

PAR REHAB SERVICES
CHILD/ADOLESCENT PATIENT INFORMATION

TODAY'S DATE: _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City, State: _____ Zip: _____

DOB: _____ SSN: _____ Sex: _____ Home Phone: _____

Race/Ethnicity: ☐ African American ☐ Caucasian/White ☐ Asian ☐ Other
☐ Hispanic/Latino ☐ Native American ☐ Pacific Islander ☐ Decline

School Name: _____

Father's Name: _____ SSN: _____ DOB: _____

Address (if different than above): _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Mother's Name: _____ SSN: _____ DOB: _____

Address (if different than above): _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Who has physical custody of the patient? _____ legal custody? _____

If joint custody, please indicate schedule. _____

Emergency Contact: _____ **Phone #:** _____

Primary Care Physician: _____ PCP Address: _____

PCP Phone: _____ Referral Source: _____

Other physicians involved in child's care: _____

Insurance: _____ Contract #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Current Medications: _____

Allergies: _____

Is Condition Auto Accident Related? _____ If so, Date of Injury: _____

Auto Insurance Carrier and Agent: _____ Auto Policy #: _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE OF THIS FORM



RELEASE OF INFORMATION:

I, hereby authorize PAR Rehab Services to release medical and financial information pertaining to services rendered to the third party insurance carrier (s) for charges incurred in my treatment.

PAYMENT AUTHORIZATION FOR BENEFITS:

I, hereby authorize that the benefits payable be directly paid to the provider by the third party carrier (s).

CONSENT FOR TREATMENT:

I, hereby consent to receive and participate in treatment/testing with PAR Rehab Services.



Signature: _____

Date: _____



PAR

REHAB SERVICES

In regards to the fee for the service(s) we will be rendering, we will assist you with a courtesy billing to the primary insurance carrier and any available secondary carrier (s). However, we would like to advise you that **you are responsible for payment for the services rendered.** If we have not secured payment from your insurance company within 90 days, you will be responsible for the bill.

In order to provide the courtesy billing, we need your assistance in providing full and complete information in regards to your health insurance policy and any secondary insurance plan(s) that might be applicable. If we are a non-participating facility with your insurance plan, you may receive all information, such as Explanation of Benefits, and all payments. We need your cooperation in promptly providing our office with originals or copies of any payment, correspondence, rejection notices, etc. that you receive from your insurance carrier(s). We will be happy to provide you with a stamped, addressed envelope for this purpose.

Because insurance plans and benefits vary greatly by individual plan and employer, **we do not quote specific insurance benefits.** As the insured, you are ultimately responsible to know your copay and deductible information. We are more than happy to provide you with the procedure codes we use for billing so that you may contact your insurance company for detailed benefit information.

Additionally, as the insured, you are responsible for knowing if PAR Rehab Services is in-network with your insurance. We participate with a wide range of insurance plans, however, we do not participate with MI Child, Ingham Health Plan, or straight Medicaid. If you have one of these insurances as primary or secondary, you will be responsible for any copays, deductibles, or balances associated with your visits.

FINANCIAL RESPONSIBILITY STATEMENT:

I understand that the charges for services received may exceed the benefits payable or may not be a covered benefit under my present health insurance plan. I also understand that my cooperation is required in providing PAR Rehab Services with any and all payments, and copies of the Explanation of Benefits, which accompanies the payment or any notice of rejection of payment. I agree to accept responsibility for providing the necessary paperwork, or copies thereof to secure payment for services rendered.

Additionally, I understand that PAR Rehab Services has a **48-hour cancellation policy** for all scheduled appointments. We reserve the right to charge a no show/late cancellation fee for appointments that are not cancelled 48 hours prior to the scheduled appointment time. No show/late cancellation fees are as follows:

Psychotherapy appointments - \$35

Psychological or Neuropsychological testing - \$150

Psychiatric appointments – up to 100% of the billable visit

No appointments will be rescheduled until this fee has been paid or payment arrangements have been made. These late cancellation fees are non-refundable and are not payable by your insurance carrier.

Co-payments are due at the time of the visit, unless other arrangements have been made. All accounts past due more than 30 days will be charged an 8% interest fee. There is a \$30.00 fee for all returned checks. If your account is 90 days' delinquent, services may be discontinued and your account turned over to a collection agency. Additional fees may be assessed for medical records requests and form completion.

I understand and agree to all of the conditions listed above. I agree to accept financial responsibility for payment in full or for any balance remaining after insurance payments has been made to PAR Rehab Services.



Signature: _____

Date:

PAR Employee: _____

Date:

**PAR REHAB SERVICES
RELEASE OF INFORMATION
TO PRIMARY CARE PHYSICIAN (PCP)**

The information released in this authorization is confidential. Further disclosure of this information is prohibited unless otherwise permitted by Federal and State laws.

Patient Name: _____ **Date of Birth:** _____

☐ I hereby **DECLINE** to allow PAR to release and/or obtain written and verbal information with my Primary Care Physician.

☐ I hereby **AUTHORIZE** PAR to release and/or obtain written and verbal information with the Primary Care Physician identified below, and under the conditions specified below:

Primary Care Physician: _____ **Phone Number:** _____

Address: _____ **Fax Number:** _____

<input checked="" type="checkbox"/> Psychological/Neuropsychological Report	<input type="checkbox"/> School Records
<input type="checkbox"/> Psychiatric Records	<input type="checkbox"/> Hospital Records
<input checked="" type="checkbox"/> Progress Notes	<input type="checkbox"/> Verbal Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Therapy Intake	

The purpose for the disclosure is to assist in the development of a medical treatment plan.

My signature indicates that I know what information is being released, and any consequences that may arise as a result of my signing this authorization, or refusing to sign. I have read this form, or had it read to me and explained in language that I can understand. All the blank spaces have been filled out except for my signature and the dates. This consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on it. Unless this consent has been revoked in writing, it will automatically expire one year from the date signed.



Patient Signature: (Parent/Guardian if Patient is a Minor)

Date:

PAR Employee:

Date:

Authority: from mental health services: Michigan Mental Health Code, PA 258 of 1974 as amended. For substance abuse services: Federal requisitions governing confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR part two and PA 368 of 1978, Michigan Mental Health Code. For HIV, AIDS, and ARC related conditions: PA 271 of 1981, PA 488 of 1989. For communicable and infectious disease records (including venereal disease and TB records) as defined by the Michigan Department of Community Health.

PAR Rehab Services, 3960 Patient Care Dr., Suites 104 & 117, Lansing, MI 48911

**PAR REHAB SERVICES
RELEASE OF INFORMATION**

The information released in this authorization is confidential. Further disclosure of this information is prohibited unless otherwise permitted by Federal and State laws.



Patient Name: _____ **Date of Birth:** _____

I hereby authorize PAR to release and/or obtain written and verbal information with the individuals listed, and under the conditions specified below:



Information will be released to / obtained from: **(one individual or office per release, please)**

Name	Phone Number
<hr/>	
Address	Fax Number

Information to be released and/or obtained:

<input type="checkbox"/> Psychological/Neuropsychological Report <input type="checkbox"/> Psychiatric Records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Verbal Communication	<input type="checkbox"/> School Records <input type="checkbox"/> Hospital/Medical records <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other: _____
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My signature indicates that I know what information is being released, and any consequences that may arise as a result of my signing this authorization, or refusing to sign. I have read this form, or had it read to me and explained in language that I can understand. All the blank spaces have been filled out except for my signature and the dates. This consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on it. Unless this consent has been revoked in writing, it will automatically expire one year from the date signed.



Patient Signature (Parent/Guardian if Patient is a Minor)

Date

PAR Employee

Date

Authority: from mental health services: Michigan Mental Health Code, PA 258 of 1974 as amended. For substance abuse services: Federal requisitions governing confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR part two and PA 368 of 1978, Michigan Mental Health Code. For HIV, AIDS, and ARC related conditions: PA 271 of 1981, PA 488 of 1989. For communicable and infectious disease records (including venereal disease and TB records) as defined by the Michigan Department of Community Health.

PAR Rehab Services, 3960 Patient Care Dr., Ste. 104, Lansing, MI 48911

**PSYCHOLOGICAL ASSOCIATES IN REHABILITATION
PROFESSIONAL ASSOCIATES IN REHABILITATION
DBA PRR REHAB SERVICES**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Please sign below **acknowledging** that you have received a copy of our notice of privacy practices.

 Patient Name: _____

 Signature: _____


Relationship to Patient: _____

Date: _____

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

 _____
Patient Signature: (Parent/Guardian if patient is a minor) Patient Name: (please print)

Date: _____

.....
OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Reason: _____

Date: _____ Initials: _____

PATIENT'S RIGHTS, RESPONSIBILITIES, AND CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

MISSION STATEMENT:

Our mission is to provide comprehensive rehabilitation and mental health services to individuals of all ages, with a wide range of disabilities and needs. We provide services for our patients in a mutually respectful and compassionate (supportive) environment. We strive to treat each individual with respect and dignity as we work collaboratively to achieve functional goals and increase independence.

GOALS FOR SERVICE:

The goal of our mental health and substance abuse programs is targeted to help our patients deal with a variety of problems, and to help the patient connect with outside community resources, as needed. The goal for this program too is to help the patient function at his or her maximum potential while supporting the notion of self-determination.

CODE OF ETHICS:

1. PAR staff shall conduct themselves in a professional manner.
2. PAR staff shall treat co-workers, professionals in the community, and organizations with respect, and comply with patient confidentiality.
3. PAR staff shall comply with the ethical codes specific to their disciplines.
4. PAR staff shall respect the agency property, and comply with all health and safety regulations to assure the protection of staff, patients, and property.
5. PAR staff shall conduct themselves in a professional and fair manner in their business and marketing manners.
6. PAR staff shall seek out opportunities for professional growth and attainment for professional knowledge.
7. PAR staff shall respect all patient rights, treat patients with dignity, and comply with confidentiality guidelines.
8. PAR staff shall treat all patients as individuals and unique persons, without prejudice regarding their disability, race, creed, color, religion, age, or ethnic background.

9. PAR staff shall not condone or employ dual or multiple relationships with patients, nor exploit those relationships for personal gain.
10. PAR staff shall put serving the patient's best interests at their highest priority.

THE THERAPEUTIC RELATIONSHIP:

PAR Rehab Services employees and interns shall establish a professional relationship with patients, and therapists shall maintain a professional working relationship based on honesty and trust. PAR Rehab Services encourages family and friends to support the patient in treatment with the patient's permission. All PAR Rehab Services employees and interns must abide by the PAR code of ethics, and each therapist must also abide by his or her discipline-specific code of ethics. If you feel that an ethical violation has occurred, please contact the Executive Director.

LIMITATIONS OF TREATMENT:

Therapeutic services cannot guarantee complete resolution of problems. However, PAR's therapeutic staff is committed to providing their best professional efforts to assure patient's goals are met. For treatment to have an optimal impact, patients are encouraged to be committed to the therapeutic process and to follow treatment recommendations.

In some instances, patients may be transferred to other providers or discharged from the practice prior to meeting the goals set out in the patient's treatment plan. Any potential transfers or discharges from service will be discussed with the patient prior to any change taking place. Transfers or discharges can be made at the request of the patient. The provider may also request a transfer or discharge in the event of a conflict of interest or non-compliance on the part of the patient.

AFTER HOURS SERVICE:

If patients require after hours services (weekly after 5:00 p.m. or weekends), they may call PAR Rehab Services' office at (517) 887-9801. The answering service shall contact the appropriate therapist, who will then call the patient back.

PATIENT RESPONSIBILITIES:

1. Patients have the responsibility to attend at least 90% of treatment sessions.
2. Patients have the responsibility to provide information about themselves as honestly as possible to assure the most appropriate service delivery.
3. Patients have the responsibility to participate in their own treatment planning process.
4. Patients have the responsibility to work cooperatively with the PAR Rehab Services Office Manager to make arrangements to cover any account balances, as necessary.
5. Patients have the responsibility to give a 48 hour notice for appointment cancellations.
6. Patients have the responsibility to keep information about other patients confidential (i.e., information shared in group therapy sessions).

7. Patients at PAR Rehab Services are expected to adhere to a code of conduct whereby they show respect for themselves, respect for others, and a respect for PAR property. Any individuals displaying disrespectful behavior may be asked to leave the premises and may be discharged.
8. In keeping with PAR's intent to provide a safe and healthful work environment, smoking is prohibited throughout the premises. This includes all forms of tobacco products, including but not limited to: cigarettes, cigars, chewing tobacco, electronic cigarettes, snuff, etc. In accordance with state laws, smoking is permitted outside the building. Legal and prescription drugs may be brought on site in a secured manner. They must be kept in their original containers and kept out of public view. This can include a purse, briefcase, etc. PAR prohibits the use and/or distribution of illegal substances throughout the premises. In addition, PAR maintains a weapons free policy throughout the entire campus. This policy applies equally to all employees, patients, and visitors.

PATIENT RIGHTS:

1. Patients have the right to be treated with dignity and respect.
2. Patients have the right to be treated in a safe environment.
3. Patients have the right to be free from abuse, whether be emotional, physical, or sexual. Patients shall not be psychologically abused, including humiliating, threatening, or exploitative actions.
4. Patients have the right to confidentiality. All patient records are kept confidential. PAR Rehab Services complies with all federal and state confidentiality regulations.
5. Patients have the right to be informed of their treatment status and progress. Patients may request status reports of their treatment progress at any time, from any of their therapists.
6. Patients have the right to have access to their records via an approved procedure.
7. Patients have the right to information about their billing and account balances.
8. Patients have the right to receive treatment at PAR Rehab Services that is appropriate to their needs.
9. Patients have the right to file any complaints about their rights with the PAR Rehab Services Patient Rights Advocate.
10. Patients have the right to utilize staff advocates to assist with referrals for appropriate services (i.e., self-help groups, guardians, or conservators).

CONFIDENTIALITY:

PAR Rehab Services holds all information given by patients as confidential except in the following instances:

1. Information regarding the threat of harm to self or to others. PAR Rehab Services has the legal and ethical duty to report such information to the proper authorities.
2. Cases of suspected child abuse or adult abuse must be reported by law.
3. When necessary to comply with provisions of the law.

4. If the patient has been adjudicated as not being competent, and has a legal guardian. If the patient has not been adjudicated, however, PAR Rehab Services assumes the patient is competent to give an informed consent.
5. All clinical personnel are designated as "Mandated Reporters" and have a duty to warn in the event of a critical incident. A "critical incident" is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant. Any person who becomes aware of a critical incident is required to report the incident.

FORMAL COMPLAINTS:

Complaints can be categorized as informal or formal. Informal complaints are discussion based, not always documented, and the complainant does not seek a formal resolution for their concern. Formal complaints are documented as outlined below and require a resolution.

While all formal complaints are routed through the Patient Right's Advocate, any staff member at PAR Rehab Services can assist you in filing a complaint. Patients will not be criticized, humiliated, degraded, threatened, or discharged from services for filing a Patient Right's Complaint. PAR staff members may file a Patient's Right Complaint on your behalf at any time as well. If you choose to terminate services from PAR Rehab Services as a result of a right's issue, the Patient Rights Advocate will assist you in finding additional suitable services elsewhere without threat or reprisal.

Complaints can be filed:

- Anonymously: A patient who files a complaint would not indicate their name on the form. (However, this patient may not be entitled to knowledge of the resolution or remedial action).
- Confidential: The patient name is kept private and only given to the Executive Director.

All formal complaints are documented. Written analyses of all formal complaints are prepared annually. Analyzing the formal complaints that PAR Rehab received in the course of the year allows us to understand areas for improvements. PAR takes formal complaints seriously and makes sure that any mistakes made are corrected and not made again. If changes need to be made to the policies and procedures at PAR to correct complaints, the appropriate actions are taken and implemented.

Verbal Complaint

All patients may discuss a Rights Complaint with any staff at any time. A verbal complaint will be documented, reviewed, and the patient will be contacted about the results if requested. The Patient Rights Advocate can also be contacted via telephone at (517) 887-9801 to take your verbal complaint over the phone.

Written Complaint

A patient may wish to file a complaint in writing. PAR has an established Patient Complaint Form that can be made available to anyone wishing to file a written complaint. This form can be obtained from any staff member or at the front office. Patients may also wish to fill out their own complaint form or draft a letter of complaint. All written complaints can be dropped off in the office or mailed to PAR. They should be directed to the attention of the Patient Rights Advocate or the Executive Director.

CONFIDENTIALITY OF RECORDS RELATED TO ALCOHOL AND DRUG ABUSE

Confidentiality of patient records related to alcohol and drug abuse is protected by federal law and regulations. Generally, PAR Rehab Services may not disclose information identifying a patient as an alcohol or drug abuser unless:

- (1) the patient consents in writing;
- (2) the disclosure is allowed by a court order;
- (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; or
- (4) the patient commits to threatens to commit a crime either at the program or against any person who works for the program.

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurred.

PATIENT'S ACKNOWLEDGEMENT

I hereby acknowledge that I have received a copy of the PAR Rehab Services' Patient's Rights and Responsibilities information. I have reviewed the information and understand its content. If I do not understand the information, it shall be explained to me in a language that I comprehend. If I have questions or concerns regarding my rights and responsibilities as a patient at PAR Rehab Services, I can direct these issues to the Patient's Rights Advocate at PAR Rehab Services.

I have read this informed consent document, and discussed it with a member of the staff at PAR Rehab Services. Any questions that I have had concerning its contents have been answered. I understand its contents fully, and hereby agree to treatment under the conditions stipulated in this document. I understand that I am required to follow the rules and expectations stipulated in the document and can be discharged for non-compliance.

Patient's Signature

Date

PAR Staff Signature

Date