21650 W 11 Mile Road, Suite 107
Southfield, MI 48076
Phone: (248) 262-7396

Patient Information Form

Date:_____

Patient Name:_____ **DOB:**_____

Address:_____

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

Phone:_____

Gender: Male // Female // Trans // Other

SSN:_____

Marital Status: Single // Married // Separated // Divorced // Widowed

If applicable, Spouse's Name: _____

Patient's Occupation:_____

Place of Employment:_____

Person to Contact in Case of Emergency

Name:_____

Relationship:_____

Phone:_____

Person Responsible for Payment

Name:_____

Address:_____

City:_____

State:_____ Zip: _____

Relationship:_____

Occupation:_____

Place of Employment:_____

21650 W 11 Mile Road, Suite 107
Southfield, MI 48076
Phone: (248) 262-7396

Patient Name:_____

Information for New Patients

Stellar Pointe Counseling & Psychological Services, LLC providers are Limited Licensed Professional Counselors and/or Limited Licensed Clinical Psychologists, practicing under the supervision of a Fully Licensed Psychologist and/or a Fully Licensed Professional Counselor. The providers of Stellar Pointe Counseling & Psychological Services, LLC are dedicated to providing psychological treatment in collaboration with your other healthcare providers (with your written permission) in order to provide holistic/integrative healthcare services that care for you as a whole person.

Sessions: Sessions are scheduled for 45-60 minutes. They are expected to start and end at the scheduled time.

Fees: The fees for psychological assessment, psychotherapy sessions, and testing vary depending upon time and services offered. The fee schedule is available for your review and discussion with your provider.

Billing: Your health insurance will be billed for psychological services. You are responsible for any co- - payments, deductibles, and keeping your account current. In the event that you do not have insurance or your insurance does not cover our services, a fee for service will be assessed as mentioned above.

Confidentiality: Patients are assured confidentiality that is protected by ethical practice and Michigan law. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, 1) the law requires the treating therapist to notify relevant others if a patient is judged to have intention to harm him/herself or another; 2) the therapist is obliged by the law to report suspected child abuse or neglect; 3) in the event of a legal case the therapist's records may be subpoenaed by the court.

Records: A brief summary note from each session will be recorded in your medical chart. This is a necessary record keeping function for billing and a general standard of/ care. In addition, this record will help us communicate with your other healthcare providers when necessary.

Cancellation: Because the appointment time is reserved for you, it is necessary to ask you to give 24---hour advanced notice if you are unable to keep your appointment. We understand there are emergency circumstances where 24---hour advance notice may not be possible, but in all other situations this requirement is necessary. If prior 24--hour notice is not provided, **you are still responsible for your entire session fee**. Cancellations may be accomplished by following the directions below for "Telephone Contacts."

Telephone Contacts: To change/cancel an appointment, you may contact the office at (248) 262-7396 voicemail message or talk to the provider, if he/she is available at the time you call.

21650 W 11 Mile Road, Suite 107
Southfield, MI 48076
Phone: (248) 262-7396

Emergencies: Due to varying office hours for each therapist, we cannot guarantee that you will be able to reach your therapist immediately in the case of psychological emergency or crisis. If you are unable to reach your therapist, we strongly recommend you to contact alternative emergency services such as 911 or the Emergency Room at your local hospital.

Office Hours: Office hours vary for each therapist. Appointments are scheduled in advance.

Acknowledgement: I have read the above information, understand the material presented, have had the opportunity to ask questions, and agree to the guidelines presented.

Patient Name: _____

If applicable (Guardian name): _____

Patient/Guardian Signature: _____

Date: _____

21650 W 11 Mile Road, Suite 107
Southfield, MI 48076
Phone: (248) 262-7396

HIPAA Privacy Notice

This Notice describes how medical information about you may be used and disclosed. This notice applies to information and records regarding your health care maintained at Stellar Pointe Counseling & Psychological Services, LLC, including medical records and insurance information.

MEDICAL INFORMATION Stellar Pointe Counseling & Psychological Services, LLC is committed to protecting your medical information. We maintain a record of the care and services you receive in our offices for use in your ongoing care and treatment. This Notice tells you about the ways in which we may use and disclose your medical information. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- Protect your medical information.
- Give you this Notice describing our legal duties and privacy practices with respect to medical information about you.

How We May Use and Disclose Your Medical Information

FOR TREATMENT

We may use your medical information in providing you with medical treatment or services. We may disclose your medical information to doctors, nurses, counselors or other health system personnel who are involved in your treatment in our office, at a hospital, physician's office or clinic setting.

LEGAL ACTIONS

We may disclose information about you in response to a subpoena, warrant or other lawful process.

PUBLIC HEALTH RISKS

We may disclose medical information about you for public health purposes, which may include the following:

- Preventing or controlling disease.
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notifying the appropriate authority if we believe the patient is in danger of fatal self---harm.
- Notifying the appropriate authority if we believe a patient, or minors in the patient's care, has/have been a victim(s) of abuse; we will make this disclosure as required by law.
- Notifying the appropriate authority and an individual(s) if he/she/they is/are in danger due to the stated intended actions of the patient and/or his/her designees; we will make this disclosure as required by law.

FOR PAYMENT

It is expected that the patient will pay Stellar Pointe Counseling & Psychological Services, LLC directly for services rendered. If payment is not received directly from you as agreed upon, we may disclose medical information about you so that treatment and services you receive at Stellar Pointe Counseling & Psychological Services, LLC may be collected, possibly by a third party collection agency.

Your Rights Regarding Medical Information About You

Your medical record is the property of Stellar Pointe Counseling & Psychological Services, LLC. You have the following rights regarding medical information we maintain for you:

RIGHT TO COPY AND REVIEW

You have the right to review and receive a copy of your medical records. A request in writing is required for obtaining a copy of your medical records.

Patient Name // (Guardian name): _____ // _____

Patient/Guardian Signature: _____ **Date:** _____

21650 W 11 Mile Road, Suite 107
Southfield, MI 48076
Phone: (248) 262-7396

Authorization to Release Patient Information

Patient Name: _____

Patient Phone: _____home _____cell

Date of Birth: _____

I authorize the use or disclosure of the above named individual's health information as described below:
The type and amount of information to be used or disclosed as follows:

☐ Diagnosis ☐ Medication List ☐ Entire Record ☐ Other:

This information may be disclosed to and used by the following individual or organization:

_____

Address: _____

Phone/Fax: _____

For the purpose of: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to my therapist or a Stellar Pointe Counseling & Psychological Services, LLC representative. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information to the individual or organization named above is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact a representative of Stellar Pointe Counseling at (248) 262-7396.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____
Patient or Personal Representative Signature **Date**

If you are signing this form as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____

Print Name: _____