Hamilton Wellness, PLC

A Bridge to Your Best Self

Statement of Patient Financial Responsibility & Consent for Treatment

Patient Name:_____ DOB:_____

I, the abovesigned , voluntarily enter into treatment, or give my consent for the minor or person under my legal guardianship mentioned above.

Hamilton Wellness, PLC 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 Hamilton Wellness, PLC, 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 Hamilton Wellness, PLC, 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_____

(If guarantor is not the patient)

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 **$60.00 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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2020 PATIENT DEMOGRAPHICS

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: _____

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***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

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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

Practice Hours

Monday-Thursday: 9am- 7pm

Fridays:9am-2pm

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 within 48 hours or as needed.
- 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 needed (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 Email

DATE:_____

ADULT PERSONAL HISTORY FORM

Client's Name:_____ Birthdate:_____

Reason for seeking treatment: _____

_____

Emergency contact: _____

Name Phone #

	Name	Sex	Age	Lives with you (Yes/ No)	Indicate if deceased
Spouse/Significant other					
Children					
Mother					
Father					
Brothers/Sisters					

PARENTAL INFORMATION

Children not listed or not living with you: _____

_____

Special Circumstances (eg. raised by someone other than a parent, adoption, etc.)_____

_____

ISSUES THAT AFFECTED YOUR DEVELOPMENT (physical or sexual abuse, nutrition, illness, neglect, etc.)

_____

_____

_____

_____

ADULT MARITAL HISTORY

Your Current Marital Status: ☐Single ☐Married ☐Dating ☐ Divorced ☐Separated

☐Widowed ☐Other_____

Your first marriage: _____/_____/_____/_____

Age Date # Of Children Divorce Date (if applicable)

Your second marriage: _____/_____/_____/_____

Age Date # Of Children Divorce Date (if applicable)

Your third marriage: _____/_____/_____/_____

Age Date # Of Children Divorce Date (if applicable)

Check the best description of your relationship with your present significant other**:**

☐Excellent ☐Good ☐Fair ☐Poor

Comment:_____

Social Information

Social time is usually spent: ☐Alone ☐Immediate family ☐Peers ☐Other_____

Please describe:_____

_____

Do you isolate yourself from other people?_____

Cultural/Ethnic Background

What is the ethnic group of your parents? (Hispanic, African American, Asian, etc.)

_____

Do you identify with this same group, or another? _____

Spiritual/Religious Background

Were you raised in a home that practiced a religion? ☐Yes ☐No

If yes, which religion: _____

Do you consider yourself a religious person? ☐Yes ☐No

Do you practice a formal religion now? ☐Yes ☐No

Spiritual/Religious Background Cont'd

If yes, which religion?_____

Do you consider yourself a spiritual person? ☐Yes ☐No

If yes, explain:_____

Employment/ Vocational Information

Employers (most recent first)	Dates	Job Descriptions

Are you currently employed outside the home? ☐Yes ☐No ☐Full time ☐Part time

Other circumstances (retired, laid off, medical leave, suspended, etc.):_____

_____

Total family income:_____ Do you currently have financial problems? ☐ yes ☐ no

If yes, please explain:_____

Counseling/Prior Treatment History

Have you had psychotherapy/counseling before? ☐Yes ☐No If yes, where:

Name of Center	Type of Service (Outpatient/Inpatient/Day Treatment)	Dates	Drug of Alcohol Treatment (Yes/No)

Do you attend "A.A." or "N.A." ☐ Yes ☐ No

How often?_____

Do you attend any other support groups? ☐ Yes ☐ No

If yes, describe: _____

Have you ever experienced thoughts of harming yourself or another person? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever harmed yourself or another person? ☐ Yes ☐ No

If yes, please explain: _____

_____

Counseling/Prior Treatment History Cont'd

Do you have a history of any suicidal attempts? ☐Yes ☐No

If yes, please describe:_____

_____

Chemical Use History

Substance	Age at first use	Age at regular use	Age at last use	Amount used In last 48 hrs.	Amount used in last 30 days
Alcohol					
Barbiturates					
Valium/Librium					
Cocaine/Crack method of use: _____					
Heroin/Opiates method of use: _____					
Marijuana					
PCP/LSD/Mesc.					
Inhalants					
Caffeine					
Nicotine					
Over-Counter					
Rx Drugs					
Other Drugs					

Substance of Preference

1 ._____2._____

Describe when and where you typically use: _____

_____

Describe any changes in your use patterns:_____

_____

Do you use to build up your confidence? ☐ Yes ☐ No

What is your perception of your use?_____

CHEMICAL HISTORY CONT'D

Who in your family (present/past) has had a problem with drugs or alcohol?

_____

_____

Have you had withdrawal symptoms when trying to stop drinking? □ Yes □ No
If yes, describe:_____

_____

Does your temperament change when you drink? (Describe):_____

_____

Do you have an increased tolerance with drugs or alcohol? (Describe)

_____

Have you experienced blackouts? □ Yes □ No If yes, describe _____

_____

Have you ever overdosed? □ Yes □ No If yes, describe:_____

_____

Legal Information

Have you ever been involved with the police or the courts? □ Yes □ No
If yes, please specify: Date(s)_____

Charge(s)_____

Results_____

_____

_____

Was this related to alcohol or drug use? □ Yes □ No
Are you presently on probation or parole? □ Yes □ No
If yes, please explain:

_____

_____

_____

Military Service

Have you ever served in the armed forces? □ Yes □ No

Branch:_____ Enlistment date:_____

Discharge date:_____ Rank:_____

Combat experience: □ Yes □ No

If yes, when and where?_____

_____

_____

Education

Highest grade completed? (Please check)

□ High School Diploma □ G.E.D. □ Night School □ Some College

□ College Degree _____ (major) □ Graduate Degree _____(field)

List any vocational training you have had:_____

Are you satisfied with your education? □ Yes □ No If no, why?_____

Leisure & Recreational

List your hobbies, leisure time activities, interests: _____

_____

Has your activity level changed? □ yes □ no If yes, explain how_____

_____

Physical Health

Your current physician:

Name:_____

Address:_____

Phone Number:_____ Last date seen:_____

Reason for seeing physician: *(optional)*_____

Current medications:_____

_____

Over the counter medications:_____

_____

List any surgeries, hospitalizations, or past treatment procedures: _____

_____

Are you allergic to any medication or drugs? □ Yes □ No

If yes, what?_____

Family history of medical and emotional problems: _____

_____

_____

Client signature:_____ Date:_____

STAFF USE ONLY

Provider signature:_____ Date:_____

Based on the information provided above, a physical exam □ is not required □ is required

Provider Comments: _____

_____

_____

Supervising Provider:_____Date:_____

Clinician Signature:_____Date:_____