InSight Behavioral Wellness of Northern Michigan, LLC

955 East Eighth St., Ste. B #1; Traverse City, MI 49686

Phone: 231-392-6155 Fax: 231-525-2125

www.ibwnmi.com

PATIENT INFORMATION

Date _____ DOB ____/____/_____ Age _____ Marital Status _____

Name _____

Email _____

Phone _____ _____ _____
(Home) (Cell) (Work)

Address_____
(Street)

_____ _____ _____
(City) (State) (Zip Code)

Gender: ☐ Male ☐ Female ☐Nonbinary/3rd gender ☐ Prefer to self-describe_____ ☐ Prefer not to say

Sexual Orientation: _____ Race_____

Who Referred You _____

May we contact your referral source? ☐ Yes ☐ No Phone _____Fax_____

May we contact your primary care physician? ☐ Yes ☐ No

Physician Name _____ Phone Number _____Fax Number _____

Physician Address _____

Primary Insurance Company _____ Phone _____

Mental Health Carrier_____ Phone_____
(If Different from Primary Insurance Company)

Name of Policy Holder_____ Policy Holder DOB ____/____/_____

Address of Policy Holder _____

Phone number of Policy Holder _____ Relationship to Patient_____

Member I.D./Subscriber # _____Group # _____Employer_____

Authorization # _____ Co-Pay $_____ Deductible $_____

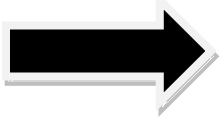
Emergency Contact _____ _____ _____
(Name) (Phone Number) (Relationship to Patient)

Email and text messaging are not HIPPA compliant forms of communication. IBWNMI uses these for administrative purposes.

May we: **Contact you by phone? ☐ Yes ☐ No** **Contact you by email? ☐ Yes ☐ No**
Leave you a text message? ☐ Yes ☐ No **Leave you a voice mail message? ☐ Yes ☐ No**

Communication and privacy explained by: _____

PLEASE COMPLETE REVERSE SIDE



PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of mental health services depends on efforts of the patient as well as those of the practitioner (Clinician) and I promise to make my best effort to comply with these procedures. These best efforts will include open and honest discussion of my thoughts and feelings, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged, any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials. I understand that the effectiveness of the procedures cannot be guaranteed and that the Clinician has sole professional responsibility for all services provided.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the Clinician at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify the Clinician at least 24 business hours in advance if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged for the full cost of the session, which will not be reimbursable by my insurance company. I agree to be responsible for these charges.

I understand that conversations with the Clinician will be of a confidential nature. I authorize my Clinician to discuss my treatment with other treatment providers to coordinate my care. I further understand that the Clinician, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the Clinician has a legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the Clinician will make reasonable efforts to resolve these situations before breaking confidentiality. I also understand that in order to ensure patient confidentiality and privacy, electronic recording is strictly prohibited within any of InSight Behavioral Wellness of Northern Michigan, LLC's offices.

My signature below indicates that I have agreed to these terms and have read and understand a "Notice of Privacy Practices" and a "Welcome Letter" informational letter describing my rights and responsibilities as a patient or guardian.

_____ _____

(Signature of Patient or Guardian) **(Date)**

FINANCIAL AGREEMENT

Patients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate information will make patients fully responsible for all charges. Patients are responsible for notifying InSight Behavioral Wellness of Northern Michigan, LLC of any changes in insurance within 30 days; otherwise, you will be responsible for payment in full. In most cases, patients are responsible for making the initial phone call to their insurance companies.

I request that InSight Behavioral Wellness of Northern Michigan, LLC, as the agent for the Clinician, submit bills to the insurance company that I have listed above on this form, and I grant permission to the Clinician and InSight Behavioral Wellness of Northern Michigan, LLC to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Michigan prompt pay standards or otherwise fails to adhere to relevant rules and standards, I grant permission to InSight Behavioral Wellness of Northern Michigan, LLC to share information related to my insurance claim with the Michigan Department of Insurance and Financial Services.

I understand that I am financially responsible for the cost of the mental health services to me (my child) and for any portion of the fees not reimbursed or covered by my health insurance. I understand that my copay/outstanding balance is due at time of service. If my mental health care is provided under the terms and conditions of a managed mental health care program to which the Clinician is contracted, my financial responsibilities may be limited by the terms of that contract. I understand if a personal check does not clear ("bounces") I will be charged $15.00 per incident. I understand that my failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by the Clinician or a collection agency contracted by the Clinician to collect these bills. I also understand that if my account is placed in collection procedures, neither I nor any other patient of InSight Behavioral Wellness of Northern Michigan, LLC for whom I am the guarantor will be able to schedule appointments with any other InSight Behavioral Wellness of Northern Michigan, LLC clinician.

I understand that professional services will be rendered to me by_____ (Clinician) and that the fee for a 45-55 minute initial consultation session will be $_____ and the fee for follow-up appointments will be $_____ along with fees for any testing materials. I authorize the release of any medical information necessary to process my claim. Fees may be different for additional services such as psychological testing, legal consultation/testimony, report preparation, consultations with others on my behalf, phone/e-sessions etc. and will be explained to me if these services are necessary.

My signature below indicates that I have agreed to the above terms.

_____ _____

(Signature of Patient or Guardian) (Date)

FINANCIAL RESPONSIBILITY (if other than patient)

Name _____ ☐ Male ☐ Female DOB ____/____/_____

Address (If Different from Patient) _____ SSN_____ONLY ON REQUEST_____

_____ Phone_____

Signature of Financially Responsible Party _____ Date _____

☐ *ID Verified* _____ *(Staff Use Only)* *Revised 5/17/2020*