



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 \$70.00 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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Practice Hours

Monday - Thursday 9am - 7pm

Friday 9am - 12pm

Saturday - Sunday - Closed

- Should you have an AFTER HOURS issue, please contact me by email and I will respond as quickly as possible. I will direct you with the next steps to attend to your needs.
- 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 my care, please contact your Primary Care Physician.

Ask any of our staff 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 this website:

www.referweb.net/uwjc

Patient Signature

Therapist Signature

Patient Email

Therapist Signature

Date: _____

16931 19 Mile Road, Suite 140, Clinton Township, MI 48038

Phone: 586-226-2822; Fax: 586-226-2833

www.hamiltonpsychological.com

Credit Card on File

Type: _____

Card # _____

CVV: _____ Expiration: ____/____

Cardholder Name: _____

Copy of Receipt? No / Yes...Via:

Text: (____) _____

Email: _____

**Please also provide a Copy (front and back) of your
Driver's License and Insurance Card**

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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Hamilton Wellness, PLC by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ Date of Birth: _____

Authorize Hamilton Wellness PLC to:

___ **Release to:**

___ **Obtain from:**

___ **Exchange with:**

Name (Person(s) or facility) _____

Address _____

Phone _____

Fax _____

The following information:

___ Treatment summary

___ History/Intake

___ Diagnosis

___ Psychological Evaluation Material

___ Dates of Treatment Attendance

___ Other
(specify) _____

For the purpose of:

___ Evaluation/Assessment

___ Coordination of Care

___ Other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time. (Except to the extent of information which has already been released.)

Signature of Client or Legal Guardian

Date

Signature of Witness

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



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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 _____