Ann Arbor
COUNSELING
ASSOCIATES

Ann Arbor Location
2002 Hogback Rd. Ste #17
Ann Arbor, MI 48105

Canton Location
8554 N. Canton Ctr.
Canton, MI 48187

734-956-0051
welcome@annarborcounselingservices.com

Patient Name:

Patient DOB:

AACA ID:

Thank you for reaching out to Ann Arbor Counseling Associates to help you with your mental health, wellness, or relationship goals.

It is a big step to reach out and we are so glad you did! We look forward to meeting you and getting to know more about you and what brings you in. Before we meet, please complete this packet so we can spend your first session focused on you and not on paperwork. Thank you for filling this out in advance, we will see you soon!

1. Please upload a copy of your ID here.
2. If you are using insurance, please upload a copy of any and all active insurance policies you have here.
3. IF YOU ARE A DIVORCED PARENT SEEKING TREATMENT FOR A MINOR CHILD: we must have a divorce/custody agreement on file identifying you as the parent who has sole or joint authority to make medical decisions for the minor child. Please attach that agreement here.

By signing this form, *"I attest that all the information above is true and accurate."*

Signature Date Signed

Print Name Relation to Patient

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Practice Disclosures & Consent to Receive Treatment

Patient Rights

- Attending counseling is voluntary
- You have a right to terminate counseling at any time for any reason
- You have a right to work with a counselor who suites your needs and purposes

What to Expect From Your Clinician

A professional Counselor, Psychologist, or Social Worker can help provide insight, identify problem areas, and work with you to come up with solutions, and support you while you are working towards your goals. Counseling is tailored to the individual and to the successful attainment of your goals.

Your therapist might draw from various therapeutic orientations in order to help you reach your goals. Your therapist may also highlight strengths and encourage exploration of solutions to help you maintain your goals long term while developing confidence in your ability to solve problems in the future. At any point in treatment if your therapist understands that your presenting issues have fallen outside of their professional scope or that of the practice you will be provided appropriate referrals for outside providers.

All the providers in this practice have obtained at minimum of a Master's Degree in either Social Work, Counseling, Psychology, or Child and Family Therapy, have passed state licensing exams, and have a current and valid Michigan license to practice in the mental health field. A selection of the therapists within this practice have completed training beyond a Master's degree to obtain certification in specific areas of mental health treatment, substance abuse and trauma.

Therapist and Patient Service Agreement

To get the most out of counseling we ask that you agree to the following:

- Be willing to work inside and outside your sessions on your goal and communicate with your therapist if your priorities, schedule, or commitment has changed.
- Be willing and curious when it comes to exploring material, discovering solutions, and experimenting with new skills.
- Be as honest as you can during your sessions and put on the breaks when you need to.
- Follow through with mutually agreed upon treatment recommendations or discussing barriers get in the way with your therapist.
- Attend sessions regularly as recommended by your therapist and be ready to start on time.

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● Go into this with positive intentions with a desire to build trust with your counselor. However, if you feel like it just is not a good fit, let us know! There will be no hard feelings. All therapists have different personalities and approaches. The most important determinant factor in your success is your relationship with your counselor. We take that seriously!
● Be focused on your goals and willing to revisit and re-evaluate them throughout your time with us.
● Be open to receiving feedback and giving feedback to your therapist and the practice.
● Take financial responsibility for any balance at the next service date in order to avoid disruption of services and communicate any change in financial ability immediately to your therapist and our billing department.
● If you have any changes in your insurance during treatment, please provide that to us without hesitation so that we may properly bill your sessions and help avoid sending you an unexpected bill later on.
● Audio and/or video recording of appointments is NOT permitted.

Attendance Policy

Sessions are scheduled based on the recommendation of your therapist and your goals. A time slot will be mutually agreed upon. It is important that you commit to a time slot that works for you on a regular basis.

_____ I understand that reaching my goals require regular attendance to therapy and that missing appointments will undermine my ability to reach the goals I have set with my therapist.

_____ I understand that **I must provide adequate cancellation notice by communicating appointment cancellations with more than 24 hour notice.** If I provide adequate cancellation notice, I will NOT be charged a late cancellation/no-show fee.

_____ I understand that **communicating appointment cancellations with less than 24 hours notice will result in a $100 late cancellation/no-show fee.** This is a fee that insurance will not pay, and it **will be charged to the card I have on file within 1-2 days** of the missed appointment.

_____ I understand that if I have an **unavoidable and emergent situation** that prevents me from providing adequate notice for missing a scheduled appointment, it is my responsibility to communicate this with my provider within 24 hours of the missed appointment.

_____ I understand that i**f I reschedule my missed appointment within the same week,** my fee will be reduced to $50. *Please note: the ability to reschedule the same week is completely dependent on the provider having open availability and is not in any way guaranteed.*

_____ I understand that if I have **3 no showed or late cancellations**, my services at AACA may be terminated and I may be referred to outside providers to continue treatment.

Confidentiality and the Exceptions

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Everything you discuss in session is confidential with a few exceptions. Michigan Law requires your therapist to disclose the following types of communication to ensure your safety or safety of others:

● Threatening to harm yourself or others
● Suspicion that you are abusing a person in a vulnerable population such as children, elderly, disabled, cognitively impaired.
● If you are using insurance to pay for your sessions, identifying information will be disclosed to the medical biller to process your claims however the content of our sessions will not be shared
● Ann Arbor Counseling Associates, LLC participates in coordination of care with other clinicians that contract with this practice. This means that your therapist might consult with other members of the team and utilize their experience or expertise to assist in determining best treatment strategies.
● If you decide to communicate through non-secure means or subscribe to the AACA's social media pages your confidentiality cannot be guaranteed. Please use these methods of contact sparingly and cautiously.

Contact Information and Communication

Your therapist will discuss with you the best way to reach them in between appointments. Here are other ways to get in touch with the practice:

- **Practice Main Number (734) 956-0051 or hello@annarborcounselingservices.com**
  Call this number to reach our Patient Coordinator or your therapist's direct voicemail. Please allow for 2 business days for a return call from our administrative staff.
- **Practice Biller (734) 224-4392 or billing@annarborcounselingservices.com**
  Contact our biller for any questions regarding your balance, to make payments, or to set up a payment plan.

Notice: We are not a crisis center. If you feel you are a threat to yourself or others, please call 911 or go to the nearest emergency room

Suicide Prevention Hotline: 1-800-273-8255
Crisis Text Line: Text HOME to 741741 in the United States

Billing and Fees

● Counseling sessions range from $100-$175 per session, depending on your provider.
● Copies of records can be requested in writing to your therapist and will be provided after an administrative and transmission fee is paid based on Michigan Medical Record Fee Laws.
● Individual letters for non-legal matters will be provided at your therapist's approval at their cash rate minimum for 30 minutes of time.
● Requests to complete paperwork/forms incur a $20 fee per 1-2 pages, and the fee is due prior to delivery of form.
● We do not participate in legal matters at any cost. However, if we are subpoenaed against this policy a full cash retainer will be due prior to any court appearance or testimony at our existing rate.

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_____ I understand that payments are due at the time of service.

_____ I understand that if I accumulate a balance for any reason, the balance must be paid at the following session or there must be an approved payment plan arranged with our practice biller to avoid disruption in services.

_____ I understand that if I overpay on my account, the payment will be applied as a credit to my account and be applied to future charges. Any remaining credits will be reimbursed at termination OR at the end of the calendar year.

_____ I understand that insurance benefits are verified as a courtesy and while AACA does strive to get accurate information, AACA cannot guarantee the accuracy of the information received by my insurance company. It is my responsibility to notify AACA of any changes in my policy or coverage.

_____ I understand that I will be responsible for any balances due as a result of no-shows, late cancellations, copays, deductibles, denied claims, paperwork requests, returned checks, and any fees associated with canceled charges or insufficient funds.

Legal Requests for Custody or Testimony

● We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings.
● If we get subpoenaed by you or your lawyer's request, we will require an advanced paid $1,500 retainer to deliver the requested services. This payment must be made by cash or certified check in advance of any court appearances, document requests, or conversations with lawyers. Insurance does not cover these fees and the patient or guarantor will be fully responsible for this fee. This fee is non-refundable if the court appearance is cancelled or rescheduled.

By signing this form, *"I have read and acknowledged the information above."*

Signature Date Signed

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HIPAA 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.

1. We have a legal duty to protect health information about you.

We are required by law to protect the privacy and confidentiality of health information about you, which we call “protected health information,” or “PHI” for short. We are required to explain how we may use PHI about you and when we can give out PHI to others. You have rights regarding PHI about you as described in this Notice. We are required to follow the procedures in this Notice. We have the right to change our privacy practices and to make new Notice provisions effective for all PHI that we maintain by posting the revised notice at our location, making copies of the revised notice available upon request, and posting the revised notice on our website.

2. How we use or disclose protected health information:

- We must use and disclose your health information to provide information:
- To you or someone who has the legal right to act for you (your personal representative).
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.
- Where required by law.
- We have the right to use and disclose health information to pay for your health care and operate our business, and for your treatment by your health care providers. For example, we may use your health information: To provide healthcare treatment to you.
- We may use and disclose PHI about you to provide, coordinate or manage your health care and related services.For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.
- To obtain payment for services. We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. o For health care operations. We may use and disclose PHI in performing business activities that allow us to improve the quality of care we provide and reduce health care costs. Examples include: reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients; reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you; providing training programs for students, trainees, health care providers or non-healthcare professionals to help them practice or improve their skills.
- To provide healthcare treatment to you. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. For example, we

may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

- To obtain payment for services. We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you.
- For health care operations. We may use and disclose PHI in performing business activities that allow us to improve the quality of care we provide and reduce health care costs. Examples include: reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients; reviewing and evaluating the skills, qualifications, and performance of health care providers taking care of you; providing training programs for students, trainees, health care providers or non-healthcare professionals to help them practice or improve their skills.

We may use or disclose PHI without your permission in the following limited circumstances:

- When required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding. ○ When necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. o For reporting of victims of abuse, neglect or domestic violence.
- For health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations
- For judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal
- For law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner as necessary to carry out their duties.
- To manage or coordinate your health care. This may include telling you about treatments, services, products and/or other health care providers.

3. More stringent law:

Highly Confidential Information. Federal and applicable state laws may require special privacy protections for highly confidential information about you. “Highly confidential information” may include confidential information under Federal and State law governing alcohol and drug abuse information as well as state laws that often protect information such as that dealing with HIV/AIDS.

4. You have the right to object to certain uses and disclosures of private health information and, unless you object, we may use or disclose private health information in the following circumstances:

We may share with a family member, relative, friend or other person identified by you, PHI directly related to that person’s involvement in your care or payment for your care. We may

share with a family member, personal representative or other person responsible for your care PHI necessary to notify such individuals of your location, general condition or death. If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our Privacy Officer listed below on this Notice.

5. Any other use or disclosure of private health information about you requires your written authorization.

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose PHI about you. If you sign a written authorization allowing us to disclose PHI about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose PHI about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

By signing this form, *"I have read and acknowledged the information above."*

Signature Date Signed

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Electronic Communication Disclosure and Consent

TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your clinician and AACA, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with clinician and AACA
- Third parties on the Internet such as server administrators and others who monitor Internet traffic
- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Any other questions that the client may ask or information client requests via email or mobile phone text messaging.

Electronic Communication Agreement

By signing this form, *"I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that if I reach out to my therapist using unsecured methods that I am inviting my therapist to respond to me using the same means of communication. It is advised that such communication is limited to appointment information or administrative needs only and more detailed information that would typically be discussed during sessions should be communicated through secure means or saved for session time."*

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Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Ann Arbor Counseling clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

Patient Rights with Respect to Telehealth

1. The laws that protect the confidentiality of personal information that I have already signed also apply to telehealth. Copy of our Office Policies and Therapeutic Informed Consent can be provided.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. AACA utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via G Suite Meet or other back-up telehealth platforms as needed.

4. AACA clinicians follow the State of Michigan Licensure and insurance requirements for delivering telehealth services.

5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

Ann Arbor Counseling Associates will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company. We encourage you to contact your insurance company and find out if telehealth services are covered and demand services for telehealth during the covid-19 crisis.

Patient Name:

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Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Telehealth Agreement

By signing this form, *"I have read and acknowledge the information above."*

Signature Date Signed

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_____ I understand that if I am out of the the state of Michigan I need to provide at least 24 hours notice to my clinician, because services cannot be rendered if I am in another state.

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Guarantor for Services

Adult patients (18+): you are the guarantor.

Minor patients (under 18): the guarantor is the legal parent seeking services on behalf of a minor child, and the legal parent must complete this form.

The signer below agrees to take final and full responsibility of any balances that accrue and understand that any fees that are not covered by insurance will be billed to this guarantor for prompt payment. The signer of this form cannot designate a third party as the guarantor. If the Guarantor is someone other than this client, then Ann Arbor Counseling Associates (AACA) reserves the right to contact this person to resolve financial matters while not releasing any clinical information. This form is required to establish services at AACA.

This agreement will supersede any other agreements that were made between the client and their therapist or payment agreements made outside of AACA.

_____ I understand that if my insurance lapses, I am responsible for paying for the services I rendered out of pocket. This includes patients who are covered under a Medicaid policy since AACA is not participating with straight Medicaid, and will not "back-bill" for services that occur during lapsed coverage.

_____ I understand that payment is due at the time of service. Delay in payment for balances due at the time of service may result in an immediate disruption of services and/or submission to collections. Payment plans are available and can be arranged by contacting our office at (734) 956-0051.

Guarantor First Name	Guarantor Last Name	Date of Birth

Relation to Patient	Employer	Last 4 Digits of SSN

Patient Name:

Patient DOB:

AACA ID:

Guarantor Agreement

By signing this form, *“I attest that the above information is mine and that I am taking full responsibility for any balances that accrue on this client's account as a result of insurance non-payment, no-shows or late cancellation fees, administrative, document, and records fees or any fees generated by this client and that I will make full prompt payment when presented with a statement or immediately contact this office to set up an approved payment plan if the balance exceeds the amount I am able to pay in full.”*

Signature	Date Signed
Print Name	Relation to Patient

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Credit Card Authorization Form

Patient Information

Patient First Name | Patient Last Name

Patient Date of Birth

Primary Credit Card

Credit Card Number | CVC Code | Expiration Date

Full Name of Card Holder | Card Holder Relation to Patient

Is this an HSA or FSA account? ▢ Yes ▢ No

If your primary method of payment is an HSA or FSA account, we ask that you provide a secondary payment method. If your primary payment method is ever declined we will automatically try to charge payment to your secondary payment method instead.

Secondary Credit Card

Credit Card Number | CVC Code | Expiration Date

Full Name of Card Holder | Card Holder Relation to Patient

Patient Name:

DOB:

AACA ID:

Credit Card Authorization Agreement

By signing this form, *“I authorize Ann Arbor Counseling Associates to keep this credit card on file in an encrypted format and charge unpaid balances accrued on the identified patient accounts until removed in writing. I understand that services may be disrupted if a balance is unpaid prior to your next session or an agreed upon payment plan is established and on file with the practice biller."*

"By filling out and signing this form, I acknowledge that, by default, the adult client OR parent/guardian of a minor client is responsible for any and all fees on their account.”

Signature Date Signed

Print Name Relation to Patient