MICHIGAN NOTICE FORM
Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Patient's Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI), for treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  - --*Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - --*Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - --*Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes I have made about our conversation during a private, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to suspect child abuse or neglect, I must report this suspicion to the appropriate authorities as required law.
- *Adult and Domestic Abuse* – If I have reasonable cause to suspect you have been criminally abused, I must report this suspicion to the appropriate authorities as required by law.
- *Health Oversight Activities* – If I receive a subpoena or other lawful request from the Department of Health or the Michigan Board of Psychology, must disclose the relevant PHI pursuant to that subpoena or lawful request.
- *Judicial and Administrative Proceedings* – If you are involved in court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Minors (under 18 years of age)* - When minors are seen in therapy, the parent or guardian holds the legal privilege regarding release of information. Your therapist may discuss your case with their supervisor. The supervisor has the same ethical obligation to preserve your confidentiality.
- *Serious Threat to Health or Safety* – If you communicate to me a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, I may disclose relevant PHI to take the reasonable steps permitted by law to prevent the threatened harm from occurring. If I believe that there is an imminent risk that you will inflict serious physical harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with the laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. 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. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- R*ight to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist'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 notify you in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at the office.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to:

Dr. Peter Newhouse
Winning At Home, Inc.
300 South State Street, Suite 13
Zeeland, MI 49464
Phone: 616.772.1733

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This updated notice will go into effect on January 1, 2014.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person or by mail.

- In the event of a breach of PHI, the client will be notified.

- Your PHI is never sold for marketing purposes.

- You should not be contacted to raise funds. However, if you are, you have the right to opt out of receiving such communications.

- You have the right to restrict certain disclosures of PHI to a health plan when you (or any person other than the health plan) pay for treatment at issue out of pocket in full.

Winning At Home
300 South State Street, Suite 13
Zeeland, Michigan 49464
Tel: 616.772.1733
Fax: 616.772.1736

Winning At Home®

Effective Date: January 1, 2014

Winning At Home ©

Confidential Intake Form

Today's Date: _____

Name: _____	**Name:** _____
Date of Birth: _____ **Sex: M**____ **F**____	**Date of Birth:** _____ **Sex: M**____ **F**____
Address: _____	**Address:** _____
City: _____ **ZIP:** _____	**City:** _____ **ZIP:** _____
Employed by: _____	**Employed by:** _____
Address: _____	**Address:** _____
Home Phone: _____	**Home Phone:** _____
Cell Phone: _____	**Cell Phone:** _____
Work Phone: _____	**Work Phone:** _____
Email: _____	**Email:** _____
Social Security #: _____	**Social Security #:** _____
Marital Status: Single: _____ **Married:** _____ **Separated:** _____ **Divorced:** _____ **Widowed:** _____ **Living Together:** _____	**Religious Affiliation** _____

CHILDREN:

NAME	AGE	SCHOOL/GRADE	BIOLOGICAL OR ADOPTED

Name of anyone else living in the home: _____

Physician's name: _____ Date of last physical: _____

Are you currently being treated for any medical conditions? Y N If yes, please explain: _____

_____

Are you currently taking any medications? Y N If yes, please list: _____

_____

_____

Have you received previous counseling? Y N If yes, by whom? _____ Date/Year? _____

Please briefly state why you are currently seeking counseling: _____

_____

_____

*__Referred By:__ _____ __Address:__ _____

I would like to send a note of appreciation to the person who referred you for supporting our ministry . Please sign below for your permission.

__Name:__ _____ __Date:__ _____

CONFIDENTIAL **SELF-ASSESSMENT** CONFIDENTIAL

Use the scale below to indicate the level of distress with the following items by circling the number corresponding to the response. Please rate all issues that apply.

Anxiety/Depression	***No Concern***		***Minimal***		***Moderate***	***Urgent***
Issues with appetite	0	1	2	3	4	5
Issues with eating	0	1	2	3	4	5
Fears or worries	0	1	2	3	4	5
Fear of harming others or yourself (suicidal thoughts)	0	1	2	3	4	5
Irritability, anger, hostility	0	1	2	3	4	5
Perfectionism	0	1	2	3	4	5
Loss of motivation or ambition	0	1	2	3	4	5
Panic attacks	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Symptoms of stress (headaches, nausea, difficulty concentrating, etc.)	0	1	2	3	4	5
Loneliness	0	1	2	3	4	5
Low self-esteem	0	1	2	3	4	5
Negative or critical thinking	0	1	2	3	4	5
Additional Comments:						

Relationships	***No Concern***		***Minimal***		***Moderate***	***Urgent***
Communication concerns	0	1	2	3	4	5
Divorce/Separation	0	1	2	3	4	5
Financial concerns	0	1	2	3	4	5
Loss of significant person/relationship	0	1	2	3	4	5
Parenting concerns	0	1	2	3	4	5
Difficulty with friends	0	1	2	3	4	5
Difficulty with family/parents/children	0	1	2	3	4	5
Difficulty with spouse/partner	0	1	2	3	4	5
Sexual or intimacy concerns	0	1	2	3	4	5
Additional Comments:						

General	***No Concern***		***Minimal***		***Moderate***	***Urgent***
Addictive concerns (pornography/sex, food, gambling, shopping, etc.)	0	1	2	3	4	5
Substance abuse (Drugs, alcohol, nicotine, caffeine, etc.)	0	1	2	3	4	5
Substance abuse within the family	0	1	2	3	4	5
Grief Issues (death, loss, etc.)	0	1	2	3	4	5
Losing contact with reality	0	1	2	3	4	5
Survivor of abuse (trauma)	0	1	2	3	4	5
Occupational or school related stress	0	1	2	3	4	5
Additional Comments:						

Client Name _____ Person filling out form _____

Person who this form is about _____ Relationship to client _____

Date _____

Winning At Home

WINNING AT HOME FAMILY WELLNESS COUNSELING SERVICES
INFORMATION AND CONSENT FORM

1. The **WINNING AT HOME FAMILY WELLNESS CENTER** exists to provide mental health services to adults, children, and families. The main mission is to help individuals and families cope with daily life and to live more fully.

2. **SERVICE PROVIDERS: Licensed therapists provide professional services**:

Peter Newhouse, PhD, LMSW, ACSW, Director of Family Wellness
Emilie DeYoung, PhD, LMSW, ACSW, Child/Adolescent Supervisor
Matthew Biller, MA, LMFT, Adult Therapy Supervisor
Theresa Gargala, PsyD, CDWF, Adult Therapy Supervisor
Michelle VanNoord, MA, LPC
Kurt Stevens, PhD, LPC
Chase Hoekwater, MA, LLPC
Sarah Ingram, MA, LLPC
Deborah Brink, LMSW, ACSW
Steven Kreitzer, MA, MDiv,LPC
Sarah Young, MA, LPC
Stephanie Witteveen, MA, LPC
Amanda Szubelak, MA,LLP
Joshua Zoerhof, MA, LLPC
Jill Nagelkirk, MA Intern

3. **CONFIDENTIALITY**: **Please read our HIPAA Privacy Policy.**
   a. Master's level counseling students have become a vital part of the WAH culture. From time to time, my counselor may request my permission for a student to observe my session.

4. **INFORMED CONSENT**: Most people who seek counseling are experiencing some form of internal distress or conflict in relationships. The goal of therapy is to reduce such problems; however, in spite of our best efforts, there are times when these issues do not improve, or even become worse. It is important to communicate your concerns with your counselor.

5. **PAYMENT FOR SERVICES AND INSURANCE REIMBURSEMENT**: Fees are based on a sliding scale for an individual session. *Fees are payable before your scheduled session*. Charges will be assessed for additional services such as court reports or other third party reports, phone therapy sessions, etc.

   IMPORTANT CONSIDERATIONS WHEN USING INSURANCE: Be aware that using insurance for mental health services may have negative consequences:

   ºLoss of confidentiality ºLoss of control of your treatment ºA psychiatric diagnosis will be in your medical history

   If you elect to use your insurance, the Winning At Home Family Wellness Staff will submit claims to certain insurance carriers to collect the benefit. Other insurances may require you to submit statements for reimbursement. *You are required to pay your deductible, co-pay, and/or any outstanding balance prior to your session*. By signing this form, I am giving permission for my insurance to be billed.

   THIRD PARTY PAYOR: If you have been referred by a third party, by signing this form, you are authorizing Winning At Home Family Wellness Staff to submit a statement for services rendered.

6. **CANCELLATIONS**: *We require a 24-hour notice of cancellation by calling (616) 772-1733*. ***In the event that you do not call within the specified time, you may be charged the full fee of the missed session***. ***These charges are not billable to insurances or reimbursable by flex.***

7. **EMERGENCIES**: Voice mail is available for your non-urgent messages. (For cancellations or changes to your appointments, please call our office.) If you have a more emergent need, but not life threatening, please call (616)834-4587, and the on-call counselor will contact you at their earliest convenience. In the event of an emergency, call 9-1-1 or go to the nearest emergency room.

I HAVE READ THE ABOVE AND RECEIVED A COPY OF THE HIPAA PRIVACY POLICY. I UNDERSTAND AND ACCEPT THESE CONDITIONS TO RECEIVING BEHAVIORAL HEALTH SERVICES. I MAY ASK QUESTIONS AT ANY TIME IN THE FUTURE.

_____ _____

Client/Parent/Guardian's Signature Date

_____

Printed Name

WAH USE ONLY – These policies were revoked: _____ Date _____

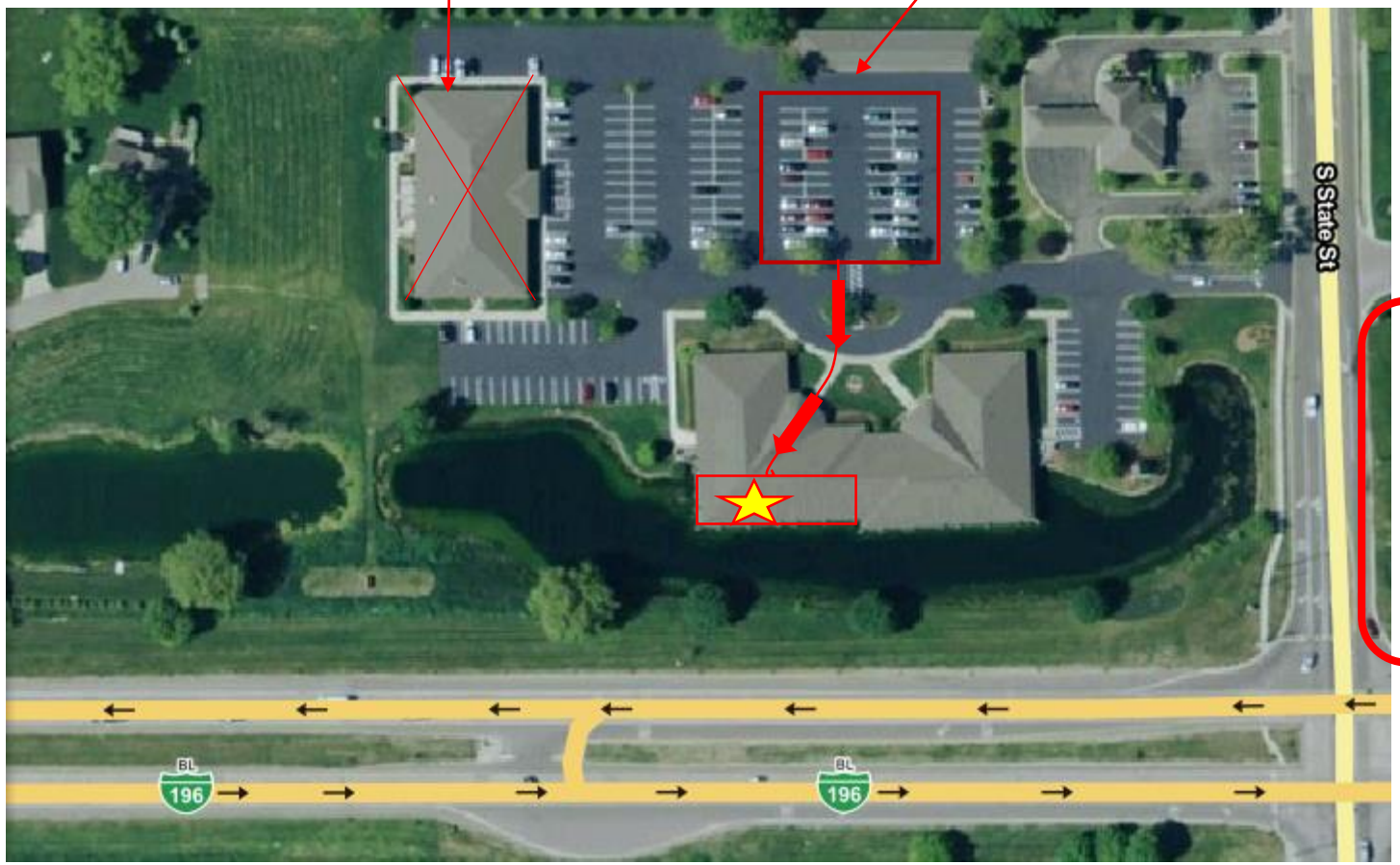
Winning At Home Corporate
Please do not go here!!

Park here!! Follow arrows to our office

N
W
E
S

Winning At Home
Family Wellness

For further instructions, please call (616)772-1733
Mon-Thurs 8-5
Friday 8-3
(Lunch 12:15-1:15; leave message)



Burger King