PEER & ASSOCIATES
Psychological Health and Wellness Services

CONSENT TO TREATMENT

I, ____, acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the therapy processes.

I understand that no promises have been made to me about the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 business day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment in the amount of $60.00.

I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

______________________________ ______________________________ ____/____/____

Signature of client or legal representative Printed name Date

______________________________ ______________________________

Printed name of legal representative Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

___/___/___ ____

Signature of therapist

Date

❑ Copy accepted by client and copy sent to chart

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

PEER & ASSOCIATES
Psychological Health and Wellness Services

Consent to Use and Disclose Your Health Information

This form is an agreement between you, ___________________________, and Peer & Associates. When we use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here:

____.

When we examine, evaluate, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide what treatment is best for you and to provide this treatment to you. We may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let us use your PHI here and to send it to others for the purposes described just above. **Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information.** If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use your PHI to evaluate, diagnose, and treat you.

In the future, we may change how we use and share your PHI, and so we may change our Notice of Privacy Practices. If we do change it, you can get a copy from our compliance officer, Dr. Justin W. Peer, who can be reached at (734) 235-0001 or peerandassociates@gmail.com.

After you have signed this consent, you have the right to revoke it by writing to our compliance officer. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

____/____/____ ____

Date Signature of patient/personal representative

____ ________________________

Printed name of patient/legal representative Relationship to client

____

Signature of witness/treating clinician

❑ Copy given to the client/parent/personal representative [5/1/19]

PEER AND ASSOCIATES, PSYCHOLOGICAL HEALTH AND WELLNESS SERVICES

PRIMARY CARE PHYSICIAN NOTIFICATION FORM

Name of Patient____

Name of Parent/Legal Guardian (if necessary) ____

Name of Physician____

Address____

CONSENT TO EXCHANGE INFORMATION

I, ____, agree to release my, or my son's/daughter's medical records to the above-named physician. I understand the purpose of, and agree to, providing this information to assist my physician in coordinating the necessary care between my behavioral health care provider and my primary care physician. I understand that such information may include my primary diagnosis, associated symptomology, and treatment recommendations.

____ __________
Patient/Parent/Legal Guardian Signature **Date**

____ __________
Clinician/Witness Signature **Date**

_______(Initials) I do not wish to exchange information with my primary care physician. I understand that I take full responsibility to communicate to my primary care physician my diagnosis and treatment recommendations offered to me by Peer and Associates.

PEER AND ASSOCIATES, PSYCHOLOGICAL HEALTH AND WELLNESS SERVICES

INSURANCE BENEFITS AND PAYMENT AUTHORIZATION FORM

I, ______________________________, authorize Peer & Associates, Psychological Health and Wellness Services, to charge my credit/debit/health saving account card listed below after each visit, effective immediately, for the co-payment and/or balance due on my account. In addition, I authorize Peer & Associates Psychological Health and Wellness Services to save the credit card information I provide my clinician and to process this credit card as "Card on File" (without the card present) for all subsequent visits.

This payment authorization is valid and to remain in effect unless I notify Peer & Associates, Psychological Health and Wellness Services of its cancellation by phone, email, written correspondence, or in person.

I fully understand that I am responsible for any fees that are not covered by insurance. Peer & Associates, Psychological Health and Wellness Services assumes no liability for any benefit information that is misquoted by your insurance carrier. It is my responsibility to be aware of my insurance coverage, limitations, and terms/conditions that are a part of my policy.

Benefits and verification are performed as a courtesy to you. Peer & Associates, Psychological Health and Wellness Services will not be responsible for any information that is obtained directly from my insurance carrier that is later deemed inaccurate. I am responsible for payment of any deductible, copayment and coinsurances as determined by my policy **at the time that services are rendered**.

My insurance benefits are as follows:

Insurance Type: ______________________________________

Deductible: ____

Co-Pay/Co-Insurance per visit: __________________________

or

(Continued on next page)

I will not be using healthcare insurance to pay for the cost of the services I receive. I agree to pay privately the following amount per session:

$_______________

I acknowledge receipt of this information, understand this information, and have provided my clinician my credit card information to be kept securely and confidentially on file.

Signature Date

I have explained benefit information to the above named. I have received the credit card information for the above named and have placed securely and confidentially on file.

Clinician Date

PEER AND ASSOCIATES, PSYCHOLOGICAL HEALTH & WELLNESS SERVICES
CANCELLATION/NO SHOW POLICY & PHONE USAGE PROTOCOL

Cancellation/No Show Policy:
We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you do so 24 hours prior to the appointment occurring and/or as soon as you know you will not be able to attend. This will allow others who are waiting for an appointment to be scheduled in that appointment slot. When appointments are not cancelled, we are unable to offer that slot to another person. This causes a significant inconvenience to our providers and other patients.

Our practice will allow for one (1) cancelled appointment within 24 hours. At the next scheduled appointment your clinician will re-educate on this policy. **Subsequent appointments that are not cancelled 24 hours ahead of the scheduled time (ie. a "no show") will be subject to a $60.00 fee.** Insurance will NOT pay this fee. This fee will be billed directly to the credit card that you have on file.

Phone Usage Protocol:
Your clinician may choose to provide you with a cellular phone number and/or an email address to reach him/her directly. Your clinician is not "on call" and may not be able to respond immediately to calls/text messages/emails. Emails, voicemails, and text messages are responded to within regular business hours. If your clinician provides you with their cellphone number and/or email address, please understand that it is not to be used in case of crisis or emergency. This number is provided **ONLY** to discuss scheduling, to cancel appointments, and/or to "check in" regarding any other mutually agreed upon concerns. If you are in a psychiatric emergency, dial 988 (suicide and crisis lifeline) or go directly to the nearest emergency room.

Please sign that you have read, understand, and agree to this Cancellation/No Show Policy and Phone Usage Protocol.

____
Printed Patient Name

_______________________________________ ____________________
Signature of Patient or Patient Representative Date

PEER & ASSOCIATES
Psychological Health and Wellness Services

TELETHERAPY CONSENT FORM

Definition of Services:

I,____, hereby consent to engage in teletherapy with _____________________________. Teletherapy is a form of psychological/counseling service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy/counseling sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Patient's Rights, Risks/Limitations, and Responsibilities:

1. I, the patient, need to be a resident of Michigan. (This is a legal requirement for practitioners practicing in this state under a MI license.)

2. I, the patient, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Service Agreement I received at the start of my treatment.

4. I understand that there are risks and potential consequences associated with participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my practitioner, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be not be physically present and cannot render any emergency assistance if I experience a crisis.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my practitioner believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, as noted in the original Service Agreement, and that these apply also to teletherapy.

8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support. Patients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my practitioner will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (a.) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (b.) arranging a location with enough lighting and privacy that is free from distractions or intrusions for my teletherapy session, (c.) refraining from engaging in activities that may be distracting or inappropriate. I will treat teletherapy as I would a face-to-face session. It is the responsibility of the practitioner to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I have read, understand and agree to the information provided above regarding teletherapy:

Patient Signature: ________________________________ Date____________

Practitioner Signature: ____________________________ Date____________

JWP 11/2020