivity	0	1	2	3	4
Being fidgety	0	1	2	3	4
Difficulty sitting still	0	1	2	3	4
Being easily distracted	0	1	2	3	4
Forgetting easily	0	1	2	3	4
Not turning in assignments	0	1	2	3	4
Being disorganized	0	1	2	3	4
Poor grades	0	1	2	3	4
Academically behind	0	1	2	3	4
Learning difficulty	0	1	2	3	4
Speech problems	0	1	2	3	4
Reading difficulty	0	1	2	3	4
Math difficulty	0	1	2	3	4
Defying authority	0	1	2	3	4
Losing temper	0	1	2	3	4
Being argumentative	0	1	2	3	4
Getting angry easily	0	1	2	3	4
Getting into fights	0	1	2	3	4
Throwing or breaking objects	0	1	2	3	4
Problems with temper	0	1	2	3	4
Hurting animals	0	1	2	3	4
Lying	0	1	2	3	4
Setting fires	0	1	2	3	4
Stealing, shoplifting	0	1	2	3	4
Breaking curfew	0	1	2	3	4
Running away from home	0	1	2	3	4
Skipping school	0	1	2	3	4
Legal problems	0	1	2	3	4
Is or has been on probation	0	1	2	3	4
Is or was in juvenile detention	0	1	2	3	4
Problem making or keeping friends	0	1	2	3	4

Suicidal thoughts, present	Yes	No
Suicidal thoughts, past	Yes	No
Suicide attempt or gesture	Yes	No
Homicidal thoughts	Yes	No

Child/Adolescent Symptom Checklist, page 2

Name: **Age:** **Date:**

During the past **TWO (2) WEEKS,** how often has your child been bothered by:	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Loss of appetite	0	1	2	3	4
Dental problems	0	1	2	3	4
Eating disorder	0	1	2	3	4
Picky eater	0	1	2	3	4
Binge-eating, purging	0	1	2	3	4
Anorexia	0	1	2	3	4
Weight loss or gain	0	1	2	3	4
If so, how much in the last 3 months:					
Gained: Lost:					
Difficulty separating	0	1	2	3	4
Won't sleep in own bed	0	1	2	3	4
Night terrors	0	1	2	3	4
Fears of ordinary things For example: crowds, storms, doctor, germs, flying, closed spaces	0	1	2	3	4
Panic/anxiety attacks	0	1	2	3	4
Suspiciousness, paranoia	0	1	2	3	4
Wets bed	0	1	2	3	4
Soils underclothing	0	1	2	3	4
Oversleeping	0	1	2	3	4
Mood swings	0	1	2	3	4
Crying spells	0	1	2	3	4
Low energy, tired	0	1	2	3	4
Trauma, other abuse	0	1	2	3	4

COLUMBIA SUICIDE SEVERITY RATING SCALE

Patient Name:	DOB:
Date:	Case #(Staff use only):

SUICIDE IDEATION DEFINITION AND PROMPTS		
Ask questions that are bold and underlined.	**YES**	**NO**
1) Wish to be Dead: Person endorses thoughts of a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. **<u>Have you actually had any thoughts of killing yourself?</u>**		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. **<u>Have you actually had any thoughts of killing yourself?</u>**		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it… and I would never go through with it." **<u>Have you been thinking about how you might kill yourself?</u>**		
4) Suicidal intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to "I have the thoughts but I definitely will not do anything about them." **Have you had these thoughts and had some intention of acting on them?**		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. **<u>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</u>**		
6) Suicide Behavior **<u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u>** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but did not swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but did not jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

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Consent to Treatment

Huron Valley Consultation Center
Ann Arbor, Michigan

I understand that I am voluntarily consenting to treatment at Huron Valley Consultation Center, Inc. (HVCC). The benefits, risks, and expected outcomes of treatment will be explained to me by my therapist, nurse, and/or psychiatrist. Psychotherapy and/or medication treatment can be beneficial to most people; however, I understand that this cannot be guaranteed.

I understand that I have the right to ask questions about treatment at any time and am entitled to be a part of all decisions made about my care, including alternatives. Once I have agreed upon a plan of treatment, I understand it is my responsibility to carry out the treatment recommendations.

I understand that I may be referred to a psychiatrist or nurse for medication evaluation, but I will be included in this decision.

I understand that I may withdraw from treatment at any time.

I understand that all patient records are confidential and no information can be released without written permission. However, state law and professional ethics dictate some exceptions to this which include:

- -suspected abuse or neglect of a child or vulnerable adult
- -threat to physically harm self or others
- -disclosure of the patient record when allowed by court order.

When clinical records are requested, HVCC strives to meet the Minimum Necessary Rule under HIPAA, the federal privacy law. This rule requires that health care providers release as little of your private information as possible, while still fulfilling the purpose of the records request. For example, your therapist, nurse, and/or psychiatrist reserves the right to submit a summarizing letter, rather than the entirety of your (or your child's) clinical record, in response to a request for records from any entity.

I have the right to be treated with respect and dignity by all staff members of HVCC, and I agree to treat other people and property with consideration.

I authorize HVCC to furnish information to my third party payor concerning my treatment in order to process payments and benefit utilization. I understand that I am responsible for fulfilling my financial obligations to HVCC in a timely manner, including paying insurance copayments, deductibles, and private pay sessions at the time of service. I agree to notify HVCC promptly of any changes in insurance. I understand that I have the right to have my bill explained to me.

I acknowledge that I am responsible for knowing the HVCC policy on scheduling appointments, missed appointments, and payments. Failure to give 24 hour notice of cancellation of a scheduled appointment to the psychiatrist/nurse practitioner and 24-48 hour notice of cancellation to the therapist may result in being charged a missed appointment rate of $75. I understand that if I miss a substantial number of appointments, treatment may be terminated.

I acknowledge I have received a copy of ***Your Rights When You Receive Mental Health Services at Huron Valley Consultation Center*** pamphlet and ***Notice of Privacy Practices*** brochure.

Patient or Parent/Guardian's signature	Date
Witness	Date

Revised 7/2018

Email/Text Consent Form | **Huron Valley Consultation Center**
Ann Arbor, Michigan

Patient Name:
Email:
Phone #:

1. Risk of Using Email and Texting

Transmitting confidential information by email or text has a number of risks that patients should consider. These include but are not limited to the following risks:

a. emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients
b. email and text senders can easily misaddress a message
c. backup copies of email and or texts may exist even after the sender or the recipient has deleted his or her copy
d. employers and on-line services have a right to inspect email transmitted through their systems
e. email can be used to introduce viruses into computer systems
g. email and texts can be used as evidence in court
h. emails and texts may not be secure and it is possible that the confidentiality of such communications may be breached by a third party

2. Conditions

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Providers are not liable for improper disclosure of confidential information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients acknowledge and consent to the following conditions:

a. **email is not appropriate for urgent or emergency situations**. Providers cannot guarantee that any particular email or text will be read and responded to within any particular period of time
b. all emails may be printed and placed in the patient's medical record
d. Providers will not forward patient emails outside of the HVCC email system
e. Providers are not liable for breaches of confidentiality caused by patients or any third party

3. Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with email communication between the provider and me and consent to the conditions and instructions outlined, as well as any other instructions that the provider may impose to communicate with me by email. If I have any questions I may inquire with my treating professional or the HVCC Privacy Officer.

Patient signature:	Date:
Witness:	Date:

If you are declining this consent to the use of email/text, please sign and date below.

Patient signature:	Date:
Witness:	Date:

Adopted 1/2015

HEALTH INSURANCE CLAIM FORM **NOTE TO PATIENTS OR PARENTS/GUARDIANS:**

This form will be filled out by HVCC. We only need you to sign your name and date it twice in the middle boxes **where you see the bold type. Your signature allows us to bill your insurance.** Page 2 is for HVCC to read only.

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER		1a. INSURED'S ID NUMBER:
2. PATIENT'S NAME (Last Name, First Name, Middle Initial	3.PATIENT'S BIRTH DATE SEX M F	4.INSURED'S NAME (Last name, First Name, Middle Initial
5.PATIENT'S ADDRESS (No., Street)	6.PATIENT RELATIONSHIP TO INSURED Self___Spouse___Child___Other_____	7.INSURED'S ADDRESS (No., Street)
CITY________________________STATE_________	8.RESERVED FOR NUCC USE	CITY____________________STATE_______
ZIP CODE TELEPHONE		ZIP CODE TELEPHONE
9. OTHER INSURED'S NAME (Last name, First name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT (Current or Previous)? b. AUTO ACCIDENT? Place (state)_______ c. OTHER ACCIDENT?	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. INSURED'S DOB:___________ SEX: M______F________
b. RESERVED FOR NUCC USE		b. OTHER CLAIM ID
c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN OR PROGRAM NAME		d.IS THERE ANOTHER HEALTH BENEFIT PLAN? YES___NO___ If yes, complete items 9, 9a, and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: Date:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Signed: Date:

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGANCY_____________	15. OTHER DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM____________TO____________
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE_____________________	17a.____________________________ 17b. NPI__________________	18. HOSPITALIZATION DATE RELATED TO CURRENT SERVICES FROM_____________TO_______________
19. ADDITIONAL CLAIM INFORMATION	20. OUTSIDE LAB? YES_______NO________	$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. a.________________b.________________c.________________d.________________ e.________________f.________________g.________________h.________________ i.________________j.________________k.________________l.________________		22. RESUBMISSION CODE ORIGINAL REF. NO.
		22. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To	B. PLACE OF SERVICE	C. EMG	D.PROCEDURES, SERVICES, OR SUPPLIES (Explain unusual circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSD T Family Plan	I. ID QUAL .	J. RENDERING PROVIDER ID #
1.									
2.									
3.									
4.									
5.									
6.									

25. FEDERAL TAX ID SSN_____EIN______	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT YES____NO_____	28. TOTAL CHARGE $____________	29. AMOUNT PAID $________	30. Rsvd. for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.	33. BILLING PROVIDER INFO & PH # a. b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BYAPPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information maybe guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to processthe claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signatureauthorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group healthinsurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned orCHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge,and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the chargedetermination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program butmakes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in thoseitems captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure anddiagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnishedincident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUSregulations.For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervisionby his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician'soffices, and 4) the services of nonphysicians must be included on the physician's bills.For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employeeof the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims,I further certify that the services performed were for a Black Lung-related disorder.No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subjectto fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lungprograms. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the servicesand supplies you received are covered by these programs and to insure that proper payment is made.The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federalagencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessaryto administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosuresare made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28,1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS:PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishmentof eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/orthe Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation ofthe Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupmentclaims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be madeto other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claimsadjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil andcriminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussedbelow, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services renderedor the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delaypayment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computermatches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnishinformation regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exceptionof authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and werepersonally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and Statefunds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existingdate sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate orany other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, DC 20503.

Primary Care Physician Letter

Huron Valley Consultation Center 2750 South State Street Ann Arbor, Michigan 48104

Note to Patients: This letter would be filled out by the therapist or psychiatric staff. If you **do not** want this letter to go to your PCP, please check after "Consent… is declined" at the bottom of this page (**in bold**), sign and date.

To: Doctor's name:	Practice Name (if any):
Street:	City, State, Zip:
Date:	
Dear Dr.	
Your patient:	DOB:
is currently being seen by : at Huron Valley Consultation Center.	
Diagnosis:	Date of evaluation:
Date of next appointment:	
Medications and prescribed by whom:	
Type of service: Individual therapy Conjoint therapy Family therapy Psychiatric evaluation/medication review	
Frequency seen:	
Treatment plan includes:	
Psychiatric hospitalizations:	

As we both work on the collaborative care of this patient, please feel free to contact me if you have any questions, concerns, new information, and pertinent medical issues.

Sincerely,

Signature of therapist or psychiatric staff:	
Patient's written release of information on file (check if letter is being sent):	
Consent to release information to primary care physician declined:	
Patient or Parent/Guardian signature (if consent declined):	**Date:**

Revised 12/2001

HURON VALLEY CONSULTATION CENTER
Missed Appointment Policy-Therapy

We want to thank you for choosing us as your mental healthcare provider. In order to give you and all our patients the best possible care, we request that you review our policy regarding fees and missed appointments. If you have health insurance that covers all or a portion of your fees, you are expected to provide HVCC with your insurance information at the time of your first appointment. Payment for copays or other fees is expected at the time of each visit. Please notify HVCC promptly of any changes in your insurance. You are responsible for all charges and fees not covered by your insurance including copayments, deductibles, private pay sessions, and other additional fees. You have the right to see a fee schedule and to have your bill explained to you.

A missed appointment is when you fail to show up for an allotted appointment time without a phone call or cancellation notice of at least 24-hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24-hour notice in order to reschedule your appointment. This will enable us to offer your time slot to other patients, helping us to provide continuous care to all of our valued patients. If you miss three scheduled appointments with your therapist, your therapist may not schedule any future appointments with you.

If you are unable to keep your scheduled appointment time, please contact your therapist at least 24 hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. If you fail to give notice of your inability to attend an appointment, you may be charged $75.00 missed appointment fee. The specific circumstances under which you will be charged will be determined by your therapist, and you should discuss that with your therapist. If you are a Medicaid patient, including commercial Medicaid, you cannot be charged a missed appointment fee. However, as with any other patient of HVCC, if you miss 2 scheduled appointments, you may be terminated from treatment with this therapist.

My signature indicates that I have reviewed, understood, and agreed to this policy.

Patient or Parent/Guardian signature:	Date:
Witness:	Date:

Revised 5/17

Release of Confidential Information **Huron Valley Consultation Center**
Ann Arbor, Michigan

Patient Name:
Date of Birth:

This authorization to release/exchange patient information is being requested of you to comply with the terms consistent with federal and state regulations.

I hereby authorize: Huron Valley Consultation Center
2750 South State Street
Ann Arbor, MI 48104
Phone: (734)662-6300 Fax: (734)662-3365

To release/exchange information to the individual, organization, or representative listed below. Information may be transferred in written, verbal, or electronic form.

Person and/or Organization with whom information is to be released/exchanged:

Name:
Street:
City, State, Zip Code:
Telephone number:

Please check the following that apply:

Psychiatric Chart Only:	Diagnosis:	Discharge Summary:
Therapist Chart Only:	Treatment Summary:	Evaluation:
Both Psychiatric and Therapist:	Medical Records and Reports:	Court Records:
All HVCC medical records:	Academic/school Records:	
	Substance Abuse:	
	HIV/Communicable Diseases:	
	Psychological Testing:	
	Other:	

The purpose and need for information disclosure; please check all that apply:

Assessment and treatment planning:	Coordination of Treatment:
Court ordered:	Other (please specify):

I understand that my records are protected under Federal and/or State Confidentiality regulations and cannot be disclosed without my written consent except as otherwise provided for in these regulations. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has already been taken in reliance on it. This consent shall expire:

One year from date signed:	When requested information has been shipped:
At termination of treatment:	Other (please specify):
Patient, Parent/Legal Guardian Signature*:	Date:
Relationship: Patient Parent Legal Guardian	
Witness:	Date:

*If legal guardian, copy of guardianship paper or Power of Attorney must be included.

Rev. 9/15

Telehealth Services Consent to Treatment **Huron Valley Consultation Center**
Ann Arbor, Michigan

Definition of Telehealth: Telehealth involves the use of electronic communications to enable HVCC's mental health professionals to connect with individuals using interactive video/ audio communications. Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, referral to resources and education.

*I understand the laws that protect the confidentiality of my personal information also apply to telehealth.

*I understand that the information disclosed by me during the course of my sessions is confidential. However, there are both mandatory and permissive exceptions to confidentiality, such as: reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and/or a court ordered subpoena.

*I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

*I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider; the transmission of my personal information could be disrupted or distorted by technical failures and the transmission of my personal information could be interrupted by unauthorized persons. I am hereby advised to use a secure internet connection rather than a public WIFI service.

*I understand the alternatives to intervention through telehealth as they have been explained to me and in choosing to participate in telehealth; I am agreeing to participate using audio/video conferencing technology.

*I understand that a follow up phone call may be necessary to complete the service, given unforeseen technical disruptions to the telehealth service.

*I also understand that at my request or at the request of my provider, I may be directed to “face-to-face” mental health services.

*I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

*I understand that my provider's cancellation policy is in effect for telehealth services.

*By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based mental health services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

* I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

* I understand that I may be personally responsible for any fees not covered by my insurance carrier and that I am advised to confirm payment for these services directly with my insurance carrier.

* By my signature below, I hereby state that I have read, understand, and agree to the terms of agreement.

Signature:	Date:
Parent/Guardian:	Date:
Witness:	Date:

Adopted 4/2020