

## Child and Adolescent Self-Report Questionnaire

Today's Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

Clinician's Name: \_\_\_\_\_

**Instructions:** Read each statement carefully. Circle the number that best describes how true the statement has been **during the past 7 days**. Check only one answer for each statement.

**Instructions for Parents/Guardians:** If your child is under 12, the parent or other responsible adult is asked to complete this questionnaire. In this case, respond to the statements as if each began with "My child..." or "My child's..." rather than "My..." or "I..." It is important that you answer as accurately as possible based on your own observation and knowledge.

**Person Completing Form:**     Adolescent     Parent/Guardian     Other \_\_\_\_\_

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I have headaches or feel dizzy.....	0	1	2	3	4
2. I don't participate in activities that used to be fun.....	0	1	2	3	4
3. I argue or speak rudely to others.....	0	1	2	3	4
4. I have a hard time finishing my assignments or do them carelessly.....	0	1	2	3	4
5. My emotions are strong and change quickly.....	0	1	2	3	4
6. I have physical fights (hitting, biting, or scratching) with family or others my age.....	0	1	2	3	4
7. I worry and can't get thoughts out of my mind.....	0	1	2	3	4
8. I steal or lie.....	0	1	2	3	4
9. I have a hard time sitting still (or I have too much energy).....	0	1	2	3	4
10. I use alcohol or drugs.....	0	1	2	3	4
11. I am tense and easily startled (jumpy).....	0	1	2	3	4
12. I am sad or unhappy.....	0	1	2	3	4
13. I have a hard time trusting family members or other adults.....	0	1	2	3	4
14. I think that others are trying to hurt me even though they are not.....	0	1	2	3	4
15. I have threatened to, or have, run away from home.....	0	1	2	3	4
16. I physically fight with adults.....	0	1	2	3	4
17. My stomach hurts or I feel sick more than others my age.....	0	1	2	3	4
18. I don't have friends or I don't keep friends very long.....	0	1	2	3	4
19. I think about suicide or feel I would be better off dead.....	0	1	2	3	4
20. I have nightmares, trouble getting to sleep, oversleeping, or waking too early.....	0	1	2	3	4
21. I complain about or question rules, expectations, or responsibilities.....	0	1	2	3	4
22. I break rules, laws, or don't meet others expectations on purpose.....	0	1	2	3	4
23. I feel irritated.....	0	1	2	3	4
24. I get angry enough to threaten others.....	0	1	2	3	4
25. I get in trouble when I am bored.....	0	1	2	3	4
26. I destroy property on purpose.....	0	1	2	3	4
27. I have a hard time concentrating, thinking clearly, or staying on task.....	0	1	2	3	4
28. I withdraw from my family and friends.....	0	1	2	3	4
29. I act without thinking and don't worry about what will happen.....	0	1	2	3	4
30. I feel that I don't have any friends or that no one likes me.....	0	1	2	3	4

Staff Use:

Check One

Intake Assessment

Quarterly Assessment

Discharge Assessment

# Abaris Behavioral Health

## Child and Adolescent Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive understanding of your (your child's) life experience and background. Responding to these questions as completely as you can will benefit you (your child) through the development of a treatment program suited to your (your child's) specific needs. Please return this form when completed, or at your (your child's) scheduled appointment.

Date: \_\_\_\_\_

Person completing form: \_\_\_\_\_

Relationship to child or adolescent: \_\_\_\_\_

How did you find Abaris Behavioral health? \_\_\_\_\_

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-mail: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

### Primary Insurance

Name of Subscriber: \_\_\_\_\_

Relationship: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Contract Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

### Secondary Insurance

Name of Subscriber: \_\_\_\_\_

Relationship: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Contract Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Please describe the problem that brings you here:

---

---

---

---

When did your problem begin?

---

---

Please rate the severity of your problem on the scale below:

Low    0    1    2    3    4    5    6    7    8    9    10    High

What are your current goals for treatment?

---

---

**General Information**

How long have you lived at your current address? \_\_\_\_\_

Is this residence owned by your family? Yes \_\_\_ No \_\_\_

Of what race do you consider yourself? \_\_\_\_\_

Do you have a religious preference? Yes \_\_\_ No \_\_\_ Religion: \_\_\_\_\_

If no, did you have a religious preference in the past? Yes \_\_\_ No \_\_\_ Religion: \_\_\_\_\_

**Medical History**

What is your height? \_\_\_\_\_ feet \_\_\_\_\_ inches What is your weight? \_\_\_\_\_ pounds

How many times have you been hospitalized for a medical problem in your life? \_\_\_\_\_

Date	Length of Stay	Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any medical problems when you were younger? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Do you have any current medical problems? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Are you taking any prescribed medication for a physical problem? Yes \_\_\_ No \_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_

Are your immunizations complete and up to date? Yes \_\_\_ No \_\_\_

If no, explain: \_\_\_\_\_

Circle any of the following health problems that you **have now** or have **had in the past**:

	Age		Age		Age
high fevers	_____	flu	_____	pneumonia	_____
weight problems	_____	dental problems	_____	allergies	_____
encephalitis	_____	skin problems	_____	meningitis	_____
asthma	_____	convulsions	_____	headaches	_____
unconsciousness	_____	anemia	_____	concussions	_____
accident prone	_____	stomach problems	_____	head injury	_____
fainting	_____	high/low blood pressure	_____	dizziness	_____
sinus problems	_____	tonsils removed	_____	heart problems	_____
earaches	_____	hyperactivity	_____	diabetes	_____
hearing problems	_____	speech problems	_____	vision problems	_____

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental History**

Did your mother use alcohol and/or drugs during pregnancy? Yes \_\_\_ No \_\_\_ Unknown \_\_\_

Did your mother use tobacco products during pregnancy? Yes \_\_\_ No \_\_\_ Unknown \_\_\_

Did your mother have any problems during pregnancy? Yes \_\_\_ No \_\_\_ Unknown \_\_\_

If yes, explain: \_\_\_\_\_

Did your mother have any problems during labor and/or delivery? Yes \_\_\_ No \_\_\_ Unknown \_\_\_

If yes, explain: \_\_\_\_\_

Did you have any problems immediately after birth? Yes \_\_\_ No \_\_\_ Unknown \_\_\_

If yes, explain: \_\_\_\_\_

### Early Social Development

How was your relationship with brothers, sisters or other children? \_\_\_\_\_

Describe special interests, habits and/or fears: \_\_\_\_\_

### Educational History

What is the highest grade you've completed in school? \_\_\_\_\_

Name of School	City and State	Dates Attended	Highest Grade Completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Type of classes:

Regular \_\_\_ Learning Disability \_\_\_ Emotionally Handicapped \_\_\_  
Continuation \_\_\_ Opportunity \_\_\_ Other: \_\_\_\_\_

Did you skip a grade? Yes \_\_\_ No \_\_\_ Did you repeat a grade? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you ever had any specific learning difficulties? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you ever had a tutor or other special help with schoolwork? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Do you attend school on a regular basis? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Do you enjoy school? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you ever been expelled or suspended? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

What was the highest grade on your last report card? \_\_\_\_\_

What was the lowest grade on your last report card? \_\_\_\_\_

What is your favorite subject? \_\_\_\_\_

What is your least favorite subject? \_\_\_\_\_

Do you participate in after school activities? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

How many friends do you have at school? \_\_\_\_\_

Have you ever had any special testing in school? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

**Employment History**

Have you ever been employed? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

What has been your usual employment pattern in the past 3 years?

Full-time (35+ hours per week) \_\_\_ Part-time (less than 35 hours per week) \_\_\_

Only occasional work \_\_\_ Not working \_\_\_

**Alcohol and Drug Use History**

How often have you used any of the following substances?

	Current Use (Number of days in past month)	Past Use (Number of days in average month)
Alcohol	_____	_____
Amphetamines	_____	_____
Barbiturates	_____	_____
Cocaine	_____	_____
Hallucinogens	_____	_____
Heroin	_____	_____
Inhalants	_____	_____
Marijuana	_____	_____
Sedatives	_____	_____
Tobacco	_____	_____
Other: _____	_____	_____

How many times have you been treated for alcohol problems? \_\_\_\_\_

Date	Length of Treatment	Length of Abstinence from Alcohol
_____	_____	_____
_____	_____	_____

How many times have you been treated for drug problems? \_\_\_\_\_

Date	Length of Treatment	Length of Abstinence from Drugs
_____	_____	_____
_____	_____	_____

**Legal History**

Was this treatment prompted or suggested by the criminal justice system? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you ever been in trouble with the police? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you ever appeared in juvenile court? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you ever been on probation? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Are you presently awaiting charges, trial or sentencing? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

**Family History**

Marital Status of Parents

Married \_\_\_ (How long? \_\_\_\_\_) Separated \_\_\_ Divorced \_\_\_ Never Married \_\_\_

Living Together \_\_\_ (How long? \_\_\_\_\_) Deceased \_\_\_ (Mother or Father? How long ago? \_\_\_\_\_)

Were you adopted? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Family Members

Name	Relationship	Age	Quality of Relationship	Living with you?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever lived away from your family? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

With whom do you spend most of your free time?

Family \_\_\_ Friends \_\_\_ Alone \_\_\_ Other: \_\_\_\_\_

How many close friends do you have? \_\_\_\_\_

What do you like to do in your free time?

\_\_\_\_\_  
\_\_\_\_\_

Has anyone ever abused you emotionally? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Has anyone ever abused you physically? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Has anyone ever sexually abused you? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you had any serious conflicts with family members in the past 30 days? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Have you had any serious conflicts with family members at other times in the past? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

**Mental Health History**

How many times have you been hospitalized for a mental health problem? \_\_\_\_\_

Date	Length of Stay	Reason for Hospitalization
_____	_____	_____
_____	_____	_____

How many times have you been treated for a mental health problem in an outpatient setting? \_\_\_\_\_

Date	Length of Treatment	Reason for Treatment
_____	_____	_____
_____	_____	_____

Have you ever had a significant period of time in which you have experienced:

Serious depression? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Serious anxiety? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Hallucinations (saw something that other people didn't see)? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Trouble understanding, concentrating or remembering? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Trouble controlling violent behavior? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Serious thoughts of suicide? Yes \_\_\_ No \_\_\_

If yes, explain: \_\_\_\_\_

Are you currently taking any medications for a mental health problem? Yes \_\_\_ No \_\_\_

If yes, list medications: \_\_\_\_\_

In the past, have you taken any medications for a mental health problem? Yes \_\_\_ No \_\_\_

If yes, list medications: \_\_\_\_\_

Circle any of the following words or terms that apply to you:

- |             |             |               |                 |                           |
|-------------|-------------|---------------|-----------------|---------------------------|
| worthless   | useless     | a “nobody”    | “life is empty” | “can’t do anything right” |
| inadequate  | stupid      | incompetent   | naïve           | morally wrong             |
| guilty      | evil        | hostile       | full of hate    | horrible thoughts         |
| anxious     | agitated    | cowardly      | unassertive     | panicky                   |
| aggressive  | ugly        | unattractive  | repulsive       | depressed                 |
| lonely      | unloved     | misunderstood | bored           | restless                  |
| confused    | unconfident | in conflict   | full of regrets | worthwhile                |
| sympathetic | intelligent | attractive    | confident       | considerate               |

Other: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Abaris Behavioral Health

## Practice Orientation and Service Agreement

### Your Rights and Responsibilities as a Client:

- You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- You have the right to privacy and confidentiality regarding the services you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.
- You have the responsibility to provide informed consent to services offered to you.
- You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. If you should decide to withdraw your consent for services, you must do so in writing.
- You have a right to information concerning your treatment and/or care.
- You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.
- You have the responsibility to assist in planning your treatment at every stage.
- You have the right to express any concerns or complaints regarding the services you receive. We encourage you to first contact your clinician to resolve any issues. You may also contact the Rights Advisor for assistance.
- You have the responsibility to be timely for your appointments. Late arrivals *may* result in rescheduled appointments.
- You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. You *may* be charged a practice fee, up to \$125, for non-cancelled appointments where an emergency was not involved, as insurance companies and other third-party payers do not cover missed appointments.
- You are responsible for checking your insurance plan benefits, including any deductibles and/or co-pays. As a courtesy, we may check eligibility and benefits for you.
- You are responsible for any fees that may be charged to you at the time of service and knowing your insurance benefits coverage. You will be charged \$25 for any returned checks.
- Your case will be closed following 90 days of inactivity, unless other arrangements have been made.

### Services Offered

Abaris Behavioral Health offers an array of mental health and substance abuse services. These services include: individual psychotherapy, group therapy, family therapy, marital therapy, psychological testing, case management, psychiatric evaluations and medication therapy. Your clinician will provide you with a detailed description of the nature of services, expected benefits and potential risks. More information is available on our website at [www.AbarisHealth.com](http://www.AbarisHealth.com).

### Client Input

Abaris Behavioral Health will be asking you for ongoing feedback regarding the quality and effectiveness of services you receive. We will periodically ask you to complete clinical outcome questionnaires and satisfaction surveys. We will also review and/or investigate any complaints or suggestions you may have. Your feedback is considered an important part of your treatment and/or care.

### Operations

Office hours are usually between 7:00 am and 10:00 pm, 7 days a week. Not all clinicians are available during all open hours. Appointment dates and times, and after-hours contact, will be arranged between you and your treating clinician. In the case of an emergency, you can contact the nearest crisis center (Oakland County Crisis Center at 248-456-0909; Macomb County Crisis Center at 586-307-9100). You may also contact the nearest emergency room. We practice in a non-smoking environment. Illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

# Abaris Behavioral Health

## Confidentiality

Federal and State laws protect the privacy of communications between a client and a clinician. In most situations, information about your treatment can only be released to others if you sign a written Authorization for Release of Information. That authorization must meet certain legal requirements. However, there are some limits to confidentiality. Information about privacy and limits to confidentiality will be provided by your primary clinician and are also provided in our Notice of Privacy Practices.

## Financial Responsibility

You are expected to pay for service at the time it is rendered, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. A fee adjustment or a payment installment plan may be negotiated in circumstances of unusual financial hardship. All clients will be informed of payment fee schedules prior to rendering services. Although we are likely to inform you of your insurance deductible and co-pays, you are ultimately responsible for knowing this information and for paying both in full.

If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, legal action may be used to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his or her name, the nature of services provided, and total amount due. If such legal action is necessary, its cost will be included in the claim.

## Minors and Parents

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that clients over age 14 can consent to (and control access to information about) their own mental health treatment, although that treatment cannot extend beyond 12 sessions or 4 months. While privacy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is Abaris Behavioral Health policy to request (but not require) an agreement from any client between ages 14 and 18 and his/her parents allowing clinicians to share general information with parents about attendance at scheduled sessions and progress in treatment.

## Consent for Services

My initials below indicate that I:

- \_\_\_\_\_ have been made aware of my rights and responsibilities and how to file a grievance or complaint.
- \_\_\_\_\_ have been informed of the name, discipline, and credentials of my primary clinician.
- \_\_\_\_\_ have been informed of practice-specific information and given an orientation to services including fees.
- \_\_\_\_\_ have been informed of privacy practices, confidentiality, and limits to confidentiality.

My signature below indicates that I consent to receive services at Abaris Behavioral Health, and that I understand I may discuss any questions I have regarding services and that I maintain the option to terminate my consent at any time.

---

**Client Signature**

**Date**

---

**Parent/Guardian Signature**

**Date**

---

**Abaris Behavioral Health  
Staff Signature**

**Date**

## Abaris Behavioral Health

### **When you are in treatment, what your doctors need to know.....**

When you, or your family member, need to see more than one type of healthcare professional, your care can become more complex. This is true whether you see more than one doctor or a therapist.

You may ask:

- Why is it anybody's business when I go to therapy or see a psychiatrist?
- Why do my doctors need to know about my personal problems?

The answer to these questions should be discussed with your doctor or therapist. However, it is very important for doctors and therapists to communicate at these times.

- **When you start therapy.** Sometimes problems can be caused by medical conditions. For instance, depression and anxiety is sometimes linked to certain medical problems.
- **When you start or change medications.** Your doctors can help make sure that the medicines you take can be safely used together.
- **Changes in health status.** If your health changes, your doctors need to know to see if you need to have any tests or changes to your medicines

Also, to ensure quality care, many insurance companies request that therapists, at Abaris Behavioral Health, notify patients' primary care/family doctor when services begin. We must have your written permission to comply with this insurance company request. Please complete the Primary Care Physician Notification Form on the next page so we know if you wish to authorize us, or not authorize us, to notify your primary care/family doctor that you are receiving services at Abaris Behavioral Health.

# Primary Care Physician Notification Form

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

**Attention Primary Care Physician:** Your patient is being seen at Abaris Behavioral Health. With patient authorization, we herein provide diagnoses and medications, including medication changes. Please retain for your records.

Patient Name: \_\_\_\_\_

DSM-IV Diagnoses (Including Codes): \_\_\_\_\_

Treatment Information, including medications: \_\_\_\_\_

\_\_\_\_\_  
Therapist/Psychiatrist Signature

\_\_\_\_\_  
Print Therapist/Psychiatrist Name and Credentials

### **TO THE PATIENT:**

If you **do** wish us to notify your primary care/family doctor that you are 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, (print name here) \_\_\_\_\_ DOB: \_\_\_\_\_ hereby **authorize** Abaris Behavioral Health to exchange information regarding my mental health and/or substance abuse treatment and medical health care 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 by behavioral health care provider if I choose to change my primary care physician.

If you **do not** wish to authorize us to notify your primary care/family doctor, please complete the section below:

\_\_\_\_ I don't have a primary care/family doctor.

\_\_\_\_ I don't want my primary care/family doctor to know I'm receiving services.

\_\_\_\_ I just don't want to.

\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (or Parent/Guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

# Abaris Behavioral Health Notice of Privacy Practices

Effective 4/14/03

**This notice describes how health information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.**

Our staff uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our organization.

## **We May Use or Disclose Your Health Information for:**

**Treatment.** We may use your health information to provide you with mental health treatment or services. For example, information obtained by a mental health provider, such as a psychiatrist, psychologist, social worker, or other person providing mental health services to you, will record information in your record that is related to your treatment. This information is necessary for mental health providers to determine what treatment you should receive. Mental health providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

**Payment.** We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you of a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment or service.

**Health Care Operations.** We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the clinical staff, risk or quality improvement personnel, and other to:

- evaluate the performance of staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the mental health care we provide.

**Appointments.** We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Fund Raising.** We use your information to contact you to raise funds for our organization.

**Required by Law.** We may use and disclose information about you as required by law. For example, we may disclose information for the purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victim of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

**Public Health.** Your health information may be used or disclosed for public health authorities or other legal authorities to prevent or control disease, injury, or disability or for other health oversight activities.

**Decedents.** Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

**Organ/Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation.

**Research.** We may review your mental health information to determine if your protected health information is needed for research projects. To the extent that information is needed, an institutional review board or privacy board will review the research proposal and established protocols to ensure the privacy of your health information.

**Health and Safety.** Your health information may be disclosed to avert a serious threat to the health and safety of you or any other person pursuant to applicable law.

**Government Functions.** Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed forces.

**Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

**Other Uses.** Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent we have relied on it.

## **Your Health Information Rights**

You have the right to:

- request restriction on certain uses and disclosures of your information as provided; however, we are not required to agree to a requested restriction;
- to obtain a paper copy of this notice of Privacy Practices upon request;
- inspect, and obtain a copy of your health record as provided by law;
- request communications of your health information by alternative means or at alternative locations;
- revoke your authorization to use or disclose health information except to the extent we have already taken action based upon your authorization; and
- receive an accounting of disclosures made of your health information.

If you have any questions or complaints, please contact the Privacy Official at 248-650-8383. You may also complain to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be made available to you at our offices, and via mail.

## ABARIS BEHAVIORAL HEALTH

### Fee Schedule for Supplemental Clinical Services

**Effective: 5/16/2010**

It is my sincere goal to provide the best clinical care and professional outpatient psychotherapy services to my clients. This fee schedule is meant to allow the clinician to deliver professional clinical services in the most effective and clinically appropriate manner possible. These are charges for additional clinical services that insurance companies and other third party payers do not cover and if provided/requested these charges are billed directly to the client.

1. Phone calls:

- Phone calls lasting under 15 minutes are considered part of ongoing clinical care and gladly answered and returned by the clinician as soon as possible without charge.
- Phone calls lasting 15 minutes or longer: The clinician will encourage client to schedule an appointment to discuss matter in the context of a scheduled face-to-face session.
- Phone calls between 20 – 30 minutes are subject to a flat fee of \$60.
- Phone calls exceeding 30 minutes are subject to fee of \$60 for the first 30 minutes, and \$5 a minute for each additional minute.
- These rates apply for phone conversations with clients as well as with approved (authorization/release form signed) 3<sup>rd</sup> party contacts such as school teachers, lawyers, primary care physicians, psychiatrists, etc...).

\*While the clinician makes every effort to address issues of clinical concern over the phone on in a concise and time-sensitive manner, phone calls between the client and the clinician lasting longer than 15 minutes suggest the need for a face-to-face session to address issues of such depth and/or intensity. Phone calls with 3<sup>rd</sup> party contacts are at times needed and/or requested to address important coordination of care concerns and the clinician will gladly participate in them. However, if these phone calls exceed 15 minutes, these calls impact the clinician's ability to provide face-to-face sessions for clients, and as such, compensation for time spent engaging in these calls is warranted. The above rates are comparable to current standard insurance rates for face-to-face session. Having a face-to-face session to discuss issues and work towards solutions is often much more therapeutic and overall effective for the client.

2. Emails:

- Emails to inform the clinician of updates and or other information are welcomed. Every effort will be made to return emails in a timely manner. However, clients who specifically request 2 or more email responses from the clinician in any 24 hour period will be asked to schedule a face-to-face session and will be charged \$15 for their 2nd and any additional email reply request. Having a face-to-face session to discuss issues and work towards solutions is often much more therapeutic and overall effective for the client.

3. Letters written to 3<sup>rd</sup> parties such as schools, court, lawyers, employers etc. (This does not include missing work/school letters.):

- 1<sup>st</sup> letter is written with no charge.
- 2<sup>nd</sup> and any additional letters are subject to a fee of \$35 per letter.

4. Individualized Education Plan (IEP) Meetings:

- Meetings where clinician is attending on site are subject to a fee of \$75 per hour including travel, waiting, and actual meeting time.

5. Court appearances and/or testimony:

- Any presence in court or taped disposition is subject to a fee of \$200 per hour including travel, waiting, and actual service time.

6. No Shows (Appointments not kept without any prior notification of needing to cancel or reschedule):

- Just a reminder: As stated in the "Practice Orientation and Agreement" form signed at the start of treatment, "you may be charged a practice fee, up to \$125 for non-cancelled appointments, where an emergency was not involved, as insurance companies and other third-part payers do not cover missed appointments."
- It is important to remember that appointment times are scheduled and reserved for those that they are scheduled for. Prompt notification of the need to reschedule or cancel appointments (Within 24 hours if at all

