

BIRMINGHAM FAMILY THERAPY CLINIC, INC.

FIRST APPOINTMENT ORIENTATION

Thank you for choosing the Birmingham Family Therapy Clinic, Inc. for your therapeutic healthcare services. We recognize you have many choices and we appreciate you allowing us the opportunity to work with you.

The following paperwork needs to be filled out and/or signed prior to beginning therapy. Please feel free to print, complete and bring it with you to our first session so that we may spend more time with you on clinical rather than administrative issues.

Some things to keep in mind:

- ✓ Remember, you can download and print, review, or ask for a complete set of Birmingham Family Therapy Clinic, Inc. Privacy Policies.
- ✓ Your therapist will review and answer any questions about this paperwork or other matters.
- ✓ If you were referred by your insurance plan, please contact the company and bring with you your insurance card, authorization number and any co-payment and/or deductible information.
- ✓ Please provide us with your primary care physician's telephone number.
- ✓ If you have seen a therapist or psychiatrist within the last two years, please provide us with their telephone number.
- ✓ If there is any additional paperwork or documents that contain information that you believe important to helping you achieve your goals, please feel free to bring a copy for your file.

BIRMINGHAM FAMILY THERAPY CLINIC, INC.

CLIENT INFORMATION

NAME: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

PLEASE LIST PREFERRED PHONE NUMBERS WHERE WE MAY CALL OR LEAVE A MESSAGE:

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MAY WE LEAVE A DETAILED MESSAGE AT ANY OF THESE NUMBERS? Yes No if yes, indicate which number

OCCUPATION: _____ EMPLOYER: _____

EMAIL ADDRESS: _____

BIRTH DATE: ____ / ____ / ____ AGE: _____ GENDER: MALE FEMALE

RELATIONSHIP STATUS: SINGLE MARRIED SEPARATED

 ENGAGED LIVING TOGETHER WIDOWED

 DIVORCED TEEN/CHILD REMARRIED

PARTNER INFORMATION (if involved in a relationship) or CUSTODIAL PARENT/GUARDIAN INFORMATION (if client is a child/adolescent):

NAME: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

PLEASE LIST THE PREFERRED PHONE NUMBERS WHERE WE MAY CALL OR LEAVE A MESSAGE:

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MAY WE LEAVE A DETAILED MESSAGE AT ANY OF THESE NUMBERS? Yes No if yes, indicate which number

OCCUPATION: _____ EMPLOYER: _____

EMAIL ADDRESS: _____

BIRTH DATE: ____ / ____ / ____ AGE: _____ GENDER: MALE FEMALE

LENGTH OF CURRENT RELATIONSHIP: _____ IF MARRIED, FOR HOW LONG: _____

HAVE EITHER YOU OR YOUR PARTNER BEEN MARRIED PREVIOUSLY? Yes No

LENGTH OF PREVIOUS MARRIAGES: CLIENT _____ PARTNER _____

WHOM MAY WE THANK FOR THE REFERRAL? _____

WHO WOULD YOU LIKE NOTIFIED IN CASE OF EMERGENCY?

NAME: _____ RELATIONSHIP TO YOU: _____

EMERGENCY CONTACT PHONE NUMBER: _____

IF YOU HAVE CHILDREN PLEASE LIST THEM BELOW (indicate type such as: biological, adopted, foster, step etc)

<u>NAME</u>	<u>GENDER</u>	<u>AGE</u>	<u>TYPE: (bio, step, etc)</u>	<u>LIVING W/ YOU?</u>
_____	_____	_____	_____	<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

PLEASE LIST ANYONE ELSE LIVING IN YOUR HOME:

<u>NAME</u>	<u>RELATIONSHIP TO YOU</u>
_____	_____
_____	_____
_____	_____

ONLY IF THE CLIENT IS A CHILD/ADOLESCENT:

ARE BIOLOGICAL PARENTS SEPARATED OR DIVORCED? Yes No IF YES, FOR HOW LONG? _____

DOES NON-CUSTODIAL PARENT SHARE: LEGAL CUSTODY? Yes No PHYSICAL CUSTODY? Yes No

PLEASE PROVIDE NON-CUSTODIAL PARENT INFORMATION:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PLEASE LIST THE PREFERRED PHONE NUMBERS WHERE WE MAY CALL OR LEAVE A MESSAGE:

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

MAY WE LEAVE A DETAILED MESSAGE AT ANY OF THESE NUMBERS? Yes No if yes, indicate which number

OCCUPATION: _____ EMPLOYER: _____

EMAIL ADDRESS: _____

BIRTH DATE: ____/____/____ AGE: _____ GENDER: MALE FEMALE

COUNSELING ISSUES

BRIEFLY DESCRIBE THE REASON(S) FOR WHICH YOU ARE SEEKING COUNSELING AT THIS TIME:

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF COUNSELING?

INSURANCE INFORMATION (ONLY IF REFERRED BY YOUR PLAN)

NAME OF INSURED (if different than client): _____ ADDRESS _____

GENDER: MALE FEMALE BIRTHDATE: _____ SS#: _____

INSURANCE COMPANY: _____ PHONE: _____

MEMBER ID# _____ GROUP NUMBER: _____

INSURED'S EMPLOYER: _____ AUTHORIZATION # _____

INSURANCE TYPE: HMO PPO OTHER DEDUCTIBLE: _____

PHYSICAL/MENTAL HEALTH INFORMATION

PLEASE COMPLETE FOR ALL PARTICIPANTS (if applicable) IN THERAPY

● NAME OF PARTICIPANT: _____
PHYSICIAN/PEDIATRICIAN NAME: _____ PHONE: _____
PSYCHIATRIST NAME (last two years): _____ PHONE: _____
THERAPIST NAME (last two years): _____ PHONE: _____
IMPORTANT PHYSICAL OR EMOTIONAL EVENTS AND/OR CONDITIONS: _____

MEDICATIONS TAKEN (prescribed, over the counter and herbal): _____
DRUG/ALCOHOL USE (type, amount, frequency, length of time using): _____

● NAME OF PARTICIPANT: _____
PHYSICIAN/PEDIATRICIAN NAME: _____ PHONE: _____
PSYCHIATRIST NAME (last two years): _____ PHONE: _____
THERAPIST NAME (last two years): _____ PHONE: _____
IMPORTANT PHYSICAL OR EMOTIONAL EVENTS AND/OR CONDITIONS: _____

MEDICATIONS TAKEN (prescribed, over the counter and herbal): _____
DRUG/ALCOHOL USE (type, amount, frequency, length of time using): _____

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IMPORTANT PHYSICAL OR EMOTIONAL EVENTS AND/OR CONDITIONS: _____

MEDICATIONS TAKEN (prescribed, over the counter and herbal): _____
DRUG/ALCOHOL USE (type, amount, frequency, length of time using): _____

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PSYCHIATRIST NAME (last two years): _____ PHONE: _____
THERAPIST NAME (last two years): _____ PHONE: _____
IMPORTANT PHYSICAL OR EMOTIONAL EVENTS AND/OR CONDITIONS: _____

MEDICATIONS TAKEN (prescribed, over the counter and herbal): _____
DRUG/ALCOHOL USE (type, amount, frequency, length of time using): _____

PLEASE LIST ANY FAMILY HISTORY THAT MAY BE IMPORTANT FOR US TO KNOW IN ORDER TO HELP YOU FURTHER:

AUTHORIZATIONS AND DISCLOSURES

(For all participants over 18 years of age)

AUTHORIZATIONS

I authorize the Birmingham Family Therapy Clinic, Inc. to contact the referral source for treatment, payment, or healthcare operations, **understanding that personal information will need to be released to my insurance company or the company that manages my benefits or provides payment.**

yes no

If I was referred by my insurance plan, I authorize the Birmingham Family Therapy Clinic, Inc. to bill my insurance/managed care company for the psychotherapy and authorize them to make payment directly to the Birmingham Family Therapy Clinic, Inc. for the benefit specified and otherwise payable to me, but not to exceed the usual and customary charges for the services. The Birmingham Family Therapy Clinic, Inc. may need to disclose clinical information necessary to process all claims.

yes no

I authorize the Birmingham Family Therapy Clinic, Inc to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment and educational programs during and after the completion of my treatment to my home mailing address.

yes no

DISCLOSURES

I understand that the Birmingham Family Therapy Clinic, Inc is required by law to report all cases of suspected child abuse or neglect, threats of harm towards oneself or someone else if the client is not complying with treatment or if the threat is beyond what can be dealt with in the therapeutic setting.

yes no

I understand that my therapist at the Birmingham Family Therapy Clinic, Inc will seek consultation about my situation if they deem necessary.

yes no

I understand that while I hope to experience beneficial change, there is no guarantee that this will occur and in reality, I may experience no improvement in my situation or I may think that things have gotten worse after treatment. For example, I may wish to save my marriage but in the end, still divorce.

yes no

I understand the Birmingham Family Therapy Clinic, Inc cannot be held responsible for being unable to access me due to telephone devices that may block their calls, my use of a pager system in which I cannot be directly reached, any form of caller identification, **or any type of device that does not allow my therapist to make direct telephone contact with me.**

yes no

I realize that the Birmingham Family Therapy Clinic, Inc is a training center and conducts research. I understand that sometimes sessions will be observed by therapists in training and/or their supervisors; in session, behind a one-way mirror and/or videotaped. My consent to live observation is voluntary. I understand that all research and training is calculated, reported, and described in a manner that maintains my confidentiality and total anonymity.

yes no

I understand that my session will be discontinued if I am under the influence of any non prescription drug, including alcohol, or if I become verbally or physically violent.

yes no

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FINANCIAL CONTRACT

- My usual and customary rate for providing direct face-to-face psychotherapy services is \$195.00 per 45 minute session. We accept payment by credit card, check, or cash.
- I require **a minimum of 24 hours notification** of cancellation. You may cancel by calling the clinic during normal business hours at (248) 258-9189; my cell phone after hours at (248) 703-5871 or on-line at <http://www.appointmentquest.com/provider/2080082437> if you have been provided a username and password. You will be billed **your full session fee for not providing a minimum of 24 hours notification** of cancellation. This outstanding balance must be paid prior to additional psychotherapy services being delivered, even if a third party is responsible for psychotherapy payment.
- You will be billed for non covered and non routine services such as: extended telephone consultation, crisis intervention, report writing, reading of case file, legal reporting, consultation or coordination and extended care coordination with other providers at a rate of \$4.00 per minute. You will be informed of events involving additional billing prior to the event.
- The cost for each returned check from the bank is \$25.00. This outstanding balance must be paid prior to additional psychotherapy services being delivered.
- Please list any additional comments/special conditions that may affect payment such as: Third party payment arrangement for face to face psychotherapy.

Signature

Date

Signature

Date

Witness

Date

BIRMINGHAM FAMILY THERAPY CLINIC, INC.

PRIVACY NOTICE

To comply with federal health insurance portability and accountability act guidelines the Birmingham Family Therapy Clinic, Inc. has implemented the following policy regarding patient privacy and confidentiality. You may request a copy of our complete set of guidelines, you can review the guidelines posted in the waiting room, or you may review and download the policies from our web site. Our office holds patient record information confidential and we will only use your information for the following reasons: **treatment, payment and health care operations**. The following is a partial list of whom your information can be disclosed, if needed, to:

- Primary care physicians
- Psychiatrists
- Medical specialists
- Diagnostic facilities
- Hospitals, including psychiatric
- Labs
- Insurance companies
- Billing and collection services
- School officials: administrators, counselors, teachers
- State and /or County officials
- Attorneys or other agents assigned to your case by the Sate and/or County

Disclosing Record Information

Release of information to any other entity not listed above will require a signed authorization from you or your guardian. This request must be dated, show who the information is to be released to or requested from, the specific information to be released or acquired. These authorizations will have an end date. Additional requests beyond the end date will require a new authorization. We will keep a record of all disclosures in your file. This information will be available for you to review.

You Have a Right to Access Your Records

You can review and obtain copies of your records, with exceptions listed in our complete set of guidelines. Our office requires a written request, and we will make the records available within 10 days of your request.

Record Storage

The Birmingham Family Therapy Clinic, Inc. stores paper copies of **administrative** and **Clinical records** for the appropriate length of time per clinician regulations.

Miscellaneous

If we need to contact you by telephone and leave a message we will only leave our name and our phone number. We will not leave any information on an answering machine or with anyone other than the client or guardian unless we have your consent. It will be your responsibility to return the call.

Acknowledgment

I acknowledge that I have reviewed this privacy notice and that I may request or download the Birmingham Family Therapy Clinic, Inc. full privacy policy.

Signature

Date

Signature

Date