Hampton
PSYCHOLOGICAL SERVICES

Welcome to Hampton Psychological Services

Thank you for choosing me as a provider for your mental health needs. I appreciate and acknowledge the courage it takes to want to make a change, and am delighted, honored and privileged to be working with you through this journey. It is my aim to provide personalized care and assist you in making changes that you will benefit from.

Please complete the new patient forms listed below prior to your first appointment. You may email signed and completed forms to me at drhampton@hamptonps.com, mail them to Hampton Psychological Services 104 S. Adelaide St. Suite D Fenton, MI 48430, or bring them with you to your initial appointment.

- Consent Policies and Agreement
- HIPPA
- Assignment of Insurance Benefits
- Technology Assisted Counseling Consent
- Adult or Child Intake Form

Please bring your driver's license/ID and insurance card to your first appointment. Your initial appointment will last approximately 45-60 minutes and will include a diagnostic evaluation to determine your treatment needs. Subsequent therapy sessions will last approximately 60 minutes and occur weekly or every other week depending on clinical needs and availability. Treatment needs will also be evaluated on an ongoing basis and sessions will be adjusted accordingly with increased or decreased frequency.

If you plan on using your insurance benefits, I recommend that you verify your benefits by calling your insurance company. Please note that you will be billed and held responsible for any portion of the services you receive and your insurance does not cover, regardless of the reason for denial. If you have a co-payment, coinsurance, or deductible with your insurance company, please know what it is and be prepared to pay this amount at the time of your appointment.

I look forward to working with you. Should you have any questions prior to our appointment please feel free to give me a call or send me an email.

Thank you,

Rebecca Hampton, PsyD
Licensed Clinical Psychologist

Hampton Psychological Services
Tel: (810) 201-4827 Fax: (810) 626-4594
104 S. Adelaide St. Suite D
Fenton, MI, 48430

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THERAPY CONSENT, POLICIES, & AGREEMENT

PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaboratively work to identify your therapeutic goals. Treatment planning will be aimed at reducing symptoms and improving functioning as well as meeting your individual goals. Specific goals and treatment plans may be adjusted depending on circumstances and clinical issues present.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 60 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment in advanced of 24 hours of the scheduled appointment time or you will receive a $50 fee. If***

you cancel or reschedule more than three times, we may re-evaluate your needs, desires, and motivations for treatment. Each insurance panel has a different policy on whether clinicians can charge for missed appointments. Check your provider's policies regarding cancellations and/or no shows.

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

FEES: The standard fee for each initial evaluation appointment is $250 and the standard fee for each subsequent 60-minute therapy appointment is $200. If you use insurance, you are financially responsible for all charges not covered or reimbursed. Payment is due at the time of service. Acceptable forms of payment are: exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $30 for any returned check), or credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if **3** sessions are missed without proper notification.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of $300 per hour to include travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $1 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are currently 8:00 AM to 5:00 PM on Fridays and 8:00 AM to 12:00 PM on Saturdays, with the expectation to increase in the near future. If you need to contact the clinician for any reason please call (810) 201-4827, leave a voicemail, and a return call will be made as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, go to your nearest hospital emergency room or dial 911.

PART II: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health

oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.

- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when a your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if the there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about an you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
    - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.
    - **Do not use e-mail for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

PART III: HEALTH INSURANCE

YOUR INSURANCE COMPANY: By using insurance, I am required to give a mental health disorder diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

IMPORTANT: In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. Hampton Psychological Services reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

EMERGENCY CONTACT:

It is necessary that Hampton Psychological Services has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number(s)

Please check here that you agree and sign below. Thank-you.

☐ I agree to allow Hampton Psychological Services to contact my emergency contact on my behalf in the case of emergency

_____

Signature Date

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Dr. Rebecca Hampton. My signature below indicates that I am voluntarily giving my informed consent to receive psychological services and agree to abide by the agreement and policies listed in this consent. I authorize Dr. Rebecca Hampton to provide psychological services that are considered necessary and advisable.

2. I authorize the release of treatment and diagnosis information (as described in Part III, above) necessary to process bills for services to my insurance company, and request payment of benefits to Hampton Psychological Services. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, Hampton Psychological Services may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek psychological treatment or services for minor(s) in my custody and give permission to Dr. Rebecca Hampton to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to Dr. Hampton prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Printed Name of Minor Child	DOB	Date

Your signature signifies that you have read the above statements in "Therapy Agreement, Policies and Consent*" are accepting of the terms.*

_____

Client/Guardian Signature *Date*

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TECHNOLOGY ASSISTED COUNSELING
CONSENT, POLICIES, & AGREEMENT

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in technology assisted counseling sessions. Technology assisted counseling incorporates email, phone and video counseling. Prior to engaging in technology assisted counseling an assessment/consultation will be done to assure that it is an appropriate form of counseling for you as well as to inform you about what you can expect regarding your participation in technology assisted counseling.

Benefits:

The benefits to technology assisted counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients, clients with limited mobility, and clients without convenient transportation options.

Limitations:

It is important to note that there are limitations to technology assisted counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations, I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the technology assisted counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics:

When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own

confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines, I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, I will call you back immediately. Please also attempt to call me at (810) 201-4827 if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you two times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is sufficient time left in your session we will continue. If the reason for a connection loss i.e. technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

Connection Loss During Video Sessions: If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is sufficient time left in your session we will continue. If the reason for a connection loss i.e. technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via phone or plan an alternate time to complete the remaining minutes of our session.

Please list your main number and an alternate number below.

_____

Number(s)

Recording of Sessions:
Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

Payment for Services:
All professional services rendered are charged to the patient and are due at the time of service. If you use insurance, you are financially responsible for all charges including those not covered or reimbursed.

Cancellation Policy:
If you must cancel or reschedule an appointment, **24-hour advance notice is required**. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged the **$50 no show fee** for your missed appointment. If clients have more than 2 cancellations during the course of treatment/therapy the therapist and client may address the need for ongoing therapy.

Phone/video sessions should be treated as regular in office sessions. If you are late getting on the phone, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

Emergencies and Confidentiality:
I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____

Full Name Relationship Number(s)

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____

Street Address

_____

City State Zip Code

_____

City and State of Local Police Department Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433.

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in Technology Assisted Counseling Sessions:
By signing below you agree that you have read and understand all of the above sections of technology assisted counseling informed consent. You agree that you also understand the limitations associated with participating in technology assisted counseling sessions and consent to attend sessions under the terms described in this document.

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Clinician's Signature/Credentials: _____ Date: _____

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ASSIGNMENT OF BENEFITS AND BILLING AUTHORIZATION FORM

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. You agree to fill out and execute any additional necessary forms that may be required for your particular insurance carrier. In some cases the exact insurance benefits cannot be determined until the insurance company receives the claim and the claim is adjudicated.

Client Name _____ Date of Birth _____

Insurance Policy Holder Name _____

Relation to client: ☐ Self ☐ Spouse ☐ Parent

Primary Insurance _____

Secondary Insurance _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____

Primary Insurance Policy # _____ Group # _____

Secondary Insurance Policy # _____ Group # _____

Assignment of Benefits
I hereby assign all medical and mental health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other mental health/medical plan, to issue payment check(s) directly to Hampton Psychological Services for therapy services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize Hampton Psychological Services to:

1. Release any information necessary to insurance carriers regarding my therapy and sessions. I understand that my therapist may be required to release certain information to the insurance company at their request in order to procure necessary authorizations and or process claims for payment. This information may include, but is not limited to types of service, dates of service, times of service, diagnosis, treatment plans, progress of therapy

and at times, treatment notes and/or summaries. I authorize the release of such information if necessary, understanding the limits of confidentiality regarding the use of my insurance benefits. I also acknowledge receipt of Hampton Psychological Services' Notice of Privacy Practices.

2. Request payment of insurance benefits be made directly to Hampton Psychological Services for services performed.

3. If necessary, file a formal written complaint, if permitted by law, on my behalf to the state Insurance Commissioner, or other appropriate state agency, if payment for services is not timely received.

I have requested therapy services from Hampton Psychological Services on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinician Typed Name & Credentials: _____ Date: _____

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with Michigan Department of Health & Human Services. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with Michigan Department of Health & Human Services. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your

health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.

- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Michigan Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature: _____Date: _____

Printed Name: _____Date: _____

Clinician Signature: _____ Date: _____

Clinician Typed Name & Credentials: _____ Date: _____

Hampton Psychological Services
104 S. Adelaide St. Suite D. Fenton, MI, 48430
Tel: (810) 201-4827 Fax: (810) 626-4594
Email: drhampton@hamptonps.com
Website: www.hamptonps.com

BIOPSYCHOSOCIAL INTAKE ASSESSMENT & CLIENT INFORMATION
CHILD AND ADOLESCENT

Demographic Information

Name: _____ Date: _____

DOB: _____ Age: _____

Gender: _____ Race: _____ Ethnicity: _____

Address: _____

Name of parent(s)/guardian(s) who have legal custody of child:

_____

* *Address if parent/guardian lives in another residence:*

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____
Is it ok to leave a voicemail? *YES* *NO*

Email Address: _____
Is it ok to email you? *YES* *NO*

How were you introduced to us? _____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one?

1. _____
2. _____
3. _____

What do you think your child would say their biggest concern(s) is/are?

Has your child had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for (include previous diagnoses), and results.

Change is Coming…

What are your expectations from therapy and the therapist?

List concrete changes you would like to see happen during the course of therapy:

What other things would you like to see change in your life and your family's life?

Do you foresee any obstacles to achieving your goals/changes?

What are your child's strengths?

Medical Background

Has your child ever received psychiatric services before? YES NO
If yes, how long ago, with whom, for what (include previous diagnoses), and results:

Does your child have any allergies (food, environmental, medicinal, animal, etc.)

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

_____

_____

Is your child presently under a physician's care? If so, for what?

_____

_____

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

_____

_____

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

_____

_____

Tell us about your child's development milestones (delayed, on time, early)

_____

_____

Important Questions We Must Ask

Has your child ever had thoughts of killing themselves? YES NO
If yes, please explain:

_____

_____

Has your child ever planned on killing themselves? YES NO
If yes, please explain:

_____

_____

Has your child ever attempted to kill themselves? YES NO
If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain:

_____

_____

_____

Has your child ever felt like they wanted to seriously hurt or kill someone else?
If yes, please explain: YES NO

_____

_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____

_____

Is there any past or present abuse or violence? YES NO
If so, please explain:

_____

_____

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

_____

_____

Has your child ever witnessed or experienced a trauma? If so, please explain:

_____

_____

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain:

_____

_____

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put them at risk? If so, please explain?

_____

_____

Do you have any concerns about your child's sexuality, gender or sexual development?

_____

_____

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or receive specialized academic services? If so, for what?

_____

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc.)?

_____

_____

What would your child say they likes and dislike about school:
Likes: _____
Dislikes: _____

What issues or concerns do you see with your child at home?

_____

_____

What responsibilities or skills would you like to see your child have/achieve?

_____

_____

Understanding Your Family

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

If 1 or both parents are absent, if so for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

Who lives in the house with the child?

_____

_____

If parents are not together who lives in the other house with the child?

_____

_____

Are there issues within your family that negatively impact your child or ways your child negatively impacts your family? If so, please explain.

_____

_____

Name, relationship and description of relationship below:
Parent 1:

_____

Parent 2:

_____

Step-parents or parent's significant other:

_____

Siblings: Name and Age:

a. Sibling 1
   _____
b. Sibling 2
   _____
c. Sibling 3
   _____
d. Sibling 4
   _____

Other important relationships:

_____
_____

Does your family belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

_____
_____

Who else do you consider to be part of or supportive to your family (people or affiliations):

_____
_____

Is there anything else that you think is important for me to know about your child?

_____
_____
_____
_____