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

Patient Information Form

Date: _____

Patient Name: _____

Address: _____

City: _____

State: _____ **Zip:** _____

Phone: _____

Email Address: _____

DOB: _____ **SSN:** _____

Gender: Male ◯ Female ◯ **Marital Status:** Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯

If applicable, Spouse's Name: _____

Patient's Occupation: _____

Place of Employment: _____

Person to Contact in Case of Emergency

Name: _____

Relationship: _____

Phone: _____

Payment/Insurance Information

Insurance Name: _____

Insurance ID: _____ **Group #:** _____

Insurance Subscriber: _____

Person Responsible for out-of-pocket costs: _____

Contact Information for Person Responsible, if not self: _____

_____

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

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

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Information for New Patients

The providers of Total Health & Wellness Associates, PLLC are dedicated to collaborative care, which includes communication with your other healthcare providers in order to provide holistic/integrative healthcare services that care for you as a whole person. If your other providers are outside of the practice, written permission to discuss your care will be necessary prior to any communication occurring.

The psychological services of Total Health & Wellness Associates, PLLC are provided by Licensed Psychologists, Limited Licensed Psychologists, Licensed Professional Counselors, and Licensed Social Workers, all independently licensed as well as clinically supervised by doctoral level psychologists specializing in Health Psychology. Services provided by other disciplines, such as nutrition education, massage therapy, yoga therapy, reiki, or other treatment modalities are provided by individuals licensed, certified, or trained in those disciplines.

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.

Duration of Sessions: Sessions length depends upon the service. Please confirm with your provider the length of time allotted for the service you are receiving. Session times are expected to start and end at the scheduled times. Arrival 15 minutes or later than your scheduled start time will result in not being seen, as well as a late cancel/no show fee.

Fees: Fees vary. The fee schedule is available for your review and discussion with your provider.

Billing: Your health insurance will be billed for psychological services. All other services are patient responsibility. With insurance, 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. This fee is NOT billable through insurance. **Your credit card on file will be charged the full amount of the session at the time of the missed appointment.** Please note, **two or more late cancelations or no shows within one month will result in discharge of services. _____ (patient initials)**

Credit Card: On File We require that patients keep a credit card on file. Your credit card on file will be charged for no shows, appointments not canceled prior to 24 hours before a scheduled appointment, and past due balances (unless a payment plan is set up). You may also use the credit card on file to pay for patient responsibility on each date of service or to buy product, if you choose to do so.

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:** _____

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Credit Card Authorization

Effective November 1, 2019 Total Health & Wellness Associates, PLLC will require that patients keep a credit card on file. Your credit card on file will be charged for no shows, appointments not cancelled within 24 hours of a scheduled appointment, and past due balances (unless a payment plan is set up). You may also use the credit card on file to pay for your regular session costs or to buy product if you choose to do so.

Patient Name: _____

Date of Birth: _____

Cardholder Information

Name:_____

Billing Street Address:_____

Street Address (cont.):_____

City:_____ **State:**_____ **Postal Code:**_____

Email Address:_____

Direct Telephone: (___)_____-_____

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number:_____

Expiration Month:____ **Expiration Year:**_____

Security Code:___

Cardholder Signature: _____ **Date:** _____/____/____

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HIPAA Privacy Notice

This Notice describes how medical information about you may be used and disclosed. This notice applies to information and records regarding your health care maintained at Total Health & Wellness Associates, PLLC, including medical records and insurance information.

MEDICAL INFORMATION

Total Health & Wellness Associates, PLLC is committed to protecting your medical information. We maintain a record of the care and services you receive in our offices for use in your ongoing care and treatment. This Notice tells you about the ways in which we may use and disclose your medical information. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

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

How We May Use and Disclose Your Medical Information

FOR TREATMENT

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

LEGAL ACTIONS

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

PUBLIC HEALTH RISKS

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

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

FOR PAYMENT

It is expected that the patient will pay Total Health & Wellness Associates, PLLC directly for services rendered. If payment is not received directly from you as agreed upon, we may disclose medical information about you so that treatment and services you receive at Total Health & Wellness Associates, PLLC may be collected, possibly by a third-party collection agency.

Your Rights Regarding Medical Information About You

Your medical record is the property of Total Health & Wellness Associates, PLLC. You have the following rights regarding medical information we maintain for you:

RIGHT TO COPY AND REVIEW

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

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

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

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Medication List

Patient Name: _____

Date of Birth: _____

Allergies: _____

Name of Medication		Reason / Health Condition	Prescriber	Notes (e.g. not taking, etc.)

☐ I am NOT currently on any medication.

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

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

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LEGAL SERVICES/FEES AGREEMENT

I, _____, hereby understand and agree to the following requirement and charges that I may incur if my therapist is involved in a court case or related matter on behalf of myself, my spouse, my children, or my family. I understand that these terms are applicable both while I am receiving services, as well as following termination of services.

COURT ORDERED COUNSELING

1. **A <u>signed</u> copy of the court order must be received by Total Health and Wellness Associates, PLLC.** Once the order has been reviewed and it has been determined that Total Health and Wellness Associates, PLLC can offer services which will comply with the order, services will be scheduled.
2. **Release:** For those cases referred by the court system, clients **MUST** sign release of information forms allowing the therapist to **communicate necessary information to the court/legal system representative.**

FEES FOR COURT-RELATED SERVICES

1. **Phone Consultations with Attorneys, Mediators, Family Court Therapists, District Attorneys:**
   $120 ≤ 30 minutes _____ (client's initials)
   $240 for 30 min - 1 hour _____ (client's initials)
2. **Reports for court, attorneys:**
   $120 ≤ 30 minutes _____ (client's initials)
   $240 30 min - 1 hour _____ (client's initials)
3. **Court deposition or court testimony:**
   $240/hour for time spent in route and onsite; four (4) hour minimum charge **(Must be paid in advance)**. Any out-of-town charges must be reimbursed as above and will include actual out-of-pocket travel expenses, to include mileage and/or transportation costs, tolls, parking fees, meals, and lodging.
4. **Copies of client file** (per Michigan Public Act 47 of 2004/CY2019 Rates), **must be paid at time of service, prior to release of records:**
   Retrieval Fee: $25.06
   Per page, pages 1-20: $1.25
   Per page, pages 21-50: $0.63
   Per page, pages 51+: $0.25
5. **Subpoenas:** All subpoenas will be responded to in a legal and ethical manner. Costs may be attributed to the client or other parties as deemed appropriate by the law and following the guidelines outlined in the other sections of this document.

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

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

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Consent for Electronic Communication

Many providers and clients find that electronic communication is preferred for non-urgent/emergent concerns. If electronic communication is chosen as an option, the following must be understood and agreed to:

1. We cannot guarantee security and confidentiality of email/text information, although we will use reasonable means to maintain such.
2. We use electronic methods of communication only for non-sensitive, non-urgent, and non-emergent issues. **In case of emergency, dial 911.**
3. Emails should not be time sensitive. While we try to respond to emails daily, we cannot guarantee prompt response. If your concern is time sensitive, text or call.
4. Complex and/or time sensitive concerns should be communicated verbally, via phone or in-person.
5. Use your best judgment when communicating via text or email, particularly when wanting to communicate about sensitive health information. We cannot be responsible for the content of the messages you send to us.
6. All electronic communication may be made part of your medical record.
7. Your email or text communication may be forwarded to another provider within the practice as necessary to be appropriately responded to and/or addressed.
8. Email and text messages will not be shared with outside parties without your written consent, unless there is concern for your safety or the safety of someone else.
9. Total Health & Wellness Associates, along with any of our staff, are not liable for breaches of confidentiality caused by your or any third party resulting from electronic communication.
10. Text messaging may be utilized to remind you of scheduled appointments.

Withdrawal of consent: I understand that I may revoke this consent at any time by advising Total Health & Wellness Associates/my provider(s) in writing. Revoking consent will not affect my ability to obtain future care, nor will it cause the loss of any benefits to which I am otherwise entitled.

Acknowledgement and Agreement: I acknowledge that I have read and fully understand all information included here regarding electronic communication. I understand the risks associated with the use of email and text messages as a means of communicating with my provider(s)/Total Health & Wellness Associates. I consent to the conditions detailed above.

Alternatively, I do **NOT** consent to communicate with THWA staff via: (please check)

- ☐ Email
- ☐ Texting messaging (including appointment reminders)
- ☐ Email and texting

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

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

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Social Media Policy

Friending: Although we appreciate every person that follows, likes and shares our social media, our individual providers do not accept friend requests from current or former patients on any social networking site (Facebook, LinkedIn, etc.). Adding patients as friends on social media can compromise your privacy/confidentiality and blur the professional boundaries necessary within healing relationships. If you need to contact your provider between sessions, the best way to do so is to via phone or email.

Following: We encourage you to follow Total Health & Wellness Associates on social media, but please note our providers will not follow you. Our professional media profiles follow other health professionals on social media and will not follow current or former patients. Our top priority is your privacy. If there are things you would like to address from your online life with your provider, please share within your appointment time. Your provider would be happy to explore the topic with you at that time.

Online Interaction: Although our social media pages provide mental health resources, information, and links to support you on your journey, these are not a replacement for therapy. If you have questions or concerns regarding any of the content shared via social media, please contact your individual provider or our organization through email rather than through social media messaging in order to protect your privacy and ensure responses are timely. Please consider social media public communication. If you comment or respond to a post, our responses are visible to others who follow our page.

Where to Find Us

Website: www.MyTotalHealthAndWellness.com

Facebook: www.Facebook.com/MyTotalHealthAndWellness

Instagram: www.Instagram.com/MyTotalHealthAndWellness

LinkedIn: www.Linkedin.com/Company/MyTotalHealth