

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 _____ 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 _____ Secondary Insurance _____
Subscriber _____ Subscriber _____
Subscriber Date of Birth _____ Subscriber Date of Birth _____
Relationship _____ Relationship _____
Phone _____ Phone _____
Contract/ID# _____ Contract/ID# _____
Group/Acct# _____ Group/Acct# _____
Employer _____ 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 Health, 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:

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

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

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

		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. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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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 _____