McDowell Healing Arts Center, LLC
3253 Congress Ave. Saginaw, MI 48602
2387 S. Linden Rd., Suite 138, Flint, MI 48532
OFFICE (989) 475-4171 FAX (989) 393-6021

DIRECTIONS ON HOW TO FILL OUT THIS PAPERWORK

1. **School Based Community Resource Form:** This form is to be filled out by either the school official assisting the family with connecting with the services or by the parent/guardian. ***PLEASE TAKE NOTE:*** At the top of the form there is a space to check the **PRIORITY** of this referral. Emergency referrals are typically left for children who are possibly an IMMEDIATE harm to themselves or others. We take Emergency Referrals very serious, so please identify this referral as such. Please note that there may be times when our staff cannot get to your school until the next day. If you do not hear from us quickly, please call 911 or other means of help for the child. Then call our office for an update.

2. **Consent to Treatment & Notice of Privacy Practices Form:** This is to be filled out and signed by the guardian/parent. This form gives permission to treat. It also identifies that you know your rights and have access to those rights in written form via our website or by request. You also identify that you understand that MHAC is a training facility and that we work with Master level and Bachelors level interns, and some if not all services may be provided by interns under the direction of a Fully Licensed Therapist.

3. **Financial Consent and Services Agreement:** This form is filled out and signed by the guardian/parent. Signing this form acknowledges that you give MHAC permission to bill your child's insurance and you understand that you are liable for anything that is not paid. ***IF your child has Molina, McLaren, or Meridian Medicaid, these services are paid in full on behalf of the Medicaid provider. United Medicaid does not allow for school based therapy sessions. If you choose to switch insurances, that is your choice, but please remember to check with the child's primary care physician to ensure that they accept the new insurance that you will be switching to. If your child has a commercial insurance such as HAP, Blue Cross or Blue Care Network, please contact our office, as you may have a copay or deductible.

4. **Release of Information:** This form is filled out by the guardian/parent. The release of information is the parent giving MHAC and the School permission to converse with one another concerning the child. This could be verbal, in written form, or both. A release for the school has to be filled out so that at a minimum, the school will allow our staff to see the child and to communicate to the staff on how the child is doing. ***PLEASE NOTE, staff DOES NOT Communicate with the school concerning any personal, private, or medical information. If information is requested by the school, the guardians/parents, will be contacted.

The attached forms are bare minimum forms that our agency requires. Parent's/Guardians may be contacted at a later date to get releases for the Physician, other workers in the child's life, or the other parent.

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School Based Community Resource Form

(*Please fill out as much of this information as possible*)

Priority: _____**Low** (Schedule when available) _____**High** (Schedule as soon as possible) _____**Emergency** (See Now)

School Name: _____

School Staff's Name & Title: _____Date: _____

Student's Name: _____Student's Grade: _____

Student's Date of Birth: _____Has Parent Been Notified □YES □NO

Parent/Guardian's Name: _____Primary Phone Number ( ) _____

Is this student prescribed Meds: □YES □NO Is student taking their Meds: □YES □NO

Does student receive Special Education Services □YES □NO 504 Planning □YES □NO

Reason for Referral (*Check all that apply*)

	Dramatic change in behavior		Nervous/Anxious		Chews (things)
	Worries		Perfectionist		Makes Odd Sounds
	Daydream/Fantasizes		Aggression/Anger		Stealing
	Grief		Swearing		Destruction of Property
	Fears		Fighting		Sexually acting out
	Sadness		Lying		Peer Relationships
	Always tired		Bullying		Social Skills
	Motivation		Disrespectful		Personal Hygiene
	Inattentive		Defiant		Family Concerns
	Withdrawn		Hurts Self		Academics
	Cries easily for age		Impulsive		Absences
	Self-Image/Confidence Challenges		Over Active		Tardy
	Non-touchable/pulls away		Easily Distracted		Work habits/Organizational
	Other:_____		Suicide Ideation		

Clarify Referral Problem/History:

_____
_____
_____
_____
_____
_____

If child was ever taken out of classroom for a session what would be ideal days & times: _____

Please Fax Form to (989)393-6021 or email to: admin@mhacenter.com

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Consent to Treatment
&
Notice of Privacy Practices

_____ _____ _____
Client Name Client DOB Date

The following is to be read, completed, and signed by the client or the client's parent/guardian:

Check all that **may** apply

I agree to attend psychotherapy on an:

_____ Individual Basis _____ Other: _____

_____ Family Basis

_____Group Basis

Michigan Public Act 258 requires a written consent for participation in Mental Health Services.

I hereby authorize and give consent to McDowell Healing Arts Center, LLC, to provide mental health services. This includes the full array of services available as I agree upon. I understand that future Consent for Mental Health treatments may be indicated from my signature on the Treatment Plan. I also understand that I (or the person that I am representing child, vulnerable adult, ect), may receive services from a Masters Level Intern (for Clinical services) or a Bachelors level Intern (for Case Management Services) under the direction of a fully licensed and insurance paneled provider/clinician. I understand I may withdraw my consent at any time, unless I am under a court order to receive mental health services. I also consent to allow McDowell Healing Arts Center, to use outcome data of assessments, scales, and any demographic information (excluding any information that will allow others to identify me personally).

I also attest that I received and/or was offered a copy of the Notice of Privacy Practices for McDowell Healing Arts, LLC and I understand my rights. I also understand that a copy can be retrieved from the website associated with the agency and I may also obtain a copy from the front office by request.

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Signature Date

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Financial Consent & Service Agreement

_____ _____ _____
Client Name Client DOB Date

In relation to services rendered by McDowell Healing Arts Center, LLC, to the client named above, I, the undersigned responsible person, hereby Authorize:

My signature will be retained in my file as authorization of the release of any information including diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and/or health practitioners or to the persons designated in my emergency contacts. This signature will be used in conjunction with all insurance submissions and the filing of insurance claims, including Medicare, for the reimbursement of such services.

I assign directly to McDowell Healing Arts Center, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, whether paid by insurance or not. I hereby authorize McDowell Healing Arts Center, LLC to release all information necessary to secure the payment of my benefits.

I AGREE: To pay for services at the time provided, unless prior arrangements have been made. I will also pay any portion of the cost of services that is denied by a third-party payer or insurance company and I understand that I will be automatically billed, and the remainder will be my responsibility and I agree to pay. McDowell Healing Arts Center, LLC, may also assign unpaid balances to collection agencies after a written warning. I give McDowell Healing Arts Center, LLC permission to bill my insurance and all the insurance information that I have provided. I also agree to keep McDowell Healing Arts Center, LLC, informed of any changes to my insurance so that it can be billed in a timely manner and correctly.

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Signature Date

If you are a cash paying client, please contact our office to discuss prices

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AUTHORIZED RELEASE OF INFORMATION

This authorization for release of information is in accordance with Section 748, Public Acts of 1974, as amended and follows Title 42 CFR, Part II and the requirements for security and privacy under the Health Insurance Portability and Accountability Act 45 CFR, Part 160 and Part 164. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, my payment or my eligibility for benefits. I understand that information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and may no longer be protected by the federal privacy regulations. See revocation rights below:

I, _____ ☐ **AUTHORIZE** ☐ **DECLINE**: McDowell Healing Arts Center, LLC to

(**Client, Parent, Guardian, or Personal Representative**)

☐ **RELEASE/DISCLOSE <u>and/or</u>** ☐ **OBTAIN** the personal health information described below **<u>to and from</u>**:

_____ **<u>Pertaining to (CHILD):</u>**

School Name

Name: _____

_____

School Address

DOB: _____

_____

City State Zip

<u>INFORMATION TO BE RELEASED, DISCLOSED, & OBTAINED BY MCDOWELL HEALING ARTS CENTER:</u>

I understand that I may limit, restrict and/or specifically define the information to be disclosed. I understand that I may revoke or rescind this authorization for release by notifying my Case Manager, Therapist or designee in writing at any time. I understand that if I revoke this authorization it will not have any effect on actions taken by MCDOWELL HEALING ARTS CENTER in reliance on it before it was revoked.

RELEASE & DISCLOSE	**OBTAIN**
_____ All records including verbal &/or written	_____ All records including verbal & written
_____ Assessment	_____ Assessment
_____ Demographic Information	_____ Demographic Information
_____ Diagnosis	_____ Diagnosis
_____ Discharge/Transfer Information	_____ Discharge/Transfer Information
_____ Other: _____	_____ Other: _____
_____ Presence/Participation in Treatment	_____ Presence/Participation in Treatment
_____ Progress in Treatment	_____ Progress in Treatment
_____ Progress Notes	_____ Progress Notes
_____ Treatment Plan or Summary communications	_____ School Records
_____ Excluding: _____	_____ Treatment Plan or Summary communications
	_____ Excluding: _____

Purpose of this Disclosure: ***To assist with the coordination of services between clinic and the above-named person or entity*** and/or for the following purposes: ☐ Consultation ☐ Evaluation of Academic concern ☐ Personal Use

☐ Parent/Partner Consult ☐ Insurance ☐ Other: _____

I understand that this authorization will expire one year from the date that I indicate below alongside my signature or by my notice of revocation, or on the happening of the event of completion of treatment.

Client Name: _____ Address: _____

Signature of Client/Guardian/Representative: _____ Date: _____
Signature of Witness/Office Staff: _____ Date: _____