

CANCELLATION POLICY

Our therapists and physicians have a waiting list to see patients, due to this fact we must insist that you give us at least a 24-hour notice if in fact you need to cancel or reschedule an appointment. This allows us to try and fill the spot with a client that may be on our waiting list.

If we do not receive ample notification *prior* to your appointment, you will be charged \$45.

I acknowledge my financial responsibility if I do not comply with The Center for Counseling's Cancellation Policy.

Signature client/guardian

Date

Clinician

Date



CLIENT'S BILL OF RIGHTS

- Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.
- Each client has the right to accept or refuse all or part of his/her care and /or have the expected consequences explained.
- Each client has the right to expect that all treatment records or information will be kept confidential in compliance with agency policy except as authorized and as required by law. No information/records will be released without written permission of client or other appropriate designee, except to the physician, insurance company or hospital/facility client transferred to. The client will have access to all their health care records.
- Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action.
- Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service.
- Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.
- It is the right of each client to receive individualized treatment which includes:
 - Adequate and humane services regardless of the source of financial support.
 - Services provided in the least restrictive environment possible.
 - An individualized treatment plan which is reviewed periodically and as needed.
 - To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.
- If at any time during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency - they have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.
- The client has the right to request a referral for services which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.
- The client will be informed of his/her rights in a language they can understand.
- Each client has the right to refuse to participate in any research projects without compromising their access to the organizations resources.
- Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
- Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.

Recipients have rights protected by state and federal law and promulgated rules. For information contact:

Office Manager
50630 Chesterfield Road
Chesterfield Twp., MI 48051

or

Office of Substance Abuse Services
Recipient Rights Coordinator
PO Box 30035, 3500 North Logan
Lansing, MI 48909

The above Bills of Rights have been reviewed with me and any questions I may have had were explained to my understanding. A copy of the Client's Bill of Rights was given to me.

Client/Guardian Signature

Date



50630 Chesterfield Road
Chesterfield Twp., MI 48051
Phone: 586.949.7680
Fax: 586.949.7681

Client's Name: _____ Phone #: _____

Address: _____
Street City State Zip

Your Therapist's Name is: _____

CLIENT EMERGENCY PLAN

FOR A LIFE THREATENING EMERGENCY: CALL 911

If you believe you are in danger or in imminent risk, suicidal or homicidal with intent: Please do not waste time calling our office or the clinician on call! You may want to attempt to contact your physician, but transport to the emergency room right away.

BUSINESS HOURS:

The Center for Counseling is dedicated to delivering personal, client focused care. Our office is open 9 am-9 pm Monday through Thursday and 9 am – 4 pm Fridays to meet your needs. During business hours if you have the need to speak with your clinician prior to your next appointment, please call our office at 1-586-716-0980. If your clinician is not available, we will make every attempt to contact them in a timely manner to return your phone call within 24 hours. If this is an **EMERGENCY** as defined above, please follow the directions. Your clinician will do their best to provide intervention over the phone. However, your clinician may request after no more than 10 minutes on the phone, that you schedule an appointment within 72 hours.

It will be the policy of The Center for Counseling to formally charge a fee for phone calls. These charges are non-billable to your insurance and will need to be paid by your next session. The fees are: 10-30 minutes = \$45, 30-60 minutes = \$90, and after 60 minutes, the charge will be \$1.00 per additional minute. _____

BEFORE/AFTER BUSINESS HOURS:

If an urgent matter arises which you would like to discuss with your clinician, **dial 1-586-949-7680** to receive the pager number. You will receive instructions to page the on-call clinician and leave a number. You will receive a return call within 15 minutes. If your call is not returned, please re-page the number, or call the **24-HOUR CRISIS LINE at 1-586-307-9100**. The on-call clinician will make every effort to contact your clinician in a timely manner to return your call within 24 hours.

Client / Guardian Signature:

Date:

Clinician Signature / Credentials

Date:

Consent for Treatment

1. I voluntarily consent to participate in the initial intake and assessment process.
2. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
3. I will be informed and take part in my treatment and goal planning.
4. I understand:
 - a. That I may withdraw my consent in writing at any time.
 - b. That I must notify The Center for Counseling if my insurance carrier or coverage changes.
 - c. I am responsible for monitoring my insurance. It is my responsibility to ensure participation and non-participation. I am responsible for payment of any services not covered by insurance and will pay any and all charges, co-pays, and deductibles owing The Center for Counseling in accordance with their regular rates. Any insurance balance not paid within 120 days will become my responsibility; The Center for Counseling will provide receipts so that I may turn them into insurance company.
 - d. Any and all balances will need to be paid off at the time of appointment. Next appointments cannot be made until balances are paid.
 - e. That if I must cancel an appointment, I am required to contact the office 24 hours prior to the appointment. Voice mail is available 24 hours a day, 7 days a week. **If I fail to contact the office, I will be charged at the rate \$45, NO EXCEPTIONS!!** This fee is **not** billable to your insurance, and is due at the beginning of the next session. _____
 - f. Balances over 30 days will accrue a service charge of 1.5% monthly, 18% annually. In addition to the above service charge, I agree to pay all costs of collection, including filing fees, court costs, and reasonable attorney fees.
 - g. That I will be charged \$25 for any non-sufficient funds checks.
 - h. That in case of inclement weather, I am to call the office prior to my appointment to confirm that the CFC is open. If we have closed, there will be a message on our recording indicating the closure.
 - i. That if I am a late cancellation or no call no show twice in a one year period my case will be closed.
 - j. That if my therapist or physician must write letters or fill out insurance forms there will be a \$75 charge for this service and that it takes up to a week to complete.
5. I have read and received a copy of the fire evacuation, fire drill procedure, tornado warning drill procedure and building map.
6. The Center for Counseling will use and disclose personal health information to treat you, to receive payment for the care we provide. We have prepared a detailed "Notice of Privacy Practices Brochure" to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notices in our office, on our website and have copies available for distribution. I have received a copy of the Notice of Privacy Practices.

Client/Guardian Signature

Date

Clinician Signature

Date

CHILD AND ADOLESCENT PERSONAL HISTORY FORM

MENTAL HEALTH SUBSTANCE ABUSE BOTH CLIENT ID #: _____

FORM COMPLETED BY (Must be over 18 years of age) _____ Relation: _____

A. What brought child into treatment: _____

B. What are your expectations for treatment: _____

C. Prior treatment experiences (Dates and Location): _____

D. Name of Primary Care Physician: _____ Phone: _____

E. Current Living Arrangements:

1. House Group Living Apartment Other (specify): _____

2. Alone With Family Unrelated Significant Other

I. CLIENT INFORMATION (Past and present)

1. TREATMENT EXPERIENCES

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

2. PRESENTING PROBLEM (Check all boxes that apply)

Medical/Organic condition

Anxiety

Depression

Aggressive Behavior

Mania

Suicidal Ideation's

Chemical Abuse/Dependency

Self-destructive Behavior

Delusions/Hallucinations

Anger

Family Issues

Life Decision

Relationship Issues

Uncertain

Other (please elaborate) _____

II. INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS (Past and present)

1. FAMILY CONSTELLATION

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
			YES	NO	YES	NO
Client						
Mother						
Father						
Significant Other						
Children						
Significant Others:						
(Brothers, Sisters, Grandparents, Step-relatives, Half-relatives)						
<i>Specify Relationship</i>						

2. FAMILY / EXTENDED FAMILY HISTORY

	Yes	No	Inpat/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

3. FAMILY HISTORY

1. In what City/State was child born? _____
2. Where did child grow-up? _____
3. Who raised child? _____

4. PARENTAL INFORMATION

- Parents legally married Mother remarried (number of times) _____
- Parents ever separated Father remarried (number of times) _____
- Parents ever divorced

Describe relationships with parents, step-parents

5. SIBLING INFORMATION

Number of living siblings / step-siblings _____ Number of deceased siblings/step-siblings _____

What position is child in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) _____

Describe your relationships with siblings:

Family will be involved in treatment Family uninvolved

Why/Why Not: _____

III. CHILD'S HISTORY

PREGNANCY: Planned: Yes No Length of pregnancy: _____

Mother's weight gain: _____

While pregnant, did you smoke? Yes No Amount: _____

Did you use alcohol and/or drugs? Yes No Type and amount: _____

While pregnant, did you have any medical or emotional difficulties: (e.g. Hypertension, surgery, medication, depression etc)

BIRTH:

Length of labor: _____ Induced: Yes No Caesarian: Yes No

Describe any physical or emotional complications with delivery: _____

Baby's birth weight: _____ Baby's birth length: _____

Describe any complications for mother or baby after birth: _____

Length of hospitalization: Mother: _____ Baby: _____

INFANCY / TODDLERHOOD: (check all that apply)

Breast Fed Milk Allergies Vomiting Diarrhea

Bottle Fed Constipation Colic Rashes

Describe any particular eating or feeding problems: (e.g. over eating, under eating):

Describe your child as an infant: (e.g. happy, nervous, overactive, under active, playful, etc.)

Describe any changes/differences as a toddler:

Describe any past/current problems with wetting or soiling:

Describe any past/current sleeping problems:

Other than parents, describe significant caretakers:

Child's Age	Caretaker (babysitter, relative, etc)	Describe arrangements
_____	_____	_____
_____	_____	_____
_____	_____	_____

DEVELOPMENTAL HISTORY:

Age at which child:

Sat alone: _____	Toilet trained: _____
Took first steps: _____	Dry during day: _____
Spoke words: _____	Dry during night: _____
Spoke sentences: _____	Dressed self: _____
Weaned: _____	Tied shoelaces: _____
Fed self: _____	Rode 2-wheel bike: _____

PAST / CURRENT DIFFICULTIES WITH ANY OF THE FOLLOWING:

- Attachment to doll, stuffed animal, blanket, etc
- Nervous habits (eye blinking, nail biting, etc
- Over activity
- Imaginary friends
- Sexual difficulties
- Separation difficulties
- Thumb sucking
- Teeth grinding
- Social contacts
- Temper tantrums
- Short attention span
- Fears
- Fascinations
- Head banging
- Masturbation
- Other

If yes, describe when and nature of problem:

AGE FOR FOLLOWING DEVELOPMENTS: (to be completed where applicable)

Voice change: _____ Breast development: _____ Body hair: _____ Menstruation: _____

MEDICAL:

Immunization Record:

	DTP	POLIO	
2 months:	_____	_____	
4 months:	_____	_____	15 months _____ MMR (Measles, Mumps, Rubella)
6 months:	_____	_____	24 months _____ HBPV (hib)
1 ½-2 years:	_____	_____	Hepatitis Series _____
4-5 years:	_____	_____	

IV. SOCIAL BEHAVIOR:

How well does your child get along with other children his/her own age:

Does child have friends: Yes No Duration of best friendship: _____

Your opinion of child's choice of friends:

Family members your child is close to:

Family members your child has difficulties with:

THERAPY IMPLICATIONS: _____

Interests/Hobbies

Art _____

Book/Films _____

Music _____

Physical Fitness _____

Crafts _____

Outdoor Activity _____

Sports _____

Diet/Health _____

Current Memberships (church, clubs, organizations): _____

Do you participate in any cultural activities related to your ethnic background? Yes No

THERAPY IMPLICATIONS: _____

DESCRIBE THE FOLLOWING:

Recent change in child's feelings/attitudes toward family members:

Physical, emotional, sexual abuse, past or present:

Child's problem behavior(s):

Effect of problem behaviors on other family members:

Child's response to authority figures and reasonable limit setting:

Geographical moves (how many, when, where, and child's response)

EDUCATION:

Present School: _____ School Phone #: _____

Grade: _____ Teacher: _____ School Counselor: _____

DESCRIBE THE FOLLOWING:

Placement in gifted/special education program:

Retention or acceleration in grade placement:

Past/current behavioral adjustment in school:

Past/current academic performance in school:

Your opinion of child's academic performance:

Child's attitude toward school:

Other pertinent information:

SPIRITUALITY:

Do you believe in a god or a power greater than yourself? Yes No

What religion were you raised? _____

What religion are you currently affiliated? _____

At this point in your life, what is most important to you? _____

THERAPY IMPLICATIONS: _____

V. EMPLOYMENT / VOCATIONAL:

Has child had any after school jobs? Yes No

If yes: Where _____ Dates _____

THERAPY IMPLICATIONS: _____

VI. LEGAL DATA:

Are you presently on probation or parole: Yes No

If yes, reason _____ From _____ To _____

Current Status:

Are you currently involved in any active legal cases (traffic, civil, criminal): Yes No

If yes, please describe and indicate the court hearing/trial date _____

THERAPY IMPLICATIONS: _____

VII. NUTRITIONAL ASSESSMENT:

Please circle the answer or indicated number and total the score from both columns at the bottom.

Do you have an illness/condition that made you change the type/amount of food you eat?	Yes - 2	No
Do you eat at least two or more meals per day?	Yes	No - 3
Do you eat fruits or vegetables, or milk products every day?	Yes	No - 2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes - 2	No
Do you have teeth or mouth problems that make it hard for you to eat?	Yes - 2	No
Do you always have enough money to buy the food you need?	Yes	No - 4
Do you eat alone most of the time?	Yes - 1	No
Do you take 3 or more prescription or over-the-counter drugs?	Yes - 1	No
Have you lost or gained 10 lbs. in the last six months?	Yes - 1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No - 2
TOTAL SCORE:		

0 – 2 = Low Risk 3 – 5 = Moderate Risk 6 – 21 = High Risk* * Referral

THERAPY IMPLICATIONS: _____

VIII. MEDICAL INFORMATION (past and present)

1. RECENT TREATMENT HISTORY

	DATE	REASON	RESULTS
Last physical check-up			
Last Doctor ' s visit			
Last Dental visit			

2. REVIEW OF PAST/PRESENT CONDITIONS

Please check any of the following medical problems you have, or have had in the past:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Adrenal problems | <input type="checkbox"/> Head Injury/Loss of Consciousness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Meningitis or Encephalitis | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Allergies | |

If yes to any of the above, please describe and give dates: _____

3. Is child in any physical pain? Yes No

If yes, where/what kind? _____

If yes please rate pain _____ 0 = none 5 = mild (tolerable) 10 = severe (referral)

4. CURRENT MEDICAL SYMPTOMS / PROBLEMS: Please check all that pertain to child now:

EYES:

- Double Vision
- Eye Pain
- Problems with Vision

EARS:

- Hearing Aid
- Buzzing/Ringing in ears
- Infection in ears
- Problems with balancing
- Problems with hearing

NOSE:

- Nose bleeds
- Stuffy nose

MOUTH:

- Loss of taste
- Problems with teeth
- Dentures

RESPIRATORY:

- Shortness of breath
- Chronic cough
- Sputum/mucus production
- Positive TB test
- Coughing up blood

SKIN/JOINT/MUSCLE

- Changes in skin
- Changes in nails
- Changes in hair
- Skin rash
- Skin itchy/dry
- Cramps in legs/arms
- Stiff/swollen joints
- Difficulty walking

GASTROINTESTINAL:

- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in stool
- Black tarry stool
- Abdominal pain

GENITO/URINARY:

- Pain/burning with urination
- Frequent urination at night
- Bloody/brown urine
- Difficulty starting urine flow
- Constant need to urinate

NERVOUS SYSTEM:

- Headaches
- Numbness
- Fainting spells
- Convulsions/seizures
- Memory problems
- Coordination problems
- Tremors/shakes
- Loss of movement
- Loss of sensation

GENERAL HEALTH:

- Overweight
- Underweight
- Chills
- Fever
- Tire easily
- Night/day sweats

CARDIOVASCULAR:

- High blood pressure
- Low blood pressure
- Heart skips a beat
- Palpitations
- Fast heart rate
- Chest pains
- Swollen ankles

FEMALES ONLY:

- Menstrual irregularities
- Menopause
- Problem pregnancy
- Miscarriage #: _____
- Abortion #: _____
- Premenstrual problems
- Infertility
- Currently pregnant

If you checked any of the above, please describe: _____

5. MEDICATION AND DRUG USE Include prescription, non-prescription, and illegal drugs

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hrs
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					
	<input type="checkbox"/> Yes <input type="checkbox"/> No					

Any history of drug overdose: Yes No If yes, please describe: _____

Any history of drug allergies? Yes No If yes, please describe: _____

THERAPY IMPLICATIONS: _____

Do you believe child would benefit from any of the following?

- Anger Management Education Series
- Substance Abuse Education Series
- Grief Group

STAFF USE ONLY

Yes No N/A Client currently being treated by Primary Care Physician for symptoms checked on page 8.

Yes No Referred for physical.

CLINICIAN SIGNATURE/CREDENTIALS

DATE

PSYCHOLOGIST SIGNATURE

DATE

Physician Agrees Disagrees with referral

If disagree, reason: _____

PHYSICIAN SIGNATURE

DATE

Notice of Privacy Policies and Practices

Our promise to you on the privacy of your health information

The following notice describes how your medical information may be used and made known, and how you can get access to this information. Please review the information carefully.

- Your private healthcare information may be released to other healthcare professionals within The Center for Counseling for the purpose of providing you with quality mental health and substance abuse care.
- Your private healthcare information may be released to your insurance company for the purpose of The Center for Counseling receiving payment for providing you with needed healthcare services.
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by the agency to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to limit the use of your private healthcare information. However, the agency may choose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- The agency is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- The agency will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to the agency: The Center for Counseling, ATTN: Office Manager, 50630 Chesterfield Road, Chesterfield Twp., MI 48051.

All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency. For further information about this Privacy Notice, please call us at 586.949.7680.