Kalamazoo Office
5340 Holiday Terrace
Kalamazoo, MI 49009
(269) 372-4140

cfps
Child & Family Psychological Services, P.C.

Portage Office
1662 E. Centre Ave.
Portage, MI 49002
(269) 321-8564

PERSONAL INFORMATION

PLEASE PRINT CLEARLY Today's Date ____________________________

CLIENT NAME ____ Date of Birth _____________________ Gender ____________

CLIENT NAME ____ Date of Birth _____________________ Gender ____________

Address ____ City, State ______________________________ Zip _______________

Home Phone ____________________________ Cell Phone __________________________ Work Phone ____________________________

Please indicate with an * which phone numbers we may NOT leave a message.

Email address: ____

Please review our Informed Consent, Information and Policies regarding use of email correspondence

RESPONSIBLE PARTY ____ Responsible Party's SSN ________________________

(If client is a minor, the responsible party is the parent or guardian bringing the minor for treatment and signing this form)

If different from client:

Address ____ City, State ______________________________ Zip _______________

Home Phone ______________________________ Work Phone _________________________ Cell Phone __________________________

Person to contact in case of emergency ____

Name Phone # Relationship

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder's Name ____________________________________

Policy Holder's Date of Birth ________________________________

Relationship to Client ____________________________________

Home Address (if different) _________________________________

____

Insurance Company Name __________________________________

Policy Holder's ID# _______________________________________

Group # ____

Employer Name____

SECONDARY INSURANCE

Policy Holder's Name ____

Policy Holder's Date of Birth ___________________________________

Relationship to Client _______________________________________

Home Address (if different) ____________________________________

____

Insurance Company Name _____________________________________

Policy Holder's ID# ____

Group # ____

Employer Name ____

REFERRAL INFORMATION

How did you find out about Child & Family Psychological Services (check appropriate box)?

_____Family Member _____Friend(s)/ Neighbors _____Web Search/Internet _____School System

_____Lawyer/Mediator _____Therapist _____Physician/Family Doctor _____Church/Synagogue

_____Other (please specify) ____

AUTOMATED APPOINTMENT REMINDERS

How would you like to receive appointment reminders (Check ONE option only)?

_____Via text message to my cell phone number (______) __________________________ (normal text message rates may apply)

_____Via email message to the following email address: ____

_____Via automated telephone message to my home or cell phone number (______) ___________________________

_____None of the above, I'll remember my appointments on my own

Appointment information is considered "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

____ ______________________________

Signature Date

FAMILY INFORMATION

Name	Age	Relationship to Client	Education	Occupation
Client (s)				
Parent (s), if client is a minor				
Children/Step Children/Siblings				
Others Living in Household				

MEDICAL INFORMATION

1. **Client Name** ____

   Have you received mental health services (counseling/therapy) before? ____Yes ____ No

   When? ___________________ Where and With Whom?____

   Have you been hospitalized for psychiatric reasons? (List) ______________________________________

   Primary Care Physician: Name/Practice ____

   Address ____ Phone ________________________

   List any current health concerns ____

   List any current medications ____

2. **Client Name** ____

   Have you received mental health services (counseling/therapy) before? ____Yes ____ No

   When? ___________________ Where and With Whom?____

   Have you been hospitalized for psychiatric reasons? (List) ______________________________________

   Primary Care Physician: Name/Practice ____

   Address ____ Phone ________________________

   List any current health concerns ____

   List any current medications ____

PLEASE MARK ALL THAT APPLY: (If more than one client, please separately initial)

☐ Excessive crying	☐ Impulsive, acts without thinking	☐ Problems in relationships with partner or children	☐ Feels bullied or picked on
☐ Decreased energy	☐ Can't sit still, antsy	☐ History of traumatic experiences	☐ Has few or no friends
☐ Feelings of being worthless	☐ Always on the go, hyper	☐ Full of energy, little need for sleep	☐ Considered weird by others
☐ Thoughts of suicide	☐ Problems following rules	☐ Feeling overly important	☐ Socially awkward or inappropriate
☐ Feeling overwhelmed, trouble making decisions	☐ Difficulty with authority	☐ Talking fast and excessively	☐ Lacks physical boundaries with peers
☐ Experiencing panic attacks	☐ Unmotivated, Procrastinating	☐ Hoarding food or objects	☐ Skin picking, hair pulling, nail biting
☐ Excessive worrying	☐ Problems with work or school	☐ Poor body image	☐ Inflexible, trouble handling change
☐ Avoiding going places	☐ Apathetic, doesn't seem to care	☐ Problems with eating or food	☐ Self-injury or cutting
☐ Isolating from others	☐ Angry, easily irritated	☐ Stomachaches, digestion issues	☐ Problems in relationships with parents
☐ Checking things repeatedly	☐ Abruptly changing moods	☐ Trouble managing pain or disabling condition	☐ Problems in relationships with friends, siblings, roommates
☐ Afraid of being judged or rejected	☐ Difficulty controlling temper	☐ Lots of aches and pains	☐ Trouble sleeping, nightmares
☐ Sensitive to criticism	☐ Reckless behaviors, taking excessive risks	☐ Legal problems	☐ Suspicious, paranoid
☐ Needs things to be perfect	☐ Abusive toward others	☐ Financial concerns	☐ Threatens or bullies others
☐ Excessive anxiety about separation from caregivers	☐ Lying, stealing	☐ Sexual concerns	☐ Thoughts of hurting others

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AUTHORIZATION TO SHARE MEDICAL INFORMATION

CLIENT NAME ___________________________________ Date of Birth _________________

☐ I authorize Child & Family Psychological Services to share my:

- ☐ Scheduling information
- ☐ Medical information – excluding _________________________________
- ☐ Billing/financial/insurance information
- ☐ All information

With the following:

Name	Phone number	Relationship to me
Name	Phone number	Relationship to me
Name	Phone number	Relationship to me
Name	Phone number	Relationship to me

OR

☐ I do NOT authorize Child & Family Psychological Services to release any of my medical information to anyone, with the exception of coordination of benefits (i.e. insurance) or continuation of care (i.e. referrals).

This authorization will remain in effect until revoked in writing by the above listed client.

____ ______________________

Client Signature Date

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INFORMED CONSENT, INFORMATION AND POLICIES

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist at Child & Family Psychological Services (CFPS). We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   b) type of therapy needed (individual, group, family, etc.)
   c) frequency of therapy sessions (weekly, biweekly, etc.)
   d) goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 45-55 minutes. At the end of each appointment you can discuss future appointments with your therapist.

3. EMERGENCY PROCEDURES: If you, or a family member, are in crisis after normal business hours, please call Gryphon Place at 269-381-4357. If there is an emergency, please call 911 or go to your nearest emergency room for immediate psychiatric evaluation.

4. LATE CANCELLATIONS & NO SHOWS: If you need to cancel an appointment, **you must call the office and/or leave a message at least 24 hours in advance to avoid a Late Cancellation Fee**. **If you do not show for a scheduled appointment, you are subject to a No Show Fee.** The late cancellation and no show fee is $65.00 and will be billed to you directly as this fee is not reimbursed by insurance companies.

5. PAYMENTS: Payment is expected in full for each office visit when you come for your appointment. If you do not pay in full at the time of service, we expect your approval by signature to allow the insurance payment to be sent directly to us from your insurance company. If there is a co-payment required, you will be responsible for payment at the time of service or to establish other arrangements with your therapist. Charges for services in addition to therapy (i.e., medical records, document preparation, etc.) will be negotiated individually with your therapist. Personal checks returned due to insufficient funds will be billed to the client at a rate of $25.00 per returned check and your therapist will not accept future checks. Future payments must be paid in cash or by credit card at the time of service.

   In the case of minor children, the parent or guardian bringing the child in for treatment and signing below will be held financially responsible for all payments. THERE ARE NO EXCEPTIONS TO THIS POLICY.

6. INSURANCE: Most insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company to find out specific requirements and limitations of this coverage. We will be happy to assist in billing your insurance company; however, payment for services received through Child & Family Psychological Services are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the preauthorization process, i.e. contacting your primary care physician or insurance company. Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. MEDICAID plans: CFPS therapists do not participate with straight Medicaid. Some therapists can accept specific HMO Medicaid plans; please confirm if your plan is accepted. It is the responsibility of the client for full payment of services if Medicaid denies payment due to member not covered by a participating plan.

7. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at Child & Family Psychological Services and is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists at CFPS as deemed necessary.

8. COPY OF MEDICAL RECORDS: There is a medical records handling charge of $25.00 per request to release records to cover the cost of time, copies and postage for closed charts, this fee is not reimbursed by insurance companies. An Authorization to Release Medical Records is required in order to release records.

OVER

9. EMAIL: By providing your email address with CFPS, you consent to receive general communication between you and CFPS for non-therapy communications (i.e. newsletters, practice information and paperwork). Your email address will never be sold or shared with any other parties.

10. ONLINE ACCOUNT STATEMENTS AND BILL PAY: You can receive monthly account statements via email and/or pay you bill online through our website www.childandfamilypsych.com. Click on "Account Access," enter your therapist's name and then enter your login name and password identified below.

    I understand that this information is considered "Protected Health Information" under HIPAA and therefore by my signature below, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted below.

    PLEASE PRINT CLEARLY – Case Sensitive

    Requested login name: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___| (max 15 characters)
    (letters and/or numbers only – NO symbols)

    Temporary password: A temporary password will be assigned. Client's last name plus the number 1. If not at least 8 characters long, additional numbers will be added (i.e. 2, 3, 4 . . .). You will be asked to change your password after logging in for the first time.

SIGNATURE REQUIRED

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions. *If more than one adult client, each person should check and initial boxes.*

☐ Yes ☐ No I have received a copy of the HIPAA Privacy Notice.

☐ Yes ☐ No I authorize the release of any medical information necessary to process my insurance claims and I authorize benefits to be paid directly to Child & Family Psychological Services.

☐ Yes ☐ No I consent to the exchange of treatment information between CFPS and my primary care physician.

Client(s) Physician's Name/Office and Phone Number ______________________________

______________________________ ______________________________
Client/Responsible Party Signature & Printed Name Date

______________________________ ______________________________
Client/Responsible Party Signature & Printed Name Date