Transformational Choices
Mindful, Contemplative, & Creative Holistic Therapy / www.transformationalchoices.com / info@transformationalchoices.com / 734-559-3540

Name _____

Address _____ City _____

State _____ Zip _____ DOB_____

Telephone (Home / Cell) _____(Work)_____

Email _____

Primary Insurance Provider: _____

Policy Number: _____ Group Number:_____

Insurance Type: (HMO/ PPO/ etc.) _____Co-Pay Amount:_____

Name of Person on Policy _____

Secondary Insurance Provider: _____

Policy Number: _____ Group Number:_____

Insurance Type: (HMO/ PPO/ etc.) _____Co-Pay Amount:_____

**********For Office Use Only**********

CONSENT TO SERVICES / RIGHTS ACKNOWLEDGEMENT

I hereby request and consent to services for myself/dependent which includes therapy, diagnostic assessment, case coordination, consultation, and other treatment/services recommended and considered necessary. I understand that developing a treatment plan with my therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by my therapist.

I am aware that I may stop my treatment with my therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to face other consequences if I stop treatment (for example, if my treatment has been court ordered, I will have to answer to the court).

I agree that traditional (face-to-face) and virtual (online) therapy involves the use of electronic communications (video, telephone, texts, emails, appointment reminders, etc.) with Transformational Choices mental health professionals to connect with individuals and may include interactive video and audio communications. When applicable, virtual therapy includes the practice of psychological and behavioral health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive at this clinic. I understand that if payments for the services I receive at this clinic are not rendered, then the clinic may stop my treatment.

By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based, in-person psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

I have been informed that any information regarding services at Transformational Choices are subject to release only by my informed and written consent or by subpoena and/or court order. I have also been informed that patient identifying information about me may be exchanged between office staff and other designated/contracted providers for continuity of care purposes.

I authorize this clinic to release any medical information necessary to process claims for the services provided. I authorize payment of governmental/medical benefits to this clinic for services provided. I understand that I remain responsible for any and all charges not met by my insurance company.

Client Signature_____ Date _____

CONSENT FOR TREATMENT OF MINOR

I authorize this clinic to provide services for _____. I agree to follow-up with phone conversations regarding progress in therapy and to participate in therapy as recommended.

Client Signature_____ Date _____

Parent or Representative Signature_____ (relationship)_____ Date_____

Client Agreement to Pay for Service

I agree to pay all charges for the services I receive. If I use insurance to cover some or all of my counseling at Transformational Choices, I agree to pay any amounts that my insurance carrier does not pay. These may include (but are not limited to) services and charges determined by my insurance carrier not to be medically necessary, and/or services and charges not covered by my insurance plan. **These charges also include all co-payments and co-insurances and deductibles.** If I incur a charge for a missed or late-canceled appointment, I understand that I will be responsible for payment of that charge. Client understands that all fees 90 days over original service date will incur an additional monthly 10% late fee. All fees over 180 days will be turned over to debt collection services. The following are my agreed upon fees:

Rates

$225 for the initial appointment (2 hours) / Or Health Care Provider Contracted Amount
$150 for family therapy / Or Health Care Provider Contracted Amount
$165 per session / Or Health Care Provider Contracted Amount
$103 Additional Out of Session Paperwork Fee / Or Health Care Provider Contracted Amount
$25 to $50 per person for group sessions / Or Health Care Provider Contracted Amount

Services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by asking the following questions:

- Do I have mental health insurance benefits?
- What is my deductible and has it been met?
- How many sessions per year does my health insurance cover?
- What is the coverage amount per therapy session?
- Is approval required from my primary care physician?

____*My/Our initials here indicate I/we do **not** plan to use insurance.*

____*My/ Our initials here indicate I/we **do** plan to use insurance*

I/we have read, understand, and agree to the above and to pay all copay / deductible amounts.

Client(s) Signature _____Date_____

** It is the client's responsibility to secure prior authorization for services when necessary.*

NOTICE: Health Insurance Deductibles

Client is responsible for payment of all health insurance deductibles as applicable. These rates are non-negotiable and must be paid in full at the rate stated by health insurance provider. ***I/we have read, understand, and agree to the above.***

Client(s) Signature _____Date_____

Private Pay and Income Based Sliding Scale Rates

Rates

$225 for the initial appointment (2 hours)
$150 for family therapy
$165 per session

$103 Additional Out of Session Paperwork Fee or agreed insurance provider-based amount
$5 to $50 per person for group sessions

Reduced Rates

Sliding Scale available for cash payments

Income based sliding scale is as follows:
Household income consists of your income and the income of others with whom you reside.

$60.00 per session	Household income of $25,000 or less
$75.00 per session	Household income between $25,001 - $35,000
$85.00 per session	Household income between $35,001 - $45,000
$103.00 per session	Household income of $45,001 and above

Payment
Cash, check and credit cards are accepted for payment. There may be a 3% processing fee for all electronic (credit / debit card) payments. There is a flat $3.00 service fee for credit / debit payments taken over the telephone.

Cancellation Policy
If you do not show up for your scheduled therapy appointment, and you have not notified us at least 24 hours in advance, you may be required to pay the full cost of the session. Please see Cancellation Policy for additional details and client responsibility.

Schedule Appointments
Please contact your therapist directly or request a therapy appointment by calling 734-559-3540 or emailing info@transformationalchoices.com or by visiting our website at www.transformationalchoices.com

Contact
Questions? Please call 734-559-3540 or email info@transformationalchoices.com or visit our website at www.transformationalchoices.com

Client Signature_____ Date _____

CANCELLATION POLICY

We look forward to working with you. Our appointment sessions are approximately forty-five (45) to seventy-five (75) minutes long. It is our strict policy to stay on time for all scheduled appointments. Therefore, if at all necessary, your wait time is kept to a minimum. Due to the length of time provided for each appointment, it is critical that you arrive on time for your appointments. **If you are more than 15 minutes late, your appointment will be rescheduled, and you will be charged the full cost of your session**. If 24-hour notice of cancellation is provided, no fee will be charged. We require at least twenty-four (24) hours notice for all cancellations, unless your appointment is on Monday, for which cancellation needs to be before 3pm on the prior THURSDAY.

Insurance companies will not pay for "No Shows or Late Cancellations," therefore you will be responsible for half (50%) of the fee for a missed appointment at the first no show or late cancellation. After the second no show or late cancellation, you are responsible for the entire fee, and to continue scheduling, you may have to pre-pay the third session. Fees will be collected prior to the next scheduled appointment.

After 3 cancellations or no shows, you will not be able to schedule another appointment. If you have arranged with your therapist to have standing appointments, then after the first no show, all appointments will be removed from the schedule and will have to arrange appointments weekly.

I have read and understand the cancellation policy.

Client Signature _____Date _____

Parent or Representative Signature _____(relationship) _____Date_____

The guidelines that govern traditional therapy also apply to virtual therapy. Transformational Choices is not responsible for additional risks related to virtual therapy. I understand that there are risks and consequences from virtual therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Transformational Choices, that: the transmission of my personal information could be disrupted or distorted by technical failures, could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Clients are not allowed to make an audio or video recording of any portion of the virtual session. Client understand that if counselor believes they would be better served by another form of intervention (e.g., face-to-face services), they will be referred to a mental health professional that can provide such services in my area. Client understands that there are potential risks and benefits associated with any form of psychotherapy. If virtual services are not available due to an unplanned equipment or service malfunction, sessions will occur via telephone or by other alternative method. Client agrees to maintain an environment of confidentiality in location they choose to participate in virtual sessions. Fees for virtual sessions must be paid in advance. Fees will apply to no-show and late cancel appointments. I have read and understand the information provided and consent to any associated risks for virtual therapy.

Client Signature _____Date _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATIONS ABOUT YOU MAY BE USED AND DISCLOSED AND HOU YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other used required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining authorization for treatment may require that your relevant protected health information be disclosed to the health plan.

Healthcare Operations: We may use or disclosed, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of Licensed Professional Counselor Interns, and licensing. For example, we may call you by a name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health issues, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your authorization or opportunity to object unless required by lay.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

II. Your Rights

You have the right to inspect and receive a copy of your protected health information. Our practice will accept such requests in writing. You may not inspect or receive a copy of the following records: psychotherapy therapists notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on the disclosure of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.

You have the right to have your physician amend you protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

III. Complaints

You may file any complaints with our office staff, at 734-559-3540, if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

I, _____, have read and understand the information contained in the HIPAA Notice of Privacy Practices form.

Please acknowledge your receipt and understanding of this Notice of Privacy Practices by signing below.

Client Signature_____ Date_____

Parent or Representative Signature (relationship)_____Date_____

We welcome you. We will welcome you regardless of your present status; anxious, sad, angry, lonely, happy, questioning, depressed, lost or otherwise. We will welcome you regardless of your current family situation, relationship or marital status or lack thereof. We will welcome you if you have been to therapy in the past, are looking to come in for the first time, or have no idea what to expect. We will not judge you based upon your personal history, age, race, ethnic background, appearance, sexual orientation or gender identity. We welcome all beliefs, religions, spirituality, and affiliations. We welcome children, even when they act like children. We welcome adults, families, couples, and we welcome you. We welcome your tears, your laughter, your thoughts, your moods, your journey, and your story. We are all in this together, trying to find our way. All are welcome. You are welcome.

Main Office and mailing address:
Transformational Choices, 9409 Haggerty Rd, Plymouth MI 48170
734-559-3540 / info@transformationalchoices.com
www.transformationalchoices.com

Virtual Therapy (Statewide across Michigan)
virtual@transformationalchoices.com / 734-559-3540

Ann Arbor Office
3200 W. Liberty Rd. C2 Ann Arbor, MI 48103

Southfield Office
17515 W. 9 Mile Rd. Suite 345 Southfield, MI 48075

Chelsea Office
140 W. Middle St. Suite C, Chelsea, MI 48118

Monroe Office
824 S. Monroe St. Monroe, MI 48161