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

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:
   a. type of therapy needed (individual, group, family, etc.)
   b. frequency of therapy sessions (weekly, biweekly, etc.)
   c. 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 find that 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.

CLIENT COPY

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 ______________________________

SIGNATURE ON FILE
Client/Responsible Party Signature & Printed Name

____
Date

CLIENT COPY

cfps
Child & Family Psychological Services, P.C.

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. * PLEASE REVIEW IT CAREFULLY.
Effective April 14, 2003

HIPAA & RECIPIENT RIGHTS
A federal act called the Health Insurance Portability and Accountability Act (HIPAA) gives you some additional rights to what you have through state laws. This notice gives you information on these additional rights through HIPAA.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE
We obtain information about you when you receive services through Child & Family Psychological Services, PC (CFPS). It includes your date of birth, gender, Social Security Number and other personal information.

OUR PRIVACY COMMITMENT TO YOU
We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the need and legal right may see your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment/services, payment, business operations or when we are required by law to do so. We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy or security of your information.

- **Treatment/Services:** We may disclose information about you with your written consent to coordinate your services. For example, we may give information to your other healthcare providers.
- **Payment:** We may also use and disclose information so the care you get can be properly billed and paid for. For example, we will submit bills to your insurance company or other entities.
- **Business Operations:** We may need to use and disclose information for our business operations. For example, we may use information to review the quality of the services you receive.
- **Exceptions:** For certain kinds of records, your permission may be needed even for release for treatment, payment, and business operations.
- **As Required By Law:** We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, workers' compensation claims, medical examiner or funeral director if an individual dies, subpoenas or other court orders, communicable disease reporting, review of our activities by government agencies, to avert a serious threat to health or safety, reporting suspected abuse, neglect, or domestic violence, or in other kinds of emergencies.
- **With Your Permission:** If you give permission in writing, we may use and disclose your personal information. If you give permission, you have the right to change your mind and revoke it. This must be in writing also. We cannot take back any uses or disclosures already made with your permission.

YOUR PRIVACY RIGHTS
You have the following rights regarding the health information that we have about you. Your requests must be made in writing to the Privacy Officer at CFPS.

- **Your Right to Inspect and Copy:** In most cases, you have the right to look at or get copies of your paper or electronic health records. We will provide a copy or a summary of your health information, usually within 30 days of your request. You may be charged a fee for the cost of copying records.
- **Your Right to Amend:** You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we will give you a written reason for our denial within 60 days.
- **Your Right to a List of Disclosures:** You have the right to ask for a list of disclosures or your health information for six years prior to the date you ask, who we shared it with and why. This list will not include the times that information was disclosed for treatment, payment, or business operations. This list will not include information provided directly to you or your family, or information that was sent with your authorization.
- **Your Right to Request Restrictions on Our Use or Disclosure of Information:** You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to your request if it would affect your care. If you pay for your services out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer unless a law requires us to share that information.
- **Your Right to Request Confidential Communications:** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis for your request.
- **Your Right to Choose Someone to Act on Your Behalf:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that person has this authority and can act for you before we take any action.
- **Your Right to Share Health Information:** You have both the right and choice for us to share information with your family, close friends, or others involved in your care or share information in a disaster relief situation. We never share psychotherapy notes unless you give us written permission or in response to a complaint filed against the counselor. We never market or share personal information.

CHANGES TO THIS NOTICE
We reserve the right to revise this notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on our website. Go to www.childandfamilypsych.com. If the changes are material, a new notice will be mailed to you before it takes effect.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE
If you have questions or would like more information, you may contact our Privacy Officer at (269) 372-4140. If you believe your privacy rights have been violated, you can file a complaint with: the Privacy Officer or the Department of Health and Human Services. ***You will not be penalized for filing a complaint.***

COMPLAINTS AND COMMUNICATIONS TO US
You may write: Privacy Officer
Child & Family Psychological Services, P.C.
5340 Holiday Terrace
Kalamazoo, MI 49009
Phone: (269) 372-4140
Email: childandfamilypsych@gmail.com

COMPLAINTS TO THE FEDERAL GOVERNMENT
You may write: Office of Civil Rights
Dept. of Health & Human Services
200 Independence Ave, SW
Washington, DC 20201
Phone: (877) 696-6775
Website: www.hhs.gov/ocr/privacy/hipaa/complaints/

COPIES OF THIS NOTICE
You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

* This adds to your protections through Recipient Rights

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