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:** ________________

Hamilton Wellness, PLC

A Bridge to Your Best Self

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been offered the opportunity to obtain a Notice of Privacy Practices from Hamilton Wellness, PLC.

____ _____/_____/_____

Signature of Patient/Authorized Representative Date

____ _____/_____/_____

Printed Name of Patient/Authorized Representative Date

If Authorized Representative, relationship to Patient: ____________________

Please circle: I **Request** / **Decline** a copy of the Notice of Privacy Practices.

____ _____/_____/_____

Signature Date

For Office Use only:

____ _____/_____/_____

Witness Signature Date

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

Hamilton Wellness, PLC

A Bridge to Your Best Self

Date: _____/_____/________

PATIENT NAME:__________________________________ ***Preferred Name*:** ______________

Birthdate: ______/______/________ **Birth Sex:** *circle* Male Female

Martial 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: ____

Hamilton Wellness, PLC

A Bridge to Your Best Self

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: ______________________

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

Child Speech/Language Intake Form

Name:	DOB:	Age:	Sex: ☐ M ☐ F ☐ Other
School:		Grade:	
Legal Guardian 1:		☐ Mom ☐ Dad ☐ Other ______	
Address:		Phone:	
Legal Guardian 2:		☐ Mom ☐ Dad ☐ Other ______	
Address *(If Different)*:		Phone:	

Birth History:

Were there any problems during pregnancy and/or birth? Yes ☐ No ☐ *(If yes, briefly describe)*

Home Environment

Who lives at home with the child? *(Siblings (and ages), mother, father, step-parents, grandparents, etc)*

How often is English spoken at home? ☐ Always ☐ Most of the Time ☐ Sometimes ☐ Never

If another language is spoken, what language(s) is/are used in the home? ______________________

Any special circumstances?

☐ Parents divorced ☐ Joint physical custody ☐ Child adopted ☐ Other ______________________

Any cultural or religious considerations for therapy? *(holiday celebrations, prohibitions, etc)*

Health History:

Please Mark Appropriate Box(es) If Your Child Has Had Any of The Following:

☐ Frequent Ear Infections ☐ Occupational Therapy ☐ Developmental Delay ☐ Early Intervention
☐ Hearing Problems ☐ Physical Therapy ☐ Premature Birth ☐ Tubes In Ears
☐ Speech Therapy ☐ Head Injury ☐ Hospitalization ☐ Behavior Therapy
☐ Allergies *(list below)* ☐ Prescription Medication *(list below)*

Please Provide Further Explanations for Items Checked Above:

Is Your Child Diagnosed with Any Developmental or Sensory Disorders?

☐ ADHD ☐ Anxiety ☐ Autism ☐ Articulation Disorder
☐ Blind/Visually Impaired ☐ Cerebral Palsy ☐ Deaf/Hard of Hearing ☐ Degenerative Condition
☐ Dyslexia ☐ Down's Syndrome ☐ Fragile X Syndrome ☐ Intellectual Disability
☐ Language Disorder ☐ Learning Disorder ☐ Opposition Defiance Disorder ☐ Sensory Processing Disorder
☐ Social Communication Disorder ☐ Stuttering ☐ Other *(list)* ______________________

Please Provide Further Explanations for Items Checked Above:

Do You Suspect Your Child Has Any Undiagnosed Disorders? ☐ Yes ☐ No

If yes, explain:

Developmental History:

Please include approximate age of occurrence
First word _____ Spoke sentences clearly _____ Typical Motor Development? ☐ Yes ☐ No

Education:

How Is Your Child Currently Educated?: ☐ Caregiver-led at home ☐ Distance Learning ☐ Pre-school/School
Has Your Child Ever Been Held Back a Grade? ☐ Yes ☐ No
Which Subjects In School Is Your Child on Grade Level for? ☐ Reading ☐ Math ☐ Science ☐ Social Studies
Does Your Child Receive Special Education Services? ☐ Yes ☐ No
Does Your Child Have an IEP or IFSP? ☐ Yes ☐ No
If yes, what is it targeting?

Communication & Social Interaction

Does Your Child Play Well with Other Children? ☐ Yes ☐ No
Which of the Following Apply to Your Child?

☐ Cooperative
☐ Hyperactive
☐ Frequent self-stimulation (spinning, hand flapping, etc)
☐ Easily frustrated/impulsive
☐ Minimal eye contact
☐ Anxious
☐ Frequent tantrums
☐ Plays independently with others
☐ Inappropriate behavior
☐ Poor understanding of danger

Can Your Child Clearly and Appropriately Communicate the Following?
☐ Statements ☐ Questions ☐ Answers ☐ Wants ☐ Needs (ex: help) ☐ Feelings ☐ Denial/Protests ☐ Discomfort
About How Much of What Your Child Says Can You Understand? ☐ Almost All ☐ Most ☐ Half ☐ Quarter or Less
About How Much Could a Stranger Understand? ☐ Almost All ☐ Most ☐ Half ☐ Quarter or Less

Your Thoughts:

Why Do You Think Your Child Has a Communication Delay/Disorder?

What Have You Already Tried to Remedy the Communication Delay/Disorder? Has It Helped?

What Is the Main Goal You Wish to Accomplish with Speech/Language Therapy?

What Methods Do You Consent to Be Utilized for Communication Regarding Your Child?
☐ Text ☐ Email ☐ Voicemail

PLEASE PRINT YOUR NAME: ______________________________ Date: ______________

SIGNATURE: ______________________________

PLEASE INDICATE RELATIONSHIP TO CHILD: ☐ Parent ☐ Other Legal Guardian

Hamilton Wellness, PLC

A Bridge to Your Best Self

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

Hamilton Wellness, PLC

A Bridge to Your Best Self

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

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 conversion. 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.