CHILD/ADOLESCENT LIFE HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive understanding of your child's life experience and background. Responding to these questions will benefit your child through the development of a treatment program suited to your child's specific needs.

If you have any problems or questions regarding this form, we will be pleased to help you.

Please answer as completely as you can and return this form at your scheduled appointment.

Today's Date: _____ Appointment Date: _____

Person completing form: _____ Relationship to child/adolescent: _____

How did you hear about Abaris Behavioral Health? _____

CONFIDENTIAL

Child's Name			Age	Sex	Date of Birth
Address			Social Security Number		
How long have you lived at your current address?	Race/Ethnicity		Religion/Spiritual Belief		
Home Phone ☐	Cell Phone ☐	Work Phone ☐	Email address ☐		
Do you authorize us to leave messages on your telephone? YES ☐ NO ☐ If yes, check boxes above (Home, Cell, Work, Email) that you authorize.			Driver's License Number or State ID		
Legal Guardian/Parent Name			Phone Number		
Legal Guardian Status: ☐ Biological Parent ☐ Foster Parent ☐ Adoptive Parent ☐ Other: _____			If shared/joint legal custody, please provider name for second legal guardian:		
Address (second guardian)			Primary Phone		
Name of Emergency Contact	Relationship to Child				
Phone	Alternate Phone				

OFFICE USE:

INSURANCE

Primary Insurance Company	Contract Number	
Name of Subscriber	Subscriber's Date of Birth	Group Number
Employer	Effective Date	Relationship to Subscriber
Secondary Insurance Company	Contract Number	
Name of Subscriber	Subscriber's Date of Birth	Group Number
Employer	Effective Date	Relationship to Subscriber

OFFICE USE:

PRESENTING PROBLEM

Check the main reason(s) you and your child are here today:

☐ Stress	☐ Homicidal Ideation	☐ Self-Injury/Cutting
☐ Hyperactivity	☐ Inattentive	☐ Drug Problem
☐ Anxiety	☐ Shyness	☐ Fatigue/ Lack of Energy
☐ Suspension/Expulsion	☐ Gender Identity Issues	☐ Hearing Voices
☐ Depression	☐ Anger	☐ Racing Thoughts
☐ Suicidal Ideation/Attempt	☐ Alcohol Problem	☐ Bullying/Being Bullied
☐ Poor Impulse Control	☐ Bad Dreams/Nightmares	☐ Developmental Delay
☐ Confusion	☐ Low Self-Esteem	☐ Family Problem
☐ Panic Attack	☐ Eating Disorder	☐ Other: _____

Please describe the problem(s) checked above and any other concerns: _____

When did this problem begin? _____

Is there a prior history of this problem? YES ☐ NO ☐ If yes, how long ago? _____

Name three (3) things you would like changed in the current situation:

1.

2.

3.

OFFICE USE:

MEDICAL HISTORY

Present state of general physical health: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Current weight: _____ Height: ___ Ft ___ In

How many times has your child been hospitalized for a medical problem? _____

Date(s)	Reason for Hospitalization	Length of Stay

Describe your child's present eating pattern: _____

Describe your child's present sleeping pattern (hours per night, problems getting to sleep or waking early): _____

Are your child's immunizations complete and up to date? YES ☐ NO ☐

If no, please explain: _____

Is your child taking any prescribed medications for a physical problem? YES ☐ NO ☐ If yes, please explain: _____

List any significant hospitalizations or surgeries: _____

Allergies: _____

MENTAL HEALTH HISTORY

Please check any existing psychiatric problems your child has:

☐ ADD/ADHD	☐ Conduct Disorder	☐ Substance Abuse
☐ Depression	☐ Developmental Delay	☐ Anxiety Disorder
☐ OCD	☐ Bipolar Disorder	☐ Schizophrenia
☐ Trauma	☐ PTSD	☐ Communication Disorder
☐ Learning Disorder	☐ Tic Disorder	☐ Other: _____

Abuse or Neglect? Yes ☐ No ☐ Unsure ☐

If yes, please explain: _____

What treatments has your child had in the past? Outpatient ☐ Hospitalization ☐ Partial Hospitalization ☐ Other ☐

Please explain: _____

What are the goals for your child's treatment?

Who would you like to be involved in your child's treatment (example: teachers, other family members, etc.)?

What strengths does your family have that help your child to be successful?

OFFICE USE – MENTAL HEALTH HISTORY

MEDICATIONS

List **all *current*** medications or over the counter medications. (use an additional page if needed)

Medication	Dose	Frequency	How Long?	For	Prescribed by: PCP	Prescribed by: Psychiatrist
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

List any ***previous*** **psychiatric** medications such as antidepressants, mood stabilizers, etc. (use an additional page if needed)

Medication	Highest Dose	Was it effective?	Side effects	Prescribed by: PCP	Prescribed by: Psychiatrist
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

Allergies to Medication ☐ No Known Allergies

Name of Medication	Reaction to Medication (i.e., hives, swollen tongue)

OFFICE USE – MEDICATIONS

SUBSTANCE ABUSE

Indicate the amount and frequency of use of the following:

	Amounts	Frequency	Currently using?	How Long?
Alcohol			YES ☐ NO ☐	
Amphetamines			YES ☐ NO ☐	
Barbiturates			YES ☐ NO ☐	
Caffeine			YES ☐ NO ☐	
Cocaine			YES ☐ NO ☐	
Hallucinogens			YES ☐ NO ☐	
Heroin			YES ☐ NO ☐	
Inhalants			YES ☐ NO ☐	
Marijuana			YES ☐ NO ☐	
Nicotine/Tobacco			YES ☐ NO ☐	
Sedatives			YES ☐ NO ☐	
Other			YES ☐ NO ☐	

Indicate preferred substance(s): _____

Substance abuse treatment type & dates: _____

Any family members with substance use history or mental health concerns? If so, please complete section below.

Relationship (i.e., Grandmother)	Substance Used (i.e., Alcohol):	Mental Health Diagnosis (i.e., Depression)	Received Treatment
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐

OFFICE USE – SUBSTANCE USE

CHILD SELF REPORT QUESTIONNAIRE

Instructions: Read each statement carefully. Circle the number that best describes how true the statement has been **during the past 7 days.** Check only one answer for each statement.

Instructions for Parents/Guardians: If your child is under 12, the parent or other responsible adult is asked to complete this questionnaire. In this case, respond to the statements as if each began with "My child..." or "My child's..." rather than "My..." or "I..." It is important that you answer as accurately as possible based on your own observation and knowledge.

Person Completing Questionnaire: _____ Adolescent _____Parent/Guardian _____ Other: _____

		Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1	I have headaches or feel dizzy	0	1	2	3	4
2	I don't participate in activities that used to be fun	0	1	2	3	4
3	I argue or speak rudely to others	0	1	2	3	4
4	I have a hard time finishing my assignments or do them carelessly	0	1	2	3	4
5	My emotions are strong and change quickly	0	1	2	3	4
6	I have physical fights (hitting, biting or scratching) with family or others my age	0	1	2	3	4
7	I worry and can't get thoughts out of my head	0	1	2	3	4
8	I steal or lie	0	1	2	3	4
9	I have a hard time sitting still (or I have too much energy)	0	1	2	3	4
10	I use alcohol or drugs	0	1	2	3	4
11	I am tense and easily startled (jumpy)	0	1	2	3	4
12	I am sad or unhappy	0	1	2	3	4
13	I have a hard time trusting family members or other adults	0	1	2	3	4
14	I think that others are trying to hurt me even though they are not	0	1	2	3	4
15	I have threatened to, or have, run away from home	0	1	2	3	4
16	I physically fight with adults	0	1	2	3	4
17	My stomach hurts or I feel sick more than others my age	0	1	2	3	4
18	I don't have friends or I don't keep friends very long	0	1	2	3	4
19	I think about suicide or feel I would be better off dead	0	1	2	3	4
20	I have nightmares, trouble getting to sleep, oversleeping, or waking too early	0	1	2	3	4
21	I complain about or question rules, expectations, or responsibilities	0	1	2	3	4
22	I break rules, laws, or don't meet others expectations on purpose	0	1	2	3	4
23	I feel irritated	0	1	2	3	4
24	I get angry enough to threaten others	0	1	2	3	4
25	I get in trouble when I am bored	0	1	2	3	4
26	I destroy property on purpose	0	1	2	3	4
27	I have a hard time concentrating, thinking clearly, or staying on task	0	1	2	3	4
28	I withdraw from friends and family	0	1	2	3	4
29	I act without thinking and don't worry about what will happen	0	1	2	3	4
30	I feel that I don't have any friends or that no one likes me	0	1	2	3	4

OFFICE USE – MENTAL HEALTH

LEGAL

Was this treatment prompted or suggest by the juvenile justice system? YES ☐ NO ☐ If YES, please explain: _____

Is your child currently on probation? YES ☐ NO ☐ If YES, please explain: _____

Has your child ever been arrested for any of the following?

- ☐ Driving While Intoxicated
- ☐ Public Intoxication
- ☐ Disorderly Conduct
- ☐ Drug Possession
- ☐ Shoplifting
- ☐ Burglary or Robbery
- ☐ Weapons Offense
- ☐ Assault
- ☐ Probation Violation
- ☐ Contempt of Court
- ☐ Truancy /Curfew Violation
- ☐ Major Driving Violation
- ☐ Domestic Violence
- ☐ Incorrigibility
- ☐ Other: _____

Has your child ever been ordered by the court for treatment? YES ☐ NO ☐ If YES, please explain: _____

Has your child ever been in a juvenile detention facility? YES ☐ NO ☐

Date	Length of Incarceration	Reason

OFFICE USE – LEGAL

FAMILY

Marital Status of Parents:

- ☐ Married (How long? _____)
- ☐ Living Together (How Long _____)
- ☐ Deceased Mother (How Long _____)
- ☐ Deceased Father (How Long _____)
- ☐ Divorced
- ☐ Separated
- ☐ Never Married/Single

Is the above-mentioned child adopted? YES ☐ NO ☐

Foster care? YES ☐ NO ☐

Is the caregiver/legal guardian willing to take part in treatment with the child? YES ☐ NO ☐

Name (parents and siblings)	Quality of Relationship	Age	Living with you?
	GOOD ☐ FAIR ☐ POOR ☐		YES ☐ NO ☐
	GOOD ☐ FAIR ☐ POOR ☐		YES ☐ NO ☐
	GOOD ☐ FAIR ☐ POOR ☐		YES ☐ NO ☐
	GOOD ☐ FAIR ☐ POOR ☐		YES ☐ NO ☐
	GOOD ☐ FAIR ☐ POOR ☐		YES ☐ NO ☐

Additional comments regarding family history:

DEVELOPMENT

Was this child a planned pregnancy? YES ☐ NO ☐

Was the mother under a physician's care? YES ☐ NO ☐

Did the mother use alcohol or drugs during pregnancy? YES ☐ NO ☐

Did the mother use tobacco products during pregnancy? YES ☐ NO ☐

Did the mother have any problems during pregnancy? YES ☐ NO ☐

Did the mother have any problems during labor / delivery? YES ☐ NO ☐

Did you have any problems immediately after birth? YES ☐ NO ☐

Please list medications used during pregnancy, if any: _____

Check any of the following complications that occurred during pregnancy.

☐ Difficulty in Conception
☐ Measles
☐ Excessive Swelling
☐ Flu
☐ Toxemia
☐ Emotional Problems
☐ Anemia
☐ Abnormal Weight Gain
☐ Gestational Diabetes
☐ Vaginal Bleeding
☐ High Blood Pressure
☐ Other: _____

Child's Birth Weight: _____ lbs. _____ oz.

As an infant was your child/adolescent:

☐ Easy to Manage
☐ Alert/Responsive
☐ A Poor/Picky Eater
☐ Demanding
☐ A Poor Sleeper
☐ Irritable/ Excessive Crying

At what age did your child do the following:

Turn Over: _____ Crawl: _____ Sit Alone: _____

Stand Alone: _____ Walk Alone: _____ Use First Words: _____

Use Sentences: _____ Walk Up Stairs: _____ Walk Down Stairs: _____

When was this child toilet trained? Days: _____ Nights: _____

Did bed-wetting occur after toilet training? YES ☐ NO ☐ If yes, until what age? _____

Did bed-soiling occur after toilet training? YES ☐ NO ☐ If yes, until what age? _____

Were there any medical reasons for bed-wetting? Bed-soiling? YES ☐ NO ☐ If yes, explain:

Has this child experienced **any** of the following problems?

Walking Difficulty?	YES ☐	NO ☐	Sleep Problem?	YES ☐	NO ☐
Unclear Speech?	YES ☐	NO ☐	Colic?	YES ☐	NO ☐
Feeding Problem?	YES ☐	NO ☐	Underweight?	YES ☐	NO ☐
Eating Problem?	YES ☐	NO ☐	Overweight?	YES ☐	NO ☐

If yes to any of the above mentioned, please describe: _____

During this child's **first 4 years**, were any special problems noted in the following areas?

Sleeping Too Much?	YES ☐	NO ☐	Eating?	YES ☐	NO ☐
Temper Tantrums?	YES ☐	NO ☐	Motor Skills?	YES ☐	NO ☐
Sleeping Too Little?	YES ☐	NO ☐	Excessive Crying?	YES ☐	NO ☐
Separating from Parents?	YES ☐	NO ☐	Failure to Thrive?	YES ☐	NO ☐

If yes to any of the above mentioned, please describe: _____

Did you, your child's physician, or teachers have concerns with any of the following areas of development?

☐ Language Development	☐ Behavior Problems	☐ Vision
☐ Speech Difficulties	☐ Hearing	☐ Balance/Coordination
☐ Fine Motor Development	☐ Social Development	☐ Intelligence

OFFICE USE – FAMILY/ DEVELOPMENT

BEHAVIOR

Please indicate if this child exhibits any of the following behaviors:

Easily Overstimulated in Play	YES ☐	NO ☐	Has Fears	YES ☐	NO ☐
Has a Short Attention Span	YES ☐	NO ☐	Seems Impulsive	YES ☐	NO ☐
Overreacts When Faced with a Problem	YES ☐	NO ☐	Hides Feelings	YES ☐	NO ☐
Seems Unhappy Most of the Time	YES ☐	NO ☐	Cannot Calm Down	YES ☐	NO ☐
Requires a Lot of Parental Attention	YES ☐	NO ☐	Lacks Self-Control	YES ☐	NO ☐
Uncomfortable Meeting New People	YES ☐	NO ☐	Withholds Affection	YES ☐	NO ☐
Seems Overly Energetic in Play	YES ☐	NO ☐	If yes, please describe:		

Please indicate how this child relates to other children.

Has Problems Relating to Other Children	YES ☐	NO ☐
Fights Frequently with Playmates	YES ☐	NO ☐
Has Difficulty Making Friends	YES ☐	NO ☐
Prefers to Play Alone	YES ☐	NO ☐

Are there children in the neighborhood with whom this child could play? YES ☐ NO ☐

What role does this child take in peer group games (follower, leader, etc.)? _____

Please indicate whether any of this child's **friends** engage in any of the following behaviors

Smoke Cigarettes/ E-Cigarettes	YES ☐	NO ☐	Chew Tobacco	YES ☐	NO ☐
Inhale Toxic Substances (i.e., paint)	YES ☐	NO ☐	Drink Alcohol	YES ☐	NO ☐
Use Illegal Drugs	YES ☐	NO ☐	Other:		

What activities does this child enjoy?

Sports: _____

Hobbies: _____

Other: _____

Has this child's interest in participating in these activities declined recently? YES ☐ NO ☐

If yes, explain: _____

OFFICE USE – BEHAVIOR

Preschool and Daycare

Amount of Time per Day: _____ Days per Week: _____

Any problems in preschool / daycare? YES ☐ NO ☐

If yes, please describe: _____

_____

Does, or did, this child attend kindergarten? YES ☐ NO ☐

Any problems in kindergarten? YES ☐ NO ☐

If yes, please describe _____

Elementary/ High School

EDUCATION

Please indicate whether this child has had any of the following school experiences.

Has changed schools for reasons other than normal academic progression. YES ☐ NO ☐

If yes, when and why? _____

Has skipped a grade YES ☐ NO ☐

If yes, when and why? _____

Has failed a grade YES ☐ NO ☐

If yes, when and why? _____

Has difficulty with Reading YES ☐ NO ☐

If yes, please describe _____

Has difficulty with Math YES ☐ NO ☐

If yes, please describe _____

Gets poor grades YES ☐ NO ☐

Please describe the most recent report card or provide a copy

_____

Has been tested for Special Education Services or Class YES ☐ NO ☐

Currently placed in Special-Education Class YES ☐ NO ☐

If yes, what type of class _____ Hrs. per Day _____

Dislikes going to School YES ☐ NO ☐

Frequently Absent YES ☐ NO ☐

If yes, describe _____

If in High School, when will this child graduate? _____

Do you have any concerns about the quality of your child's school or teachers? YES ☐ NO ☐

If yes, describe? _____

Questionnaire completed by:

_____ _____

Signature Date

_____ _____

Printed Name Relationship to child

Abaris Behavioral Health

Practice Orientation and Service Agreement

Your Rights and Responsibilities as a Client:

- ✓You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- ✓You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- ✓You have the right to privacy and confidentiality regarding the services you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.
- ✓You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. If you should decide to withdraw your consent for services, you must do so in writing.
- ✓You have a right to information concerning your treatment and/or care.
- ✓You have the right to express any concerns or complaints regarding the services you receive. We encourage you to first contact your clinician to resolve any issues. You may also contact the Rights Advisor for assistance.
- ✓You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.
- ✓You are responsible for checking your insurance plan benefits, including any deductibles and/or co-pays. As a courtesy, we may check eligibility and benefits for you.
- ✓You have the responsibility to provide informed consent to services offered to you.
- ✓You have the responsibility to assist in planning your treatment at every stage.
- ✓You have the responsibility to be timely for your appointments. Late arrivals *may* result in rescheduled appointments.
- ✓You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. You *may* be charged a practice fee, up to $125, for non-cancelled appointments where an emergency was not involved, as insurance companies and other third-party payers do not cover missed appointments (or late cancellations).
- ✓You are responsible for any fees that may be charged to you at the time of service and knowing your insurance benefits coverage. You will be charged $25 for any returned checks.
- ✓Your case will be closed following 90 days of inactivity, unless other arrangements have been made.

Services Offered

Abaris Behavioral Health offers an array of mental health and substance abuse services. These services include: individual psychotherapy, group therapy, family therapy, martial therapy, psychological testing, case management, psychiatric evaluations and medication therapy. Your clinician will provide you with a detailed description of the nature of services, expected benefits and potential risks. Clinicians will maintain a therapeutic alliance with you as you are receiving services to aid you in the goals you have selected for your recovery and well-being. More information is available on our website at **www.AbarisHealth.com**.

Advance Directives

Advance Directives are written instructions which communicate your wishes about the care and treatment you want if you reach a point where you can no longer make your own health care decisions. All organizations that receive Medicare and Medicaid payments must provide patients with written information concerning their right to prepare advance directives. The law does not require that you actually have or make an advance directive. If you would like to an Advance Directive please inform your clinician or administrative staff.

Mandated Reporting
All staff are trained to recognize indicators of child abuse and dependent adult abuse. Health care staff and professionals are mandated reports. This organization has a legal obligation to inform the appropriate and applicable authorities of any suspected abuse and/or neglect.

Health & Safety
Abaris is committed to maintaining healthy, safe, clean and accessible environments that support quality services and minimize risk of harm to persons served, personnel and other stakeholders. Crisis intervention is provided to all persons served without seclusion or restraint. We take necessary steps to ensure safely. We also strive to de-escalate and support persons served without physical intervention and provide treatment with the upmost dignity and respect. In the event there is threat of harm to personnel or persons served the individual will be discharged from the outpatient program. We practice in a non-smoking environment. Illicit drugs are not allowed on the premises. All weapons are prohibited with no exceptions. Persons in possession of either will be asked to leave immediately.

Client Input
Abaris Behavioral Health will be asking you for ongoing feedback regarding the quality and effectiveness of services you receive. We will periodically ask you to complete clinical outcome questionnaires and satisfaction surveys. We will also review and/or investigate any complaints or suggestions you may have. Your feedback is considered an important part of your treatment and/or care.

Operations
Office hours are usually between 7:00 am and 10:00 pm, 7 days a week. Not all clinicians are available during all open hours. Appointment dates and times, and after-hours contact, will be arranged between you and your treating clinician. In the case of an emergency, you can contact the nearest crisis center (Oakland County Crisis Center at 248-456-0909; Macomb County Crisis Center at 586-307-9100). You may also contact the nearest emergency room.

Confidentiality
Federal and State laws protect the privacy of communications between a client and a clinician. In most situations, information about your treatment can only be released to others if you sign a written Authorization for Release of Information. That authorization must meet certain legal requirements. However, there are some limits to confidentiality. Information about privacy and limits to confidentiality will be provided by your primary clinician and are also provided in our Notice of Privacy Practices.

Financial Responsibility
You are expected to pay for service at the time it is rendered, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. A fee adjustment or a payment installment plan may be negotiated in circumstances of unusual financial hardship. All clients will be informed of payment fee schedules prior to rendering services. Although we are likely to inform you of your insurance deductible and co-pays, you are ultimately responsible for knowing this information and for paying both in full.

If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, legal action may be used to secure the payment. This may involve a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his or her name, the nature of services provided, and total amount due. If such legal action is necessary, its cost will be included in the claim.

Minors and Parents

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the current law may allow parents to examine their child's treatment records. They should also be aware that clients over age 14 can consent to (and control access to information about) their own mental health treatment, although that treatment cannot extend beyond 12 sessions or 4 months without parental / guardian consent. While privacy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is Abaris Behavioral Health policy to request (but not require) an agreement from any client between ages 14 and 18 and his/her parents allowing clinicians to share general information with parents about attendance at scheduled sessions and progress in treatment.

Consent for Services

My initials below indicate that I:

_____ have been made aware of my rights and responsibilities and how to file a grievance or complaint.

_____ have been informed of the name, discipline, and credentials of my primary clinician.

_____ have been informed of practice-specific information / given an orientation to services including fees.

_____ have been informed of privacy practices, confidentiality, and limits to confidentiality.

My signature below indicates that I consent to receive services at Abaris Behavioral Health, that I understand I may discuss any questions I have regarding services, and that I maintain the option to terminate my consent at any time.

Client Signature	**Date**	**Parent/Guardian Signature**	**Date**

Abaris Behavioral Health Staff Signature	**Date**

ABARIS
BEHAVIORAL HEALTH

Fee Schedule for Supplemental Clinical Services

It is our sincere goal to provide the best clinical care & professional outpatient psychotherapy services to our clients. This fee schedule is meant to allow the clinician to deliver professional clinical services in the most effective & clinically appropriate manner possible. These are charges for additional clinical services that insurance companies and other third-party payers do not cover and if provided/requested these charges are billed directly to the client.

1. Phone calls:
   - Phone calls lasting under 15 minutes are considered part of ongoing clinical care and gladly answered and returned by the clinician as soon as possible without charge.
   - Phone calls lasting 15 minutes or longer: The clinician will encourage client to schedule an appointment to discuss the matter in the context of a scheduled face-to-face session.
   - Phone calls between 20 - 30 minutes are subject to a flat fee of $60. Phone calls exceeding 30 minutes are subject to fee of $60 for the first 30 minutes, and $5 a minute for each additional minute.
   - These rates apply for phone conversations with clients as well as with approved (authorization/release form signed) 3rd party contacts such as school teachers, lawyers, primary care physicians, psychiatrists, etc.

*While the clinician makes every effort to address issues of clinical concern over the phone in a concise and time-sensitive manner, phone calls between the client and the clinician lasting longer than 15 minutes suggest the need for a face-to-face session. Phone calls with 3rd party contacts are at times needed and/or requested for care coordination. However, if these phone calls exceed 15 minutes, these calls impact the clinician's ability to provide face-to-face sessions, and as such, compensation for time spent engaging in these calls is warranted. The above rates are comparable to current standard insurance rates for face-to-face session. Having a face-to-face session to discuss issues and work towards solutions is more therapeutic and effective for the person served.

1) Emails:
   Emails to inform the clinician of updates and or other information are welcomed. Every effort will be made to return emails in a timely manner. However, clients who specifically request 2 or more email responses from the clinician in any 24-hour period will be asked to schedule a face-to-face session and will be charged $15 for their 2nd and any additional email reply request. Having a face-to-face session to discuss issues and work towards solutions is often much more therapeutic and effective overall for the client.

2) Letters written to 3rd parties such as schools, lawyers, employers etc. (Does not include missing work/school letters.):
   letters are subject to a fee of $35 per letter

3) Completion of requested paperwork and forms (such as disability or FMLA paperwork.):
   Forms are subject to a fee of up to $75 per form

4) Individualized Education Plan {IEP)Meetings & Court appearances and/or testimony:
   - ✓ Meetings where clinician is attending on site are subject to a fee of $75 per hour including travel, waiting, and actual meeting time.
   - ✓ Any presence in court or taped disposition is subject to a fee of $200 per hour including travel, waiting, and actual service time.

5) No Shows (Appointments not kept without any prior notification of needing to cancel / reschedule):
   - ✓ Just a reminder: As stated in the "Practice Orientation and Agreement" form signed at the start of treatment, "you may be charged a practice fee, up to $125 for non-cancelled appointments, where an emergency was not involved, as insurance companies and other third-party payers do not cover missed appointments."
   - ✓ It is important to remember that appointment times are scheduled and reserved for those that they are scheduled for. Prompt notification of the need to reschedule or cancel appointments (Within 24 hours if at all possible) is appreciated so that your reserved time slot can be opened for another client who may be in need of scheduling.

My signature below is free from pressure or influence from any person or entity and indicates that I have been informed of and understand the fees that are associated with any supplemental clinical services that insurance companies and other third-party payers do not cover. I understand that these fees will be billed directly to me, the client, and I agree to pay them. (***Please note: In cases where a court-ordered subpoena legally requires the clinician to appear in court and/or give a deposition, fees for court appearances will be charged, regardless of whether or not the client/client representative signs this document agreeing or choosing to decline to privately pay for these supplemental clinical services.) I have received a copy of this fee schedule for my records.

Client Signature _____ Date _____

Signature of Client's Representative/Guardian _____ Date _____

Clinician Signature _____ Date _____

ABARIS

Primary Care Physician Notification Form

Attention Primary Care Physician: Your patient is being seen at Abaris Behavioral Health. With patient authorization we herein provide diagnoses and medications, including medication changes. Please retain for your records.

Patient Name: _____

DSM-5 Diagnoses (including codes): _____

_____

Treatment Information (including medications): _____

_____

_____

_____

Therapist/Psychiatrist Signature & Printed Name with Credentials:

TO THE PATIENT:

Sometimes problems can be caused by medical conditions. For instance, depression and anxiety are sometimes linked to certain medical problems. When you start or change medications your doctor can help make sure that the medications you take can be safely used together. If your health changes your doctors need to know to see if you need to have any tests and / or changes to your medication. Finally, to ensure quality care, many insurance companies request that therapists, at Abaris Behavioral Health, notify patients' primary care/family doctor when services begin. We must have your written permission to comply with this insurance company request.

If you **do** wish us to notify your primary care/family doctor that you are receiving services, please provide the complete name and address of your provider:

Primary Care Physician/Clinic: _____ **Phone:** _____

Address: _____

City/State/Zip: _____ **Fax:** _____

Please read and complete the following:

I, (print name)_____DOB:_____
hereby authorize Abaris Behavioral Health to exchange information regarding my mental health and/or substance abuse treatment and medical health care for the purpose of continuity of care as may be necessary for the administration and provision of health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 and / or state laws respecting confidentiality of records and patient communication with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that it is my responsibility to notify my behavioral health care provider if I choose to change my primary care physician.

If you **do not** wish to authorize us to notify your primary care/family doctor, please complete the section below:
_____ I don't have a primary care/family doctor
_____ I don't want my primary care/family doctor to know I'm receiving services
_____ Other: _____

_____ _____
Patient or Guardian Signature **Date**

_____ _____
Witness Signature **Date**

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

Our staff uses health information about you for treatment, to evaluate the quality of care you receive, for administrative purposes, and to obtain payment for treatment. Your health information is contained in a medical record that is the physical property of our organization.

We May Use or Disclose Your Health Information for:

Treatment. We may use your health information to provide you with mental health treatment or services. For example, information obtained by a mental health provider, such as a psychiatrist, psychologist, social worker, or other person providing mental health services to you, will record information in your record that is related to your treatment. This information is necessary for mental health providers to determine what treatment you should receive. Mental health providers will also record actions taken in the course of your treatment and note how you respond to the interventions and actions.

Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the clinical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities & services; and
- determine how to continue to improve the quality and effectiveness of the mental health care we provide.

Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you from a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment or service.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising. We may use your information to contact you to raise funds for our organization.

Required by Law. We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to any (suspected) victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health authorities or other legal authorities to prevent or control disease, injury, or disability or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation.

Research. We may review your mental health information to determine if your protected health information is needed for research projects. To the extent that information is needed, an institutional review board or privacy board will review the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health and safety of you or any other person pursuant to applicable law.

Coroners/Medical Examiners. Your health information may be disclosed when such individuals are performing duties authorized by law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed forces.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Lawsuits/Disputes: If you are involved in a lawsuit, information regarding your health information may be disclosed in response to court/ administrative order. Health information may be disclosed about your child in response to subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent we have relied on it or have already disclosed the information.

Your Health Information Rights

You have the right to:

- request restriction on certain uses and disclosures or your information as provided; however, we are not required to agree to a requested restriction;
- to obtain a copy of this notice of Privacy Practices upon request;
- inspect, and obtain a copy of your health record as provided by law;
- request communications of your health information by alternative means or at alternative locations;
- get a list of disclosures that have been made;
- correct and/or update your protected health information;
- revoke your authorization to use or disclose health information except to the extent we have already taken action based upon your authorization; and
- receive an accounting of disclosures made of your health information.

If you have any questions, concerns, or complaints, please contact the Privacy Officer at 248-650-8383. You may also submit formal complaints to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

We reserve the right to update / change our privacy practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be made available to you at our offices.