Avalon Behavioral Health, PLC

Growth Revealed Through Change

491 E. Columbia Ave. Ste. 4, Battle Creek, MI 49014 – Phone (269)962-9611 – Fax (269)962-9612

Personal Information (Please Print**)**

Client's Name _____ Birthdate _____/_____/_____
Parent/Guardian Name (if minor) _____
Address _____
City _____ State _____ Zip_____
Telephone (Cell) _____ (Work) _____ (Home)_____
Age 6 Sex _____ Gender Identity _____ Ethnicity _____
Marital Status _____ Religious Affiliation _____
Veteran _____ Employer _____

Email _____

In case of emergency, contact: _____ Phone_____
Relationship to client _____

History
Legal History _____
Substance Abuse History _____
Highest Level of Education _____ Developmental Delays _____
If Student provide name of school _____
Teacher's name/may we contact _____
Past Psychiatric Hospitalization _____
Past Mental Health Issues _____

Referral Source
How did you hear of our clinic (or from whom)? _____
Reason for Referral_____
Physician _____ Phone _____
Psychiatrist _____ Phone_____
Current Medications _____
_____

****Please complete each form prior to the scheduled appointment. If the forms are not completed and signed appropriately, it may result in your appointment needing to be rescheduled. Thank you.**

Signature_____ Date_____

Insurance Information

Primary Insurance _____
Subscriber _____
Subscriber Date of Birth _____
Relationship _____
Phone _____
Contract/ID# _____
Group/Acct#_____
Employer _____

Secondary Insurance_____
Subscriber _____
Subscriber Date of Birth _____
Relationship _____
Phone _____
Contract/ID# _____
Group/Acct# _____
Employer _____

Patients relationship to Responsible Party: Self ☒ Partner ☐ Child ☐ Other ☐

AUTHORIZATION TO BILL INSURANCE

I, _____, hereby give my consent for Avalon Behavioral Health to bill my/my child's insurance carrier for the services rendered to me/ my child/family by the above-mentioned provider. In addition, I agree to pay Avalon Behavioral Health any deductibles or uncovered charges in accordance with my health care plan.

Client/Guardian Signature _____

Relationship to Client_____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, understand that my consent is required to release any health care information relating to testing, diagnosis, and/or treatment for mental health disorders, drug, and/or alcohol abuse. I hereby give my consent to Avalon Behavioral Health to release information to:

- ☐ Insurance Company
- ☐ Family Physician (Please provide name) _____
- ☐ Referring Physician Please provide name) _____
- ☐ Family Member(s) _____
- ☐ Other _____

Client/Guardian Signature _____

Relationship to Client_____ Date _____

Consent to Treatment and Recipients Rights

Client_____ Date_____

I, _____ (relationship if minor)_____the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent and have the legal right to consent for the minor or person under my legal guardianship mentioned above, at **Avalon Behavioral Health, PLC**. Further, I consent to have treatment provided by a psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with treatment have been explained to me. I understand that therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Office Manager.

Non-voluntarily Discharge from Treatment: A client may be terminated from **Avalon Behavioral Health, PLC** non-voluntarily, if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by **Avalon Behavioral Health, PLC** is protected by federal and/or state law and regulations. Generally, **Avalon Behavioral Health, PLC** may not say to a person outside the clinic that a patient attends therapy or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for auditing purposes or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either in the clinic, against any person who works for the **Avalon Behavioral Health, PLC**, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is **Avalon Behavioral Heath, PLC**'s duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client may have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to request the client's records, however, it could be denied.

When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information.

My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. I consent to treatment and agree to abide by the above-stated policies and agreements with **Avalon Behavioral Health, PLC.**

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Witness Date

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Financial Policy

The staff at Avalon Behavioral Health (hereafter referred to as ABH) is committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of ABH is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of ABH. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, ABH will bill insurance companies and other third-party payers but cannot guarantee benefits or the amount covered and are not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases, the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 30 days. Payments not received after 90 days are subject to collections.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by ABH until the deductible payment is verified to ABH by the insurance company or third-party provider.

All insurance benefits will be assigned to ABH (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved payment plan, charge card, or payment at the time of service.

Cancellations with less than 24 hours' notice will be charged a fee of $15.00 and a fee of $35.00 will be charged for missed appointments without notice.

Payment methods include check, cash, or credit card.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____Date: _____/_____/_____

Co-responsible party: _____Date: _____/_____/_____

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PLEASE CHECK ANY CONCERNS FROM THE PAST TWO MONTHS:

- ☐ Excessive crying
- ☐ Decreased energy
- ☐ Feelings of being worthless
- ☐ Thoughts of suicide
- ☐ Feeling overwhelmed, trouble making decisions
- ☐ Experience panic attacks
- ☐ Excessive worrying
- ☐ Avoiding going places
- ☐ Isolating from others
- ☐ Afraid of being judged or rejected
- ☐ Sensitive to criticism
- ☐ Needs things to be perfect
- ☐ Excessive anxiety about separation from caregivers
- ☐ Obsessive behaviors or thoughts
- ☐ Impulsive, acts without thinking
- ☐ Can't sit still, antsy
- ☐ Always on the go, hyper
- ☐ Problems following rules
- ☐ Difficulty with authority
- ☐ Unmotivated, procrastinating
- ☐ Trust issues
- ☐ Health concerns
- ☐ Concerns related to life change
- ☐ Memory problems
- ☐ Attention problems
- ☐ Problems with work or school
- ☐ Apathetic, doesn't seem to care
- ☐ Abruptly changing moods
- ☐ Angry, easily irritated
- ☐ Difficulty controlling temper
- ☐ Reckless behaviors, taking excessive risks
- ☐ Abusive toward others
- ☐ Lying, stealing
- ☐ Avoid conflict
- ☐ History of traumatic experiences
- ☐ Full of energy, little need for sleep
- ☐ Feeling overly important
- ☐ Talking fast and excessively
- ☐ Hoarding food or objects
- ☐ Poor body image
- ☐ Problems with eating or food
- ☐ Stomach aches, digestion issues
- ☐ Trouble managing pain or disabling condition
- ☐ Aches and pains
- ☐ Financial concerns
- ☐ Legal problems
- ☐ Sexual concerns
- ☐ Feels bullied/picked on
- ☐ Few or no friends
- ☐ Considered "weird" by others
- ☐ Socially awkward or inappropriate
- ☐ Problems with boundaries
- ☐ Skin picking, hair pulling, nail biting
- ☐ Inflexible, trouble handling change
- ☐ Self-harm or cutting
- ☐ Problems in relationships with parents
- ☐ Problems in relationships with friends, siblings, roommates
- ☐ Problems in relationships with partner or children
- ☐ Difficulties with sleep
- ☐ Suspicious, paranoid
- ☐ Threatens or bullies others
- ☐ Thoughts of hurting others
- ☐ Gender Identity issues
- ☐ LGBTQ
- ☐ Hearing or seeing things others do not
- ☐ Learning difficulties
- ☐ Abused or neglected by others
- ☐ Current (or past) history of sexual abuse
- ☐ Current (or past) excessive use of alcohol, drugs, or medications

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** 6 **Sex:** ☐ Male ☐ Female **Date:** _____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

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HIPAA – ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Avalon Behavioral Health reserves the right to modify the privacy practices outlined in the notice

I, _____, (please print your full legal name) have been shown the Privacy Policy for this Office, and have been offered a copy of such policy to keep for my records.

I hereby give permission for this Office to leave messages on the answering service/ voicemail/ text messages or emails at:

☐ My Home (please initial) _____ ☐ My Cell (please initial) _____

☐ My Work (please initial) _____ ☐ My Email (please initial) _____

I hereby give the following people permission to receive information from this office on my behalf:

_____ _____

Name of Person Relationship to Client

_____ _____

Name of Person Relationship to Client

Signature_____ Date _____

----------FOR OFFICE USE ONLY----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because the individual refused to sign.

☐ Individual refused to sign ☐ An emergency situation prevented us from obtaining acknowledgement

☐ Communication barriers prohibited obtaining the document ☐ Other (Specify)_____

Employee Signature_____Date_____