Psychology Associates
OF GRAND RAPIDS, PC

Office Use Only
Acct#:_____
Provider: _____
ICD10:_____

Date: _____

Who referred you to our practice?: _____

Patient Name: _____ **Sex:** M F

First Middle Int. Last

Date of Birth: _____ **Social Security:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone 1: _____ H/W/C **Phone 2:** _____ H/W/C

Patient's Employer: _____

Primary Care Physician or Psychiatrist: _____

Address or Phone: _____

In the event that we need to contact you, may we:

Accounts must be kept current or statements will be mailed and calls will be made.

Leave a voicemail on above #'s? Yes _____ No_____ Send mail to home? Yes_____ No _____

Leave our name and number with another person at above #'s? Yes _____ No _____

FOR MINOR CHILDREN OR PATIENTS WITH GUARDIANS:

(The parent/guardian who is bringing the child to the appointments will be listed as the responsible party. Please list that parties name first)

Parent/Guardian #1: _____ **Relationship:** _____

Address: _____

Contact #1: _____ **Contact #2:** _____

Parent/Guardian #2: _____ **Relationship:** _____

Address: _____

Contact #1: _____ **Contact #2:** _____

Emergency Contact:

Name: _____ **Relationship:** _____

Phone: _____

PRIMARY INSURANCE COMPANY: _____

Name of Policy Holder: _____ **Sex:** M F

Relationship to Patient: _____ **DOB:** _____ **Soc. #:** _____

Contract/Member ID: _____ **Group #:** _____

Employer: _____

SECONDARY INSURANCE COMPANY: _____

Name of Policy Holder: _____ **Sex:** M F

Relationship to Patient: _____ **DOB:** _____ **Soc. #:** _____

Contract/Member ID: _____ **Group:** _____

Employer: _____

ALL COPAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

INSURANCE RELEASE: I authorize the release of any information my clinician may feel is necessary to process my insurance claims. This may include information about my mental health. I authorize participating insurance payments directly to my provider. I fully understand that I will be responsible for any amounts due following a response from my insurance, including deductible and non-covered services. I understand that if I have an insurance that Psychology Associates does not participate with that I am responsible for payment in full at the time of service and a courtesy claim will be billed on my behalf and any reimbursement will be sent directly to me from my insurance company.

_____ Date: _____

Signature of Patient/Parent/Guardian

PSYCHOLOGY ASSOCIATES MID TOWNE

555 Mid Towne Street NE Suite 304 / Grand Rapids, Michigan 49503 / Phone 616.458.4444 / Fax 616.458.4440

POLICY INFORMATION

Thank you for choosing Psychology Associates Mid Towne for your mental health needs. We are committed to providing you with the highest quality, professional and ethical treatment. Please understand that payment of your bill is considered part of your treatment.

PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS

The following is Psychology Associate's policy information, which we require you to ***read, initial, and sign*** prior to any treatment. If you do not understand, or if you have any questions, please ask.

Confidentiality _____

All information disclosed within sessions is confidential and may not be revealed to anyone without your expressed, written consent. There are exceptions to confidentiality, specifically IN CASES WHERE THE THERAPIST IS MANDATED BY LAW TO REPORT TO THE APPROPRIATE AUTHORITIES (i.e. WHERE THERE IS REASONABLE SUSPICION OF ABUSE OF CHILDREN, ELDERLY OR DISABLED PERSONS; WHERE THE CLIENT IS LIKELY TO HARM HIM/HERSELF OR OTHERS UNLESS PROTECTIVE MEASURES ARE TAKEN). If you have any questions about confidentiality, especially as it relates to children and adolescents, please ask your therapist. Please note that if you use insurance to help pay for your sessions, your signature on the bottom of our intake sheet grants us permission to provide your insurance carrier with information about you.

Insurance _____

We participate with several insurance companies. Participation means that we will accept what your insurance company approves. **You are responsible for any copays, deductibles or non-covered services at the time of service.** If we do not participate with your insurance company you are responsible for the full fee at the time of service. We will turn in a courtesy claim for you to your insurance so that they can reimburse you directly, apply the visit to your deductible, etc.

Payment for Services _____

Payment is expected at the time of the scheduled session unless you request other arrangements. If you are having difficulty paying your bill please talk with us regarding payment arrangements. If we receive payment other than expected from your insurance company, the remaining balance will be transferred to your account. Any outstanding balance must be paid in full within 30 days. We will mail a statement to all clients who have a balance due on their account. **If payment is not received within the calendar month, a $10 statement fee will be assessed.** If an account remains unpaid, we will pursue collection of this past due account.

Minor Patients _____

The adult accompanying a minor and/or the parents/guardians of the minor are responsible for full payment. For unaccompanied minors treatment will be denied unless charges have been pre-authorized to an approved credit card or payment is made by cash or check at time of service, unless prior arrangements have been made.

Building Policies _____

Psychology Associates Mid Towne, located in the Women's Health Center of West Michigan, has parking available in the attached Ellis parking structure. Please bring your parking ticket with you to your appointment and you will be given a parking voucher. You will need both the ticket and the voucher to exit the lot. Please note that this voucher will provide 1½ hours free parking for your time spent in our office. Without this voucher, you will be required to use credit card payment to exit the ramp.

There are fire alarm pull stations throughout the building. If a pull station is activated to create a false or nuisance alarm the fire department may assess a $1000 fine to the responsible party.

Women's Health Center of West Michigan is a smoke-free campus. This includes the building, the parking structure, and its surrounding property. Please dispose of your cigarettes, etc. before leaving your vehicle.

Cancellations / Missed Appointments _____

We request that appointment cancellations be made 48 hours in advance. Cancellations made less than 24 hours prior to the appointment or no show appointments may result in a charge that may total the full fee of your appointment

Client Acknowledgement and Agreement:

* I have read and understood the above information.
* I have had the opportunity to ask questions and have any questions answered.
* I agree to pay the fee for each visit for services rendered.

_____ Date _____

Signature of patient or responsible party

Revised 06.15.17

Psychology Associates of Grand Rapids, P.C.
& Affiliated Therapists and Psychiatrists

PSYCHIATRIC ADDENDUM POLICY INFORMATION

The following is an addendum to Psychology Associate's policy information, which we require you to ***read*** and ***initial*** prior to any treatment.

Medication Refills _____
Medication refills will be addressed during scheduled appointments. A $20 charge will be applied for refills needed outside of scheduled appointment times.

Promptness _____
Please arrive on time for your appointment. If you arrive more than 10 minutes late for a med check appointment, the visit will have to be rescheduled. A late fee may be charged.

Additional Psychotherapy Charge _____
An additional psychotherapy charge may be added when psychotherapy is provided as part of the medication management visit. The amount of charge will vary with length of visit time.

Cancellations / Missed Appointments _____
Scheduled appointments must be kept, or cancelled/rescheduled with at least 24 hour notice. Cancellations made less than 24 hours prior to the appointment will result in a **$65** charge. Broken appointments without notice will be billed the full fee of **$110**.

Practice Model _____
Patients must be ***actively*** involved in psychotherapy while receiving medication management services. This model supports the research that a combination of psychotherapy and medications is most effective in managing mental health problems. When therapy is terminated by the patient or therapist, patients will be referred to other community providers for long-term medication management (ex. PCP, Pine Rest, Forest View, or their insurance company for other suggestions.)

Psychology Associates of Grand Rapids, P.C.
& Affiliated Therapists and Psychiatrists

Notice of Privacy Practices Acknowledgement of Receipt

I acknowledge that I have been offered the Psychology Associates of Grand Rapids, P.C. and Affiliated Therapists and Psychiatrists Notice of Privacy Practices.

_____

Print Patient Name

_____

Patient or Patient Representative Signature Date

Psychology Associates
OF GRAND RAPIDS, PC

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using video conferencing. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session.

- Crisis management and intervention. In the event of a life-threatening emergency please call the office and speak with a support staff or follow the after hours prompts for contacting our answering service.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications
We will be using the _____ telecommunication service. You will need a cell phone, tablet or computer with a camera and microphone to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. Our system is HIPAA compliant and does not store session content. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. You should also take reasonable steps to ensure the security of our communications (for example, having passwords to protect the device you use for telepsychology).

Technical Concerns
If the session is interrupted, disconnect from the session and I will wait two (2) minutes and then re-contact me via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then I will contact you via phone. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records
The telepsychology sessions shall not be recorded in any way. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____
Client Date

_____ _____
Therapist Date

Psychology Associates of Grand Rapids PC

CLIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

Client Name:_____ **Birth Date:** _____

Purpose of Request: I authorize the Practice and my Provider, _____, to disclose Protected Health Information (as described below) directly to me at the e-mail address and/or text number I have indicated. I understand that it is my responsibility to notify the Practice and my Provider of any changes in my e-mail address and that any disclosure made to the e-mail address, indicated by me, is subject to the redisclosure statement within this authorization.

E-Mail Address: _____ **Text Phone Number:** _____

I authorize the Practice and my Provider to disclose the following Protected Health Information about me to the e-mail address I have indicated (please provide a written description of the information to be disclosed):

☐ Appt Scheduling Only ☐ Clinical Updates ☐ Other:_____

Purpose of Disclosure: I am authorizing the disclosure of my Protected Health Information to the specified e-mail address as a means of enhancing communication with my healthcare Provider and the Practice.

Expirations or Termination of Authorization: This authorization will expire one year from the date it was initiated, unless I specify an earlier termination. I understand that I must submit a new authorization after the expiration date to continue the authorization. I also understand that I have the right to terminate this authorization at any time. Desired termination date: _____.

Right to Revoke or Terminate: As stated in the Practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization by submitting a written request to the Practice's Privacy Manager. This may be presented in person, or by mailing a request to the Practice, Attn: Privacy Manager.

Re-Disclosure: I understand that the Practice has no control regarding persons who may have access to the e-mail address I have listed to receive my Protected Health Information. Therefore, I understand that my Protected Health Information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this Practice.

Use of Electronic Communication: I understand that electronic communication is not intended to be used for therapy. I also understand that it is not to be used for clinical emergencies or urgencies. I acknowledge that there may be a fee associated with the exchange of electronic communications, and the clinical review of and response to that communication. I understand that any fee charged will not be billed to my insurance carrier and I hereby agree to pay any fee assessed. Fees will be charged at the clinical hourly rate unless otherwise indentified as _____.

_____ _____

Client Signature Witness Signature

Date: _____ Client Copy Provided: ____ Yes ____ No

Date: / /

New Patient Information

Legal Name: _____ Preferred Name: _____

Biological Sex: _____ Preferred Gender Pronoun: _____ Gender Identity: _____

Birthdate: _____ Age: _____

Questions or Concerns You'd Like Addressed

Write down any questions or concerns about treatment you'd like us to address:

_____

_____

Mental Health History: ☐ None

Have you received counseling in the past? ☐ Yes ☐ No
If yes, when, with whom, and for what reason?

Substance Use History:

	None	Past	Present	Frequency/Amount
Alcohol	☐	☐	☐	_____
Drugs	☐	☐	☐	_____
Nicotine	☐	☐	☐	_____
Caffeine	☐	☐	☐	_____

Have you received treatment for any of the above substances? ☐ Yes ☐ No
If yes, when, for what substance and for how long?

Family/Social/Personal History:

Do you have any family members with substance abuse or mental health problems? ☐ Yes ☐ No
If yes, list relationship and the problem.

Describe your current family relationships and living arrangements.

Is there any history of verbal, physical, or sexual abuse or assault in your past? ☐ Yes ☐ No
If yes, please describe.

Have there been other very difficult or stressful things in your past (*for example, serious accident; life-threatening or serious illness or injury: a sudden, violent or unexpected death of someone close to you, other significant losses such as a partner, child, parent, pet*)

☐ Yes ☐ No
If yes, please describe.

Relationship History:

☐ Single ☐ Married (# of years: _____) ☐ Separated (Date: _____) ☐ Divorced (Date: _____)

☐ Living Together (# of years: _____) ☐ Name of Spouse/Partner: _____
If in a relationship, how would you describe the quality/satisfaction of your present relationship?

_____

How many children do you have and what are their ages?

_____

Educational/Employment History:

What is the highest grade you completed in school? _____ GED? ☐ Yes ☐ No

Other education/training? _____ Occupation/Vocation: _____

Current Employer: _____ How long? _____

Legal History:

Number of arrests: _____ Nature of arrests: _____

Other legal concerns: _____

Religious/Spiritual Background:

List any formal religious affiliation.

_____

Cultural/Racial Identity:

☐ White/Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian

☐ Middle Eastern ☐ Muslim ☐ Hindu/Buddhist

Recent Symptoms

Circle how many days you've felt well in the past week (mentally & physically)

0 1 2 3 4 5 6 7 days

Circle any sleep problems you've had in the past week

1: falling asleep 2: staying asleep 3: waking too early

Next, rate how you've felt over the past week...	None	Mild (infrequent or rarely causes a problem)		Moderate (often or causes some problems)		Severe (constant or causes many problems)	
Depression, including lack of pleasure/motivation	0	1	2	3	4	5	6
Inactive, withdrawing or not doing much	0	1	2	3	4	5	6
Trouble making decisions, concentrating, planning or organizing	0	1	2	3	4	5	6
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	4	5	6
Anxiety, fear, or nervousness	0	1	2	3	4	5	6
Irritable, impatient, or argumentative	0	1	2	3	4	5	6
Energized, agitated, restless, wired; or still active despite few hours of sleep	0	1	2	3	4	5	6
More hyper, driven, active, or doing a lot more than normal for you	0	1	2	3	4	5	6
Doing things that others might think are risky, impulsive or excessive	0	1	2	3	4	5	6
Rapid thoughts that move so fast it's hard to follow them	0	1	2	3	4	5	6
Difficulty sustaining attention (e.g. reading, lectures, conversation, TV)	0	1	2	3	4	5	6
Distracted by noises around you or by your own thoughts	0	1	2	3	4	5	6
Procrastinating, avoiding tasks, or not finishing them	0	1	2	3	4	5	6

Circle any recent symptoms (regardless of their cause) **Current Weight:** _____

Mental: 1) emotional numbing 2) paranoid sensations 3) panic attacks (how many per week ___?) 4) Hearing voices or seeing things 5) tired 6) memory problems **Sleep:** 7) needing > 10 hr sleep 8) needing < 4 hr sleep 9) vivid dreams 10) sleep-walking 11) snoring **Neurologic:** 12) inner tension or restlessness 13) muscle stiffness 14) slowing or weakness in muscles 15) unwanted muscle movements (besides tremor) 16) imbalance 17) dizziness 18) fainting or falling 19) tremor 20) sensory changes 21) taste changes 22) headaches 23) teeth grinding **General:** 24) flu-like feelings 25) sexual difficulties 26) physical pain (rate 1-10, 10=worst: _____) **Eyes:** 27) blurry vision 28) visual changes 29) double vision **Stomach:** 30) increased appetite 31) binging or purging 32) appetite loss 33) stomach pain 34) nausea 35) diarrhea 36) constipation 37) dry mouth 38) excess thirst 39) excess salivation **Skin:** 40) rash 41) acne 42) excess sweating 43) itch 44) easily sunburned 45) unusual bruising 46) hair loss **Heart:** 47) palpitations **Urinary:** 48) frequent urination 49) difficulty urinating **Female:** 50) menstrual changes 51) breast changes

Caffeine ___ cups/day. Nicotine ___ pack/day. Alcohol: ___ drinks/day. Other drugs _____

Sleep meds: ___ #/week. If taking any meds as-needed for anxiety, how many do you use? ____ per: DAY / WEEK / MONTH

WEIGHT: _____ HEIGHT: _____ Allergies to medications? YES NO Which ones?

Current medications (including over-the-counter and vitamins):

NAME	DOSE	WHEN DID YOU START IT?

Have you ever had any of the following?

	YES	NO		YES	NO
Diabetes			Arthritis		
High blood pressure			Chronic pain		
High cholesterol or lipids			Sexually transmitted diseases		
Heart disease			Renal/kidney disease		
Thyroid illness			Restless leg syndrome		
Head injury			Sleep apnea		
Seizure			Glaucoma		
Migraines			Liver disease / hepatitis		
Multiple sclerosis			Heartburn/reflux		
Stroke			Asthma		
Psoriasis			Complications in your birth or first few months of life		
Family History of Diabetes					
Other:					

Handedness: O RIGHT O LEFT O AMBIDEXTROUS (=equally right/left)

For Women: Are you currently pregnant, breast-feeding or considering pregnancy? YES NO

Is your menstrual cycle active? YES NO

Are you in treatment with anyone else (primary care doctor, therapist)?

NAME	CITY	PHONE NUMBER

Past Treatments

Have you ever been admitted to a hospital for mental health? O YES O NO O YES to ER but not admitted

Which psychiatric medications have you tried? (refer to the list on the back to help recall)

		How did you respond to it?				
Medication	Start/stop dates or Year/duration	Felt better on it	No difference or unsure	Felt worse on it	Worked at first, wore off	Notes

Psych Meds: Examples

ANTIDEPRESSANTS

Serotonin fluoxetine/prozac, sertraline/zoloft, paroxetine/paxil, fluvoxamine/luvox, citalopram/celexa, escitalopram/lexapro, vortioxetine/trintellix, vilazodone/viibryd

SNRIs venlafaxine/effexor, duloxetine/cymbalta, desvenlafaxine/pristiq, milnacipran/savella, levomilnacipran/fetzima

Other wellbutrin (buproprion, budeprion, aplenzin), remeron/mirtazipine, serzone/nefazodone, trazodone/desyrel/oleptrol

Tricyclics imipramine, clomipramine, amitriptyline/elavil, nortriptyline, doxepin, protriptyline

MAOIs selegiline/emsam, phenelzine/nardil, tranylcypromine/parnate, isocarboxazid/marplan

Natural St John's Wort, deplin, SAMe, omega3/fish oil, NAC, chromium, theanine, lightbox, vitamin B, folate/folic acid, kava dava

MOOD STABILIZERS

Lamotrigine/lamictal

Lithium, lithobid, eskalith

Depakote/valproate

Carbamazepine, tegretol, equetro

Trileptal/oxcarbazepine

ANTIPSYCHOTICS / MOOD STABILIZERS

Atypicals aripiprazole/abilify, quetiapine/seroquel, lurasidone/latuda, olanzapine/zyprexa, symbyax, brexpiprazole/rexulti, cariprazine/vraylar, asenapine/saphris, paliperidone/invega, risperdal/risperidone, ziprasidone/geodon, iloperidone/fanapt

Older antipsychotics haldol, haloperidol, thorazine, chlorpromazine, stelazine, prolixin

Clozaril/clozapine

SLEEP MEDICINES

Newer hypnotics ambien/zolpidem, sonata/zaleplon, lunesta/eszopiclone, intermezzo, edluar, belsomra

Other trazodone/desyrel, doxepin/silenor, prazosin/minipress, ramelton/rozerem, vistaril/hydroxyzine, benadryl

Melatonin

ANTI-ADDICTION

Anti-alcohol: campral, antabuse, baclofen

Anti-nicotine: wellbutrin, chantix, nicotine replacements

Other: naltrexone, suboxone, methadone, clonidine, ofexidine/lucemyra

STIMULANTS AND ADHD TREATMENTS

Methylphenidate ritalin, metadate, methylin, concerta, focalin, quillivant

Amphetamines adderall, dexedrine, zenzedi, evekeo, vyvanse, mydayis

Other vayarin, vayacog, guanfacine/intuniv, clonidine/kapvay, strattera, atomoxetine

BENZOS

Ativan/lorazepam, klonopin/clonazepam, xanax/alprazolam, oxazepam/serax, restoril/temazepam, prosom, doral/quazepam, halcion

OTHER

Anticonvulsants neurontin/gabapentin, pregabalin/lyrica, gabatril/tiagabine, keppra/levetiracetam, topamax/topiramate, zonisamide

Provigil/modafinil, nuvigil/armodafinil

Buspar/buspirone

Synthroid, levothyroxine, cytomel, T3, T4

Mirapex, pramipexole, requip, ropinorole, neupro

Light therapy or lightbox

Electroconvulsive Therapy (ECT)

Transcranial Magnetic Therapy (TMS)