NORTHBROOK PSYCHOLOGICAL CLINIC

CONSENT TO TREATMENT AND CLINICAL SERVICES &
HEATH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Client _____ Date of Birth _____

I give my permission to Northbrook Psychological Clinic (NPC) to provide mental health, counseling, psychiatric and educational services and any testing/treatment related to those services to me or my dependent.

I understand that the services received at NPC are based on currently accepted practice in the fields of mental health or substance abuse. I also understand that the outcome of treatment cannot be guaranteed and that the services continue with my voluntary consent.

If my dependent or I threaten to harm either myself or someone else, I understand that the law obligates NPC to take whatever action is necessary to protect people from harm. This may include divulging confidential information to others. Such action would be taken when someone's life appears to be in danger.

I understand if my dependent or I have been ordered by the court to seek treatment or diagnostic services, the court will require one or more reports. My written consent to release information will be requested.

I understand if my dependant or I have been involved in litigation of any kind and the court is informed of mental health/substance abuse treatment, I may be waiving the right to keep records confidential. I further understand I may want to consult with my attorney before disclosing to a court that my dependent or I are receiving treatment or diagnostic services.

I understand it may be necessary to reach me by mail, email or telephone during or after my or my or my dependant's treatment for the purpose of scheduling or confirming appointments, billing or payment issues, completion of forms, conducting surveys or any necessary follow-up. I also understand that to communicate via email or text message I will provide consent, recognizing that email or text message is not a secure form of communication. There is some risk that any protected health information that may be contained in such email or text message may be disclosed to, or intercepted by unauthorized third parties.

I understand that the State of Michigan and Federal laws and regulations do not protect any information about suspected child and/or elder abuse or neglect from being reported to the appropriate state or local authorities.

I am voluntarily authorizing diagnostic and/or treatment services for my dependent or myself. I may refuse any aspect of treatment, understanding that such a refusal could, in some instances, result in termination of treatment and/or services.

I acknowledge that NPC's Notice of Privacy Practices is available upon request at anytime.

__ I authorize NPC to communicate with me via text message
__ I authorize NPC to communicate with me via email at this address _____

By signing below, I agree to comply with the policies and procedures of NPC.

X_____ X_____
(Client/Parent/Guardian Signature) (Date) (Witness) (Date)

NORTHBROOK PSYCHOLOGICAL CLINIC
FINANCIAL AGREEMENT

Name: _____ DOB: _____

We urge you to contact your insurance company to verify your specific insurance benefits.

If we are billing insurance for your visit, we must have complete information at the time of this visit. If you cannot provide the information, we will be unable to bill your insurance, and payment in full will be required.

Your charges for our services cannot be determined until the claim is submitted to your insurance company. Prior to receiving an Explanation of Benefits from your insurance company, we will do our best to estimate your plan deductible, co-pay and/or coinsurance. All payments are due at the time of service.

We will provide you with any necessary documentation to file for reimbursement upon your request.

For any balance left unpaid or not responded to, Northbrook Clinic reserves the right to use an outside collection agency as a means of collecting funds. A fee will be charged to cover this service.

I understand it is my responsibility to keep arranged appointment times or to notify of a need to cancel at least 48 hours prior to the appointment to avoid a missed appointment fee being charged. This fee is due at the next appointment and cannot be billed to your insurance company.

My initials below indicate:

_____ I will contact my insurance company to verify my benefits.

_____ I give Northbrook Clinic permission to bill my insurance company.

_____ I understand payment in full is due at time of service.

_____ I understand bills are not sent to current clients.

_____ I understand I am responsible for all charges not covered by my insurance.

_____ I understand I will be charged $30 for any returned check.

X_____ X_____

Client/Parent/Guardian Date Witness Date

NORTHBROOK PSYCHOLOGICAL CLINIC
23965 Novi Rd Suite 110 Novi, MI 48375
Phone: (248) 344-7420 Fax: (248) 344-7423

Primary Care Physician Notification Form

THIS IS **NOT** A REQUEST FOR MEDICAL RECORDS

TO THE PATIENT:

☐ I **DO NOT** wish Northbrook Psychological Clinic to notify my primary care/family doctor that I am receiving services.

☐ I **DO** wish Northbrook Psychological Clinic to notify my primary care/family doctor that I am receiving services. Please provide the complete name and address of your Primary Care Physician.

Primary Care Physician: _____ Phone: ( ) _____

Clinic Name (if any): _____ Fax: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Please read and complete the following:

I, _____ DOB _____ hereby authorize Northbrook Psychological Clinic to exchange information regarding my mental health and/or substance abuse treatment and medical healthcare for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the behavioral health care provider indicated herein. I also understand that it is my responsibility to notify my behavioral health care provider if I change my primary care physician.

X_____ X_____

Signature Patient/Parent/Guardian Date Witness Signature Date

ATTENTION PRIMARY CARE PHYSICIAN:

Your patient is a client at Northbrook Psychological Clinic. With patient authorization, we are providing diagnoses and the therapist's contact information. Please retain for your records.

Patient Name: _____

ICD-10 Diagnoses (Including Codes): _____

_____

Therapist Name & Credentials: _____

NOTICE:

Due to constant changes in insurance policies, it is no longer an easy job to interpret each individual insurance policy. Although we try to stay aware to changes to your insurance, *it is not always possible*.

It is your responsibility to know your individual coverage!

All insurance policies have exclusions and most have deductibles and co-payments.

Please remember that your insurance policy is between you and your insurance company, NOT between your insurance company and your therapist/our clinic.

Northbrook Psychological Clinic does not assume responsibility for inaccurate information provided to us by insurance companies.

Name: _____DOB: _____

Signature Date

Witness Date