CENTER FOR HEALING & HAPPINESS, PC
8512 N. Canton Center Road
Canton, MI 48187

NAME: _____

# REGISTRATION INFORMATION

## PATIENT INFORMATION

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

TELEPHONE: _____ /_____ Okay to leave message: Y N
Home Cell

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: Single __ Married __ Divorced __ Widowed __ STUDENT STATUS: Full-Time __ Part-Time __

EMPLOYMENT STATUS: Full-Time ____ Part-Time ____ Retired ____ Not Employed Outside Home ____

## RESPONSIBLE PARTY INFORMATION

NAME: _____
Last First Middle Initial

ADDRESS: _____
Street City State Zip

TELEPHONE: _____ / _____ Okay to leave message: Y N
Home Cell

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____

ADDRESS: _____
Street City State Zip

## INSURANCE INFORMATION (Complete both if Primary/Secondary is part of Patient Coverage)

PRIMARY INSURANCE: _____

ADDRESS: _____

POLICY #: _____

GROUP #: _____ COVERAGE CODE: _____

SUBSCRIBER: _____

SUBSCRIBER D.O.B.: _____

SECONDARY INSURANCE: _____

ADDRESS: _____

POLICY #: _____

GROUP #: _____ COVERAGE CODE: _____

SUBSCRIBER: _____

SUBSCRIBER D.O.B.: _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE BILLING AGENT OF CENTER FOR HEALING & HAPPINESS, PC, MY INSURANCE CARRIER(S) AND/OR THEIR AGENT(S) FOR PAYMENT OR DIRECT REIMBURSEMENT LESS ANY DEDUCTABLE OR CO-PAY I MAY OWE.

_____
Patient/Parent/Guardian Signature Date

## PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY

(CIRCLE ONE) Self Partner/Spouse Child Step-Child Foster-Child Grandchild

## FOR OFFICE USE ONLY

**CLINICIAN: _____** **DX: _____**

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**PERSONAL HISTORY**
(Confidential Information)

ADDRESS: _____
Street City State Zip

TELEPHONE: _____/_____ OKAY TO CALL? Yes / No
Home Cell

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

EMERGENCY TELEPHONE: _____/_____
Home Cell

Why have you decided to enter treatment now? _____

_____

What are your goals for treatment? _____

_____

What is the source of distress in your life? _____

_____

What are your main strengths and abilities? _____

_____

What are your hobbies and special interests? _____

_____

What are your weaknesses? _____

_____

Do you spend leisure time (check all that apply): ___ Alone ___ with Family ___ with Friends/Peers

At times do you isolate yourself from others? Yes / No

**EDUCATION**

Highest grade completed: _____ Are you currently in school? Yes / No

If so, where? _____ Major: _____

Are you satisfied with your current level of education? Yes / No Please explain: _____

_____

**EMPLOYMENT**

Are you employed: _____ Full-Time _____ Part-Time _____ Unemployed _____ Retired

Employer: _____

Are you satisfied with your current position? Yes / No Please explain: _____

_____

Are you experiencing any financial difficulties? Yes / No Please explain: _____

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**RESIDENTIAL SITUATION**

Do you live with: _____ Parents _____Significant Other _____ Spouse _____ Alone _____ Other: _____

**SOCIAL INFORMATION**

Religion: ___ Catholic ___ Protestant ___ Jewish ___ Hindu ___ Muslim ___ Other: _____

Were you raised in a home that practiced the above religion? Yes / No

How important are your religious, spiritual, or faith-based beliefs? _____

**MILITARY SERVICE**

Have you ever served in the armed forces? Yes / No If so, which branch? _____

Do you have combat experience? Yes / No

**LEGAL HISTORY**

Have you ever been arrested? Yes / No If so, please explain: _____

Are you currently facing any charges? Yes / No If so, please explain: _____

Are you currently on probation or parole? Yes / No If so, what court and for what reason? _____

_____

## FAMILY HISTORY

MARITAL STATUS: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

IF MARRIED: 1st Marriage _____

Age Date # of Children If divorced, provide date

2nd Marriage _____

Age Date # of Children If divorced, provide date

How would you describe your relationship with your significant other? _____

_____

What difficulties have you experienced in your present or past relationships? _____

_____

Have you ever experienced any violence in your relationships (sexual, physical, verbal, or emotional)? Yes / No
If so, please describe: _____

_____

_____

_____

_____

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NAME: _____
DATE OF BIRTH: _____

| FAMILY MEMBER | NAME | AGE | EDUCATIONAL LEVEL | DOES THIS PERSON LIVE WITH YOU? |
|---|---|---|---|---|
| Spouse/ Significant Other | | | | |
| Children | | | | |
| | | | | |
| | | | | |
| | | | | |
| Mother | | | | |
| Father | | | | |
| Siblings/Others | | | | |
| | | | | |
| | | | | |

BIOLOGICAL PARENTS WERE: _____ Married _____ Unmarried _____ Separated _____ Divorced _____ Unknown

If parents were divorced, how old were you? _____ Describe how the divorce affected you: _____

_____

How would you describe your relationship with your extended family? _____

_____

If adopted, when were you told? _____

Please indicate (circle) if there is a family history with any of the following:

Substance Abuse Yes / No If yes, who?_____
Mental Illness Yes / No If yes, who?_____
Depression Yes / No If yes, who?_____
Anxiety Yes / No If yes, who?_____
Suicide Yes / No If yes, who?_____
Developmental Disability Yes / No If yes, who?_____
Autism Yes / No If yes, who?_____
ADHD Yes / No If yes, who?_____

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## PHYSICAL/MEDICAL HISTORY

PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

TELEPHONE/FAX: _____

Last visit to your physician: _____ Reason for last visit: _____

Describe your current general health: ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___ Very Poor

Are you in any physical pain at this time? Yes / No If yes, please explain: _____

_____

Have you gained or lost weight in the last 30-60 days? Yes / No If yes, how much and why?_____

_____

Do you have any diet or nutritional concerns? Yes / No If yes, please explain: _____

_____

Have you ever binged (excessive or uncontrolled indulgence in food) or purged (self-induced vomiting, use of laxatives)? Yes / No
If yes, please indicate duration and frequency: _____

Do you have any illnesses or medical problems? Yes / No
If yes, please explain: _____

_____

Medical/surgical hospitalization history: _____

_____

| CURRENT PRESCRIPTION MEDICATION, OVER-THE- COUNTER MEDICATIONS, HERBAL, AND NATURAL REMEDIES | DOSAGE | FREQUENCY | REASON FOR USE | PHYSICIAN |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are you allergic to any medication(s)? Yes / No If so, which one(s)? _____

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**PLEASE CHECK SYMPTOMS THAT APPLY TO YOU**

**CONSTITUTIONAL SYMPTOMS**

___Recent weight change

___Fever

___Fatigue

**EARS/NOSE/MOUTH/THROAT**

___Nose Bleeds

___Bleeding gums

___Swollen glands in neck

**EYES**

___Eye disease/injury

___Blurred or double vision

___Glaucoma

**CARDIOVASCULAR**

___ Chest pain or angina pectoris

___ Palpitations

___ Shortness of breath walking/lying flat

**RESPIRATORY**

___Chronic or frequent coughs

___Spitting up blood

___Asthma or wheezing

**GASTROINTESTINAL**

___Loss of appetite

___Nausea or vomiting

___ Painful bowel movements or constipation

___ Frequent diarrhea

___ Rectal bleeding or blood in stool

___Peptic ulcer

**GENIOURINARY**

___Frequent urination

___Blood in urine

___Kidney stones

___Incontinence or dribbling

**MUSCULOSKELETAL**

___Joint Pain

___Difficulty in walking

___Muscle pain or cramps

**INTEGUMENTARY (SKIN)**

___Varicose Veins

___Rash or itching

___Change in skin color

**NEUROLOGICAL**

___ Stroke

___ Convulsions or seizures

___ Frequent or recurring headaches

**ALLERGIES/IMMUNE**

___Itchy or runny nose

___Itchy or running eyes

___Food intolerances

**ENDOCRINE**

___Thyroid disease

___Glandular or hormone problem

___Diabetes

___Change in hat or glove size

___Heat or cold intolerance

**HEMATOLOGIC/LYMPHATIC**

___ Slow to heal after cuts

___Phlebitis

___ Past transfusion

___Bleeding or bruising tendency

___Anemia

**TRANSMITTED DISEASE**

___Hepatitis

___HIV

___Syphilis

**Patient is responsible to follow up with their Primary Care Physician or Specialist for any above positives on this page.**

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## SUBSTANCE USE AND HISTORY

| SUBSTANCE | AGE OF ONSET | AGE AT REGULAR USE | AGE OF LAST USE | AMOUNT USED IN LAST 48 HOURS | AMOUNT USED IN LAST 30 DAYS | HAS AMOUNT USED INCREASED? |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | |
| Benzodiazepines (Xanax, Klonopin, Ativan, etc.) | | | | | | |
| Cocaine/Crack | | | | | | |
| Methamphetamines | | | | | | |
| Opiates (Vicodin, Oxycontin, Heroin, etc.) | | | | | | |
| Marijuana | | | | | | |
| Hallucinogens (PCP, LSD, Mescaline, etc.) | | | | | | |
| Inhalants | | | | | | |
| Caffeine | | | | | | |
| Energy Drinks | | | | | | |
| Nicotine | | | | | | |
| Other | | | | | | |

## BEHAVIORAL HEALTH

Are you now or have you ever thought of or attempted to hurt yourself? Yes / No If so, please explain: _____

_____

Are you now or have you ever thought of or attempted to hurt someone else? Yes / No If so, please explain: _____

_____

Do you have access to firearms or other weapons? Yes / No If so, please describe: _____

### MENTAL HEALTH TREATMENT

| TREATMENT PROVIDER | PERIOD OF TIME | INPATIENT OR OUTPATIENT | REASON | WHY DID YOU STOP? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

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| PAST PSYCHIATRIC MEDICATION USED | DOSAGE | DATES OF USE | RESPONSE TO MEDICATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever attended a support group (AA, NA, Grief, etc.)? Yes / No If yes, what group and for how long? _____

_____

Have you ever experienced any: ___ Physical Abuse ___ Sexual Abuse ___ Emotional Abuse ___ Abandonment/Neglect
If yes, by whom? _____
Length/duration of abuse: _____ Age of abuse: _____

| IAPT PHOBIA SCALES | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Choose a number from the scale below to show how much you would avoid each of the situations or objects listed below. Then write the number in the box opposite the situation. | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Would not avoid it | | Slightly avoid it | | Definitely avoid it | | Markedly avoid it | | Always avoid it |
| 1. | Social situations due to fear of being embarrassed or making a fool of myself. | | | | | | | |
| 2. | Certain situations because of a fear of having a panic attack or other distressing symptoms (such as loss of bladder control, vomiting or dizziness). | | | | | | | |
| 3. | Certain situations because of a fear of particular objects or activities (such as animals, heights, seeing blood, being in confined spaces, driving or flying). | | | | | | | |

| GAD-7 | Over the past 2 weeks how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| **1.** | Feeling nervous, anxious or on edge. | **0** | **1** | **2** | **3** |
| **2.** | Not able to stop or control worrying. | **0** | **1** | **2** | **3** |
| **3.** | Worrying too much about different things. | **0** | **1** | **2** | **3** |
| **4.** | Trouble relaxing. | **0** | **1** | **2** | **3** |
| **5.** | Being so restless that it is hard to sit still. | **0** | **1** | **2** | **3** |
| **6.** | Becoming easily annoyed or irritable. | **0** | **1** | **2** | **3** |
| **7.** | Feeling afraid as if something awful might happen. | **0** | **1** | **2** | **3** |
| ***For office use only*** | ***GAD-7 total score =*** | | | | |

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DATE OF BIRTH: _____

| PHQ-9 | Over the last 2 weeks how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| 1. | Little interest or pleasure in doing things. | **0** | **1** | **2** | **3** |
| 2. | Feeling down, depressed, or hopeless. | **0** | **1** | **2** | **3** |
| 3. | Trouble falling or staying asleep, or sleeping too much. | **0** | **1** | **2** | **3** |
| 4. | Feeling tired or having little energy. | **0** | **1** | **2** | **3** |
| 5. | Poor appetite or overeating. | **0** | **1** | **2** | **3** |
| 6. | Feeling bad about yourself – or that you are a failure or have let yourself or family down. | **0** | **1** | **2** | **3** |
| 7. | Trouble concentrating on things, such as reading the newspaper or watching television. | **0** | **1** | **2** | **3** |
| 8. | Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. | **0** | **1** | **2** | **3** |
| 9. | Thoughts that you would be better off dead or of hurting yourself in some way. | **0** | **1** | **2** | **3** |
| **For office use only** | ***PHQ-9 total score =*** | | | | |

**STOP!** Please sign this document during your meeting with your psychiatrist or therapist.

---

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Signature with Credentials Date

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**PATIENT FEES AND PAYMENT AGREEMENT**

We bill usual and customary fees for standard services offered.

Additional services not covered by insurance companies:

| | | |
|---|---|---|
| Letter writing, consultation, form completion | $90.00 | (every 20 minutes) |
| Late cancel or no show fee | $60.00 | |
| Medication refills without appointment | $10.00 | |
| This in no way implies that an appointment with your psychiatrist is optional or only for emergencies. | | |
| Medical record copying | according to the State of MI rates | |
| Returned check fee | $35.00 | |

**I understand payment for services is due at the time services are rendered. Statements will not be sent for current patients, unless arrangements have been made. I understand any deductibles and co-pays are my responsibility and due at the time of service. I understand any deductible or co-pay applicable to my policy is best explained by my insurance carrier.**

**I understand there will be a charge of $35.00 for any returned checks. I also understand that the Center for Healing & Happiness, PC reserves the right to use an outside collection agency as a means of collecting an outstanding balance if my account remains unpaid or payment arrangements are not made. I understand that if my account goes to collections, I will be assessed an additional $25 or 35% collections fee, whichever is more.**

**I understand it is my responsibility to keep scheduled appointments or notify the Center for Healing & Happiness, PC staff 24 hours prior to scheduled appointment or be charged a $60.00 no show fee. This fee is due at the next appointment and cannot be billed to your insurance carrier. In the case of emergencies, your therapist or psychiatrist may grant an exception.**

**I understand that my insurance carrier will not pay for me to see a psychiatrist and a therapist on the same day. It is my responsibility to not schedule these appointments on the same day. If I do schedule to see both providers on the same day, I will be responsible to pay for one of these visits. If I choose to cancel the second visit less than 24 hours prior to the scheduled appointment, I will be charged a $60.00 late cancellation fee.**

**Fees are subject to change without notice.**

PRIVATE PAY

For patients not utilizing insurance, usual and customary fees of the Center for Healing & Happiness, PC apply unless a different rate is listed below.

Service Provided _____ $_____

**I HAVE READ, UNDERSTAND, AND AGREE WITH THE FINANCIAL CONDITIONS DESCRIBED ABOVE.**

_____ _____ _____ _____
Patient/Parent/Guardian Signature Date Witness Date

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NAME: _____

DATE OF BIRTH: _____

## CONSENT TO TREATMENT AND CLINICAL SERVICES

I understand that the treatment/services my dependent or I receive will be based on currently accepted practice in the fields of mental health and/or substance abuse treatment. I also understand that the outcome of treatment cannot be guaranteed and that services continue only with my voluntary consent.

I understand that my records or the records of my dependent are confidential. These records can be released only as allowed by law under statutes of the State of Michigan and Federal guidelines, or by my signature specifying the release of information to a specific individual or agency.

I understand if my dependent or I threaten to harm ourselves or someone else that State of Michigan statute obligates mental health professionals to take whatever action is necessary to protect people from harm. This may include divulging confidential information to others. Such action would be taken when someone's life appears to be in danger.

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

I understand if my dependent or I have been ordered by the court to seek treatment or diagnostic services, the court will require one or more reports. My written consent to release information to the court will be requested. I also understand that any report regarding my dependent or myself will not be released until my account is paid in full.

I understand it may be necessary to reach me by mail or telephone during or after me or my dependent's treatment for the purpose of scheduling or confirming appointments, billing or payment issues, completion of forms, conducting surveys, and any necessary follow-up.

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

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

I have read this consent, received a copy of Center for Healing & Happiness, PC privacy practices and agree to comply with the policies and procedures.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Date

# THE CENTER FOR HEALING & HAPPINESS, PC

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

**PLEASE REVIEW CAREFULLY**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

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**OUR RESPONSIBILITIES**

Center for Healing & Happiness, PC (hereinafter referred to as CHH) takes the privacy of your/your child's health care information seriously. 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/your child's health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect June 21, 2010, 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 effective 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.

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**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you/your child's for treatment, payment, and health care operations. For example:

**Treatment:** CHH may use health information about you/your child to provide you/your child with treatment, health care or other related services. We may disclose your/your child's health information to doctors or other providers providing treatment to you. Additionally, CHH may use or disclose the health information to manage or coordinate treatment or other related services. (Examples of how we might use and disclose health information for treatment purposes include, for a referral to a physician, for a prescription, or for transfer to another clinician.)

**Payment:** CHH may use and disclose your/your child's health information to bill and collect for the treatment and services we provide to you/your child. We may send information to an insurance company or other third party for payment purposes.

**Healthcare Operations:** CHH may use and disclose your/your child's health information in connection with our healthcare operations. These uses and disclosure are necessary to run CHH, to make sure you/your child receive competent, quality health care, and to maintain and improve the quality of health care we provide.

**As Required By Law:** CHH will disclose your/your child's health information when required to do so by federal, state, or local law.

**For Public Health Purposes:** CHH may disclose your/your child's health information for public health activities. While there may be others, public health activities generally include the following:

- Preventing or controlling disease, injury or disability;
- Reporting problems with medications;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities:** CHH may disclose your/your child's health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government benefit programs and compliance with civil rights laws.

**Judicial Purposes:** CHH may disclose your/your child's health information in response to a court or administrative order.

**Law Enforcement Purposes:** CHH may release health information if asked to do so by a law enforcement official if such disclosure is:

- Required by law;
- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim or a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Covered Entity; or
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**To Avert a Serious Threat to Health or Safety:** CHH may use and disclose your/your child's health information when CHH believes it is absolutely necessary to prevent a serious threat to your/your child's health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or lessen the threat or to law enforcement authorities in particular circumstances.

**Workers' Compensation:** CHH may disclose your health information as authorized by, and to the extent necessary to comply with, worker's compensation laws relating to similar programs.

**Consent:** Your consent may also be required in order for this office to make uses and disclosures of your/your child's health information, if required by Michigan law.

**Your Authorization:** In addition to our use of your/your child's health information for treatment, payment or health care operations, you may give us written authorization to use your/your child's 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/your child's health information for any reason except those described in this Notice.

**Persons Involved in Care:** CHH may release health information about you/your child to a family member, other relative or any other person identified by you who is involved in your/your child's health care. CHH may also give information to someone who helps pay for your/your child's care. CHH may also tell your family, friends, personal representative or other person responsible for your/your child's health care that you/your child are a patient/client at CHH. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your/your child's best interest in allowing a person to pick up medications or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your/your child's health information for marketing communications without your written consent.

**Abuse or Neglect:** CHH may disclose your/your child's health information to appropriate authorities if we reasonably believe that you/your child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We will only make this disclosure if you agree, or when required to, or when authorized by law.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
**Appointment Reminders:** We may use or disclose your/your child's health information to provide you with appointment reminders such as voicemail messages or letters. If you do not wish CHH to contact you about appointment reminders, you must notify in writing the person listed at the end of this Notice.

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**OTHER USES OF HEALTH INFORMATION**
Other uses and disclosure of health information not covered by this Notice or the laws that apply to us will be made only with your written consent. If you provide us authorization to use or disclose your/your child's health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you/your child for the reasons covered without written authorization. You understand that we are unable to take back any disclosures we have already made under the authorization, and that we are required to retain our records of the care that we provided to you/your child.

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**PATIENT RIGHTS**
**Access:** You have the right to look at or get copies of your/your child's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot do so. You must make a request in writing to obtain access to your/your child's health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. We may also charge you $.50 per page for staff time to locate and copy your/your child's health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your/your child's health information in that format. If you prefer, we will prepare a summary or an explanation of your/your child's health information for a fee.
**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your/your child's health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last six years, but not before June 2010. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
**Restriction:** You have the right to request a restriction or limitation on the health information we use to disclose about you/your child for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you/your child to someone who is involved in you/your child's care or the payment for that care. In most cases, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer.
**Alternative Communication:** Typically, we communicate with you regarding you/your child's health care either through your home phone or through the mail at your home address. You have the right to request that we communicate with you or your responsible party about you/your child's health care in an alternative way or at a certain location. To request confidential communications, you must make your request in writing to our Privacy Officer. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
**Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about you/your child's health care. To inspect and copy health information that may be used to make decisions about you/your child, you can submit your request in writing or orally to our Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, and/or supplies associated with your request.
**Right to Amend:** You have the right to ask us to amend your/your child's health and/or billing information for as long as the information is kept by CHH. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for CHH;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time.
**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/your child's privacy rights, or you disagree with a decision we have made about access to your/your child's health information, or in response to a request you made to amend or restrict the use or disclosure of your/your child's health information, or to have us communicate with you by alternative means or at alternative locations, you may file a complaint to us using the contact information listed at the end 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/your child's 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.

Privacy Officer: Jeanette Niemisto, M.D.

Telephone Number: (734) 459-1760

Address: 8512 N. Canton Center Road, Canton, MI 48187

CENTER FOR HEALING & HAPPINESS, PC
8512 N. Canton Center Road
Canton, MI 48187
(734) 459-1760 Office
(734) 459-1797 Fax

NAME: _____
DATE OF BIRTH: _____

## BEHAVIORAL HEALTH PROVIDER COMMUNICATION FORM

Patient Consent to Release/Exchange Medical Information (to be completed by patient or parent/guardian)

I, _____, _____, authorize / do not authorize the exchange of information
(Patient Name) (Date of Birth) (Circle One)

between the Center for Healing and Happiness, PC and: _____
Physician Name

_____
Physician Address City State Zip

_____
Physician Telephone Number / Physician Fax Number

To release/exchange information regarding my mental health/substance abuse treatment and including medical records for coordination of care purposes and as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care, HIV status, substance abuse care, diagnosis, treatment, psychotherapy notes, and/or treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my physician. The information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations.

Requested information: _____
_____
_____
_____
_____

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

---

Assessment/Admission Date: _____ Diagnosis:_____

Treatment Type: _____ Frequency:_____
(individual, family, group, medication) (weekly, bi-weekly, monthly)

_____ _____
Signature with Credentials Date