MONARCH
BEHAVIORAL HEALTH, PLLC
Live at Full Potential

INTAKE PACKET
UNDER 18 YEARS OF AGE

Welcome to Monarch Behavioral Health, PLLC. Please fill out and review the following questionnaires and information so that we may best help you. In this packet you will find:

- Intake Background Questionnaire for Individuals under age 18 (fill out and sign)
- MBH Policies
- MBH Privacy Practices Notice
- MBH Receipt of Privacy Practices
- Email Permission Form
- Coordination of Care Authorization Forms
- Payment Authorization Form

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35980 Woodward Ave., Suite 100, Bloomfield Hills, MI 48304
Phone:248-220-3332| Fax:248-462-6963| Email:office@mbh-mi.com| Website: www.mbh-mi.com

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BEHAVIORAL HEALTH, PLLC

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INTAKE BACKGROUND QUESTIONNAIRE: UNDER AGE 18

Child's name: _____ Today's date: _____
Birth date: _____ Age:_____ Sex (circle one): Male Female
Address: _____ City: _____ Zip Code: _____
School: _____*Current Grade _____
(*if summer, grade just completed)

Pediatrician/Physician: _____
Who referred you to our office? _____
_
Person filling out this form (circle one): Mother Father Stepmother Stepfather Other (explain)_____

If necessary, I give Monarch Behavioral Health, PLLC permission to call me at the following numbers:

Home Phone# _____ OK to leave a message: Yes No
Father Work Phone #_____ OK to leave a message: Yes No
Father Cell Phone #_____ OK to leave a message: Yes No
Mother Work Phone#_____ OK to leave a message: Yes No
Mother Cell Phone #_____ OK to leave a message: Yes No

Mother's name: _____ Age: _____ Education: _____
Occupation: _____ Phone: Home _____ Business: _____
Father's name: _____ Age: _____ Education: _____
Occupation:_____ Phone: Home _____ Business: _____
Stepparent's name: _____ Age: _____ Education: _____
Occupation: _____ Phone: Home _____ Business: _____
Marital status of parents: _____If parents are separated/divorced, how old was child at time of separation? ___
List all people living in household:

Name	Relationship to Child	Age

If any brothers or sisters are living outside the home, list their names and ages: _____

Primary language spoken in the home: _____Other languages spoken in the home: _____
Name of person responsible for the bill: _____ SS# _____
Are you or your child involved in any legal issues at this time (i.e., probation, divorce, custody issues, etc): Yes No

PRESENTING PROBLEM

Describe your child's current difficulties (feel free to use back of this form or attach additional pages if needed):

_____

_____

_____

How long has this problem been of concern to you? _____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse?_____

Has the child received evaluation or treatment for the current problem or similar problems? Yes _____ No ___

If yes, when and with whom? _____

Is the child on any medication at this time? Yes _____ No _____

If yes, please note kind of medication: _____

Other Information

What are your child's favorite activities?

1._____ 2._____ 3._____

4._____ 5._____ 6._____

What activities would your child like to engage in more often than he/she does at present?

1._____ 2._____ 3._____

What activities does your child like least?

1._____ 2._____ 3._____

Has your child ever been in trouble with law? Yes _____ No _____

If yes, please describe briefly: _____

What are your child's assets or strengths? _____

_____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.

_____ Has difficulty with speech _____ Has difficulty with hearing

_____ Has difficulty with language _____ Has difficulty with vision

_____ Has difficulty with coordination _____ Is clumsy

_____ Is stubborn _____ Is aggressive

_____ Shows daredevil behavior _____ Is impulsive

_____ Bangs head _____ Has difficulty paying attention

_____ Is too active _____ Gives up easily

_____ Is shy or timid

_____ Tics or repetitive behaviors _____ Does not get along well with friends/peers

_____ Has tantrums or meltdowns.

If yes, How often?_____per day/ per week (circle one)

If yes, How long do they last?_____

If yes, What does child do during tantrum? _____

_____ Engages in behavior that could be dangerous to self or others (describe) _____

_____ Shows specific fears or phobias (describe) _____

_____ Prefers to be alone

_____Does not get along with brothers and sisters

_____ Is more interested in things (objects) than in people _____ Eats poorly

_____ Bites nails

_____ Has blank staring spells

_____ Has frequent nightmares

_____ Has trouble sleeping

_____ Sucks thumb

_____ Other (describe) _____

_____

DEVELOPMENTAL HISTORY

During pregnancy, was mother on medication? Yes_____ No _____If yes, what kind? _____

During pregnancy, did mother smoke? Yes _____ No _____ If yes, how many cigarettes each day? _____

During pregnancy, did mother drink alcoholic beverages? Yes _____ No _____

If yes, what did she drink? ____

Approximately how much alcohol was consumed each day? _____

During pregnancy, did mother use drugs? Yes _____ No _____ If yes, what kind? _____

Were forceps used during delivery? Yes _____ No _____

Was a Cesarean section performed? Yes _____ No _____. If yes, for what reason? _____

Was the child premature? Yes _____ No _____ If so, by how many months? _____

What was the child's birth weight? _____

Were there any birth defects or complications? Yes _____ No _____ If yes, please describe:

Were there any feeding problems? Yes _____ No _____ If yes, please describe:

Were there any sleeping problems? Yes _____ No _____ If yes, please describe:

As an infant, was the child quiet? Yes _____ No _____

As an infant, did the child like to be held? Yes _____ No _____

As an infant, was the child alert? Yes _____ No _____

Were there any special problems in the growth and development of the child during the first few years? Yes___No__

If yes, please describe: _____

_____

_____

The following is a list of infant and preschool behaviors. Please indicate the age at which your child first demonstrated each behavior. If you are not certain of the age but have some idea, write the age followed by a question mark. If you don't remember the age at which the behavior occurred, please write a question mark.

Behavior	Age	Behavior	Age
Showed response to mother	_____	Babbled	_____
Rolled over	_____	Spoke first word	_____
Sat alone	_____	Put several words together	_____
Crawled	_____	Became toilet trained	_____
Walked alone	_____	Stayed dry at night	_____
Fed self	_____	Rode tricycle	_____
Dressed self	_____	Rode bicycle	_____

MEDICAL HISTORY

Current Pediatrician/Physician: _____

Address:_____ Phone #: _____

CURRENT HEALTH:

Please Describe your child's current health: _____

Sleep: What time does your child go to sleep? _____ How long does it take them to fall asleep? _____

What time does your child wake up? _____ Do they appear well rested? _____

Has your child experienced any recent changes in sleep? Y N If yes, please describe:_____

Appetite: Please describe your child's appetite and eating habits: _____

Has your child experienced any recent change in appetite, eating, or weight? _____

ALLERGIES

_____

CURRENT MEDICATION

Name of Medication	Current Dose	Previous Dosage	Date Started	Response to Medication
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICATION HISTORY

Name of Medication	Dosage	Date Started	Date Stopped	Reason for Stopping
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Place a check next to any illness or condition that your child has had. When you check an item, also note the date (or age).

Check Illness or condition Date(s) or age (s) Check Illness or condition Date(s) or age(s)

_____ Measles
_____ German measles
_____ Mumps
_____ Chicken Pox
_____ Whooping cough
_____ Extreme tiredness
_____ Weakness
_____ Diphtheria
_____ Scarlet fever
_____ Rheumatic fever
_____ Meningitis
_____ Epilepsy
_____ Tuberculosis
_____ Bone or joint disease
_____ Gonorrhea or syphilis
_____ Anemia
_____ Jaundice/hepatitis
_____ Diabetes
_____ Cancer
_____ High blood pressure

Asthma _____
Bleeding Problems _____
Visual Problems _____
Frequent/Severe Headaches_____
Eczema or Hives _____
Difficulty Concentrating_____
Fainting Spells _____
Suicide Attempt _____
Memory Problems _____
Paralysis _____
Loss of consciousness _____
Encephalitis _____
High fever _____
Convulsions _____
Allergy _____
Hay fever _____
Injuries to head _____
Broken bones _____
Ear Problems _____
_____ Heart disease

Other: _____

Please list all hospitalizations (e.g., ER visits, Surgeries/Operations):

Date Reason

_____

_____

_____

FAMILY MEDICAL HISTORY

Place a check next to any illness or condition that any member of the child's family has had (or suspected). When you check an item, please note the member's relationship to the child.

_____ Addiction (circle one: alcohol/ drugs)
_____ Cancer
_____Depression
_____Learning disability

_____Diabetes _____ADHD

_____ Heart trouble _____ Intellectual Deficit

_____ Bipolar Disorder _____ Anxiety Disorder

_____ Other _____

EDUCATIONAL HISTORY

Place a check next to any educational problem that your child currently exhibits.

_____ Has difficulty with reading When was this problem first noticed? _____

_____ Has difficulty with arithmetic When was this problem first noticed? _____

_____ Has difficulty with spelling When was this problem first noticed? _____

_____ Has difficulty with writing When was this problem first noticed? _____

_____ Does not like school When was this problem first noticed? _____

_____ Has difficulty with other subjects (please list)

Other:

_____ When was this problem first noticed? _____

_____ When was this problem first noticed? _____

_____ When was this problem first noticed? _____

Has your child ever received a psychological or educational evaluation? (Please list dates and providers)

Date Provider/Institution

_____

_____

Does your child have a current IEP (special education) _____ or 504 Plan _____

If yes, when was this established and for what reason?_____

Has your child been held back in a grade? Yes _____ No _____

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school or privately? Yes _____ No _____

If yes…..

Name of Tutor/Specialist Dates of Intervention Reason for Tutoring/Intervention

_____ _____ _____ _____

_____ _____

_____ _____ _____

_____ _____ _____

Please use this space (or attach additional pages) for any other information that would be helpful for me to know when working with your child. Thank you.

Signature: _____ Date: _____

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POLICIES REGARDING PROFESSIONAL SERVICES

CONFIDENTIALITY

Any information that you provide, as well as counseling and/or evaluation records that are maintained, are kept strictly confidential, with the exception of life threatening situations, cases of suspected child abuse, when release is otherwise required by law, or when you request that the information be released. Testing and evaluation data may be entered into the computer by Monarch Behavioral Health data entry specialist. Should the need arise; your case may be discussed anonymously during case consultation with another licensed psychologist while keeping identifying information strictly confidential.

PAYMENT OF FEES It is customary to pay for professional services when they are rendered, preferably by Credit Card with automatic payment form, cash or check made payable to Monarch Behavioral Health.

CHARGES

Charges for professional services are as follows:
Initial Clinical Interview (Therapy, first session): $250.00
Individual and Family Therapy (per 45 minute session): $175
Group Therapy Services (per meeting): $55.00
Full Psycho-Educational Assessment** $2700.00-$4,625.00 (Based on age of child at time of testing)
School Visit (per hour, additional travel fees may apply): $250.00
Legal fees (per hour): $250.00
Record Review (Academic, Clinical, etc., per hour): $50.00 per 5 minute increment
Telephone/Email Communication, per 15 minutes: $50.00
**Evaluation Price quoted at Intake is valid for 90 Days.

INSURANCE Many insurance plans cover all or part of the costs of psychological services. If you expect to file for reimbursement from your insurance company, a statement of services will be uploaded to your Patient Portal. Submission of forms or receipts to the insurance company is, in all cases, the client's responsibility.

MISSED APPOINTMENTS

Because your appointment times are scheduled and held specifically for you, we ask that cancellations are made with more than 24 hour notice. To ensure delivery of notice to cancel your appointment, please e-mail our office at office@mbh-mi.com and call (248) 220-2223. Appointments cancelled less than 24 hours before appointment date and time will be charged as 45 minutes professional time and your clinician will work on details pertaining to your care. To account for emergencies and unavoidable circumstances, each patient/family is allowed one late cancellation per 6 months of service.

I give consent for myself or my child to be seen professionally by Monarch Behavioral Health, PLLC.

Please indicate that you have read the above statements by signing below.

Client signature: _____ ____/____/____
Date

Client Name Printed:_____

Parent/Guardian/Caregiver signature (If applicable):_____ ____/____/____
Date

Parent/Guardian/Caregiver Name Printed:_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (OR YOUR CHILD, IF YOUR CHILD IS THE PATIENT) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THOROUGHLY

If you have any questions about this Notice please contact our Privacy Officer at (248)-220-2223

This Notice of Privacy Practices describes how Monarch Behavioral Health, PLLC may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or otherwise required by law. It also describes your rights, as the patient, to access and control your protected health information.

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your psychologist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your psychologist's practice.

Following are examples of the types of uses and disclosures of your protected health information that your psychologist's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your doctor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical or doctoral students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the applicable law, and will be limited to the relevant requirements of the applicable law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, *as* required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security*:* When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object
We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS AS THE PATIENT
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits –

Access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Psychologist's Duties: -

 Monarch Behavioral Health, PLLC is required by law to maintain the privacy and security of your Protected Health Information and to provide you with a notice of my legal duties and privacy practices with respect to your Protected Health Information.

 Monarch Behavioral Health, PLLC reserves the right to change the privacy policies and practices described herein.

 If Monarch Behavioral Health, PLLC makes significant revisions to its policies and procedures which might affect the privacy of your Protected Health Information, we will provide you with a copy of the revisions. If you are still in treatment with Monarch Behavioral Health, PLLC, you will be provided with a copy of the revisions in a manner permitted by law, which includes hand delivery at your next appointment. Updated notices of Monarch Behavioral Health, PLLC' privacy policies will always be available for review upon request at our office.

Effective date, restrictions and Changes to Privacy Policy:

 Restriction: In the case of a minor child, the child's legal guardian has the right to inspect or obtain a copy (or both) of the Protected Health Information in our mental health and billing records which were used to make decisions about the child for as long as the Protected Health Information is maintained in the record(s). However, in order to protect the child's right to confidentiality, psychotherapy notes, including, but not limited to, statements made by a child during therapy sessions will NOT be released, unless required by law or deemed, in the professional judgment of a licensed psychologist at Monarch Behavioral Health, PLLC, to be in the best interest of the child.

 Restriction: In most cases, Monarch Behavioral Health, PLLC is prohibited by law from disclosing raw psychological test data and test materials to anyone other than a licensed psychologist qualified to interpret such data.

3. COMPLAINTS

If you believe that your privacy rights have been violated by us, you may contact us or the Secretary of the Department of Health and Human Services to file an official complaint. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.
You may contact our Privacy Officer at (248)220-2223 for further information about the complaint process.

This notice was published and becomes effective on 9/15/17.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB:

Given to Patient on: ____/_____/_____ Version/Effective Date: 9/15/17

Signature of Patient or Parent/Guardian: _____Date:_____

Relationship of Personal Representative to the Patient:

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ELECTRONIC CORRESPONDENCE AGREEMENT

Patient: _____
Parent/Guardian Name(s):_____
E-Mail Address:_____

Additional E-Mail Addresses: _____

Permission to communicate via e-mail: **Yes No**

Permission to email clinical documentation containing confidential personal patient information as an attachment to an email in PDF format: **Yes No**

Permission to email information about upcoming events and workshops, associated with Monarch Behavioral Health, PLLC, your name and e-mail address are kept private and will not be seen by anyone other than office staff: **Yes No**

Monarch Behavioral Health, PLLC will **NOT** be able to respond to clinical issues via email. Due to the nature of patient confidentiality, issues are best addressed during session, in person. However, at times, it may be more convenient to schedule appointments with the office manager via email at: office@mbh-mi.com. Issues regarding a change in schedule, please also leave a message on our voicemail at (248) 220-2223.

CONFIDENTIALITY NOTICE
Electronic messages are confidential, intended only for the named recipient(s) and may contain information that is privileged or exempt from disclosure under applicable law.

If you choose to respond to electronic email, you cannot assume anything that you communicate electronically is confidential or will not be read unwittingly, mistakenly or purposefully by another party.

Although reasonable measures are taken to protect electronic communication, there are no guarantees that your communication will be private. If you are concerned that another party may ultimately read what you have written, don't write it or send it via e-mail.

_____ _____
Signature of Patient or Parent/Guardian:_____Date: _____

Relationship of Personal Representative to the Patient: _____

MONARCH
BEHAVIORAL HEALTH, PLLC

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Permission to Exchange Information to Better Coordinate Care
(Authorization for Use and Disclosure of Protected Health Information)

**Please note that we are required to have this form on file for you, indicating whether you refuse or authorize coordination of care. Please complete and sign. You may change or update this at any time.*

Communication with other healthcare providers, institutions and service providers

We encourage you to allow us to coordinate your care with all of your healthcare providers and other service providers. Let us know if you have any concerns.

Type of provider (or institution/school) (e.g., other therapists, PCP, OB/GYN, school, etc.):

Provider's name (or institution/school name):

Address:

Phone: Fax:

Please select one of the following:

☐ I authorize the use and/or disclosure of my health information as described in this authorization with this provider/institution. I also authorize sending a Coordination of Care Letter to this provider. This letter may include impressions and/or preliminary diagnoses from evaluation, as well as recommendations for treatment and/or follow-up care.

☐ I do NOT wish any of my health information to be exchanged with the above provider/institution.

This authorization will have a duration of consent for the duration of active treatment or until notified that consent is revoked. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email (with confidentiality statements and reasonable precautions in place). Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from Monarch Behavioral Health, PLLC., or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care unless indicated otherwise by noting it at the bottom of the form. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke or cancel this authorization at any time. I understand that to revoke this authorization, I must contact Monarch Behavioral Health, PLLC and put my revocation/cancellation in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that if I authorize Monarch Behavioral Health, PLLC to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Monarch Behavioral Health, PLLC may no longer be protected by the federal rule on the privacy of medical records.

Signature of Patient or Authorized Representative: _____ _____/_____/_____
Printed Name of Patient:_____ **Date**
Printed name of Authorized Representative (if not patient): _____

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Credit Card Payment Authorization Form

Please fill in all areas completely and sign and date the bottom.

Type of card (check one): _____ MasterCard _____ VISA
Is this a Debit Card? ___ Y ___N
Is this an HSA/FSA or Flexible Spending Account card? ___Y ___N

Name of Patient: _____

Name on the card (if different from patient): _____

Billing address of cardholder:

_____

_____

_____

_____

Credit card number: _____CVV: _____

Expiration date: _____

I, _____, authorize Monarch Behavioral Health, PLLC. to charge the credit card indicated above. I understand that unless I notify my clinician otherwise, my current account balance will be charged to this credit card after each session.

Patient's Signature

_____ _____
(Date)

Credit Card Holder's Signature (** if different than Patient)

_____ _____
(Date)