PATIENT

Patient's Last Name	First	M.I.	Sex	Age	Birth Date	Social Security Number
Address	City	State	Zip Code	Telephone Number		
Employer or School Attending	Employment or School Address					
Employment or School Phone	Occupation or School Grade					
Who referred you to PPS?	If minor, who has legal custody?					
In case of emergency, contact	Relationship					
Address	Home Phone #	Work Phone #				

RESPONSIBLE PARTIES

Responsible Party	Relationship	Spouse/Other Parent	Relationship
Address City		Address City	
State Zip Code	Home Phone #	State Zip Code	Home Phone #
Social Security # Occupation		Social Security #	Occupation
Employer	Work Phone #	Employer	Work Phone #
Employer Address		Employer Address	

INSURANCE INFORMATION

Insurance Co. ______________________ Phone Number ______________________

Insurance Address ____

Policy Holder ______________________ Birth Date ________ Relationship ______________

Employed By ______________________ Business Phone ______________

Social Security # ______________________ Contract # ______________

Group # __________ Service Code # __________ Plan Code # __________ Medicaid # __________

FOR OFFICE USE ONLY

Deductible ________ Yearly Maximum ________ Copay ________ Ins. Reimburse% ________ Diagnosis Code ________

Verified with ______________________ Phone # ______________

Authorization # ______________________ Initial Auth Dates ______________

I have read the following pages and have had the opportunity to ask questions which to my satisfaction were answered. I understand and agree to the conditions specified within.

X______________________________ ______________________________

Client/ Responsible Party's Signature Date Clinician's Signature Date

PSYCHOLOGICAL PROFESSIONAL SERVICES, P.C.

BIOSOCIAL/HEALTH ASSESSMENT

Client Name: ______________________________ D.O.B: __________ Date: __________

Any past/present medical/mental problems: _____ If yes, please describe: ___________________________

____

Name/address/telephone of your doctor ____

____

Are you currently taking any prescribed medication: _____ If yes, please list: __________________________

____

Any psychotherapeutic medications taken in the past: _____ If yes, please list: ________________________

____

Any allergies to food or medication: _____ If yes, please list: ______________________________________

____

Any surgeries: _____ If yes, why: ____

Any hospitalizations (include psychiatric): _____ If yes, please list where, how long, reason why: __________

____

What would you like to achieve in counseling: ____

Describe some you your strengths: ____

Describe some areas you want to work on: ____

Symptoms within the Past 6 Weeks:

Do you have thoughts now or recently or wishing you were dead: Yes No

Do you have thoughts now or recently of harming yourself: Yes No

Do you have any thoughts now or recently of harming others: Yes No

FAMILY HISTORY (NAMES, QUALITY OF RELATIONSHIP):

Father:____

Mother:____

Spouse:____

Guardian:____

Stepparent:____

Children/Siblings:____

Overall impression of your childhood: ____

Is there a family history of mental illness:____

Is there a family history of substance abuse:____

Have you ever attempted to commit suicide or seriously harm yourself:______________________________

Have you ever attempted to seriously harm someone else:____________________________________

Have you behaved violently toward family members:_______________________________________

MARITAL HISTORY:

Current Marital Status:____

How many times married, age first married, and times divorced:_______________________________

EDUCATIONAL HISTORY:

Highest grade completed:________________________ Currently in school: ________________________

Any academic problems in school:____

Any learning disabilities:____

MILITARY HISTORY:

Any military history:____

EMPLOYMENT HISTORY:

Current employer:____

Job Title:____

Years on job:__________ Are you satisfied with your job:__________ Any current job problems:_______

Have you ever been fired from a job:____

FINANCIAL:

Do you have any financial problems:____

SPIRITUAL/ETHNIC/CULTURAL HISTORY:

Current religious/spiritual involvement or activities:____

Do you have any religious/spiritual concerns:____

Do you have any ethnic/cultural concerns:____

SEXUAL/GENDER ISSUES:

Do you have any sexual/gender issue concern:____

Any concerns about AIDS or other sexually transmitted diseases:_____________________________

Were you ever sexually abused: ___________ If yes, by whom and when: _________________________

SUBSTANCE HISTORY:

Do you use alcohol or drugs: _____ If yes, how often: ______________________________________

Where you ever treated for alcohol or drug use: ____

LEGAL HISTORY:

Have you ever been arrested: _____ If yes, why: ____

Have you ever been charged or convicted of a felony:____

Are you on probation:____

Are you currently involved in any lawsuits:____

ACTIVITIES AND INTERESTS:

What are your hobbies/special interests: ____

Do you have any close friends: ___________ Acquaintances: ___________ Both: ___________

How would you describe your relationships (short or long term): ______________________________

Do you make friends easily, shy, outgoing, keep friends, fight often, feel taken advantage of: ______________

BIRTH AND DEVELOPMENTAL HISTORY OF THE CHILD *IF THEY ARE THE CLIENT*:

Planned pregnancy: _____ Length of pregnancy: _____ Weight gain of mother: _____

During pregnancy: Did you smoke: _____ If yes, how much: ___________________________________

Did you drink: ______ If yes, how much: ___________________________________

Did you use any medication or street drugs: _____ If yes, please describe: ______________________________

Any medical interventions during pregnancy (surgery, medication, high blood pressure, depression etc):

____

Was the labor normal or caesarean: ____

Any complications during or after the birth: ____

Was the baby jaundiced or in respiratory distress: ____

How long was the baby in the hospital after birth: ____

Birth and weight of the baby: ____

INFANCY:

Breast fed: _____ If yes, how long: ____

Problem with Vomiting, Colic, Diarrhea, Dehydration, Constipation, Rashes, Sleeping Problems,

Overactive, Underactive, Weight Loss or Gain: ____

____

WHEN DID YOUR CHILD:

First smile: _____ Stand: _____ Walk: _____ Speak words: _____ Whole sentences: _____

Give example of sentence: ____

Age trained for bowels: _____ Any problems after the child was toilet trained: ___________________

Fed self: _______ Dressed self: _______ Tied shoelaces: _______ Learned to ride a bike: _______

CIRCLE ANY OF THE FOLLOWING THAT YOUR CHILD HAD DIFFICULTY WITH:

Eyes Ears Teeth Arms, legs, feet Eating Weight Allergies Teeth grinding

Thumb-sucking Head banging Fascinations Short attention span Peer contacts

Separation difficulties Temper tantrums Preschool/nursery school Lived away from home

Anything else, please explain: ____

____

Signature of person completing this form/date: ____

Clinician's signature/date: ____

Psychological Professional Services, P.C.
Consent to Treatment and Payment Agreement

I hereby give my consent to undergo psychotherapy on a voluntary basis. I understand that I may discuss any concerns I may have regarding my treatment with my therapist and that I may withdraw from treatment at any time should I feel the need to do so. I am aware, if there is not contact with my therapist for a period of 30 days, my case may be closed.

I do hereby seek and consent to take part in treatment with Dr. Cheryl A. Lewis, Ph.D., LLP. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I am aware that all efforts have been made to verify insurance coverage. However, I understand that my insurance is a contract between me and the insurance company and that I am responsible for fees and/or charges not covered by my policy, or any changes in the rate which was originally quoted to Dr. Cheryl A. Lewis, Ph.D., LLP. I am aware of the need to contact my insurance company personally to verify the accuracy of these fees.

I am aware that Limited Licensed Psychologists are required by law to be supervised by a psychologist who is fully licensed in Michigan. Robert S. Fink, Ph.D., Licensed Psychologist is supervising this clinic and the psychologist therein.

I am aware that I may be charged a fee of **$35.00** for any appointment which is not cancelled 24 hours in advance and/or not showing up for my scheduled appointment.

I understand that I will be charged a fee of $15.00/15 minutes for any phone calls which exceed a reasonable initial contact time frame of 15 minutes or longer.

I understand that any requests for completion of forms, documents, special reports or professional written letters will require a fee of $20.00/15 minutes of completion or a fee which is prearranged by my therapist. I understand that completed documents will not be released until fees have been paid.

I understand that I may stop my treatment with this therapist at any time. I am aware I am responsible for paying for the services I have already received with my therapist.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I received here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

____ ____________
Signature of client or his or her personal representative Date

____ ________________________
Printed name of client or personal representative Relationship to the client

____ ____________
Signature of authorized representative of this practice Date

Psychological Professional Services, P.C.
Acknowledgement of Recipient Rights and Privacy Notice
(HIPPA)

I, ________________________D.O.B. ________________acknowledge that I have received a copy of my Recipient Rights and Privacy Practices per the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that I have specific rights regarding any treatment and any disclosure concerning my records.

As part of the treatment process it is necessary to accumulate a client's "protected health information" (PHI). This information will be used to assist in formulation of your treatment needs. We may also use this information with others to arrange payment for your treatment and administrative purposes. Your signature below acknowledges that you have received a copy of our office of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you have any concerns regarding your PHI, you have the right to ask for specific exclusion(s) pertaining to it's usage for treatment, payment or administrative purposes. You have the right to provide in writing, any exclusion(s) you are requesting regarding your PHI. Although we will try to respect your requests, we are not required to act upon these limitations and will provide you with written documentation reflecting decisions made concerning any exclusions requested. After you have signed this consent, you have the right to revoke it by initiating written request. Upon receipt of written request to revoke, use of your PHI will be discontinued.

Client record release requests and/or client complaints may be filed by written request. All client record requests may also include supporting documentation for the request. Client record release requests will have a response within 30 days of the request.

____ _____________
Signature of client or his or her personal representative Date

____ ___________________________
Printed name of client or personal representative Relationship to the client

I witnessed that the person/person's representative understood the nature of this request/authorization and freely gave his or her consent.

____ _____________
Signature of authorized representative of this practice Date

□ Copy given to the client/parent/ representative
□ Copy of this document will be placed in the permanent client record

Psychological Professional Services, P.C.
Authorization to Release/Exchange Confidential Information

Name of Client: ____ Date of birth: ____________

I understand that the purpose of this release is to assist with my/this client's treatment by approving the release of my records. Therefore, I approve for the following to disclose/release the notated information to Dr. Cheryl A. Lewis, Ph.D., LLP. 42477 Garfield Road Clinton Township, MI 48038.

Name of person/physician/agency/organization:

____

Address: ____

Phone Number: __________________________ Fax Number: ______________________________

The information to be released:
□ Intake assessment □ Treatment plan □ Compliance with treatment □ Treatment summary
□ Discharge summary □ Psychological evaluation □ Medications □ Other: ___________________

The requested information will be used for the following purpose: To aid in the treatment of the patient.

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire:
□ One year from this date □ Upon my discharge from treatment □ Under these circumstances:

____

____ ____________
Signature of client or his or her personal representative Date

____ ___________________________
Printed name of client or personal representative Relationship to the client

I witnessed that the person/person's representative understood the nature of this request/authorization and freely gave his or her consent.

____ ____________
Signature of authorized representative of this practice Date

□ Copy given to the client/parent/ representative □ Copy will be placed in the permanent client record

Psychological Professional Services, P.C.
Consent to Release and Exchange Confidential Information with Insurance Organizations

Name of Client: ____ Date of birth: ___________

I, ____ authorize Dr. Cheryl A. Lewis, Ph.D., LLP and my insurance company to exchange information and all communications regarding my mental health and/or substance abuse treatment and medical care. The purpose of such disclosure is to enable Dr. Cheryl A. Lewis, Ph.D., LLP to evaluate and process my claims for initial and ongoing (reauthorization) insurance coverage and will not be used for any other purpose. I understand that the information exchanged with the insurance company may include but not limited to the following:

- My name and personal identifying information
- My status in treatment
- Initial Evaluation
- Assessments and Personal History
- Medications
- Treatment Plan Summary
- Progress and Treatment Compliance
- Date and Status of Discharge
- Discharge Plan
- Other: ______________________

Notice to Person/Agency Receiving this Information

This information has been disclosed to you with the consent of the consumer and is protected by federal confidentiality and privacy rues 42 C.R.F. Part 2 and the HIPPA Regulations, 45 C.F.R. pts 160 and 164. Federal Rules prohibit you from making any further disclose of this information unless it is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by the regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that my health insurance information and alcohol and/or drug treatment records are protected by Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. pts 160 and 164 and cannot be discussed without any written consent unless otherwise provided for by regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as follows:

____

(Specification of the date, event or condition upon which this consent expires)

I understand that Dr. Cheryl A. Lewis, Ph. D., LLP may not condition my treatment or whether I sign a consent form but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

____ ___________

Signature of client or his or her personal representative Date

____ ______________________

Printed name of client or personal representative Relationship to the client

____ ___________

Signature of authorized representative of this practice Date

□ Copy given to the client/parent/ representative □ Copy will be placed in the permanent client record

PSYCHOLOGICAL PROFESSIONAL SERVICES, P.C.

PATIENT RIGHTS

Psychological Professional Services, P.C. supports and protects the fundamental human, civil, constitutional and statutory rights of each client. It is the obligation of the Clinic to treat each client with dignity and respect in the provision of all care. Each client has access to treatment regardless of race, religion, gender, sexual orientation, age, ethnicity or disability.

Each client receives individualized treatment, which includes:

- The provision of adequate and humane services, regardless of source(s) of payment.
- The provision of an individual treatment plan.
- The periodic professional review of the treatment plan.
- Active participation by the client and/or responsible party in planning and decisions regarding care and services, and the provision of an adequate number of competent, qualified and experienced professional clinical staff to supervise and implement the treatment plan.
- The right to care that is considerate and respects the personal values and belief systems of individuals served.

Each client has the right to personal privacy and confidentiality of information. The maintenance of confidentiality of communications between clients and staff and of all information recorded in client records shall be the responsibility of all staff who utilizes the records for clinical and administrative purposes. Each client has the right to request the opinion of a consultant at his/her expense or to request an internal review of the individual treatment plan.

The client, and where appropriate the client's family, or the client's legal guardian shall be fully informed about the following terms.

1. The professional staff member(s) primarily responsible for his/her care, their professional status, and their staff relationship. An explanation of any professional relationships among people who are treating the individual and to any other staff.

2. The nature of the care, procedures, and treatment that he/she receives and an explanation of their condition.

3. The current and future uses and disposition of products of special observation and audiovisual techniques, such as tape recorders, television, movies or photographic materials.

4. The potential benefits, risks, and side effects of all interventions and treatment procedures used, and the likelihood of success.

5. Alternative medications, treatments, or interventions that is available.

6. The right to the extent permitted by law, to refuse specific treatment or interventions.

7. The right to designate a surrogate decision-maker when necessary.

8. The right to be informed of their rights in a language understood by the client.

9. The right to refuse treatment and be informed of the consequences of refusal. When refusal of treatment prevents the Clinic from providing services according to ethical and professional standards, the relationship with the Clinic may be terminated upon reasonable notice. Reasons for the termination will be recorded in the client's case record in the termination summary.

10. The itemized cost of services rendered, as well as an explanation of the insurance source and procedures for reimbursement, and any limitations placed on duration of services, communicated at Intake.

11. Notice of and reasons for any proposed changes in the professional staff responsible for the client, or for any transfer of the client either within or outside of the Clinic.

12. The expectations the therapist holds for the client during the course of the therapy.

13. The discharge and aftercare plans.

14. Client rights and the admission packet.

15. The rules and regulations of the Clinic applicable to his/her conduct.

16. The right to initiate a complaint or grievance and to be informed of the procedure and the appropriate means of requesting a review of the complaint.

17. The right to request a referral within or outside of the Clinic and with properly executed Release of Information forms, to have materials sent to specifically designated referral sites.

18. The right to seek pastoral care with the religious leader or organization of his/her choice.

19. The right to express spiritual beliefs and cultural practice that do not harm others.

20. The patient has the right to report and have dealt with, complaints about violations of ethics by any clinician or administrative or support staff member.

X____

Client/Parent/Guardian's Signature Date

____

Clinician's Signature Date