TREATMENT CONTRACT AND PRIVACY NOTICE

CLIENT NAME:_____

I acknowledge that I am voluntarily authorizing treatment for myself, or my child/ward upon the premises of **Heron Ridge Associates., PLC.** I have been informed of the purposes of the treatment, the service which may be provided, and any attendant risks, consequences, and/or benefits.

Further, I understand the following:

The treatment will be rendered by appropriate professional personnel; the

Therapist and/or Psychiatrist will be_____

, _____

That I may contact the program or the therapist as the need arises at the telephone number or address provided to me. If the therapist is unavailable, the program will arrange for contact as soon as possible by the therapist or another professional; I may and know how to reach my therapist if after hours;

That successful termination of treatment is determined when the therapist and the client agree that the treatment goals have been substantially completed;

That there are fees for the services rendered at the program, and that I have been informed of those charges and that I am responsible for those charges; These charges may include a fee for a statement of my account.

If a check is returned NSF or uncollectable, any/all bank fees, plus a processing fee of $35.00, will be added to the amount due and owing.

Clients who are seen under an EAP (Employee Assistance Program) benefit are not assessed any fees while under that benefit. The EAP pays for services authorized by them and under the EAP benefit

If I am entitled to insurance payments for this treatment, that the program may assist me, but assumes no responsibility for collecting them;

If the balance on an account I am responsible for, is not paid on monthly and/or outstanding balance on my account is deemed too high by Heron Ridge Associates, the program may cancel therapy sessions until the balance is brought into compliance; however, the program will inform me of this practice no less

than 24 hours before the scheduled appointment;

If I elect to not keep or cancel a therapy session less than 24 hours prior to the scheduled time, the program may charge me for this appointment; I recognize that my insurance will not cover this charge of _____;
Any charges for late cancellations or missed appointments must be paid before another appointment is scheduled.

If I do not send payment within 30 days of billing, the program may attach a 1.5% monthly interest charge; if in the event my account is submitted for collections, all applicable fee will be assumed by me.

The services offered by the program, and the hours of operation have been clearly explained to me. In general they are outpatient services for substance abuse and mental health issues. The program operates five days per week from 9am to 7:00pm Monday thru Thursday and 9am to 5 pm Friday. Ask the office if you need weekend appointments.

As a client I understand that I have certain responsibilities which include the following:

The responsibility to help develop a plan of treatment; by signing my name to this contract, I agree to help develop my treatment plan.

The responsibility (when in my best interest) to sign forms for the release of client information, since the staff cannot give this information out without permission, except in the case of a medical emergency;

The responsibility to suggest changes for the improvement of the services, when appropriate;

The responsibility to comply with the provisions of this treatment contract and to carry out the provisions of my treatment plan.

I understand that I may be discharged by the therapist for the following:

The client has completed the planned course of treatment with an acceptable degree of success;

The client chooses to terminate;

The therapist feels that termination is the most reasonable option, given the client's particular response to treatment;

Other circumstances make it necessary to discontinue treatment due to hardships

or impracticality, e.g. job transfer or family relocation;

The therapist cannot provide services in a professional and ethical manner, in compliance with the standards of all regulatory bodies;

The client fails to maintain contact with the program for a period of more than 30 days;

The client fails to comply with the provisions or this contract;

The client violates one of the program rules which identifies that to do so will result in discharge; these were stated to me at the intake.

That according to state law, certain communicable diseases must be reported to the Michigan Department of Public Health; if it is discovered that the client has such a communicable disease, I consent to such disclosure by the program staff.

I have reviewed the following program rules, and agree to abide by them:

Clients are expected to keep all scheduled appointments. Advance notice is expected when a cancellation is anticipated. In the event of an emergency or unplanned interruption, a prompt phone call is essential. Clients may be billed for missed appointments if they have not given the program 24 hours prior notice.

Repeated failure to attend the program will result in case closure, at the discretion of the therapist.

Heron Ridge is a non-smoking, outpatient facility that does not use restraint or seclusion and does not tolerate any violent behavior or weapons of any kind deemed to be threatening in nature or evidencing any form of violent behavior.

Possession and consumption of substances; including alcohol and non prescription drugs are prohibited on the program premises. Continued use of mood altering substances may result in discharge from the program. Selling of illegal substances on the premises will result in the program staff contacting the police and filing charges for the illegal behavior.

We would direct smokers off the premises wherever is acceptable to smoke.

Clients are required to refrain from disorderly conduct in the building. Physical and verbal abuse and exploitation will not be tolerated; such action will result in discharge from the program with appropriate police action sought. Likewise, deliberate deceiving and manipulation may be interpreted to be a lack of investment in health and may result in discharge.

Clients are to refrain from wandering around the building. The reception area is available for our clients' comfort. Under no circumstances shall the client enter a clinical

area or a records storage area without staff approval.

Clients are expected to participate in treatment as defined by their therapist. Disagreements over the focus of treatment should be discussed with the therapist.

Clients are to inform their therapist and the consulting physician of any and all medications which they are taking.

Clients are expected to fulfill their financial obligation to the program. Failure to pay outstanding balances may result in clients being discharged from treatment.

CARF requires our clients be familiar with emergency exits, procedures and first aid kits. Ask your therapist any questions you may have. Your signature at end of this contract acknowledges you know this information.

If a client is discharged from treatment for breaching program rules they may contact the CEO to further discuss being allowed to return to treatment, reinstate client rights, or receive an appropriate referral to another agency at 248-693-8880 ext 263.

Code of Ethics

We believe that it is our responsibility to represent our professional standards in the best possible light to all we meet and work with, be it in the office for services or in the communities we serve. Those who are not in the field of psychotherapy benefit from recognizing the high quality of care they have an opportunity to receive, from some of the best providers in the metropolitan Detroit area.

We strive to continuously better ourselves and make our profession one to be an example setter. Our marketing approach is straight forward and honest, we disclose information regarding our programs, ownership of the programs, and limitations to the services we offer. Every member of staff meets the highest level of standards for the profession and follow the present rules and regulations of the professional ethics and State licensing mandates.

The entire staff strives to protect the rights of persons served by respecting everyone's right to services which are free from abuse, financial or other exploitation, retaliation, humiliation, and neglect.

There may be occasions, during treatment, where services from more than one provider run concurrent. It is under professional standards of ethical practice that the privacy and confidentiality of our clients is protected and preserved, while coordinating services for optimal results and reduction/elimination of symptoms. If another provider is involved in treatment it will be at the agreement and plan between the client and primary therapist working together.

If it is appropriate that referrals are made for outside services for advocacy, legal, self-help, every effort will be made to provide information to facilitate the client's referral to appropriate help.

Clients who receive written bills for services, and/or rely on third party reimbursement, receive a detailed, clear and concise bill for services rendered. Any information necessary for third party payers, is sent only with proper release from the client or their responsible party. Any questions regarding billing are addressed and resolved directly between the therapist and the client. If there remains an unanswered or unacceptable response, the client is directed to the Recipient Rights advisor or the CEO for further resolution.

Heron Ridge Associates strives to work as best we can with the insurance or lack of insurance a potential client has. We do not discriminate due to ability to pay, however, we must fall within the given guidelines of certain insurances who may not accept our program to render services. We try very diligently to keep our clients aware and informed of any changes they may have with their insurance plans to keep them abreast of their financial obligation. Our fee schedule is set within the recognized and accepted norms for the experience and area we serve. All clients receive the same level of quality of care regardless of the reimbursement to the providers.

Any/all program affiliate service agreements are reviewed, approved, and signed by the CEO, after careful review of the affiliate organization. It is the policy of Heron Ridge Associates to only enter into affiliate service agreements with organizations holding the high ethical and business standards in the industry, and to those which compliment the programs of Heron Ridge Associates. We document any formal complaints received and use these, as appropriate to improve our programs and overall quality of care.

No second hand information or correspondence about a client by another facility shall be released. The information is not considered part of the Heron Ridge Associates client record and is therefore not open to re-release or court order.

All professional staff of Heron Ridge Associates are independent contractors. Our working agreement with them calls for a percentage of fee for service based on reimbursements for services rendered. As the owner of the group is also a provider of services, the risk sharing for costs associated with owning and running Heron Ridge Associates falls solely on the owner's shoulders. No other professional staff member share in the risk of ownership. It is by the design that we have eliminated the consideration of not providing quality services to our clients.

If you have complaints or concerns while in treatment or within 30 days after treatment ends, please voice them in writing to the CEO or Medical Director at the site you were seen. Doing so will not result in any retaliation or barriers to service, and will be

responded to within 25 days after the CEO or Medical Director has an opportunity to review and study the complaint and offer a resolution, if any can be offered, to remedy the concern(s). Every effort will be made to protect the rights, privacy, and confidentiality of the parties complaining and provide the best available remedy for the concern as quickly as possible. If you feel your concerns have not been adequately resolved you may contact MI Center for Substance Abuse Services (CSAS).

By signing of my hand I hereby agree to all provisions of this Treatment Contract and agree that I have requested the services described to me herein. I further attest that I have read my rights under the federal and state statutes for mental health and substance abuse services. If I have requested a copy of this information, a copy has been provided to me. I acknowledge that I have been made aware of my rights as they apply to HIPAA.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it, and that in any event, this consent shall remain active until discharge from treatment at Heron Ridge Associates, unless otherwise

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, _____, _____, _____/_____/_____
(Client Name-please print) (Client Identification Number) (Client DOB MM/DD/YYYY)

authorize _____, to release protected health information related to my evaluation and treatment to:
(Provider Name-Please Print)

PCP Name:_____ **PCP Phone:**_____

PCP Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

CLIENT PLEASE CHECK ONE

_____ To release any applicable mental health/substance abuse information to my primary care physician

_____ To release only medication information to my primary care physician
_____ I DO NOT give my authorization to release any information to my primary care physician.

Please indicate your preference(s) of being contacted (check all that apply):

( ) Home Telephone_____
( ) OK to leave message with detailed information
( ) Leave message with call-back number only
( ) OK to mail to my home address
( ) OK to mail to my work/office address

( ) Work Telephone_____
( ) OK to leave message with detailed information
( ) Written Communication
( ) Other _____
( ) OK to fax to this # _____

_____ _____
Client or Legal Guardian Date

_____ _____
Witness or Therapist Date 2017