Total Health & Wellness Associates, PLLC
Bringing it all together... Mind, Body & Spirit

Mailing Address: PO Box 3052 ● Farmington Hills, MI 48333-3052
Phone: (734) 368-7154 ● **Fax:** (248) 477-4442

Office Locations

31700 W. 12 Mile Road Suites 100 & 250 Farmington Hills, MI 48334	245 Barclay Circle Suite 400 Rochester Hills, MI 48307	1025 E. Maple Road Suite B-7A Birmingham, MI 48009	432 N. Saginaw Street Suites 415 & 433 Flint, MI 48502

Information for New Patients

The psychological services of Total Health & Wellness Associates, PLLC are provided by a Licensed Counseling Psychologist, specializing in Health Psychology and/or under the supervision of the same Licensed Psychologist. The providers of Total Health & Wellness Associates, PLLC are dedicated to providing psychological treatment in collaboration with your other healthcare providers (with your written permission) in order to provide holistic/integrative healthcare services that care for you as a whole person.

Duration of Sessions: Sessions are typically scheduled for 50 minutes. They are expected to start and end at the scheduled time.

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

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

PSYCHOLOGICAL EVALUATION REPORTS: The reports are released to the referring providers, surgical centers, and/or patients only after the insurance and/or patient has paid the balance in full.

The process related to the release of a Psychological Evaluation Report has been explained to me. My initials reflect acknowledgement and I accept full responsibility for my portion of an unpaid balance. _____ (patient initials)

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

Records: A brief summary note from each session will be recorded in your medical chart. This is a necessary record keeping function for billing and a general standard of care. In addition, this record will help us communicate with your other healthcare providers when necessary. Record requests, letters, and any other documentation require 7-10 business days for processing.

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

Contact Us: To change/cancel an appointment, you may contact the therapist directly at _____ or the office at (734) 368-7154 and leave a voicemail message or talk to the provider, if he/she is available at the time you call.

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

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

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

Patient Name: _____ **Guardian Name:** _____

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