FAMILY THERAPY & DEVELOPMENT CENTERS, INC.

830 Pleasant St., Ste 201
St. Joseph, MI 49085

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Kalamazoo, MI 49008

Phone: (269) 982-3832 www.familytherapydevelopmentcenters.com Fax: (269) 281-0351

CHILD INFORMATION FORM

(Please Print)

CLIENT INFORMATION

Client's Last Name	**First**	**Middle**	Age	Date of Birth / /

Sex (biological) ☐ M ☐ F ☐ O _____	Gender	Race/Ethnicity	Preferred Religion:	Date of 1st Appointment _____/_____/_____

Physical Street Address	City		

State	ZIP Code	Social Security Number - -	Home Phone No. [specify Mother or Father] ( )

P.O. Box	City	State	ZIP Code	Cell Phone No. [specify Mother or Father] ( )

Natural Mother's Name:	Natural Father's Name:

Who is the child currently living with: Name and Relationship?

Parent's Occupation	Parent's Employer	Work Phone No. ( )

Referred to Provider by (Please check one box & list) ☐ Dr. _____ ☐ Insurance Plan ☐ Website
☐ Family ☐ Friend ☐ Close to Home/Work ☐ Yellow Pages ☐ Social Media ☐ Other

Parent Email Address:	Alternative Email Address:

Do we have your permission to release information to the referring professional when it is appropriate? ☐ No ☐ Yes

Do you need an interpreter to assist with this visit? ☐ No ☐ Yes, we need:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.
1.			
2.			
3.			

Any remarks or notes you feel are pertinent for us to know about your insurance and/or payment of your counseling/testing services:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE STAFF)

Person Responsible for bill	Social Security Number of responsible party: SS: - -
Birth Date / /	Address of Responsible Party:
Occupation	Employer
Employer Address	Employer Phone No. ( ) Cell Phone No. ( )
Email Address:	Home Phone No. ( )

Total # of EAP visits given?___Dates approved:

Is this client covered by insurance? ☐ Yes ☐ No Name of Insurance:	Is this an EAP visit? ☐ Yes ☐ No Name of EAP:

Please Select Your Primary Insurance Provider	☐Aetna ☐ AmeriPlan ☐ Assurant ☐ASR ☐Blue Cross/Blue Shield ☐ Blue Care Network ☐CareSource ☐ChampUS ☐Cigna ☐Cofinity ☐CompCare ☐Definity Health ☐ First Health ☐HealthSmart ☐Humana ☐ Magellan ☐ Medicaid ☐ Medicare ☐ MHN/MHNet ☐ OPTUM ☐ PHCS ☐ PMHS ☐ TriCare ☐ United Behavioral Health ☐ United Healthcare ☐ Value Options ☐ Other_____

What is the authorization number?	☐ Private Pay/Self-Pay (please provide tax form 1099)	Insurance Phone No.

Insured's Name	Insured Social Security # - -	Birth Date / /	Group #	Policy #	Deductible &/or Co-Pay $

Client's Relationship to Insured ☐Self ☐Spouse ☐Child ☐Other _____

Name of Secondary Insurance (If any) Insured's Name	Group #	Policy #

Client's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Is your bill to be paid by Auto Insurance? ☐ Yes ☐ No	Name of Insurance and Contract #:	Contact Name and Phone #:

(OFFICE USE ONLY) INSURANCE INFORMATION

Client Name: _____ **DOB:** _____

Insurance Contact Name_____ Ref. # _____

Requested Therapist _____ ☐ In Network ☐ Out of Network
(If out of network, see below)

FTDC Group/Therapist Payer ID # (for electronic billing) _____

FTDC Group/Therapist NPI (National Provider Identification) Number: _____

Effective date of policy ____/____/____	Annual deductible $	Deductible met? ☐ YES ☐NO $
Authorization Required? ☐ YES ☐NO	Authorization No. _____	
No. of Sessions Authorized _____	Date Range _____/_____/_____ to _____/_____/_____	

Claims Address: _____

_____

_____

Remarks_____

_

_____

_

IF OUT OF NETWORK:

Contact Name of person you spoke with: _____

Phone number of contact person: _____

Insurance determination on payment:_____

Deductible $_____ Annual max sessions _____ Copay $ _____ % Reimburse _____

Notes:

PRESENTING PROBLEM

What are your concerns/reasons for seeking treatment for your child?

_____

_____

_____

_____

_____

When did the problem/symptoms first occur or begin to develop?

Has your child ever had a similar problem before? ☐ No ☐ Yes If yes, was the problem resolved? If so, How?

What are your expectations or desired outcome for treatment for your child?

Has your child ever been in counseling before? ☐ No ☐ Yes

If yes, please list name of counselor/facility, when seen, how long counseling lasted, and the outcome._____

_____

_____

_____

PRESENT STRESSFUL EVENTS

Check any of the following that have occurred. Please write date of occurrence next to each experience.

☐ Divorce/Separation
☐ Financial difficulties
☐ Violence (self/other)
☐ Death of a loved one
☐ Spirituality issues
☐ Other:_____
☐ Physical/sexual abuse
☐ Difficulties with family member
☐ Difficulties at work or school
☐ CPS/Foster Care Involvement
☐ Parent(s) in Military
☐ Sexual difficulties/sexual issues
☐ Breakup of important relationship
☐ Social Issues/Relationships
☐ Changed residences/schools
☐ Personal/family illness or injury

PSYCHIATRIC HISTORY

Please check any of the following diagnoses/problems your child has now or has had in the past:

☐ Depression	☐ Manic Depressive/Bipolar	☐ Schizophrenia	☐ Anxiety/panic disorders
☐ Obsessive Compulsion Disorder	☐ Eating Disorder	☐ ADHD	☐ Personality Disorder
☐ Oppositional Defiant Disorder	☐ Conduct Disorder	☐ PTSD	☐ Other:_____

Has the Child ever been hospitalized for Medical or Psychiatric reasons ☐ No ☐ Yes (If yes, please specify)

Hospital	Month / Year	Reasons
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever had suicidal ideations and/or seriously thought about suicide? ☐No ☐ Yes If Yes, describe:

Has your child ever attempted suicide? ☐No ☐ Yes If Yes, explain:

Is your child having thoughts of suicide now? ☐No ☐ Yes If Yes, describe:

Has anyone close to your child committed suicide? ☐No ☐ Yes If Yes, explain:

Has your child ever intentionally done anything to harm themselves (include headbanging, hitting self, cutting or any other self-injurious behaviors)? ☐No ☐ Yes If Yes, describe:

Has your child ever seriously thought about harming someone else? ☐No ☐ Yes If Yes, describe:

Has your child ever intentionally harmed someone else? ☐No ☐ Yes If Yes, explain:

Is your child thinking about harming someone now? ☐No ☐ Yes If Yes, describe:

Is your child currently experiencing any physical pain? ☐No ☐ Yes If Yes, Identify where: _____

If Yes, what is the severity level on a scale of 1- 10, with 10 being the highest? _____

Does your child experience migraines or headaches ☐No ☐ Yes If Yes, Explain number per week/month and duration.

Please have your child answer the following questions:

I sometimes hear voices even though no one nearby is talking to me. ☐No ☐ Yes If Yes, describe:

I sometimes feel that forces outside of me control me. ☐No ☐ Yes If Yes, describe:

I sometimes feel that other people control my thoughts. ☐No ☐ Yes If Yes, describe:

I sometimes feel that someone is out to hurt me or do something against me. ☐No ☐ Yes If Yes, describe:

SUBSTANCE ABUSE HISTORY

Does your child currently use recreational drugs? ☐ No ☐ Yes If no, have they used previously? ☐ No ☐ Yes
If yes to above, when did he/ she stop? _____ Did the child seek professional help to stop? ☐ No ☐ Yes

If yes to either above, please specify (include illicit drugs as well as marijuana/CBDs)
Type of drug _____ How much _____ Frequency _____
Type of drug _____ How much _____ Frequency _____

Has your child had a substance abuse problem in the past? ☐No ☐ Yes
If Yes, did he / she receive treatment? ☐No ☐ Yes Facility name/type: _____

If yes, what was his / her drug of choice?_____

How long has he / she been substance free?_____

Is he / she involved with any SA/NA/AA program now? ☐No ☐ Yes If Yes, which one? _____

Do you think he/ she may have a substance abuse problem now? ☐No ☐ Yes

Please check any substances he /she has used in his / her lifetime:

☐ None	☐ Alcohol	☐ Tranquilizers	☐ Cocaine (powder)	☐ Barbiturates
☐ Heroin	☐ Marijuana	☐ Sedatives	☐ Hallucinogens	☐ Pain Medications
☐ Inhalants	☐ Prescription Drugs	☐ Stimulants (Meth, Crack)	☐ CBDs	☐ Diuretics/Wt loss
☐ Other:				

Does your child drink alcohol? ☐ No ☐ Yes If no, did he / she drink previously? ☐ No ☐ Yes
If yes to either above, please specify
Type of alcohol _____ How much _____ Frequency _____
Type of alcohol _____ How much _____ Frequency _____

Nicotine use per day, past, present, (Nicotine is in cigarettes, cigars, and chewing tobacco)
Does your child currently use tobacco products or smoke cigarettes/vape? ☐ No ☐ Yes Specify: _____
Has your child attempted to quit in the past? ☐ No ☐ Yes Results? _____

Has he / she ever experience withdrawal symptoms from tobacco, alcohol or drugs? ☐ No ☐ Yes
Explain _____

Has your child ever felt guilty about his/ her drug or alcohol use? ☐ No ☐ Yes
Explain _____

Has your child ever felt annoyed when someone talked to him / her about his / her drug or alcohol use? ☐ No ☐ Yes
Explain _____

Has your child ever used drugs or alcohol first thing in the morning? ☐ No ☐ Yes
Explain _____

Caffeine use per day? (Caffeine is in coffee, tea, sodas, chocolate) ☐ No ☐ Yes
Explain _____

Has your child ever experienced withdrawal symptoms from caffeine use? ☐ No ☐ Yes
Explain _____

Has your child had a problem with addictive behaviors in the past (i.e., gambling, sex, etc.) ☐ No ☐ Yes
If yes, describe:

Please list any Mental Health or Substance Abuse Treatment your child has received in the past

Mo/Year	Therapist or Program Facility	Problem/Diagnosis on Discharge
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any family members who have experienced emotional or substance abuse problems

Relationship	Severity of Problem			Problem/Diagnosis
_____	☐ Mild	☐ Moderate	☐ Severe	_____
_____	☐ Mild	☐ Moderate	☐ Severe	_____
_____	☐ Mild	☐ Moderate	☐ Severe	_____
_____	☐ Mild	☐ Moderate	☐ Severe	_____

Which of the following best describes the family environment in which your child grew up (circle one number on the continuum below)

Warm & Accepting **Average** **Hostile & Fighting**

1 2 3 4 5 6 7 8 9 10

Does your child consider any situations in their lives to be scary, horrifying or cause them anxiety? ☐ No ☐ Yes
If yes, Specify:

Does your child have a history of childhood trauma or abuse? ☐ No ☐ Yes

If yes, what type of abuse or trauma occurred? ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect

Explain:

History of Foster Care Services or Child Protective Services ☐ No ☐ Yes If Yes, Please note date (mo/year), issue, CPS and/or FC length of time. Note assistance/help your child received. Events causing and How long?

MEDICAL HISTORY

Name of Primary Care Physician_____Facility/Clinic Name_____

Physician Address _____ Physician Phone _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your child's care with the above named doctor? ☐ No ☐ Yes

Does the PCP know of the issues and why you are seeking treatment at FTDC? ☐ No ☐ Yes

Date of last medical evaluation _____/_____/_____ Date of next appointment _____/_____/_____

Current height _____ Current weight _____ Current Medical Dx:_____

Immunizations up-to-date ☐ No ☐ Yes If No, what needs updating?_____

Current medications being taken

1)_____ Dosage/Freq _____ State Date _____ Purpose _____

2)_____ Dosage/Freq _____ State Date _____ Purpose _____

3)_____ Dosage/Freq _____ State Date _____ Purpose _____

4)_____ Dosage/Freq _____ State Date _____ Purpose _____

Prescribed by _____

Current supplements / vitamins / herbs _____

_____

Does your child have any allergies or drug intolerances? ☐ No ☐ Yes (If yes, please specify below)

_____

Please briefly describe any current medical problems _____

_____

Any history of head trauma? ☐ No ☐ Yes Any history of seizures or seizure-like activity? ☐ No ☐ Yes If yes, describe: _____

Has your child ever lost consciousness? (include head injury, fainting, etc.) ☐ No ☐ Yes If yes, describe:

_____

_____

_____

_____

Briefly describe any medical problems your child has had in the past**.** List all childhood illnesses (include chronic illnesses and infectious diseases), accidents, injuries, hospitalizations, and surgeries (include any ear surgeries/tubes, tonsils, etc.) _____

_____

_____

_____

_____

_____

Please briefly describe any abnormal lab tests, X-rays, EEG, etc.: _____

_____

_____

_____

Please describe any other health problems or important medical history about your child's immediate family members and close relatives, including genetic or chronic ailments

_____

_____

_____

Does your child have any close relatives (father, mother, sibling, grandparent) who have experienced depression, anxiety, or other emotional difficulties? ☐ No ☐ Yes If yes, please specify _____

_____

_____

Current eating problems (include anorexia, bulimia, nausea, vomiting, swallowing issues, etc.) ☐ No ☐ Yes

_____

What/whom comprises your child's support system? _____

MOTOR DEVELOPMENT: (Please write in age, parentheses are approximate normal limits**)**

Rolls over (35m) _____ Sit without support (5-7m) _____ Crawls (5-8m) _____ Walks Well (11-16m) _____

Runs Well (2yr) _____ Rides Tricycle (3yr) _____ Ride Bicycle (5 yr) _____ Throw ball overhead (4yr) _____

Current Level of Activity _____ Compared to Peers _____

LANGUAGE DEVELOPMENT: (Please write in age, parentheses are approximate normal limits**)**

Several words besides mama, dad (1yr) _____ Names several objects- ball, cup (15m) _____

3 Words together i.e., Subject, verb, object (24m) _____ Good Vocabulary ☐ No ☐ Yes Good Articulation ☐ No ☐ Yes

Good Comprehension ☐ No ☐ Yes Compared to Peers _____

Any current language problems _____

Did your child ever have temper tantrums? ☐ No ☐ Yes Explain: _____

What discipline techniques were used? _____

Did caregivers use consistent discipline? ☐ No ☐ Yes Explain: _____

BEHAVIORAL DISCIPLINE: Compliant or Non-compliant: _____

Lying/Stealing_____ Rule Breaking _____ Methods of discipline _____

Other problems _____

SOCIAL DEVELOPMENT: (Please write in age, parentheses are approximate normal limits)

Smile (2m) _____ Shy with Strangers (6-10m) _____ Separates from parent easily (2-3y) _____

Cooperatively plays with others (4y) ____ ☐ No ☐ Yes Able to see things from others perspectives ☐ No ☐ Yes

Special hobbies / Interests_____

Does child make friends easily? ☐ No ☒ Yes Keep friends? ☐ No ☐ Yes Bossy/Intrusive ☐ No ☐ Yes

EMOTIONAL DEVELOPMENT: Early temperament _____

Current Personality _____

Mood_____ Habits _____

Special Objects (Blankets, dolls, etc.) _____ Ability to Express Feelings _____

PERSONAL HISTORY

Name of Bio-Mother:_____ Name of Bio-Father: _____

Please describe who currently lives in your household, and specify your relationship to each

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Development (include marriages, separations, divorces, deaths, traumatic events, losses, etc.) _____

_____

_____

_____

_____

_____

.

Prenatal and birth events: Parents' attitude towards pregnancy (ex: pos/neg) _____

Conception—ease of: ____ Planned ____Unplanned _____ Fertility Clinic: ☐ No ☐ Yes

Was the pregnancy full term? ☐ No ☐ Yes Gestation week of birth (ex: 38wk 5days) _____

Medications prescribed and used during pregnancy: _____

Delivery: Vaginal ___ C-Section ___ Birth weight _____ Length_____ Labor duration_____

Any birth problems? Trauma, forceps or complications? _____

APGAR Scores (if known) ____at 1 min ___ at 5 min. Jaundice? ☐ No ☐ Yes Length of time in Hospital _____

Pregnancy complications (bleeding, excess vomiting, medications, infections, x-rays, smoking, alcohol/drug use, etc.)

_____

At what week did mother find out she was pregnant? _____ Any stressful events: ☐ No ☐ Yes

Were any medications/drugs/alcohol used during pregnancy prior to knowledge of pregnancy? ☐ No ☐ Yes If Yes,

Please list:_____

Were there any alcohol, drugs or non-prescribed medications used during pregnancy? ☐ No ☐ Yes

If yes, please describe:_____

Mother's health after delivery_____

Post-delivery/Postpartum Blues/Depression? ☐ No ☐ Yes If yes, how long_____

Primary caretaker for Child's first year?_____

Thereafter?_____

Feeding history: breast____ bottle____ both____ age weaned_____ Food allergies_____

Current eating problems _____

Child's Sleep behavior: Sleepwalking, nightmares, recurrent dreams, current problems (Retire time, Awake time)

_____

_____

Any separation from mother and/or father: age duration, reaction to_____

_____

_____

Toilet training: Age reached Bladder control: Day ___ Night ___ Age of Bowel control: Day ___ Night ___

Methods used _____ _____Current function_____

LEGAL ISSUES:

Has your child had any legal problems in the past? (include any criminal charges/sentences) ☐ No ☐ Yes If yes, please explain: _____

_____

Does he /she have any current legal issues? ☐ No ☐ Yes If yes, please explain: _____

_____

EDUCATION/ EMPLOYMENT HISTORY

Current Grade____ Number of Schools attended _____ Average Grades Received _____ Last grade completed _____

Please list schools your child is currently attending, last attended, and/or graduated below:

School_____ Year (s) _____

School_____ Year (s) _____

School_____ Year (s) _____

Has your child ever repeated or skipped a grade? ☐ No ☐ Yes Explain: _____

Specific learning disabilities _____ Learning strengths _____

Does your child have an Individual Education Plan (IEP) or 504 Behavior Plan? ☐ No ☐ Yes

If yes, what for: _____

What have teachers said about your child?_____

Does your child like school? Explain: _____ If Graduated, GPA: _____

If your child did not complete high school/GED, please explain

_____

_____

Did your child complete any college/university? ☐ No ☐ Yes Degree obtained? ☐ No ☐ Yes Major:_____

Please list college/schools your child is currently attending, has attended, and/or graduated from below:

School _____ Year (s) _____

School _____ Year (s) _____

School _____ Year (s) _____

Any Homework Problems _____

Did your child experience developmental/behavior problems while in school with peers or teachers? ☐ No ☐ Yes

If Yes, explain: _____

What is your child's attendance like? _____

Has your child had any discipline problems at school? Has your child ever been suspended or expelled? ☐ No ☐ Yes

What for? _____

Was your child ever expelled from school? ☐ No ☐ Yes If Yes, Please explain:_____

_____

CHILD EMPLOYMENT HISTORY

Occupation	Business/Company Name	Month(s)/Year(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any work-related problems? ☐ No ☐ Yes If yes, please describe _____

_____

What would your child's employers or supervisors say about him / her? _____

CHILD SEXUAL HISTORY

Age at time of first sexual experience: _____ Number of sexual partners: _____

Any history of sexually transmitted diseases? ☐ No ☐ Yes History of abortion? ☐ No ☐ Yes

History of sexual abuse, molestation, or rape? ☐ No ☐ Yes Current sexual problems? ☐ No ☐ Yes

PARENT MARITAL HISTORY

Marital status: ___Single / Never married ___Married ____Separated ___Divorced ____Widowed ____Living w/ someone

If currently divorced, how old was your child? _____ If living w/ someone, how long? _____

Does your child have any children ☐ No ☐ Yes

Name	Age	Relationship (biological / step)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Please check all information which applies to your child's parents

MOTHER: (Natural) _____ FATHER: (Natural) _____

_____ living _____ deceased _____ living _____ deceased

_____ 1st marriage _____ divorced date ___/___/___ _____1st marriage _____ divorced date ___/___/___

_____ 2nd marriage _____ divorced date ___/___/___ _____1st marriage _____ divorced date ___/___/___

_____ remarried ____ # of times _____ remarried ____ # of times

Mother's DOB _____ Father's DOB _____

Where does mother live? _____ Where does father live? _____

Does your child consider someone else (step-parent, grandparent, etc.) to be one of both of his /her "real" parents? If so, whom?_____

Where do they live? Mother _____

(whom he/she considers parents) Father _____

Information about Parents of child:

Mother: **Father:**

Highest grade/degree completed _____ Highest grade/degree completed _____

Outside work _____ Outside work _____

Learning problems _____ Learning problems _____

Medical Problems (Bio-Mother) _____

Medical Problems (Bio-Father) _____

Mother's Childhood atmosphere (family position, abuse, illnesses, etc) _____

_____

Father's Childhood atmosphere (family position, abuse, illnesses, etc) ___ _____

_____

Describe your child's relationship with his /her mother while growing up:_____

_____

Currently _____

_____

Describe your child's relationship with his / her father while growing up:_____

_____

Currently _____

_____

Please describe any family problems which occurred while growing up relating to:

Cultural /Ethnic Background _____

Economic problems, loss of homes (accident/fire/bankruptcy), multiple caregivers, moves (new homes/schools)

_____

Parental relationship (parents argue/fight)_____

Disrespect to others, Witness to Domestic Violence _____

Neglect/Lack of affection _____

Lack of supervision/Raised yourself:_____

Involvement with gangs or other affiliations (cults)? Name_____

Please list the names and ages of child's brothers and sisters below (bio, step, half, foster/adopted)

Name	Age	Relationship (natural, step, half, adopted, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Therapy & Development Centers, Inc. / Neuro-Psychology Consultants
Office Phone: 269-982-3832 Fax: 269-281-0351

INFORMED CONSENT FOR TREATMENT

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at Family Therapy & Development Centers, Inc., / Neuro-Psychology Consultants, a behavioral health care provider and assessment / testing center. I understand that I am consenting and agreeing only to those serves that the above provider is qualified to provide within: (1) the scope of the provider's license, certification, & training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual & consent to treatment on behalf of this individual.

Signature_____ Date: _____

Relationship to Patient (If applicable): _____

TEXTING/EMAIL NOTIFICATION CONSENT

Patient/ Parent/ Guardian agrees that if you choose to text / Email with FTDC employees is necessary in care, you agree to receive text/ Email message service. Text/ Email messages may be for appointment setting and / or confirmation, exchange of symptoms and / or issues with your clinician, or in regard to administration/ accounting. The agreement to receive text/Email messages potentially benefits by serving your needs quicker, allowing for effective communication and review of information, as well as providing you with alternative access to our office and clinicians. By signing this agreement, I authorize FTDC to contact me by SMS text/ Email message for health related notifications which may include appointment reminders. You accept potential risks of potential loss of privacy/ Protected Health Information (PHI) if your phone/ tablet/ computer is lost or someone else accesses your phone/ tablet/ computer. I understand that message/ data rates may apply to messages sent by FTDC under my cell phone plan. Any charges that your service carrier may charge per text/ EMAIL or for services is fully accepted by the patient/ parent/ guardian. I know that I am under no obligation to authorize FTDC to send me text/Email messages. I may opt-out of receiving these communications at any time by calling the office. I understand that text/ Email messages are not a substitute for professional or medical attention. By signing below, I indicate that I am the person legally responsible for all use of mobile/ computer accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text/Email messaging services. By signing below, I agree to texting/Email notifications and communication.

Signature_____ Date: _____

Texting Phone Number: _____

☐ *No, I do not wish to participate in text/Email messages.*

TELEPHONE NOTIFICATION CONSENT

Patient confidentiality is a top priority at Family Therapy & Development Center, Inc. (FTDC) In order to meet your needs in regards to this matter, we are asking that you sign a release allowing us to call your home, cell, or work and leave a message identifying us as calling from Family Therapy & Development Centers, Inc. or FTDC.

☐ Yes, I give permission for the office staff to leave detailed information regarding my appointment or general information regarding my business with this office with the following telephone number(s) & people.

Telephone Numbers	**Contact People**
Home #_____	**_____**
Work #_____	**_____**
Cell # _____	**_____**
Text # _____	**_____**

Approved Email address for communication _____

☐ No, I do not wish to give permission

HIPAA NOTIFICATION

Your signature below indicates that you give authorization for Family Therapy & Development Centers, Inc. to share necessary information among the center (for billing & consultation purposes). It also indicates that you have read HIPAA Binder, located in our lobby, & agree to abide by its terms during our professional relationships. Your signature also verifies the telephone/ email notification consent.

_____

Patient Name (please print)

_____ _____

Patient's/Parents of or Guardian Signature *Date*

Family Therapy & Development Centers, Inc. (FTDC) / Neuro-Psychology Consultants (NPC)

Health Insurance Portability & Accountability Act (HIPAA)
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information (PHI) by FTDC/NPC for the purpose of diagnosing or providing treatment to me, obtaining payment for my heath care bills or to conduct health care operations of FTDC/NPC.

I understand that diagnosis or treatment of me by FTDC/NPC may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment payment or health care operations. FTDC/NPC is not required to agree to the restrictions that I may request. However, if FTDC/NPC agrees to a restriction that I request, the restriction is binding with FTDC/NPC.

I understand FTDC/NPC uses a variety of electronic communication methods including phone, text messages, Email to communicate with me for the limited purposes of appointments, available services and other healthcare related communication. I authorize FTDC/NPC to disclose limited PHI to other persons who may answer my electronic communications such as phone, text messages, or Email. These may include information about appointments available services, or other healthcare related communications.

I have the right to revoke this consent, in writing, at any time, except to the extent that FTDC/NPC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review FTDC/NPC's Notice of Privacy Practices before signing this document. A copy of the FTDC/NPC Notice of Privacy Practices is available in the lobby or by request. The Notice of Privacy Practices describes the types of uses and discloses of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of FTDC/NPS.

The Notice of Privacy Practice for FTDC/NPC is also provided and available in the reception area and on the FTDC/NPC web site at www.familytherapydevelopmentcenters.com

This Notice of Privacy Practices also describes my rights and the duties of FTDC/NPC with respect to my PHI. FTDC/NPC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain revised notice of my privacy practices by contacting the FTDC/NPC offices at 269/982-3832 and requesting a revised copy be sent in the mail, email or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative *Date*

_____ _____

Name of Patient or Personal Representative *Description of Personal Representative's Authority*

(Self/Parent/Guardian/Foster Parent/Case Worker)

Consent to Receive Text/Email Messages from

Family Therapy & Development Centers, Inc. (FTDC)

-and- Neuro-Psychology Consultants (NPC)

By signing below, I authorized FTDC/NPC through its vendor Verizon to contact me by SMS text message/text message/text message/Email to serve me better. FTDC/NPC will send me text/Email messages through the FTDC/NPC staff/counselors to help me or my child stay healthy, including:

- timely reminders about needed mental health counseling and/or testing appointments
- To get help scheduling appointments at no cost
- To obtain access to your counselor/ therapist (cost per agreement)

I understand that message/data rates may apply to messages sent through FTDC/NPC to my cell phone and that I may receive an undetermined amount of text/Emails per month.

I know that I am under no obligation to authorize FTDC/NPC to send me text/Email messages as part of this agreement.

I may opt-out of receiving text/Email communication from FTDC/NPC at any time by calling FTDC/NPC @ (269) 982-3832 or (269) 932-5542 (St Joseph Office), or (269) 313-6934 (Kalamazoo Office).

Name: _____

Signature: _____

Cell Phone/Text Number: _____

Email: _____

Date: _____/ _____/ _____

Family Therapy & Development Centers, Inc. / Neuro-Psychology Consultants

4384 Laurel Drive/ 830 Pleasant Street, Suite 201
Saint Joseph, MI 49085

4341 S. Westnedge Ave., Suite 1103
Kalamazoo, MI 49008

Phone: 269/982-FTDC (3832)
Fax: 269/408-0891

PSYCHOLOGICAL & NEUROPSYCHOLOGICAL SERVICE AGREEMENT

I, (Name) _____

Date of Birth: _____ SS#: _____

Agree to pay Family Therapy & Development Centers, Inc. (FTDC) the balance in full for providing the psychological services of a clinical Psychological and/or Neuropsychological Evaluation and report.

Billing and invoices may be sent to:

Address:_____

City: _____ State: _____ Zip; _____

You may contact me for any further information or remittance at:

Home Phone: _____ Cell Phone: _____

Work Phone: _____

PAYMENT AGREEMENT

***Psychologist clinician fees are per fee schedule attached for the initial 1 hour clinical interview and thereafter $300-$550.00/test hour dependent upon service. Charges for testing does not include scoring, interpretation, report writing and/or any research/review of information. Each additional hour is $300-$550/hr for these services.**

****Family Therapy & Development Centers, Inc. will bill your insurance agency for payment that they cover per your contract with them. You are responsible for all deductibles and co-pays per your insurance contract. You are responsible for knowing your insurance coverage/contract prior to your visit. Any outstanding balances following insurances payment for services rendered are your responsibility. You will be held financially responsible for any and all collection agency costs and attorney fees. You agree to not submit any FTDC/NPC financial responsibility for your fees for services received to any bankruptcy, Chapter 7, 11, 13 or any similar debt relief.**

I understand the above statement and am in agreement to it.

_____ _____

Signature **Date**

***FTDC holds the right to adjust fees based upon financial need "hardship".**

****Note: FTDC does hold contractual agreements with some insurance companies which does alter the fee per session rate.**

Family Therapy & Development Centers, Inc./Neuro-Psychology Consultants

CLIENT INTAKE FORM

(Continuation)

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

I acknowledge that I am responsible party for insurance and/or responsible for payment for all services.

x _____

CLIENT/ PARENT AND/OR GUARDIAN SIGNATURE *Date*

I acknowledge that I am responsible party for insurance and/or payment for all services.

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestion, I understand that I have a right to discontinue of refuse treatment at any time. I understand that I am responsible; however, for any balance prior to a decision to stop.

x _____

CLIENT/ GUARDIAN SIGNATURE *Date*

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

x _____

CLIENT/ GUARDIAN SIGNATURE *Date*

I authorize the payment of medical benefits to the Family Therapy & Development Centers, Inc./Neuro-Psychology Consultants/ Janene M. Donarski, PhD, LP, LMSW (provider services).

x _____

CLIENT/ GUARDIAN SIGNATURE *Date*

Family Therapy & Development Centers, Inc. (FTDC) / Neuro-Psychology Consultants (NPC)
830 Pleasant Street, Ste 201 & 4384 Laurel Drive **4341 S. Westnedge Ave., Ste 1103**
St. Joseph, MI 49085 **Kalamazoo, MI 49008**

Phone: (269) 982-3832 **www.familytherapydevelopmentcenters.com** **Fax: (269) 281 0351**

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

Professionals at FTDC/NPC Include: Psychologists, Social Workers, Professional Counselors, Marriage and Family Therapists, any other licensed therapist/clinician title/degree, paid psychometricians, as well as interns with our practice. Our office does employ a Registered Therapy Dog/Service Dog "Anya". Please note she is often on the premises. Anya is to be treated with respect. It is expected that if you or your dependent has issue to please let our staff know immediately.

Client / Therapist Relationship: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationships. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Family Therapy & Development Centers, Inc./ Neuro-Psychology Consultants (FTDC / NPC) offers a wide array of counselling services, including individual, family, couples, and group experienced licensed professional counselors, licensed clinical social workers, and doctors of phycology. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anxiety, anger, guilt, and sadness. The benefits of counseling, however, can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem-solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling, psychotherapy and or testing.

COUNSELING: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your Therapist will determine your concerns, and if both agree that your current Therapist can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of your Therapist is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if a transfer to a more suitable Therapist is right for you. You may also consult with Dr. Donarski. If you and your Therapist decide that other services would be more appropriate, we can assist you in finding a provider that may meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 45-50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office at (269) 982- 3832 at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

Fee Schedule		
	Diagnostic & Evaluation Session (1st visit)	$ 250.00
	Regular Office Visits (45-50 minutes) (Individual Therapy)	$ 165.00
	Family Sessions/ Couples (60 minutes)	$ 180.00
	90 Minute sessions	$ 230.00
	Psychological, Forensic/ Custodial or Educational Testing	$ 300.00*
	Neuropsychological Testing	$ 360.00*
	Outside Office Work (inpatient visits, court, collaborative law services)	$ 300.00*
	Written Reports (insurance companies, supervisors, etc. pro-rated)	$ 150.00
	Returned check fee per check	$ 35.00

A reasonable fee will be charged for copies of any records requested by the Client.
*Fees begin at this amount and can go upward to $600/hour dependent upon service

PAYMENT / INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your sessions begins. If you are using insurance benefits, FTDC will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursements restrictions and claim requirements. If you are not using a Managed Care/ PPO / HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options/referrals. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, the number for Janene M. Donarski PhD. will be given on our voice mail system. Please utilize this number in the event of a serious crisis, Dr. Donarski will assist you at this time and we will do all we can to have your Therapist call you as soon as possible. If you experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is not available, you will be advised and given the name of an on-call Therapist for your assistance until your Therapist returns.

CONFIDENTIALITY: FTDC / NPC follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.
Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Client's verbal consent will be used in cases of emergency. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in, and situations where the Therapist has a duty to disclose, or where, in the Therapist's judgement, it is necessary to warn or disclose; fee disputes between the Therapists and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN / DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	**Telephone Number**
_____	_____
_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapists, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/ or to deliver those records to another therapist of my choosing.

CONSENT TO TREAMTMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, FTDC/NPC will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____ _____

Signature – Client/Parent *Date*

_____ _____

Signature – Client/Parent *Date*

_____ _____

Therapist *Date*

_____ _____

Therapist *Date*

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Client/Parent *Date*

I authorize the payment of medical benefit to the provider of services/FTDC/NPC/Janene M Donarski, PhD.

_____ _____

Client/Parent *Date*

Family Therapy & Development Centers, Inc. / Neuro-Psychology Consultants

4384 Laurel Drive/ 830 Pleasant Street, Suite 201
Saint Joseph, MI 49085

4341 S. Westnedge Ave., Suite 1103
Kalamazoo, MI 49008

Phone: 269/982-FTDC (3832)
Fax: 269/408-0891

We/I, the undersigned _____, parent(s) and / or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgement indicates. This consent is given by me / us as parent(s) and / or guardian(s) of said child. We / I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and / or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

Signed this day _____ of _____, 20____

_____
Mother of Guardian

_____
Father of Guardian

The above explained to: (*circle all that apply*) Mother / Father / Guardian

By _____on the _____day of _____, 20____

_____
Witness

_____
Date

Family Therapy & Development Centers, Inc.
&
Neuro-Psychology Consultants

OFFICE AND FINANCIAL POLICIES

THANK YOU for choosing Family Therapy & Development Centers, Inc. (FTDC) and Neuro-Psychology Consultants (NPC) for your mental health care needs. We are committed to providing you the best healthcare possible. Please read the following document carefully. It explains our office and financial policies. We ask that you review them and sign them at this time. You may request a copy of these policies if you wish.

General Office Policies:

24 Hour Notice Required for the cancellation of office visit. Please note that you may be charged a $85.00 fee for a non-cancelled/missed appointment with a Master Level clinician and a $150.00 fee for a non-cancelled/missed appointment with a Doctoral Level clinician. Clinicians are at discretion for charge and amount not to exceed above amount. Your insurance company is not responsible for this payment and cannot be billed for a missed appointment. It is our policy and option to not honor future scheduled appointments following a missed appointment and/or refusal to pay fee.

Privacy Policies: There are copies of our practice's written Notice of Health Information Practices Consent to the Use and Disclosure of Health Information, Patient Rights and Responsibilities, and Therapists Confidentiality and Requests in Client Care available in our office. Also, you will receive copies at the time of your first appointment. This serves as your written notice that you have been notified and offered a copy of our privacy practices.

Charges for Documentation Preparation will range from $15.00 to $150.00/hr. depending on the time and skill required to complete the paperwork. Such documents include, but are not limited to, the composition of letters, completion of forms for employers, schools, disability, or insurance companies. This fee is due from you at the time of completion of the documents. The documents will not be faxed, mailed or released without payment. This fee is at discretion of the clinician and will not exceed $150.00/hr.

INSURANCE:

We participate with most local insurance plans and will provide services within their fee schedules. **Your Health Insurance; however, is a Contract between you and your insurance company. You are ultimately responsible for the payment of your bill. We cannot change or waive your insurance payment contract.**

Claim Submission: We will submit claims on your behalf to your insurance carrier as a courtesy. If we do not participate with your carrier, you will need to pay in full at the time of service and be reimbursed by your insurance company by submitting the documentation required for your reimbursement to them on your own.

Insurance Cards and billing information must be presented for submission of claims. We require both a copy of your insurance card and identification card/driver's license, and will require your date of birth and social security number, as this is standard protocol for medical practices in the State of Michigan. We may also ask for the date of birth and social security number of the person with whom you are covered by insurance. This is also needed for billing purposes and reimbursement for services rendered.

Payment Policy:

All Co Pays, Co Insurances, Deductibles, and Non-Covered Benefits are Due the Day the Service is Provided to avoid an automatic $10.00 late fee. If you are uncertain of your payment on the date of service, we will aid you the best we can. Any overpayments will be returned to you. Any past due FTDC account billings will be paid first by any overpayments. You may request a payment plan. This will require other information such as banking, credit card, and/or other forms for regular payment.

We Cannot Waive Co Pays, Co Insurances or Deductibles, as this would be a breach of contract between you and your insurance carrier. It is your responsibility to know and understand the provisions for co-payment and deductibles as well as non-covered items, as this is a contrast between you and your insurance carrier.

Account Statements will detail the amount owed by you after your insurance has processed the claim. Accounts not paid in full within **30 days** of your date of invoice/statement, will be considered delinquent and will be assessed a $10.00 late fee each month they are not paid in full.

In the Event Your Account Becomes 60 Days Past Due we may call and remind you of your financial obligation. If you have questions regarding your statement, you should direct them to the billing department for clarification. We will work with you to pay off your financial obligation.

In the Event Your Account Becomes 90 Days Past Due we reserve the right to refer your account to either Small Claims Court, begin garnishment, or utilize collection services where **you will be responsible for all collection, mailing, small claims, service, and legal fees accrued.**

By signing this document you agree to not place any of your FTDC/NPC financial obligations into bankruptcy, Chapter 7, 11, 13 or any other form of not being responsible for your services rendered.

Returned Checks (bad checks) will have a $35.00 fee.

Your mental health care is very important to us, and your compliance with your financial responsibilities is appreciated. Please understand that our financial staff at the billing office are always happy to work with you. The counselors do not get involved in client accounts (other than to accept payments at the time of service if needed) so as to keep their focus on client care. Please respect this policy. If a payment plan is needed, or you need to speak with someone regarding payment, please all the front office billing department at 269-982-3832.

Signature: _____ Date: _____

Name of Client if not "Self" _____

Relationship to Client if not "Self" _____

Family Therapy & Development Centers, Inc.
&
Neuro-Psychology Consultants

Payment/Billing Policy & Procedures

Individual Counseling, Couples Counseling, Family Counseling Services Charges are standard going rate psychological services for mental health counseling, $250.00 initial appointment and $165-$230.00 for following appointments depending upon length of time and number of individuals present in session. Some specialty practices are rated at $350.00 or more depending upon services rendered. Charges will be sent to your insurance company, or directly with you for private pay, or sliding scale pay, if financial hardship is determined. Telehealth, emergency phone, Kareo provided health services, or other type of tele-communications (when needed) are billed the same. You are ultimately responsible for all charges accrued whether or not your insurance company accepts them as billable. We will attempt to bill your insurance for all services rendered. If your insurance does not pay on a service, or you no-show/no-call on a scheduled appointment, you are responsible for payment of the fee accrued.

Psychological Testing Services

Charges are standard going rate for psychological, neuropsychological testing, per hour for testing administration, scoring, assessment and report writing. Approximate charge for Neuro/Psychological test unit hour/scoring/interpretation/report writing fee is per Neuro/Psychological test unit hour/scoring/interpretation/ report writing fee begins at $300.00-$360.00; per Full Neuropsychological Examination, approximate cost is $2,500.00-$7,500.00 (dependent upon number of tests involved and complexity of scoring/interpretation and report writing). Testing typically can take up to 8-15 hours for direct face-to-face testing. This does not include the time (approximately 8-15) required following direct testing to score, interpret, and write the reports.

Expert Witness Court Appearances

Charges for subpoena expert witness court appearances is $350.00-$450.00 per hour, for preparation, on the stand, plus wait time, mileage and travel time. Wait time is $150.00 per hour. Travel/drive time is $150.00 per hour and includes mileage. Berrien County Court House in St. Joseph, MI is no charge for travel/mileage. It is highly recommended that you speak to your attorney prior to the court date and ensure when the professional expert witness is expected to appear, if the location is out of town, depending on travel ability, and extended court appearances, overnight hotel accommodations may apply and will be charged directly to you and payable in full the week prior to the court appearance.

After Hours Telephone Calls

Everyone appreciates time with their families and time off of the clock. We try to permit our Therapists time with their families and time to recharge their own energy for our clients, as well to promote a healthy balanced lifestyle. Our Therapists are extremely flexible in their schedules to try to accommodate all client needs with school, work and extra-curricular activities. If you need to contact a therapist/counselor after hours please ensure it is for an emergency only otherwise call the main office number at 269/982-3832 and leave a message if you need to schedule an appointment. Our office manager, secretary or the therapist/counselor will call you back as soon as possible typically during regular office hours of 8:00am-5:00pm.

After hours telephone calls are billed each 5 minutes per call. Therefore; if you call your therapist/counselor on their private phone, they have the option to bill you and/or your insurance company for no less than a 30 minute consult even if you are on the phone for 5 minutes. If the telephone call lasts more than 30 minutes, 30 minutes increments will be added as per additional time taken. 30 minute consult sessions bill at no more than $90.00 per half hour unit depending on complexity of service.

Emails & Correspondence

Quite often our therapists/counselors are required by a client to read, produce or create correspondence to assist in therapy or with legal/court hearings, consultations, or expert assistance (i.e., bridging schedules) in areas requested. Billing is $150.00 per hour, or $ 90.00 for a half hour for correspondence and/or reports requested.

Chart Copy

At times it is required for court or primary care physician/counseling service coordination for us to copy all or parts of your chart. You will be billed 15 cents ($ 0.15) per page for copy services. Mailing/postal charges will also be billed to you. If it is possible to fax the information to a secure facsimile machine at a professional office (i.e. legal office), we will charge 10 cents ($ 0.10) per page. Any requested copies of reports, following the first report provided with cost of evaluation, is billed at 15 cents ($ 0.15) per page of copying.

Research

Our therapists/counselors are often requested by clients to "look up" specific issues, or therapy-related research subject for them. As to the therapists/counselors discretion, billable time of $ 90.00 per half hour or $150.00 per hour will be applied for such services. A signed agreement will be made with you at the time of request.

No Show/No Call/Late Cancelations

As per policy, if you do not notify the office, therapist/counselor prior 24 hours of your appointment that you will not be attending, to allow for our office to try to fil the hour with another client, you be billed $85.00 for Master's level clinicians. PhD of PsyD level Psychologists or counselors bill $100.00 for a late cancellation/no show/no call no fee. We often have a wait list for individuals. If there is a cancellation, we are then able to call those clients to take that hour. You will not be billed the $85.00 or $100.00 fee if you follow the 24 hour contact for a cancellation policy and/or we are able to fill that hour with another patient. This includes psychological testing with psychometricians – billed at $85.00 per hour scheduled and cancelled at last minute or no show.

We appreciate full payment from our clients at the time of service. Our therapists/counselors all work for a living to help you and require a paycheck to keep their own personal lives in order. They get paid as the client/insurance pays for services rendered. We often will allow clients to make payments on their accounts if there is a hardship issue. In those cases, regular payments must be continued to avoid Small Claims or other legal assistance to collect payment for services provided/rendered. All private client payments will be applied to the date of service on your account that is the most outstanding. For example, if you come into our office today and apply a payment to your account, your payment will be applied to the farthest back most outstanding date of service that is on your account to bring your account more up to date.

Quite often our professional therapists/counselors will engage in one of the above situations with a client and not require billing – that is at the sole discretion of the therapist determined by them. We often encourage, but do not require, our therapists/clients to "give back" and conduct some pro bono work for our clients, as well as continue with standard billable time.

Ultimately, you are responsible to know your insurance and to contact them prior to your first appointment to ensure you are covered for the services you are requesting. We will assist you after you have arrived for your first appointment as much as we can with information the insurance company may require for payment to be secured.

Your signature below indicates that you agree and understand all of the above fee schedules, billing policies, as well as your responsibilities with obtaining services from Family Therapy & Development Centers, Inc./Neuro-Psychology Consultants.

_____ _____

Signature *Date*

_____

Print Name

You acknowledge by your signature that you are the responsible party for payment for services rendered. Your acknowledge by your signature that you are securing mental health services from Family Therapy & Development Centers, Inc. / Neuro-Psychology Consultants for the following individual(s):

Name	Relationship to you "Self"
_____	_____
_____	_____
_____	_____
_____	_____

WHAT TO EXPECT ON YOUR FIRST VISIT

Your first visit will consist of an interview between you and your Therapist in which the two of you will determine if the Therapist is a good fit for your counseling needs. If you and the Therapist agree that the Therapist is not right for you, the Therapist will refer you to another Therapist.

Fees and times may appear incidental to the actual therapy; but, the consistency in the temporal aspect of the time frame contributes greatly to your sense of security. If your schedule is constantly changing, you will find that it is difficult to get any work done in therapy, and you will find yourself with subtle feelings of discomfort. If, however, these details remain solid and secure, your unconscious mind will see your Therapist as healthy, consistent, safe, strong, and devoted to your care.

SCHEDULE and TIME: The usual appointment schedule is once a week, though you and your Therapist may decide to meet every other week. At your first session, you and the Therapist should agree on a regular day and time for your appointment. Therapy sessions are typically 45 to 50 minutes. To maintain the secure time frame, your Therapist will hold you to that time. If you arrive late, you still must stop at the agreed time. If on the other hand, the Therapist is late, he / she should give you the full appointment time.

Your absence and lateness, as well as persistent silence, wanting to leave therapy, forgetting to pay or delaying payment, are often symptoms of "resistance", or fighting therapy. These may (or may not) reflect outside issues, and should be discussed with your Therapist. In most cases, you will be responsible for paying for any regularly scheduled sessions that you miss or cancel; you are not responsible for paying for sessions cancelled by your Therapist.

FEES: At your first session, the office/Therapist will inform you of the counseling fee. Fees vary *enormously* with geographical area, the Therapist's qualification, and the setting. Your health insurance may pay a portion of the fee. For your own mental health, you should keep your account current and paid up to date. Deductibles and copays are expected the day of your appointments and extra fees may apply for late payments on your account.

UNATTENDED CHILDREN: Due to the nature of the therapeutic process, a quiet, peaceful and private atmosphere is necessary. Children are not to be left in the waiting area while parents/others are in session. You are responsible to have your child watched by another. It is our policy that no children be left unattended in our offices at any time. If you must bring your child(ren) with you to an appointment, please bring another (over age 18) to stay with them during the session. If you are unable to do so, please reschedule your appointment at a time when arrangements can be made for the care of your child(ren). Also, if your child is the client, the Therapist may wish to have a private consultation with you during the appointment time. In such an instance, your Therapist will advise you in advance so that you may bring another adult with you to the appointment to wait with your child during the consultation.

CELL PHONE USE: To protect the privacy and therapeutic process of our clients and maintain the appropriate clinical atmosphere, we ask that you turn off your cell phone while in our offices. Should you need to make a call, you may either step outside the office area or building to make the call. However, it is best if you can postpone any telephone calls until your appointment has concluded.

PRIVACY AND CONFIDENTAIAITY: It should go without saying that you can expect absolute privacy and confidentiality. There may be instances when you choose to allow information to be released; in that case, your Therapist should obtain a signed consent form from you. If your therapy is provided as an employment benefit, such as employee assistance programs (EAPs), there may be required paperwork to be filled out and sent in order for the benefit payment.

TERMINATION: In most cases, you will be the one to decide when it is time to stop therapy. This decision should be discussed in great depth with your Therapist to make sure you are not terminating prematurely as an unconscious reflection of some important issues in your life. If, however, you both agree that problems have been resolved and termination is appropriate, set a specific date for termination and stick to it. The frame should remain absolutely intact right to the end. After terminating, you will have no further contact with your Therapist unless you experience some new emotional disturbance, in which case you can arrange another course of therapy.

FAMILY THERAPY & DEVELOPMENT CENTERS, INC.
Service Hours

The Licensed Psychologist and owner, Janene M. Donarski, PhD, LP, MSW, is available Sunday through Saturday by telephone for emergency needs. This number is not for scheduling appointments. You may contact Dr. Donarski at her cell phone number, 269/325-9119, for emergency purposes.

The Sunday through Saturday hours during which direct therapeutic care and services are available is done by scheduling an appointment directly with the Office Staff or the Therapist Practitioner, or by call/walk-in Monday through Friday during the following times:

* Early morning, M-F 7:00am-8:00am appointments available by scheduling with our Office staff or your Therapist at least two days in advance. Most therapists are available daily, M-F, from 8:00am to 5:00pm. Some night appointments are available from 6:00pm to 8:00pm by scheduling with the office.

Typical Hours of Operation

***Monday 8:00am – 8:00pm**

***Tuesday 8:00am – 8:00pm**

***Wednesday 8:00am – 8:00pm**

***Thursday 8:00am – 8:00pm**

***Friday 8:00am – 5:00pm**
(extended Friday hours available to 8:00pm by appointment only)

Saturday and Sunday appointments for emergencies or by scheduling with Therapist only

Family Therapy & Development Centers, Inc. provides the following appointment guarantees

1) The accommodation of an emergency client within 2 days if not that same day
2) The availability of urgent care within 48 hours
3) The availability of routine therapy visits within 10 working days

Family Therapy & Development Centers, Inc. (FTDC)

If I want to use insurance to pay for my counseling, what do I need to know?

Before calling and scheduling with a therapist, it is wise to call your insurance company. Some insurances will allow you to go only to therapists that the insurance companies have chosen. FTDC works with many insurance companies. Some insurance companies pay more of the bill if you go to their panel therapists, but will pay part of the bill for therapists not on their panel. Usually, you can see who is on the panel for your insurance by going to the web page for your insurance company. You can also call and get names of therapists from your insurance company. Check with your insurance to see if Dr. Janene Donarski and/or FTDC is on their panel.

Start with the phone number on the back of your insurance card. There may be a number that is just for mental health and/or substance abuse counseling. There are a number of questions you will want to ask so have paper and pen available. Write down the time of the call, the date, and the name of everyone with whom you talk. Keep this paper as long as you are in therapy. It is a way to prove that you were given certain information if the insurance company denies a claim.

Ask the insurance representative the following:

- Ask how many sessions of therapy you are allowed with your insurance contract/policy.
- Ask whether there are limitations on what therapists you can see and if there is a pre-authorization number required or process you must complete.
- Find out about your deductible and what date your insurance year starts. The deductible is the amount you must pay before your insurance starts paying. This amount must be paid to FTDC.
- Ask if you have a co-pay (the percentage or amount that you have to pay) for each session. Some companies call this co-insurance.
- If you want marriage counseling, you will need to ask if that is covered by your policy.
- Finally, ask what company the person you are talking with represents. Insurance is quite complex and sometimes the company that pays for mental health care is not the same as the one that pays for your physical health care. For instance, if you have Providence Insurance, the mental health services will be covered by Pacific Behavioral Health, which in turn, is owned by United Behavioral Health.

Marriage and couples counseling is often not covered by insurance because it is not considered "medically necessary." Please be aware that asking a therapist to bill for something else can put the therapist at risk for sanctions from the insurance company.

If, however, one person has a diagnosable problem (depression, anxiety, etc.) and it is increased by marital problems, insurance may cover counseling that approaches the problem from the marriage standpoint.

While insurances often will not pay for certain counseling, Employee Assistance Programs (EAPs) may. Always make the next step to check if your workplace has an "EAP" available to you.

Family Therapy & Development Centers, Inc.

Every person's policy differs. It is best to have the patient contact their insurance with any questions.

Deductibles, copays, co-insurance and maximums define the different ways health insurance companies pay most of the costs to keep you healthy. A premium is the amount that you pay for coverage.

Copay

A copay is what you pay when you visit the doctor, to share the costs of your healthcare. Copays vary by policy, and can change if you see a specialist instead of a regular doctor/therapist, or seek treatment out of your provider's network. It's a set cap amount that you will pay each time you receive medical services. This is typically associated with coverage through an HMO (which will also be discussed a little later). For example, every time you visit your doctor, you may have to pay $25 as a co-payment. These payments usually do not contribute toward out-of-pocket policy maximums. The co-payment and the coinsurance are not one in the same.

Coinsurance

Co-insurance is the way you and your health insurer share the costs of your care. Coinsurance and copay can mean the same thing depending on your insurance policy. Coinsurance is your share of the costs of a health care service. It's usually figured as a percentage of the amount allowed to be charged for services. You start paying coinsurance after you've paid your plan's deductible. The co-insurance amount is per family per calendar year. For example, in a co-insurance arrangement, there can be an 80/20 split between the insured and the insurance carrier in which in the insured pays 20% of the cost of care up to the deductible, but below the out-of-pocket limit set forth by the policy. This is typically associated with the coverage provided by a PPO.

Deductibles

Your deductible is the amount of your medical costs that you have to pay before your health insurance takes over. The amount that you pay out-of-pocket. Like any other type of insurance, the deductible can range in amount depending on how much you would like to pay out-of-pocket. Generally, the higher the deductible, the lower the premiums.

Stop-Loss Limit / Out-Of-Pocket Max

The cumulative dollar amount of covered expenses in excess of the deductible after which the insurance payments stops and the insurer pays 100% of covered expenses. The purpose to the stop-loss limit is to limit the out-of-pocket costs for the insured individual. The "out-of-pocket max" is the maximum out-of-pocket expense you will incur before your insurance carrier pays 100% of covered services. At this point, all you will have to pay is your premiums.

Summary of Health Insurance Deductibles, Copays, Co-insurance and Maximums

You pay copays when you see the doctor/therapist. Coinsurance is how you and your insurance company split up your care. Maximum out-of-pocket is the largest amount you will pay for treatment in one year. Lifetime Maximum is the total amount your insurance company will ever pay for your care over the course of your life. Deductibles are the portion you must pay before your insurance pays its share. What's important to remember for out-of-pocket expenses is that not all expenses go toward meeting the out-of-pocket max. Co-payments and premiums do not apply to the out-of-pocket expense maximum. Your deductible and co-insurance do apply toward this amount. It's worth noting that this may not be a standard feature with every policy. Talk to your insurance company to ensure you understand your policy.

More Understanding

Your insurance claim actually begins before you even make an appointment. Your insurance carrier is responsible only for paying benefits that are covered under your policy, so you should do some research to avoid being shocked when you settle up with your therapist. Don't hesitate to ask your insurance representative to clarify anything you don't understand.

After you've had your appointment, paid your deductible/copay/coinsurance, FTDC sends your bill to an insurance claims processing center. The processing center gathers all relevant information from FTDC—the patient information sheet, intake forms and the proper services documentation. These are compared to the insurer's explanation of benefits to see if the policy covers the services. If it does, your insurance carrier will submit payment for the remaining balance. If not, you are responsible for whatever balance is left.

Denied Health Insurance Claims

So your claim has been denied, and there's a huge bill waiting to be paid. Claims can be rejected because the plan doesn't cover the procedure/testing, testing/treatment was sought before authorization, improper claim filing, the claims weren't filed within time limits, or because the insurance company deems it medically unnecessary or experimental. If you think you've taken all the measures to avoid a rejected claim—like calling the insurance company before the visit or thoroughly reviewing your policy—you can try and turn the denial to acceptance.

If a claim is denied for any reason, including administrative error on the part of the insurance company, a quick phone call could solve the problem. If this doesn't work, you can request a formal review by the insurance provider. You must resubmit your claim, which is reviewed by a health are professional who specializes in the field in which the procedure or treatment belongs.

We must note here that you usually have to go through with these formal reviews within a strict time line. If your formal request is denied, there is one more effort that could pay off. Each state has its own department of insurance that works to ensure that consumers are protected and that the regulatory processes of the insurance companies are fair. So, a call to your state's insurance department might help

FAMILY THERAPY & DEVELOPMENT CENTERS, INC.
830 Pleasant St., Ste 201 St. Joseph, MI 49085
4341 Westnedge Ave., Ste 1103 Kalamazoo, MI 49008
Phone: (269) 982-3832 **www.familytherapydevelopmentcenters.com** **Fax: (269) 281-0351**

Authorization for Release of Patient Health Information

Patient Name _____
Patient Date of Birth _____
Address _____
City/State/ZIP _____
Telephone # _____

I hereby authorize the protected health information regarding the above-named person to be exchanged between:

From/To:
Person / Institution _____
Address _____
City _____
State / ZIP _____
Phone No: _____
Fax No: _____

From/To:
Person/Institution: Family Therapy & Development Ctrs., Inc
Mailing Address: 4384 Laurel Drive
City: Saint Joseph
State / ZIP: MI 49085

I authorize the release of information covering the period(s) of healthcare from
Date(s) _____ to date(s) _____
Birthdate *Current*

The type of information to be used or disclosed is as follows:
☐History and physical examination ☐ Progress notes ☐Abstract (documents summarizing health history)
☐Consultation reports ☐Operative reports ☐Diagnostic reports (labs, x-ray films, etc.)
☐Psychological Test Results ☐School Records/Behavioral Reports ☐**Verbal only (*please specify*)**
☐Initial Evaluation &Discharge summary ☐Other (*please specify*) _____

The following highly confidential items must be checked off to be included in the use or disclosure of other health information:
☐HIV/AIDS related health information and/or records (*the patient 12 or over must authorize this release)*
☐Behavioral or mental health information and/or records (*release must be witnessed and the patient 12 or over must authorize this release*)
☐Birth control (*the patient 12 or over must authorize this release*)
☐Drug/alcohol diagnosis, treatment, and/or referral information (*the patient 12 or older must authorize this release*)
☐Genetic testing information and/or records
☐Information about sexual assault/abuse
☐Information about child abuse and neglect
☐Domestic abuse of an adult with a disability

This information for which I am authorizing disclosure will be used for the following purpose:
☐My personal use (there is a fee for personal use copies)
☐Sharing with other health care providers (no charge if sent directly to the provider—address must be provided as recipient above)
☐Other (*please specify*) _____

Signature:_____ (Patient Parent Guardian)
Date: _____, 20_____. **If not otherwise specified, this release will expire within One Year of the signature**
Witness Signature:_____ Date: _____. 20_____.