DENNIS, MOYE, BRANSTETTER & ASSOCIATES, P.C.
1750 S. Telegraph Road, Suite 101
Bloomfield Hills, Michigan 48302
www.DMBandassociates.com
Phone (248) 451-9085
Fax (248) 451-9089

Welcome to Dennis, Moye, Branstetter & Associates. This information sheet is designed to acquaint you with the services we provide and the procedures we follow. **This information sheet is for you and does not need to be returned**. If you have any questions after reading this information, please do not hesitate to ask your therapist.

ABOUT OUR SERVICES

OFFICE HOURS:

The business office will be open Monday through Friday (closed on all major holidays). For your convenience, your therapist may arrange to see you at times and days other than those stated above.

VOICE-MAIL SERVICE:

The office has a voice mail system operating 24 hours per day. You can conveniently leave a message with your therapist by following the voice mail instruction. Your therapist will retrieve their messages frequently for your convenience. If you need to speak to the office manager follow the voice mail instruction. If you have an emergency and your therapist cannot be reached, go directly to the nearest hospital emergency room or call 911.

CONFIDENTIALITY:

By law, you have the right of confidentiality. Information about your therapy will **NOT** be discussed with anyone without your written consent. Confidentiality may be broken when there is a threat to self or others, or where child abuse becomes an issue. If you would like information shared with another person or health care provider, you **must** sign a ***Release of Information*** form. Please be advised that your insurance company will require diagnostic information before it can process your claim. If you sign the ***Insurance Authorization to Release Information*** on your insurance claim form you are giving permission to the therapist and Dennis, Moye, Branstetter & Associates to provide all required information to process your claims. This is part of your contract with your insurance company.

INFORMED CONSENT FOR TREATMENT:

Psychological services received at this facility are voluntary and can be terminated by the patient at any time. You have the right to be told what treatment involves, weekly costs, duration, and likely outcome. There are no guarantees of a favorable outcome.

Office use only:

DATE:_____ Account #

THERAPIST:_____ Provider #

Dx:

Demographic Information

(Please Print)

Patient Name: _____Drivers License#:_____

Home Address:_____
Number & Street

_____
City State Zip Code

Sex: MALE FEMALE TRANSGENDER OTHER Birth date: _____ Age: _____

Telephone Numbers, *include area code:* ( ) _____ ( ) _____
Home Work

( )_____ Email: _____
Cell/Other

Marital Status: Single Married Partnered Widowed Separated Divorced

Employer/School:_____JobTitle/Grade:_____

Emergency Contact:_____
Name Phone number

Referred by:_____
(Please include address and phone # if at all possible, please feel free to use the back of this page)

Please let us know if you would like your therapist at Dennis,Moye,Branstetter&Assoc.(DMBA) to contact and provide information to your Primary Care Physician about the treatment you receive today by checking YES or NO below. **If you check YES you MUST sign the attached Release of Information form allowing your therapist and the office to do so.**

___YES, I would like my therapist at DMBA. to provide detailed information to my primary care physician about the treatment I receive.

___NO, I do not want my therapist at DMBA to provide detailed information to my primary care physician about the treatment I receive.

Billing Information

FOR MINORS ONLY

Person responsible for bill if different from above (not insurance company):
The person listed below* MUST *be the individual signing all of the paperwork

Name: _____

SSN: _____ Relationship to patient_____

Address, if different from above: _____
Number & Street City Zip Code

Telephone Numbers, include area code*:* ( )_____ ( )_____
Home Work

( )_____
Cell/Other

PLEASE NOTE OUR OFFICE ONLY SENDS BILLS TO THE NAME AND ADDRESS OF THE PERSON SIGNING INTAKE FORMS.
BILLS WILL NOT BE SENT TO MORE THAN ONE HOUSEHOLD.

Parent Information
Only applicable if patient is a minor

Mother's Name: _____ Employer: _____

Mother's Work phone number, *include area code:* ( )_____

Father's Name: _____ Employer: _____

Father's Work phone number, *include area code:* ( )_____

Parent's Marital Status: Married Separated Divorced

Important Notice to our Clients

Due to the large number and constant changes in insurance policies, we find that we are unable to accurately know the current status of all insurance policies.

In order for us to help you with your insurance benefits, you should learn about your individual coverage.

1) **Covered Benefits**
   - **in & out of network benefits**
   - **deductible**

2) **Policy Restrictions**
   - **authorization/pre-certification requirements**
   - **pre-existing conditions that may apply**

3) **Percentages**
   - **percent your insurance will cover**
   - **percent your copayment is**

Your Insurance coverage and benefits are contracted between you and your insurance company, NOT your insurance company and this office.

Nobody likes surprises, so please contact your insurance company to answer any questions prior to your appointment

Failure to know and **understand your policy/benefits** may result in you, **the client**, being **responsible** for **Unexpected** or even **all** the costs incurred.

In order for us to bill your insurance company for you, the following <u>MUST</u> be completed:

Insurance Information

Primary Insurance Company only WE DO NOT BILL SECONDARY Insurances

Insurance Name: _____

Ins. Address:_____
Number & street **City** **State** **Zip Code**

Telephone Number, ***include area code:*** **( )**_____

Subscriber (name of policy holder):_____

SSN of Subscriber : _____ **Birth date of subscriber:** _____

Contract #: _____**Group #:** _____
If BCBS please include alpha prefix

Insurance Authorization to Release Information

I authorize the release of any medical information necessary to process insurance claims. This may include, but is not limited to, therapist's records, billings, or case summary.

_____
Patient/ Guardian Signature Date

Assignment of Insurance Benefits*

I authorize and assign payment of medical benefits to my provider at Dennis, Moye, Branstetter & Associates for the services rendered.

_____
Patient/ Guardian signature Date

***<u>Please be aware that not all insurance companies will reimburse directly to the provider</u>.**
<u>Payment in full for each visit is expected at the time of service until we are able to determine your deductible and co-payment status.</u>

<u>CO - PAYS ARE DUE AFTER EACH SESSION</u>

<u>YOU ARE RESPONSIBLE FOR BILLING YOUR SECONDARY INSURANCE</u>

Fee and Treatment agreement

1) Your fee should be established with your individual therapist prior to your first session.

2) Fees are expected to be paid at the end of each session via cash, check, money order, or charge (Master Card, Visa, or American Express).

3) **A $20.00 charge will be made to your account and must be paid prior to your next appointment for checks returned due to insufficient funds**. We cannot accept personal checks after two checks have been returned due to insufficient funds. _____ **(INITIAL)**

4) **Payment for services is due at the time of your visit.** If you have insurance, Dennis, Moye, Branstetter & Associates can bill your visits to your insurance company. We do make every effort to call your insurance company to check your coverage with them. **There is no guarantee that what has been quoted to us about your coverage is what they will pay.** Once payment has been received from your insurance company, we can then adjust your payments. _____ **(INITIAL)**

5) **We require at least 24 hours notice if you need to cancel or change an appointment. Missed appointments without prior notice, as well as appointments cancelled with less than 24hrs notice will be billed to you at the regular fee**. Insurance will not pay for missed appointments. Payment of a missed appointment is due prior to the next regularly scheduled appointment. _____ **(INITIAL)**

6) Our office does utilize an outside collection agency. In the event a patient balance remains unpaid for an extended period of time, our office will send the account, with the necessary demographic information, to the collection agency we contract with. ____**(INITIAL)**

7) Sessions conducted via audiovisual methods or over the telephone MAY NOT be covered by health insurance companies. It is imperative to contact your health insurance company before hand to ask._____**(INITIAL)**

I have read the above policies on informed consent, confidentiality, insurance billing, missed appointments and late cancellations, the payment of fees and collections process. I understand that I must pay at the completion of each session. I realize that non-payment of fees at the end of each session will result in my receiving a paper bill for all services rendered through the mail. _____ **(INITIAL)**

Patient Signature: _____
If 18 or older

Parent (Guardian) Signature: _____
If patient is a minor

Therapist Signature: _____

Supervisor Signature:_____

Date: _____

Diagnostic Code: _____

Fee: _____

Dennis, Moye, Branstetter & Associates, P.C.
1750 S. Telegraph Road, Suite 101
Bloomfield Hills, Michigan 48302
(248) 451-9085

Office Use Only

Acct#_____

Provider#_____

Credit Card Authorization

I, _____ give

Dennis, Moye, Branstetter & Associates,P.C.

authorization to **automatically** bill my **Visa/MC/AMEX/DISC** for mental health services

rendered at this facility for _____. {Patient}

Your card will be billed only in the event that a balance is incurred, such as co-pays, deductibles, etc. that are not paid. Cards are charged once a week for any unpaid balances. Be sure to stop at front desk to check for balances after each session.

If you sign this form the office will not send paper bills in the mail to your home. If you would like an itemized statement you will need to contact the office to request one.

.

Cardholder's Name as it appears on the card:
Please print

_____

Account Number: _____

Expiration Date: _____ Security Code: _____

_____ _____
(Cardholder's Signature) (Date)

Card holders billing: _____

address for Credit Card _____

Dennis, Moye, Branstetter & Associates, P.C._____
1750 S. Telegraph Road, Suite 101
Bloomfield Hills, MI 48302 Phone: 248-451-9085 Fax: 248-451-9089

AUTHORIZATION FOR THE RELEASE OF INFORMATION

CLIENT NAME: _____

I hereby request and authorize: Dennis, Moye, Branstetter & Associates, P.C. and

_____ to…
Therapist name

___**Exchange with** ___Disclose to ___Receive from

Name:_____

Company:_____

Address:_____

Phone:_____ Fax:_____

The following specific information from my records: ___**All information listed below**
___Verbal Information ___Treatment Plan ___Psychiatric/Psychological Evaluation
___Discharge Summary ___Psychological Testing ___Progress notes ___Diagnosis
___Prognosis ___Billing ___Other_____

The purpose of this authorization: ___To assist with evaluation and treatment
___Ongoing communication for continuity of treatment
___Other_____

___This authorization will end on the following date:_____

__This authorization will end when the following event occurs. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe event_____
_____.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist/psychiatrist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
(Signature of patient/guardian) (Date)

_____
(Relationship to patient)

_____
(Witness)

NOTICE OF PRIVACY PRACTICES

Dennis, Moye, Branstetter & Associates
1750 S. Telegraph Road, Suite #101
Bloomfield Hills, Michigan 48302

Effective April 14th, 2003 Revised 10/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

If you have any questions about this Privacy Notice, please contact our Director.

This Notice of Privacy Practices is being provided to you as a requirement for the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and give out "disclose" your health information to carry out treatment, payment or heath care 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 in some cases.

Treatment: We may use and disclose health information about you for the purpose of coordinating your health care. For example, we may need to disclose information to a case manager at a managed care organization who is responsible for coordinating your care.

Payment: We may use and disclose health information about you so that the services you receive can be properly billed and paid. For example, we may disclose your health information to permit your health plan to take certain actions before your health plan approves or pays for your services.

Operations: We may use or disclose health information about you, as necessary, so that we can operate the health plan and provide quality care to you. For example, we may use health information about you to review the quality of services you receive.

Other Uses and Disclosures: As part of treatment, payment and health care operations, we may also use or disclose health information about you so that we can send you health care service reminders and/or newsletters.

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons. These reasons include the following:

- **When Required by Law:** We will disclose health information about you when we are required to do so by law.
- **When There Are Risks to Public Health:** For example, we may disclose your health information to prevent, control or report a disease.
- **To Report Abuse, Neglect or Domestic Violence:** We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence.
- **To Conduct Health Oversight Activities:** We may disclose your health information to a health oversight agency for activities such as audits or inspections.
- **In Connection With Judicial and Administrative Proceedings:** We may disclose your health information in the course of any judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Michigan Court Administrator).

- **For Research Purposes:** We may use or disclose your health information for research under limited circumstances.
- **In the Event of A Serious Threat to Health or Safety:** We may use or disclose your health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of the public.
- **For Specified Government Functions:** In certain circumstances, the Federal regulations authorize us to use or disclose your health information to facilitate specified government functions such as functions relating to national security.
- **For Worker's Compensation:** We may release your health information to comply with worker's compensation laws or similar programs.

Family Matters: Unless you object, or we can infer from the circumstances that you do not object, we may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care.

Authorization: Other than as stated above, we will not disclose your health information other than with your written authorization. Clients must sign an authorization for release of Protected Health Information (PHI) for any uses and disclosures not covered in the Privacy Notice. Authorizations cover disclosures of PHI for marketing purposes, disclosures that constitute a sale of PHI, and most disclosures of psychotherapy notes if kept separate from the medical file. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

Your Right to Inspect and Copy: You may request the right to inspect and get copies of your health information. To inspect and copy your health information, you must submit a written request to the Director, whose contact information is listed on the first page of this Notice. We can deny your request for certain, limited reasons, but we must give you a written reason for denial. We may charge a fee for copying your records.

Your Right to Request a Restriction on Uses and Disclosures of Your Protected Health Information: You may ask us not to use or disclose certain parts of your health information for the purposes of treatment, payment or health care operations. We are not required to agree to a restriction. You may request a restriction by contacting the Director. Clients will have the right to restrict certain disclosure of Protected Health Information (PHI) to a health plan if the healthcare service provided is paid for in full out-of-pocket.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests only if you notify us that disclosure of the health information could put you in danger. Requests must be made in writing to our Director. This written request must also contain a statement that disclosure of the information could endanger you.

Your Right to Amend: If you feel that the information we have about you is incorrect or incomplete, you may request that we amend your information. If we deny your request, we must give you a written reason for our denial. Requests must be made in writing to our Director. In this written request, you must also provide a reason to support the requested amendments.

Your Right to a List of Disclosures: You have the right to request a listing of certain disclosures of your health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form and certain other disclosures that we are permitted to make without your authorization. The request for listing must be made in writing to our Director. We are not required to provide a listing of disclosures that took place prior to April 14th, 2003. We will provide the first listing that you request during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

Your Right to a Copy of This Notice: You have the right to receive an additional copy of this Notice at any time. Even if you have already received a copy of the Notice or have agreed to accept this Notice electronically, you are still entitled to a paper copy of this Notice. Please call or write to the Director, whose contact information is listed on the first page of this Notice, to request a copy.

How to Use Your Rights Under This Notice: For any of the above requests that must be made in writing, we will help you prepare the written request if you need assistance. For assistance with a written request and for oral requests, please call the Director, whose contact information is listed on the first page of this Notice. Written requests can be sent to the Director at the address listed on the first page of this Notice.

Our Duties: Client's have the right to be notified if there is a breach of their unsecured Protected Health Information (PHI). We are required by law to maintain the privacy of health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by the terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. If we make any major changes to our Notice, you will receive a copy of our new Notice within 60 days of the major changes.

Complaints: If you believe your privacy rights have been violated, you have the right to complain to us. You may complain to us by contacting our Director verbally or in writing. We encourage you to express any concerns you may have regarding the privacy of your information to us. You will not be retaliated against in any way for filing a complaint.

Contact Person: Our contact person for all issues regarding the privacy of your health information is the Director. Information regarding matters covered by this Notice can be requested by contacting the Director. Complaints against us can be mailed to the Director by sending it to the address listed on the first page of this Notice.

Dennis, Moye, Branstetter & Associates, P.C.
1750 S. Telegraph Road, #101
Bloomfield Hills, Mi 48302

By signing this form, I consent to the use or disclosure of my Protected Health Information by my provider, Dennis, Moye, Branstetter & Associates (DMBA), its staff and business associates for purposes of treatment, payment and healthcare operations. This is a joint consent form of DMBA and its clinical staff.

Protected Health Information means health information (including identifying information about me) collected from me or received by DMBA, another provider, a health plan, my employer or a health care clearinghouse. It may include information about my past, present or future physical or mental health or condition, the provision of my health care and payment for my health services.

DMBA agrees to maintain my Protected Health Information in accordance with the practices described in the DMBA Privacy Notice. This notice also describes my rights with respect to the use and disclosure of my Protected Health Information.

I acknowledge I have been given an opportunity to review the DMBA Privacy Notice prior to signing this consent and that a copy is available to me should I request one. The DMBA Privacy Notice is also posted at all DMBA sites.

I understand that this information may be needed to:

- Plan my care and treatment
- Communicate among the various health care professionals involved in my care
- Provide information to my health insurance company or plan
- Obtain payment from my health insurance company or plan
- Assess the quality of my care and review the care provided by my Assigned Clinicians and other staff.

I also understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that DMBA has taken action in reliance upon this consent.

I further understand that I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or health care operations of DMBA. I realize that DMBA is not required to agree to a restriction that I may request. However, if DMBA does agree, the restriction must be honored by DMA.
I understand that my signature on this form acknowledges that I have been offered and/or given DMBA's full notice of privacy practices.

Restrictions, if any, agreed to by DMBA regarding the use and disclosure of Protected Health Information:

_____

_____

Client/Guardian Signature _____Date_____

Staff Signature_____Date_____

Withdrawal of Consent: This consent is revoked on: Date: ____/____/____

_____ ____/____/____ _____ ____/____/____
Client/Guardian Signature Date Staff/Witness Signature Date