MONARCH
BEHAVIORAL HEALTH, PLLC
Live at Full Potential

CHILD & ADOLESCENT INTAKE PACKET

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 Evaluation Form
- Emotional, Social, & Behavioral Checklist
- MBH Service Agreement & Policies
- MBH HIPPA Privacy Practices Notice
- MBH Receipt of Privacy Practices
- Electronic Correspondence Agreement
- Coordination of Care Authorization Forms
- Payment Authorization Form

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35980 Woodward Ave., Suite 100, Bloomfield Hills, MI 48304
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Intake Date: ____/_____/_____

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Child & Adolescent Intake Evaluation Form

Name: _____ Who is filling out this form (name/relation)?_____

Birthdate:_____ Age:_____ SS#: _____-_____- _____

Home Address: _____ City:_____ Zip: _____

Who were you referred by?_____

Who will be responsible for billing?

Name: _____ Date of Birth_____ SS#:_____- _____- _____

Billing Address: same as above? Y N (if no, please fill out the following)

Street: _____ City:_____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

FAMILY BACKGROUND

Mother

Name: _____ Age:_____

Occupation:_____ Level of Education:_____

Cell Phone: _____ OK to leave message? Y N

Work Phone: _____ OK to leave message? Y N

Email: _____

Father

Name: _____ Age:_____

Occupation:_____ Level of Education:_____

Cell Phone: _____ OK to leave message? Y N

Work Phone: _____ OK to leave message? Y N

Email:_____

Step-Parent or Other Caregiver

Name: _____ Age:_____ Relationship:_____

Occupation:_____ Level of Education:_____

Cell Phone: _____ OK to leave message? Y N

Work Phone: _____ OK to leave message? Y N

Parents marital status: _____

If not currently married, please describe custody agreement: _____

Please list other family members or individuals currently living in the home:

Name Age Relationship to Child

_____

_____

_____

What language is predominantly spoken in the home?_____

Is your child or family currently involved in any legal proceedings (i.e., divorce, probation, ect.)? Y N

If yes, please describe: _____

How would you describe the current stress level in the home? _____

If moderate to high, please explain why: _____

CURRENT CONCERNS

What is the main concern that brings you in today? (please continue on back of page if necessary):_____

_____

_____

_____

_____

When did this problem first begin? _____

What seems to make the problem better?_____

What seems to make the problem worse? _____

Has your child had an evaluation or treatment for this problem? Y N

Provider Name Dates Outcome of evaluation or treatment

_____

_____

_____

Does your child currently take medication for this problem? Y N

If yes, please list medication and dosage _____

What are your child's favorite activities? 1._____ 2. _____ 3. _____

What are your child's least favorite activities? _____

What are your child's strengths? _____

SCHOOL INFORMATION

Grade: _____ School:_____ Teacher: _____

Is your child having difficulties at school? Yes No

If yes, please describe these difficulties: _____

_____

_____

Does your child have difficulty with the following academic areas?

Circle one	Academic Skill	When was this noticed?	Describe Difficulties
Y N	Reading		
Y N	Writing		
Y N	Spelling		
Y N	Math/Arithmetic		
	Other: Please Describe		

Has your child had a psychological, psycho-educational, or neuropsychological evaluation? Y N

Provider Date

_____

_____

_____

Does your child currently have an Individualized Education Plan (IEP) _____ or 504 _____?

If yes, when was this established? _____ For what reason?_____

What accommodations does your child currently have at school? _____

_____

_____

How does your child get along with peers at school? _____

DEVELOPMENTAL HISTORY

What week of pregnancy was the child delivered? _____ weeks. Birth weight _____lbs _____oz

Was the child born by vaginal or cesarean delivery? _____

Were there any complications during delivery? Y N

If yes, please describe: _____

Did your child stay in the neonatal unit after his/her birth? Y N

If yes, why and for how long? _____

Were there complications during pregnancy? Y N If yes, please describe: _____

Did child's mother take medication during pregnancy? _____

How often did child's mother drink alcohol during pregnancy? (circle one) Daily Weekly Monthly Never

How often did child's mother use other substances during pregnancy? Daily Weekly Monthly Never

As an infant, did the child experience feeding difficulties? Y N Please Describe:

As an infant, did the child experience sleep difficulties? Y N Please Describe:

As an infant, was the child easily soothed? Y N

As an infant, did the child like to be held? Y N

How would you describe this child's temperament as an infant? _____

Please indicate below when your child achieved each developmental milestone

Developmental Milestone	**Age**
Responsive to caregiver	
Rolled over	
Sat up on own	
Crawled	
Walked on own	
Babbled	
Spoke first word	
Spoke in sentences	
Toilet Trained: daytime	
Toilet Trained: nighttime	
Fed self	
Dressed Self	

MEDICAL HISTORY

Current Physician or Pediatrician: _____ Phone:_____

Practice Name & Address: _____

When was your child's last check up? _____

Describe your child's overall health: _____

Has your child ever been hospitalized? _____ If yes, when and why? _____

Has your child ever experienced seizures? Y N If yes, when and what type: _____

Has your child ever lost consciousness? Y N If yes, please describe: _____

Sleep: What time does your child typically go to bed?_____ Wake up? _____

Has your child experienced any recent changes in sleep? Y N Describe: _____

Do you have any concerns about your child's sleep? _____

Appetite: How is your child's appetite and eating habits? _____

Has his/her eating habits changed recently? _____

Has your child experienced any recent weight gain or loss? _____

Does your child have any allergies? Y N If yes, please list: _____

Medication History

Please list all current medications:

Medication & Dosage	Doctor who prescribed	Reason for taking	Date Started	Was this medication helpful?

Please list medications taken previously:

Medication & Dosage	Doctor who prescribed	Reason for taking	Date Started/ Date Ended	Was this medication helpful?

Family Medical History

Please indicate which medical and mental health conditions your family has experienced:

_____Cancer _____ADHD

_____Diabetes _____Mood Disorder

_____Heart Trouble/Disease _____Alcohol Addiction

_____ Chronic Pain Condition _____Substance Use Addiction

_____Learning Challenges/Disabilities _____Anxiety

_____Intellectual Deficits _____ Autism Spectrum Disorder

Parent/Guardian Signature: _____ Date: _____

EMOTIONAL, BEHAVIORAL, & SOCIAL CHECKLIST

Please place a check in the left box, next to any difficulties your child is currently experiencing. Please provide any pertinent details to the right.

✓	Difficulties	Notes:
	Fearful, anxious or worried	How often? How intense?
	Specific fears or phobias	Specify:
	Excessive anger	How often? How Intense? What sets off anger?
	Tantrums	How often? How intense? What sets off tantrums?
	Sensitivity to tactile and/or auditory sensations	
	Difficulties with speech or language development	Specify:
	Difficulty with hearing	
	Clumsy	
	Difficulty with vision	
	Difficulties initiating friendships	
	Difficulties sustaining friendships	
	Withdrawn	
	Appears sad or sullen	How often?
	Irritable	How often?
	Difficulties completing school work	In a specific area/class or in general?
	Difficulties organizing self	
	Difficulties paying attention	
	Difficulties finishing tasks	
	Difficulties remembering things	
	Acts Impulsively	Examples:
	Gives up easily	
	Harms Self	Please describe:
	Engages in repetitive speech or behaviors	Please describe:
	Complains of body aches and physical discomfort	Please describe:
	Low Self Esteem	
	Is shy/timid	
	Nightmares	How often?
	Eats poorly	
	Sleep Poorly	
	Is dangerous to self or others	Please describe:
	Stares blankly at times	How often? Are there specific triggers?

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SERVICES AGREEEMENT & POLICIES

Welcome to Monarch Behavioral Health, PLLC. This document contains important information about our professional services and business policies. Please read it carefully and let us know any questions you may have.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements and varies depending on the particular problems you hope to address. There are many different methods that may be employed in treatment, and treatment often calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Research indicates that those who engage in psychotherapy attain significant and lasting results. However, because therapy often involves discussing current and past difficulties, you or your loved one may experience discomfort at times. Psychotherapy often leads to a reduction in symptoms, better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, given the many aspect which contribute to therapy treatment outcome, results vary. Your clinician will check in with you frequently regarding your progress.

Therapy involves a commitment, and we would like you to feel confident in the therapist you select. If you have questions about procedures, please discuss them when they arise. If, for any reason, you feel your clinician is not a good match to your current needs, we will help you set up a meeting with another mental health professional for a second opinion.

CONFIDENTIALITY

All information you provide during intake, counseling, and/or evaluation process and record review are kept strictly confidential. The privacy of all communications between a patient and a psychologist are protected by law, and Monarch Behavioral Health, PLLC can only release information with your written permission, with the exception of life threatening situations, cases of suspected abuse or neglect (to minor, elder, disabled individual), when release is otherwise required by law, or when you request that the information be released.

In most legal proceedings, you have the right to prevent any information being provided about your treatment. In some legal proceedings, a judge may order a professional's testimony if he/she determines that the issues demand it, and said professional must comply with that court order.

In efforts to provide and comply with the highest standards of care, your case may be discussed anonymously with other licensed clinicians during Monarch Behavioral Health, PLLC case conference. During case conference, all identifying information is kept strictly confidential.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have. Your clinician will be happy to discuss these issues with you and provide clarification when possible.

MINORS (Individuals under 18 years of age)

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify Monarch Behavioral Health. You may be asked to provide a copy of the most recent custody decree. Both parents must consent to therapy.

Individual Parent/Guardian Communications with Me

In the course of treatment of your child, parents/guardians often meet either separately or together. Please be aware, however, that session notes must be generated regarding that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, it is required by law, or by the guidelines of this profession to disclose information, whether or not the clinician has your or your child's permission. Some of these situations are listed below.

Confidentiality cannot be maintained when:

- Minor patients express that they plan to cause serious harm or death to themselves, and the clinician believes they have the intent and ability to carry out this threat in the very near future. Steps to inform a parent, guardian, or others to ensure safety will be taken.
- Minor patients express a plan to cause serious harm or death to someone else, and the clinician believes they have the intent and ability to carry out this threat in the very near future. In this situation, steps are taken to inform a parent or guardian or others, and the clinician may be required to inform the person who is the target of the threatened harm [and/or the police].
- Minor patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, professional judgment must be utilized to decide whether a parent or guardian should be informed.
- Minors express, or your clinician otherwise learns that, it appears that a minor is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, your clinician may be required by law to report the alleged abuse to the appropriate state child-protective agency.
- Your clinician is ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

Parents and family are often involved in a minor's psychotherapy and the degree to which information is shared differs across clients. However, for some minors, increased confidentiality can prove important for treatment effectiveness. It may be important to NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then your clinician will need to use professional judgment to decide whether your child is in serious and immediate danger of harm. If your clinician feels that your child is in such danger, he/she will communicate this information to you.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although our responsibility to your child may require helping to address conflicts between the child's parents, your clinician's role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena records or ask your clinician to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing opinions about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring your clinician's testimony, even though your clinician will not do so unless legally compelled. If your clinician is required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, your clinician will provide information as needed, if appropriate releases are signed or a court order is provided, but your clinician will not make any recommendation about the final decision(s). Furthermore, if your clinician is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for clinician's participation agrees to reimburse

at the rate of $250.00 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

APPOINTMENTS & PROFESSIONAL FEES

The following fees for professional services apply:

Intake Appointment (includes clinical/diagnostic interview, 60 minute session): $250.00
Individual and Family Therapy (per 45 minute session): $175
Group Therapy Services (per meeting): $55.00
Full Psycho-Educational Assessment: Varies based on age of child at time of testing and type of testing conducted.
School Visit (per hour, additional travel fees may apply): $250.00
Record Review (Academic, Clinical, etc., per hour): $50.00 per 15 minute increment
Document Preparation or Professional Writing: $50.00 per 15 minute increment
Telephone/Email Communication, per 15 minutes: $50.00
Records Request (per request): $20.00
Legal fees (per hour): $250.00 - If you or your child become involved in legal proceedings that require clinician participation, the same fee structure applied to time spent on legal matters ($250 per hour).

BILLING AND PAYMENTS

It is customary for individuals to pay at the time of service. Therapy session payment is due on the date of service. For psycho-educational and neuropsychological testing, half of fee is due on the day of testing and half is due on the day of feedback. Payment schedules for other professional services will be agreed to when such services are requested.

Many insurance plans cover all or part of psychological services. A statement of services, including all payments and information necessary to seek reimbursement from your insurance company will be uploaded to the Patient Portal. In all cases and circumstances, it is the clients responsibility to submit receipts or forms to their insurance company.

CANCELLATION POLICY

When an appointment is scheduled, that time is dedicated and held just for you. We ask that appointments are cancelled with more than 24 hours notice. 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.

We understand that the unforeseeable sometimes occurs. When an appointment is cancelled with less than 24 hours notice due to emergency or illness, please be sure to inform our staff. Each client is allotted one free late cancellation appointment per 6 month period.

CLINICIAN CONTACT

Because our clinicians are usually engaging in professional services, such as treatment session or school meetings, they are often not immediately available by telephone. When clinicians are unavailable, the front office telephone is answered by voice mail or front office administrator. Every effort to return your call within 24 hours will be made, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If your clinician will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

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

Your signature below indicates that you have read the information in this document and agree to its terms during our professional relationship.

Patient Signature: _____ Date ____/____/____ Print Name:_____

Parent/Guardian Signature:_____ Date____/____/____ Print Name: _____

Relationship to child: _____ * For very young children, the child's signature is not necessary

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (OR YOUR MINOR CHILD, IF YOUR CHILD IS THE PATIENT) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.
(Monarch Behavioral Health, PLLC, effective as of 10/12/17).

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 calling our front 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.

The following are examples of the types of uses and disclosures of your protected health information that your psychologist's office is permitted to make. Use and disclosure of your information may occur outside of these examples, as this list is not exhaustive.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your care with another provider. For example, we would disclose your protected health information, as necessary, to a primary care physician who provides care or treats you. 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.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support, evaluate and refine the business activities of Monarch Behavioral Health, PLLC. These activities include, but are not limited to, review of treatment procedures, quality assessment activities, employee review activities, staff training, training of medical or doctoral students, compliance and 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.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Consent
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.
- **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.

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 clinician 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 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. 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 record that contains medical/mental health and billing records and any other records that your clinician and the practice uses for making decisions about you, your care, and billing. 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 prohibit under law.

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 director and/or 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. Restriction in disclosure of your protected health information for purposes of payment/billing does not relieve client or guarantor from payment responsibility.

Your clinician is not required to agree to a restriction that you may request. If your clinician 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 clinician.

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 Director or Privacy Officer.

You may have the right to have your clinician/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 Director or 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 9/15/17. 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.

3. 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 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 directly 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 Director or 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.

MONARCH
BEHAVIORAL HEALTH, PLLC

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

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____/_____/_____

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

Patient Signature: _____ Date ____/____/____ Print Name:_____

Parent/Guardian Signature:_____ Date____/____/____ Print Name: _____

Relationship to child: _____

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ELECTRONIC CORRESPONDENCE AGREEMENT

In order to maintain clarity regarding our use of electronic modes of communication, Monarch Behavioral Health PLLC has prepared the following policy. For many individuals, the use of various types of electronic communications is the preferred method of communication. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of our profession. Consequently, this policy has been prepared to assure the security and confidentiality of your personal information and to assure that it is consistent with ethics and the law.

Email Communications: Clinicians at Monarch Behavioral Health, PLLC use email communication only with your permission and only for administrative purposes, unless we have made another agreement. Email exchanges with our office will be limited to setting and changing appointments, billing matters, and other service related issues.

CONFIDENTIALITY NOTICE
Although we take all precautions and use a HIPPA complaint email server, email is never a fully secure means of communication. If you need to discuss a clinical matter with your clinician, please schedule an appointment, call your clinician to discuss the matter, or if possible, wait so that it can be discuss it during your next appointment.

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.

Clinicians at Monarch Behavioral Health, PLLC do not communicate via text message, social media sites, or website.

Patient Name: _____
Parent/Guardian Name(s) (if applicable):_____
E-Mail Address:_____
Additional E-Mail Addresses: _____

Circle to indicate permission:

Yes No	Permission to communicate via e-mail
Yes No	Permission to email clinical documentation containing confidential personal patient information as an attachment to an email.
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.

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

Relationship of Personal Representative to the Patient: _____

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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 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, Pediatrician, 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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Communication with 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.

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

MONARCH
BEHAVIORAL HEALTH, PLLC

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)