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 **$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:** _____

Hamilton Wellness, PLC

A Bridge to Your Best Self

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: _____

==========

***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

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

Practice Hours

Monday - Thursday 9am - 7pm
Friday 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.
- 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

Hamilton Wellness, PLC

A Bridge to Your Best Self

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: _____

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

___Does not feel liked
___Feels lonely
___Shy with children
___Shy with adults
___Prefers to be alone
___Worries
___Moody
___Sad
___Cries easily
___Expects failure
___Does not share
___Lakes motivation
___Sexual acting out
___Preoccupied with sexual thoughts
___Tics or twitches
___Compulsive behavior
___Ritualistic behavior
___Talks impulsively
___Acts impulsively
___Feelings of guilt

___Sleep difficulties
___Sleep walking
___Bedwetting - present
___Bedwetting - past
___Soiling
___Does not feel like self
___Needs the last word
___Stealing from home
___Will not admit blame
___Sets fires
___Unusual thinking
___Unusual behaviors
___Takes unnecessary risks
___Short attention span
___Destructive to property
___Not always truthful
___Violent behavior
___Poorly organized
___Clumsy
___Fails to understand consequences

___Poor hygiene
Aggressive with:
___Peers
___Siblings
___Adults
___Daydreams
___Jealousy
___Overactive
___Easy to anger
___Stubborn
____Defiant

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

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