

Psychological and Consultation Services (PCS)

Priscilla Wade, Ph.D.

Phone: 517-336-7366 Fax: 517-336-0808

Office: 4123 Okemos Road, Suite 15 Okemos, MI 48864

Mailing Address: P.O. Box 4455 East Lansing, MI 48826-4455

PATIENT'S ADDRESS AND PHONE NUMBERS			
Patient Name:	Social Security No:	DOB:	AGE:
Street Address:	City:	State:	Zip:
Home Ph. No:	Cell Ph. No:	Work Ph. No:	
Email:	Marital Status: S M W SEP D		
PATIENT'S EMPLOYER INFORMATION			
Employer:			
Employer's Street Address:			
City:	State:	Zip:	
Patient's Occupation:			
INSURANCE			
Primary Ins. Co. Name:	ID#	Group:	
Subscriber's Name:	Relationship to patient:		
Subscriber's DOB:	SS #		
Subscriber's Employer:			
Employer's Street Address:			
City:	State:	Zip:	
Secondary Ins. Co. Name:	ID#	Group:	
Subscriber's Name:	Relationship to patient:		
Subscriber's DOB: :	SS #		
Subscriber's Employer:			
Employer's Street Address:			
City:	State:	Zip:	

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Dr. Wade to apply for benefits on my behalf for covered services rendered by her, or by her order. I request payment from my insurance company be made directly to Dr. Wade or to the party who accepts assignment.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time, in writing. I have received the patient information booklet and understand the policies and procedures of the office. I certify the information I have reported, with regard to my insurance coverage, is correct.

Patient's Signature or Parent/Guardian

Date Signed

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We do not use or disclose your protected health information (PHI) for marketing purposes nor do we sell your protected health information (PHI) for marketing purposes.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, insurance auditing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

Other uses and disclosures not described in this Privacy Notice will be made only with authorization from you. You have the right to restrict certain disclosures of PHI to health plans/insurance companies if you pay out of pocket in full for the health care service. You have the right to be notified following a breach of unsecured protected health information.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect, Danger to Self and Others: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative

means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative location, you may advise us using the contact information listed on the first page of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient Consent and Acknowledgement Form for Use and Disclosure of Protected Health Information

With my consent, Psychological and Consultation Services, P.C. may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to PCS's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received a copy of the Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this consent. PCS reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by a written request.

With my consent, PCS may call me, or other persons at my home or other designated locations, in reference to any items assisting the practice in carrying out TPO, such as appointment reminders, insurance items, and information pertaining to my clinical care, such as test results. If necessary, a message may be left on my voice mail or answering machine.

With my consent, PCS may mail to my home or other designated locations any items assisting the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request PCS restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to PCS's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, PCS may decline to provide treatment to me.

Signature of Patient

Print Name of Patient

Date

OR

Parent or Representative's Signature

Signer's Relationship to Patient

Date

Psychological and Consultation Services, P.C.
Priscilla Wade, Ph.D.
Phone: 517-336-7366 Fax: 517-336-0808
Office: 4123 Okemos Road, Suite 15 Okemos, MI 48864
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Billing Responsibilities

I will accept responsibility for the co-payment, deductible, or account balances of any charges not covered by my insurance company for psychotherapy/testing, as needed. All and overdue accounts will be forwarded to an agency for collections.

I also understand all payments are to be made at the time of each session. Consistent failure to do so will result in the termination of treatment. A list of referrals will be given to you if termination results. The referrals will be consistent with your insurance policy/benefits.

Management of Insurance Claim Rejections

If your insurance rejects a claim, for whatever reason, the balance due will immediately become your responsibility. Insurance companies have a relationship with their members, but not with the doctor's office. If you feel your insurance company should have paid charges for a service rendered, you will need to contact them directly so we can resolve any billing issues in a timely manner. Payment is expected from you until the insurance company resolves the payment issues. Once we are paid by your insurance company, we will refund you appropriately.

Patient's Signature/ Parent or Representative's Signature

Date

Signer's Relationship to Patient

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CONSENT TO RELEASE INFORMATION FOR MEDICAL AUTHORIZATIONS

I understand, as a member of _____ (insurance company), my treatment will be periodically evaluated for continued payment for services. I am authorizing such disclosure.

Failure to authorize disclosure of treatment will result in unauthorized sessions by your insurance company, which could lead to higher co-payments or you are being responsible for the payment of sessions.

Therefore, I authorize Psychological and Consultation Services (PCS), 4123 Okemos Rd., Ste 15, Okemos MI 48864 to provide the above information to be used for the following purposes: payment of services by my insurance company.

Use of this consent to release information is effective from the date it was signed until the patient informs us, in writing, of any changes to this consent.

I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient's Signature/ Parent or Representative's Signature

Date

Signer's Relationship to Patient

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APPOINTMENT CANCELLATION POLICY

Thank you for choosing us to be part of your healthcare team. As our office is very busy and often has a wait-list, it is extremely important that you let us know 24 hours in advance if you are unable to keep your appointment. Therefore, I understand any cancellations I make less than 24 hours before my scheduled appointment time will be charged to my account.

Thank you for your cooperation in this matter.

Patient's Signature

Date

OR

Parent or Representative's Signature

Date

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CONSENT TO RELEASE INFORMATION

I authorize Psychological and Consultation Services (PCS), 4123 Okemos Rd., Ste 15, Okemos, MI 48864 to provide or receive only the following specific information:

PCS may leave messages on patient's phone answering machine or voice mail regarding changes of appointments and other appointment information, accounting information, and return messages left on PCS's answering machine.

Concerning _____
Patient's Name Birth date

To be used only for the following purpose(s): continuation of treatment.

The use of this consent to release information is effective from the date it was signed until the patient informs us, in writing, of any changes to this consent.

I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient's Signature Date

OR

Parent or Representative's Signature Date

Signer's Relationship to Patient

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TELEPSYCHOLOGY INFORMED CONSENT

As a patient receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. If a need for direct, face to face services arises, it is my responsibility to contact this office for a face to face appointment. I understand that an opening may not be immediately available.
3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.
4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
 - a. In emergency situations: Text messaging, Email, Phone, Video
 - b. Should service be disrupted: Text messaging, Email, Video
 - c. For other communication: Text Messaging, Email, Video
6. My psychologist may utilize alternative means of communication in the following circumstances:

When there is disruption of services during a session or by mutual agreement related to a specific situation discussed.
7. My psychologist will respond to communications and routine messages within 24 hours, and if you have not heard from your psychologist, please call the main office to speak to our front office staff.
8. It is my responsibility to maintain privacy on the patient/client end of communication. Insurance companies, those authorized by the patient/client, and those permitted by law may also have access to records or communications.
9. I will take the following precautions to ensure that my communications are directed only to my psychologist or other individuals: be sure I am in a space that protects confidentiality of session between myself and the psychologist. If someone else is in the room, I will share that information with my psychologist.
10. My communications exchanged with my psychologist will be stored in the following manner: with my medical records and on HIPAA compliant platforms.
11. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

Patient's Signature

Date

OR

Parent or Representative's Signature

Signer's Relationship to Patient

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Communication to Patients: Patient-Centered Medical Home

The patient centered medical home is a hub for the “medical neighborhood” and the broader community. It serves as the central “hub” for all health and social support services to achieve care coordination. With your help and permission, we will work with your primary care physician, specialists, hospitals, home health, long-term care, and clinical providers to assist in the coordination of your physical and emotional health.

Sparrow Care Network (SCN) is our Physician Organization, which is a clinically integrated organization developed by Sparrow and Physician leaders. SCN is transforming the way physicians deliver health care to their patients and region by focusing on improving the quality of care across the continuum while reducing the cost of care. SCN is led by physicians and includes both independent and employed physicians working together on a collaborative basis. We, as a provider member of the medical neighborhood, work with your primary care physician and specialist physicians to coordinate your care. Your primary care physician is the leader of your care, and we will work with and communicate with your team, through correspondence, fax, or by phone, as needed.

We will periodically provide you with a questionnaire/checklist to be sure you are communicating with your primary care physician and are up to date on your preventative care screenings and appropriate tests. This information will be faxed to your primary care physician to improve access to the appropriate preventive care measures.

I acknowledge the above, which clarifies Psychological and Consultation Services, PC is a member of the Patient-Care Medical Home.

Patient Signature

Date

Psychological and Consultation Services, PC
Priscilla Wade, Ph.D.

Ph: (517) 336-7366 Fax: (517) 336-0808

Office Location:
4123 Okemos Rd., Ste 15
Okemos, MI 48864

Mailing Address:
PO Box 4455
East Lansing, MI 48826-4455

Consent to Release Information

I authorize Psychological and Consultation Services to receive or provide the following specific information:

Fax, phone, and/or letter correspondence relating to treatment such as diagnosis, treatment plan, progress notes, test scores, testing reports, etc.

To: _____
Name of individual/s, office, or organization to receive information

Address City/State Zipcode

Phone Fax Other contact information

Concerning: _____ DOB: _____
Patient's Name

To be used only for the following purpose/s: Continuation of treatment.

Use of this consent to release information is effective from date signed until the patient informs PCS in writing of any medical treatment team changes. I understand this release may be revoked at any time by written notification to the organization holding the information, except after the release described above has taken place.

Patient Signature

Date Signed

OR

Parent or Representative's Signature

Date Signed

Signer's relationship to the patient

Witness