



Hamilton Wellness, PLC

A Bridge to Your Best Self

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY AND CONSENT FOR TREATMENT

Patient Name: _____

DOB: _____

I, the above signed, voluntarily enter treatment, or give my consent for the minor or person under my legal guardianship mentioned above.

Hamilton Wellness, PLC (HW) appreciates the confidence you have shown in choosing us to provide for your behavioral health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to HW, for providing outpatient mental health services to me or the above-named patient. I certify that the insurance information I have provided to the office is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to HW the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____

Date _____

Guarantor Signature _____

Date _____

CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment.

I understand cancellation without 24-hour notice, or a "no show" will result in a \$100.00 fee. This fee cannot be billed to your insurance and is expected to be paid at the next appointment time.

I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature _____

Date _____

SELF-PAY (If applicable)

I do not have health insurance or I am choosing not to utilize my insurance benefit and will be responsible for services rendered at Hamilton Wellness, PLC I agree to pay Hamilton Wellness, PLC the full and entire amount of treatment given to me or to the above named patient at each visit. I understand that these services cannot be submitted to my insurance after the appointment by myself or by Hamilton Wellness, PLC.

Patient/Guarantor Signature: _____

Date: _____


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Date: ____/____/____

PATIENT NAME: _____ Preferred Name: _____

Birthdate: ____/____/____

Birth Sex: *circle* Male Female

Marital Status: *circle* Married Single Other

Employment: *circle* Student Employed Other

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Leave Message: *circle* Voicemail Text No Message

Home Phone: _____ Leave Message: *circle* Voicemail No Message

Work Phone: _____ Leave Message: *circle* Voicemail No Message

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

=====

If Minor, first Parent Name: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Ok to leave messages on these phone numbers? [] Yes

Email Address: _____

If Minor, second Parent Name: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Ok to leave messages on these phone numbers? [] Yes

Email Address: _____



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Payment Authorization

Patient Name: _____

Type of Card: [] Debit [] Credit

Card Number: _____

CVV: _____ Expiration: _____ / _____

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Hamilton Wellness PLC may utilize my payment methods on file for any balances, including deductibles, copays, late cancellation, and no-show fees, without additional authorization. Authorization is in conjunction with the Hamilton Wellness Statement of Patient Financial Responsibility and Consent for Treatment form.

Printed Name of Cardholder: _____

Signature of Cardholder: _____

Date: _____



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CHILD AND ADOLESCENT HISTORY

Date: _____

Child's Name: _____ Birthdate: _____

Person completing form: _____ Relationship to child: _____

Are child's parents divorced? Yes No Who is the custodial parent? _____

(Please provide a copy of the custodial agreement)

Emergency contact: _____

Name

Phone

What are the problems your child is having? _____

Has your child ever spoken about or acted upon: Hurting self? Yes No Others: Yes No

Please explain: _____

How does your child feel about being here? _____

Has your child had previous counseling or testing? (outpatient or inpatient, where, when, with whom)

What would you like your child to gain from counseling? _____

FAMILY

	Name	Age	Marital Status	Employer/School
Mother				
Father				
Stepparents				
Sisters/Brothers				

Others living in the home: _____



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SCHOOL ADJUSTMENT

School district: _____ School: _____

Has your child ever been afraid to go to school? Yes No

Present Grade: _____ Repeated Grade? _____ Present Grades: Good Average Poor

Has your child ever had difficulties with: **Math** Yes No **Reading** Yes No

Language Yes No **Speech** Yes No

Has your child ever had special education services? Yes No

Have you received any complaints from your child's school about behavior or achievement? Yes No

Please explain: _____

How does your child relate to peers? _____

LEISURE

How does your child spend free time? (interests or hobbies) _____

ADJUSTMENT DIFFICULTIES

Please check any of the following that are typical of your child's behavior

- | | | |
|-----------------------------------------------------------|-----------------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Does not feel liked | <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Poor hygiene |
| <input type="checkbox"/> Feels lonely | <input type="checkbox"/> Sleep walking | Aggressive with: |
| <input type="checkbox"/> Shy with children | <input type="checkbox"/> Bedwetting - present | <input type="checkbox"/> Peers |
| <input type="checkbox"/> Shy with adults | <input type="checkbox"/> Bedwetting - past | <input type="checkbox"/> Siblings |
| <input type="checkbox"/> Prefers to be alone | <input type="checkbox"/> Soiling | <input type="checkbox"/> Adults |
| <input type="checkbox"/> Worries | <input type="checkbox"/> Does not feel like self | <input type="checkbox"/> Daydreams |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Needs the last word | <input type="checkbox"/> Jealousy |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Stealing from home | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Will not admit blame | <input type="checkbox"/> Easy to anger |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Sets fires | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Does not share | <input type="checkbox"/> Unusual thinking | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Lacks motivation | <input type="checkbox"/> Unusual behaviors | |
| <input type="checkbox"/> Sexual acting out | <input type="checkbox"/> Takes unnecessary risks | |
| <input type="checkbox"/> Preoccupied with sexual thoughts | <input type="checkbox"/> Short attention span | |
| <input type="checkbox"/> Tics or twitches | <input type="checkbox"/> Destructive to property | |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Not always truthful | |
| <input type="checkbox"/> Ritualistic behavior | <input type="checkbox"/> Violent behavior | |
| <input type="checkbox"/> Talks impulsively | <input type="checkbox"/> Poorly organized | |
| <input type="checkbox"/> Acts impulsively | <input type="checkbox"/> Clumsy | |
| <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Fails to understand consequences | |



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PERSONAL ADJUSTMENT

How does the child relate to: Mother? _____ Father? _____

A Stepparent? _____ Their Siblings? _____

Authority Figures? _____ Others? _____

HEALTH QUESTIONNAIRE

Present medications prescribed by the physician: _____

Present medications that do not need a prescription: _____

Medication Allergies: _____

Food or other Allergies: _____

Is there a family history for an illness? (physical or emotional) Yes No Please explain: _____

Is there a family history for substance abuse? Yes No _____

Does the child have a history of substance abuse? Yes No Type? _____

PRESENT HEALTH

Physician: _____ Phone: _____

Address: _____

Date of Last Exam: _____ Results: _____

Are your child's immunizations up to date? Yes No

Has your child had an eye exam? Yes No Glasses? Yes No

Has your child had a hearing exam? Yes No Results: _____

Has your daughter begun menstruation? Yes No Age of onset: _____

What is your child's present health? _____

Past Health Problems: Hospitalizations, Accidents, or Disabilities? _____



BIRTH AND DEVELOPMENT

Pregnancy: Normal? Yes No If complications, please explain? _____

Any prenatal exposure to alcohol, tobacco, or drugs: Yes No _____

Length of labor: _____ Premature? Yes No Weeks & Weight _____

Newborn's Health: _____

Infancy: Any problem areas?

- | | | |
|-----------------------------|-------------------|----------------------|
| ____ Colic | ____ Underactive | ____ Chronic Illness |
| ____ Eating | ____ Infections | ____ High fevers |
| ____ Sleeping | ____ Slow growth | ____ Hospitalization |
| ____ Milk or food allergies | ____ Fussy | ____ Surgery |
| ____ Sleep patterning | ____ Cried often | |
| ____ Overactive | ____ Constipation | |

EARLY CHILDHOOD: (INDICATE AGE STARTED)

Talking: Single words at _____ months; sentences at _____ months

Walking at _____ months

Began toilet training at _____ months; completed toilet training at _____ months;

Knew colors at _____ years. Knew numbers at _____ years.

Knew letters at _____ years.

RELIGIOUS AND SPIRITUAL BELIEFS

Mother's background _____ Father's background _____

Does the family practice a religion or spirituality? Please describe: _____

Does your child participate? Yes No

Legal

Has your child ever been involved with the police or the courts? Yes No

If Yes, please explain: _____

Is your child on Probation: Yes No

If Yes, please explain: _____

Has your child been part of a divorce or custody issue? Yes No

Is your child adopted? Yes No When were they told? _____

FAMILY INCOME INFORMATION

Does your child work? Yes No Hours: _____ Position: _____

Does the family have financial difficulties? Yes No _____

Parent or Guardian's Signature _____
Date _____



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Patient Provider Agreement

A Patient Centered Medical Home is a partnership between a patient and their physician/provider.

We trust you as our patient to:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms, and other important information about your health
- Tell your doctor about any changes in your health and well-being
- Take all of your medicine and follow your doctor's advice
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- **Call your doctor *first* with all problems, unless it is a medical emergency**
- Consult your doctor before going to a specialist

A Patient-Centered Medical Home (PCMH) is a system of care in which a team of health professionals work together to provide your entire healthcare needs. You, the patient, are the most important part of a patient centered medical home. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

As your Patient Centered Medical Home provider I agree to:

- Explain disorders, treatments, and results in an easy-to-understand way
- Listen to your feelings and questions to help you make decisions about your care
- Keep your treatments, discussions, and records private
- Provide instructions on how to meet your health care needs when the office is not open
- Give you clear directions about treatments
- Refer you to specialists as needed
- End every visit with clear instructions about expectations, treatment goals, and future plans

16931 19 Mile Road, Suite 140, Clinton Township, MI 48038
Phone: 586-226-2822; Fax: 586-226-2833
www.hamiltonwellnessplc.com



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Practice Hours

Monday – Thursday: 9am – 7pm

Friday: 9am – 12pm

Saturday – Sunday: Closed

- Should you have an AFTER HOURS issue, please contact your provider or the front desk by email and we will respond as quickly as possible within the next BUSINESS day. We will direct you with the next steps to attend to your needs.
- Should you have an emergency, please dial 911 or go to nearest the hospital Emergency Center.
- If it is a non-emergency, please call the office at 586-226-2822 during office hours to schedule an appointment.
- Should you have an issue not pertaining to our care, please contact your Primary Care Physician.

Ask your provider about community services, or contact the following:

NEED HELP? 2-1-1 is now available. Dial 211 from any phone and you will be connected with a referral hotline that can connect you with non-profit agencies in your area that can help with Human, Health, and Social needs (i.e., utilities, housing, health insurance, food, diapers, etc.)

A listing of the area resources can also be found on these websites:

<https://www.mi211.org/>
www.findhelp.org

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FOR OUR TELEHEALTH CLIENTS:

Telehealth Etiquette

Telehealth counseling sessions are just as important as in person sessions when it comes to etiquette. Making sure the experience is professional when you are meeting from home can be challenging, but it is very important for therapeutic results. Here are some etiquette tips to make the most of your telehealth experience.

1. Find the best location possible.

- Therapists have guidelines for confidentiality, privacy and setting locations on their end; clients are encouraged to do the same.
- Find a comfortable place to settle in. Be creative if needed; go outside or sit in your car.
- Place your device on a solid surface, so it is stabilized, with you seated in front of it.
- If using a phone for a session, again, stabilize the device. Walking around can make the other viewer distracted and even nauseous.
- Please be sure to find a location with a stable connection.

2. Try to protect your privacy.

- In order to maintain confidentiality, inform your family members that you are in an important meeting and need to not be disturbed.
- Place yourself in a location where others cannot overhear your conversation. Parents of youth receiving services are asked to also respect the ability for the youth to receive these services without others overhearing.
- Use a headset so that at least half of the conversation cannot be overheard.

3. Limit your distractions.

- Clients need to be fully present, including cameras turned on if a video session.
- Turn off notifications on the device you are using and remove other devices from your vicinity.
- Other noise and visual distractions should be limited as much as possible (pets, children, potential interruptions).
- Please refrain from eating during the session, limiting oneself to beverages.
- Please do **not** drive during therapy sessions for the safety of you and others on the road.

4. Dress for the public.

- Therapists are expected to dress professionally.
- Clients are encouraged to dress comfortably, but in public attire.

5. Reconnect, if the connection is lost.

- At the beginning of your session, be sure to confirm with your therapist how you will reconnect if your session is interrupted.
- Please know that Hamilton Wellness, PLC uses HIPAA compliant video platforms for our telehealth.