NEW OAKLAND FAMILY CENTERS

face to face

CONSUMER INFORMATION AND MEDICAL EMERGENCY

Consumer's name: Date of birth: Age: Gender:

Address: City: Zip:

Phone #: Work/alternate #: Social Security #:

COMPLETE THE FOLLOWING SECTION FOR MINORS

Parent/guardian name: Workplace:

Phone numbers: (W) (H) Other:

Parent/guardian name: Workplace:

Phone numbers: (W) (H) Other:

Employer/school: Occupation/grade:

Driver's license #: License plate #: Make/ model: Color:

Who referred you to New Oakland?:

Emergency contact person: Relationship to consumer:

Phone: (H) (W) (Other)

Primary health insurance: Address:

Policyholder name: Relationship: DOB: SS#

Address: Phone #: Employer:

Contract #: Member #: Group #:

Secondary health insurance: Address:

Policyholder name: Relationship: DOB: SS#

Address: Phone #: Employer:

Contract #: Member #: Group #:

Primary care physician's name: Phone:

Address: City: Zip:

Medical/health issues:

Food and/or drug allergies:

Current medications

Preferred pharmacy name: Pharmacy address:

Pharmacy phone #: Pharmacy FAX #:

In the event of an emergency, I give New Oakland Family Centers permission to obtain medical care for me/my child. I understand that I/my child will be transported by ambulance to the hospital of choice or the nearest emergency room and I will be responsible for this fee.

Consumer's signature: **Date:**

Parent/legal guardian's signature: **Date:**

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Consent for Treatment / Recipient Rights

Consumer's name: _____ **Gender:** _____

Date of birth: _____ **Age:** _____ **Admission date:** _____

☐ **FACE to FACE/PHP care** ☐ **Outpatient care**

I consent to and voluntarily seek treatment at New Oakland Family Centers (hereafter known as the Clinic). In the event that the consumer is a minor, I represent that I have the right and authority to authorize treatment and hereby authorize the Clinic's staff to provide services to that minor.

I acknowledge that I have received the consumer orientation manual and information regarding the services offered, program descriptions, and expectations, as well as, received rights information, specifically the "Know Your Rights" Brochure (all CMH consumers) and substance abuse recipient rights brochure. I agree to participate and commit to working with the program as scheduled. I understand the following:

1. I understand protected health information may be used and disclosed to carry out treatment, payment and health care operations (refer to Notice of Privacy Practices).
2. This consent may be revoked in writing at any time, except to the extent that the provider has taken action in reliance on it.
3. I have the right to request that the provider restrict how protected health information is used or disclosed.
4. I understand I have a right to inspect and obtain a copy of protected health information and amend the record as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
5. I understand information is considered confidential and my right to privacy shall be respected by the staff of the Clinic within legal limits; e.g., notification to health department of communicable diseases, FIA Protective Services, or if have I threatened to harm another (Duty to Warn), etc.
6. I understand that treatment may include utilization of medication. The purpose of any recommended medication(s), and any side effects of the prescribed medication(s) will be reviewed and discussed with me by the physician.
7. A treatment plan will be developed and I will be asked to participate in that process.
8. I understand that I may request a change of therapist during my treatment.
9. Termination of treatment is ideally an agreement between the therapist and consumer. However, the consumer has the freedom to discontinue treatment at any time.
10. I understand that if I am the recipient of substance abuse services, I have certain specific rights as outlined in the brochure I have received. The confidentiality of alcohol and drug abuse consumer records are protected by Federal law, rules and regulations and that I can get more information from the clinic.
11. I understand that a medical assessment will be completed as part of the partial hospital program. The medical assessment shall include, but not be limited to, obtaining medical history along with medications prescribed, review of daily activities and essential body systems, obtaining height, weight, blood pressure and other vital signs, etc. Further testing, such as an electrocardiogram (EKG), may be completed as necessary (Eating Disorder PHP consumers ONLY.)
12. I understand that I have a right to be informed of any procedures, recommendations for treatment, and/or changes in treatment.
13. I understand the nature and purpose of treatment, possible alternative methods of treatment, the risks involved and the possibility of complications. Promises and/or guarantees cannot be offered regarding the outcome of treatment.
14. Tele-psychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing. At times, New Oakland Family Centers utilizes Tele-Psychiatry for psychiatric appointments. If Tele-Psychiatry services are offered to me, I understand that I will be informed and agree with this method of service delivery prior to scheduling any appointments. I understand that I have the right to withhold or withdraw my consent to the use of Tele-Psychiatry in the course of my care at any time, without affecting my right to future care or treatment. I understand that a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time.
15. I understand that I have the right to file a complaint/grievance at any time and can do this informally by discussing my concerns with any staff member or formally (in writing) using the complaint/grievance forms made available in designated areas. All complaints/grievances will be addressed and best efforts will be made to resolve these concerns in a timely manner. If for any reason, I am not satisfied with the resolution, I have the right to appeal the decision by contacting the Director of Quality and Compliance who will investigate the matter at an administrative level.

Consumer signature: _____ **Date:** _____

Parent/legal guardian signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____

NEW OAKLAND FAMILY CENTERS

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AUTHORIZATION FOR COMMUNICATION and BILLING-NO SHOW AGREEMENT

Consumer Name: _____ DOB: _____ Age: _____

In relation to services rendered by New Oakland Family Centers (hereafter referred to as the Clinic) to

_____ **(Consumer)** I, _____ **(Responsible Party)**

Address: _____ City/State: _____ Zip Code: _____

Cell Phone #: _____ Email: _____

Agree to the following terms and conditions:

1. I understand that payment for services is due at the time services are rendered.
2. I authorize direct payment of any third-party insurance benefits to the Clinic for services rendered to the above named consumer. If the third party insurance benefits are not paid directly to the Clinic or are paid in an amount which is less than the agreed upon charge, I acknowledge my responsibility and agree to pay the amount of any charges for which the Clinic has not been paid through third party insurance benefits.
3. I hereby authorize the Clinic to release information acquired in the course of my examination or treatment which is required to obtain reimbursement for services or to obtain benefits for which I may be eligible.
4. I acknowledge that I have been informed and am aware of the Clinic charges for services rendered and agree to pay or authorize the third party insures to pay those rates or their contracted portion.
5. I understand that the **FACE to FACE** Crisis Program appointments are considered urgent care and intensive intervention, therefore, cancellation of appointments and non-participation is not acceptable. Furthermore, I understand that I will be charged for any outpatient appointments that are not kept or rescheduled at least twenty-four (24) hours prior. Finally, I understand that third party insurances do not cover “no-show” and “cancellation” fees and I am fully responsible for this charge. (Terms of this agreement are specified below).
6. In case the third party insurer refuses to acknowledge the obligation for the payment of charges for services rendered by the Clinic, I agree to be responsible for and to pay the charges for those services. I am aware that it is then my choice and my responsibility to seek resolution of any dispute with my insurer.
7. In addition to charges established for professional services, the Clinic may charge for the performance of certain administrative work requested. Work for which additional charges may be incurred includes, but is not limited to, medical records requests, completion of sick leave authorization, completion of disability forms, etc.
8. In the event that the above-named consumer is a minor, I represent that I have the right and authority to authorize treatment and hereby authorize the Clinic’s staff to provide services to that minor and to bill on their behalf.

TERMS OF NO SHOW AGREEMENT:
I, understand and agree to pay for those scheduled appointments which are not kept or cancelled at least twenty-four (24) hours prior to the appointment time, except for extreme emergencies at a rate of $50 (state and federally funded insurances excluded).

By signing this form, I consent to receive text messages/emails related to administrative functions (i.e., appointment reminders) and understand that I may be contacted by phone, mail and/or email regarding any billing issues that occur, if necessary.

Signature of responsible party	Date	Signature of clinic staff	Date

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face to face

ACKNOWLEDGEMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Consumer name: _____ **Date of birth:** _____

By signing below, I acknowledge that I have received the Notice of Privacy Practices from New Oakland Family Centers.

Consumer/legal guardian signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____

Documentation of Failure to Obtain Signed Acknowledgement

On _____ (date) , _____ (name of employee) presented this Acknowledgement

Receipt of Notice of Privacy Practices to _____ (consumer's name) .

The Consumer refused to provide a signature when requested.

Statement of Consumer Rights and Responsibilities

Consumer name: _____ **DOB:** _____

New Oakland Family Centers is committed to providing comprehensive mental health services of excellence and integrity in all areas of our professional service. To achieve this requires a team approach involving you and your assigned treatment team, and the staff at New Oakland Family Centers. As such, it is important that we understand basic obligations we have to one another.

The staff at New Oakland Family Centers will endeavor:

- To provide you with an orientation and comprehensive assessment to determine your treatment needs.
- To provide ethical and competent care to the population served by remaining culturally sensitive and to stay current with trends in treatment.
- To remain current and up-to-date on education/licensing standards.
- To provide a safe and clean environment.
- To provide dignity and respect in all interactions.
- To provide you understandable information regarding your mental health status, diagnosis, and prognosis.
- To provide continuity of care while a consumer at New Oakland.
- To respond to your needs or any questions you may have regarding your care in a timely manner.
- To inform you of your treatment options, answer any questions about your treatment, and provide all necessary information to make an informed decision about your care.
- To respect your wishes and decisions about your health care, and right to decline any treatment recommendations.
- To provide appropriate referrals and recommendations when indicated regarding your treatment and health care.
- To close your case if you have three (3) or more no-shows, cancellations without 24 hour notice prior to appointment, and/or have not attended treatment in 30 days or more, and/or do not respond to contact made by staff at New Oakland.

Cases that are closed for non-compliance or for violating any New Oakland policies will require management review and approval for re-admission. Cases closed three (3) times for these stated reasons will be permanently closed. Consumers who are involuntarily discharged for non-compliance, or who violate New Oakland policies may not receive services for up to six months and may at that time be evaluated for readmission.

I, the consumer, will strive:

- To be respectful of staff and other consumers while at New Oakland Family Centers.
- To inform staff of any changes in my address, phone number, insurance information, or medical doctor whenever they occur.
- To inform my therapist, case manager, and/or psychiatrist of any changes in my mental status or side effects to medication as they occur.
- To provide accurate and honest information regarding my present condition and past medical/psychiatric history.
- To inform staff of any special accommodations needed, including language, hearing impairment, and physical limitations.
- To not conduct any illegal activities at any New Oakland sites, or bring drugs/alcohol, or weapons in the buildings.
- To be considerate of New Oakland's rules and regulations regarding behavior/general conduct, and tobacco use.
- To participate in my treatment planning process/goal development and to follow my treatment plan to the best of my ability.
- To follow instructions prescribed to me to the best of my ability.
- To keep any medications prescribed to me in a safe place and take as prescribed.
- To inform a site supervisor/director if I feel I have been mistreated or are unsatisfied with my services in any way.
- To keep all scheduled appointments to the best of my ability, and call to cancel appointments 24 hours prior to appointment time if needing to cancel.
- To pay all copays/coinsurance and deductibles at time of service, and/or fees for services, which have been agreed upon.

Consumer signature: _____ **Date:** _____

Parent/guardian signature: _____ **Date:** _____

Witness signature: _____ **Date:** _____

New Oakland Family Centers
Coordination of Care with Primary Physician Form

face to face

☐ **Ann Arbor** 501 North Maple Rd. Ann Arbor, MI 48103	☐ **Clarkston** 6549 Town Center Dr. Clarkston, MI 48346	☐ **Flint** 2401 South Linden Rd. Flint, MI 48532	☐ **Livonia (SUD PHP)** 31500 Schoolcraft Rd. Livonia, MI 48150	☐ **Southfield** 20505 West 12 Mile Rd. Southfield, MI 48076
☐ **Bloomfield Hills** 2520 S. Telegraph Rd. Bloomfield Hills, MI 48302	☐ **Clinton Township** 42669 Garfield Rd. Clinton Township, MI 48038	☐ **Grand Rapids** 3744 28th St., SE Kentwood, MI 49512	☐ **Okemos** 2300 Jolly Oak Rd. Okemos, MI 48864	☐ **Southgate** 13305 Reeck Rd. Southgate, MI 48195
☐ **Center Line** 26522 Van Dyke Ave. Center Line, MI 48015	☐ **Farmington Hills** 32961 Middlebelt Rd. Farmington Hills, MI 48334	☐ **Livonia (Main)** 29550 Five Mile Rd. Livonia, MI 48154	☐ **Port Huron** 500 10th St., Suite A Port Huron, MI 48060	☐ **Warren** 8150 Old 13 Mile Rd. Warren, MI 48093

Consumer information

Consumer name: _____ Date of birth: _____

Physician information

Physician name: _____ ☐ Consumer does not have primary care physician

Physician address: _____

Physician phone #: _____ Physician FAX #: _____

Please check one of the following

A. ☐ I DO authorize any information on my care, including diagnosis, medications, labs to be shared between the provider listed above to facilitate my treatment.

OR

B. ☐ I DO NOT authorize information to be shared with my primary care physician or for ONLY limited information to be shared as specified below.

Please specify limited information authorized to be shared _____

Authorization to obtain/disclose information

I understand that records or information about my mental health or alcohol and drug abuse treatment and counseling are confidential; they are protected by applicable state and federal laws, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV infection, and AIDS-Related Complex and the performance of any tests, counseling and the results and treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire one year from the date signed.

Signature of consumer/guardian: _____ Date: _____

Signature of clinician: _____ Date: _____

Do not write below this line. To be filled out and sent to primary care physician (if authorized)

Diagnosis/presenting problem(s): _____

Psychotropic medication(s): _____

_____

Treatment recommendations: _____

_____

Primary care physician: Please return the following information: Current medical diagnosis, current medications, most recent labs and any pertinent medical information to assist in coordinating care.

To the recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and certain state laws. The Federal rules and the state laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for those purposes. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NEW OAKLAND FAMILY CENTERS

face to face

CONSENT FOR MEDICATION MONITORING

Client's Name: _____

DOB: _____ Age: _____ Gender: _____ Admission Date: _____

As part of the New Oakland Family Centers assessment process, I acknowledge that laboratory tests may be recommended by my psychiatrist.

By signing this form, I authorize New Oakland Family Centers or its designated service provider to run a complete Medication Monitoring profile for a period of 12 months. In addition to screening for prescribed medications, this testing will include a drug screen for non-prescribed or illegal drugs. Additionally, I authorize New Oakland Family Centers or its designated service provider to release results of this testing to the treating authorized healthcare provider or facility. I hereby authorize my insurance plan to be billed and benefits to be paid directly to New Oakland Family Centers for the services I received. I understand that I may be responsible for any charges not paid by my insurance. In some circumstances my insurance company will send proceeds directly to me. Under law, I agree to endorse the insurance check and forward it to New Oakland Family Centers within 30 days.

I understand that medication monitoring is part of the treatment process and required. I also acknowledge that declining to sign this document may result in discontinuation of psychiatric services.

Self/Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This authorization is valid only for the information, agencies and persons cited above. Redisclosure of this information is not permitted without further specific authorization. This form is in compliance with Title 42 of the Code of Federal Regulation, Part 2; Title 45 of the Code of Federal Regulation, Part 160 & 164; part 61 of Michigan Public Act 368 of 1978; and Michigan Public Act 258 of 1975, Section 748.

Disclosure of substance abuse information in the State of Michigan requires separate written consent by any person 14 or older.

NEW OAKLAND FAMILY CENTERS

Telemental Health Informed Consent

Client's name _____ Date of birth: _____

I, _____, hereby consent to participate in telemental health with, _____, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

NEW OAKLAND FAMILY CENTERS

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of client (if a minor) Date

_____ _____

Signature of therapist Date