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. **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. You understand that some, if not all services, may be provided by interns under the direction of a fully Licensed Therapist.

2. **Financial Consent and Services Agreement:** This is to be 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.

3. **Health Care Coordination w/Primary Care Physician:** This form is to be filled out by the client or guardian if the client is a child. Providing your signature and a PCP shows that you understand that we will be coordinating with the PCP and letting them know that you and/or your child is being seen here.

4. **Release of Information:** This is to be filled out and signed by the guardian/parent. The release of information is the parent giving MHAC and people such as a child's school, a previous or current provider that is not the PCP, or other family member, permission to converse with one another concerning the client. This could be verbal, in written form, or both. MHAC DOES NOT Communicate with anyone concerning any personal, private, or medical information, without written permission first.

5. **Informed Consent to Discharge Policy:** This is to be filled out and signed by the guardian/parent. This form simply states that any acts of violence, failure to maintain scheduled appointments, and failure to work towards your treatment plan, can result in closure of services.

6. **Preliminary Crisis Plan:** This is to be filled out and signed by the guardian/parent and the therapist during the first appointment (or after) if there is an identified safety/crisis concern. A signature is requested even if you choose to decline crisis planning. Please check the decline box if you are declining.

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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

CASH PAYING CLIENTS

☐ **Please check here if you are a cash paying client and/or are declining to use your insurance benefits.**

I understand that cash rates for counseling & Coaching services are as follows: $_____ for the initial intake and $_____ per session after the initial intake. I understand that initial intakes are a max of 1 hour and further sessions are 45 minutes. I also understand that appointments not cancelled within 24 hours of the appointment will be charged a $25 cancellation fee, which may be charged on my credit card on file and I give permission for this charge to my credit card. I also understand that couples' counseling is $_____ for the first session (up to 1 ½ hours) and $_____per session following (up to 1 hour). I understand that sessions will not be rescheduled if I have a balance owed to the agency. I agree to pay for these services at the time the services are rendered. I also understand that these rates can change at the discretion of the agency without notice. I have read and/or have had the information above read to me and agree to the terms.

Client/Guardian Signature	Date
Witness Signature	Date

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Health Care Coordination with Primary Care Physician (PCP)

_____ _____ _____
Client Name DOB Today's Date

_____
Primary Care Physician Name / Office Name

_____
Address *Phone* *Fax*

It is best practice and a requirement (under Michigan Public Act 559 of 2016) that McDowell Healing Arts Center, LLC., my behavioral health care provider, and my above-named primary care physician exchange information regarding my mental health/substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and /or treatment (as protected under 42 CFR Part 2) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS.

**I understand that this communication will be up to an indefinite communication as long as I am seeking services at the McDowell Healing Arts Center, LLC. I understand that I may address any concerns that I may have concerning the communication with McDowell Healing Arts Center, LLC, and its staff at any time by written notice. I further understand that it is my responsibility to notify this provider if I choose to change my primary care physician. **

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Signature Date

Behavioral Health Provider Information: (*to be completed by provider*)

Treating Provider: _____at: **McDowell Healing Arts Center, LLC**

Phone: _____ **(989) 475-4171)** _____ Fax: _____ **(989) 393-6021**_____

DSM V Diagnosis Code and name - Primary: _____

DSM V Diagnosis Code and name – Secondary: _____

Treatment Modalities:
Psychotherapy: _____ Individual _____ Family _____ Group *Frequency of Planned Visits*: _____
Inpatient or Partial Hospitalization Dates: _____
Medication Management by: _____
Other Specify: _____

MHAC OFFICE STAFF ONLY (Attach Fax Transmittal Sheet to this form, if faxed**)**
A copy of this form should be sent to the PCP.

Date sent to PCP: _____ Sent by: _____ Method: ☐Fax ☐Mail ☐ Copy given to Client to submit

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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 and/or** ☐ **OBTAIN** the personal health information described below **to and from**:

_____
Name of Person/Agency/Doctor/School

_____
Address

_____
City State Zip

Pertaining to:

Name: _____

DOB: _____

INFORMATION TO BE RELEASED, DISCLOSED, & OBTAINED BY MCDOWELL HEALING ARTS CENTER:

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: _____

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

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_____
Name of Person/Agency/Doctor/School

_____
Address

_____
City State Zip

Pertaining to:

Name: _____

DOB: _____

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_____ 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: _____

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Informed Consent to Discharge Policy

_____ _____ _____
Client Name Client DOB Date

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

Under certain circumstances, clients may be discharged for cause from treatment or participation in services at McDowell Healing Arts Center, LLC. Such conditions which may precipitate involuntary discharge are as follows:

- ✓ **Acts of violence or threats of violence against either staff or other clients of the agency.**
- ✓ **Failure to maintain scheduled appointments and/or regular contact with this agency for more than thirty (30) days. (Cancellation without 24-hour notice is considered as a NO-SHOW. Two or more NO-SHOWs is grounds for involuntary discharge.)**
- ✓ **Failure to work toward treatment plan goals and objectives. (This also means not complying to plans set out in your sessions with your therapist, such as homework and other skill development exercises.**

Clients whose actions are consistent with those listed above may be discharged by decision of the program director with possible consultation with the primary clinician, or in the case of acts of violence or threats of same, may be discharged on the spot by the clinical staff member present at the time.

If I am being considered for involuntary discharge, I will be notified of this in writing by office staff unless the action is based upon threats or acts of violence, or it has been verbally been discussed with you about the discontinuation of services.

I have reviewed the criteria for discharge and, by my signature, agree to the above.

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Signature Date

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Preliminary Crisis Plan

Name: _____ Client DOB: _____ Today's Date: _____

If no Crisis Plan is currently needed, please check here to Decline: and please sign on the bottom

The intent of the document is to assist you when a crisis arises in your life to prevent the situation from becoming worse. It is intended to help you get started towards seeking support and taking control in situations where it is often difficult to make decisions.

When I am in crisis I do the following behaviors: _____

_____

_____

These are some activities that I can do to help with the crisis: _____

_____

_____

These are supportive people that I can use to help resolve the crisis:

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

EMERGENCY CONTACTS

(Other supportive contacts that can be used if the above listed contacts are not available)

Saginaw Community Mental Health Crisis 1-800-233-0022	**Genesee Health System Crisis Hotline 1-810-257-3740**	**North Country Community Mental Health Crisis 1-877-470-7130**
Covenant Cooper Emergency Room 1-989-583-6521	**Hurley Medical Center Emergency 1-810-262-9000**	**McLaren Northern Michigan 1-800-248-6777**
Saginaw Police Department (General) 1-989-759-2188 or 911	**McLaren Medical Center Emergency 1-810-342-2000**	**Cheboygan County Law Enforcement 911**
Health Source- 24-hour admission line 1-989-790-7745	**Flint Police Department (General) 1-810-237-6800 or 911**	**Crisis Text Line text GO to the phone number 741741**
Bay-Arenac Crisis 1-989-895-2300	**National Suicide Prevention Lifeline 1-800-273-TALK (8255)**	**Psychiatric Urgent Care Center 1-616-455-9200**

My signature below signifies that I acknowledge that if I choose to not follow the crisis plan it could contribute to or result in serious consequences either for myself or others around me. My signature also signifies that I was offered a copy of the Crisis Plan. I also understand that if I call MHAC after hours, on the weekend, or a day in which they are not open, I do understand that this will cause a delay in a response back.

Parent and/or Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

****ONE COPY GOES TO THE CLIENT AND THE OTHER GOES IN THE RECORD****