Michigan School Psychological Clinic

Client Information Statement for Minor/Adolescent

Mission

The mission of the Michigan School of Psychology Psychological Clinic is to:

1) To provide affordable mental health services to individuals and families with limited access to psychological services and limited ability to pay; and
2) To provide quality clinical training experiences for master's and doctoral level students

Supervision

All services provided through the Clinic are conducted under the direct supervision of a psychologist who is licensed in the state of Michigan.

What to Expect

During your initial appointment, your child is going to be interviewed for approximately an hour about the reason(s) you and/or your child have decided to seek our services at this time. This is a very important interview. Your child may be asked to complete some questionnaires during this initial interview or at some time in the future.

The interview serves several important functions. It establishes a relationship between your child and their clinician that will allow them to feel more comfortable and at ease during therapy. It also helps your clinician determine the factors that might be contributing to the problems your child is experiencing.

Some people have concerns that they are embarrassed to tell others, such as alcohol and substance use, physical abuse, etc. Do not be shy about providing "embarrassing" information to your clinician. The more honest and open you are, the easier it will be for your clinician to help.

While the interview is being conducted, the clinician may take notes during the conversation. You may also be asked some questions about your child's family background. This kind of information can be of great assistance in helping your clinician to understand the nature of your child's problems, therefore, please do not be offended if asked these types of questions.

Initially, the therapy sessions will involve talking about your concerns and letting your clinician get to know you and your child better. This will help you to define realistic goals, explore options and make responsible decisions. A trusting relationship is essential to useful therapy. If you feel uncomfortable or have concerns about the work you are doing, please discuss these issues. This will make your therapy experience more productive and worthwhile.

Confidentiality
State laws and the code of ethics for psychologists protect a client's rights of privacy, privileged communication, and confidentiality regarding psychological services. Clinic personnel will not release any record of a client's contact with the Clinic without her/his written permission, except under the rare conditions outlined below. For MSP students, clinic files are NOT part of academic records, and no one has access to them except for Clinic staff. Complete records are maintained for seven years after treatment ends (or, for minors, records are maintained for seven years after the client reaches 18 years of age). For more information, please see the Notice of Privacy Practices.

Despite our strict respect for clients' confidentiality rights, the following are situations that may impose limits on a client's right to confidentiality based on state laws and ethical principles for mental health professionals:

1. If Clinic personnel receive information that gives them cause to believe that a child's or disabled person's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, they are required to report this information to the Michigan Department of Health and Human Services Department of Children's Protective Services.
2. If Clinic personnel receive information that leads them to determine that there is a probability of imminent physical injury by the client to himself/herself or to others, they are required to report this information to the appropriate persons and/or agencies.
3. In certain court proceedings. Clinic personnel may be required to disclose specific information regarding a client when ordered to do so by a judge and/or by state law. If we receive a subpoena to disclose information that a client has provided, the client will be informed of this, but we may not be able to prohibit disclosure if it is court-ordered.
4. If a client with third party coverage for outpatient psychological services consigns insurance benefits to the Clinic or otherwise authorizes information disclosure. Clinic personnel may be required to disclose summary information regarding the client's contact with the Clinic to the insurance company/agency providing at least partial payment for services.
5. If crimes are committed on Clinic premises, we reserve the right to report these offenses to the appropriate legal authorities. When an applicant or client commits or threatens to commit a crime while on Clinic premises, staff may seek the assistance of an appropriate law enforcement agency or report the crime. Staff may provide law enforcement personnel with the circumstances of the crime, the suspect's name, address, last known whereabouts, and status as a client of the Clinic.

These policies of confidentiality apply to all Clinic activities with clients, including supervisory contact between Student Therapists and Clinical/Faculty Supervisors.

Emergency Procedures
The Clinic cannot provide 24-hour emergency or crisis management services to the community or to its clients. When the Clinic is not open, persons in crisis are advised to seek emergency services through the services provided on our Referral List, call 911, or go to your nearest emergency room.

If you have any questions or are not sure that you are clear about any of these policies, please feel free to discuss it with your therapist.

Referral List

Oakland County Mental Health Services

Oakland Community Health Network (OCHN)
Main Office Phone: 248.858.1210 Non-emergency Service Access Phone: 248.464.6363 Customer Services Phone: 800.341.2003
OCHN's Vision:

> "OCHN will be a national leader in the delivery of quality integrated physical and mental health supports and services to children and adults with developmental disabilities, mental illnesses, and substance use disorders. We respond to our community's needs and empower people to achieve the lives that are important."

Common Ground connects people in an emergency/crisis to public mental health and community services. Call at 1.800.231.1127 to get help right away. The Resource & Crisis Helpline is available 24/7. Common Ground's responsibilities include:

- Managing the Resource & Crisis Helpline
- Addressing the needs of all individuals in crisis, including those who have Medicaid, Medicare, Healthy MI, private insurance, or no insurance.
- Determining network service eligibility
- Identifying follow up resources and supports.
- Authorizing psychiatric hospitalization

Hospitalization Centers for Minors

Harbor Oaks Hospital, 35031 23 Mile Rd, New Baltimore, MI 48047
586.725.5777

Havenwyck Hospital, 1525 University Dr, Auburn Hills, MI 48326
248.373.9200

Henry Ford Kingswood Hospital, 10300 W Eight Mile Rd, Ferndale, MI 48220
248.398.3200

BCA StoneCrest Center, 15000 Gratiot, Detroit, MI 48205
313.245.0600

Substance Abuse Treatment for Minors

Ascension Brighton Center for Recovery, 12851 Grand River Ave, Brighton, MI 48116
810.227.1211

Henry Ford Maplegrove Center, 6773 W. Maple Rd, West Bloomfield, MI 48322
248.661.6100

Client Consent for Services

1. As a parent/guardian of a minor, I understand that consent for services (signature) must be provided by both parents/guardians unless: 1) as otherwise required by legal arrangements; or 2) the other parent/guardian is deceased or cannot be located.
2. I understand that psychological services involve a joint effort between therapist and client, the results of which cannot be guaranteed.
3. I understand that my child's therapist works under the supervision of a licensed psychologist, usually a member of the MSP faculty. I understand that contact between my child and their therapist may be observed or audio/videotaped, **with my knowledge**, and observed by the faculty supervisor, students in training, or **other parties approved by me, my therapist, and the clinical/faculty supervisor**. I have been given the opportunity to discuss the use of written or audio-visual information regarding me by Clinic personnel. I am aware that (a) this is a training clinic for students enrolled in MSP Clinical Psychology programs, and (b) clinic sessions are routinely audio/video-taped and may be observed by other students and supervisors. This is done for the purpose of providing therapists with feedback on their clinical work. I understand that all tapes are erased at the end my involvement with the Clinic unless I specifically agree to the contrary in writing. I further understand that such tapes are for training purposes only and are not considered part of my clinical record. **In addition, I understand that I might be refused services at the Clinic if: 1) my child is not willing to be videotaped; or 2) I am not willing to provide permission for my child to be videotaped. In such a situation, the intake therapist will attempt to provide alternative referrals to treatment agencies that do not require taping of sessions.**
4. I understand that, due to the nature of this facility as a training clinic, my child's case may be transferred to another therapist. Typically, this would occur when a therapist completes training at the Clinic. Such a transfer will be discussed with me in advance. If my child is being transferred to another therapist (or being readmitted to see a new therapist), I understand that my child's new therapist (and his/her supervisor) will have access to their old records and will make an effort to review them as soon as possible when beginning to work with my child. However, it is also possible that my child's problems may be better addressed by a therapist or program other than that which can be delivered at this training clinic. Should it be determined that my child's needs would be better addressed by some other type of program, I understand that the therapist who has evaluated my child will attempt to provide referral information for more suitable treatment options.
5. I understand that my child's therapist may share information about their treatment in case conferences and other treatment team meetings. When information is shared among clinic personnel (i.e., staff, supervisors, and students), it is shared in a manner that eliminates identification to the extent possible. However, this cannot be guaranteed, particularly when coordination of care is required. For example, this may occur in cases where therapists treating family members are part of the same supervisory team or need to consult with one another to develop treatment plans. **Please note that while information may be shared among clinic personnel, it will not be shared with other family members or friends who may be in treatment at the clinic, unless you have explicitly consented to this in writing.** As an additional safeguard, ail clinic personnel sign Confidentiality Agreements that prohibit them from sharing information with anyone not involved with clinic operations.
6. I understand that the first two sessions will be dedicated to assessment and evaluation to determine my child's specific treatment needs. The goal of these evaluative sessions will be to clarify if the Clinic can serve my child's specific needs and, If so. to develop a treatment plan with me and my child. If it is determined that the Clinic is not capable of meeting my child's specific needs, they will be referred to community mental health practitioners or agencies.

7. I understand my child's rights of confidentiality and the legal and ethical limits of confidentiality as described in the Client Information Statement and the Notice of Privacy Practices. Specifically, I understand that my child's therapist may disclose confidential information without my consent in certain circumstances that include, but are not limited to the following:
    a. If my child is considered to be a danger to themselves or others; or if they experience a medical emergency while at the Clinic, during which time they am unable to speak on their own behalf.
    b. If I am a minor, elderly, or disabled person and the therapist believes I am the victim of abuse, or If I divulge Information about such abuse; or If I share information that leads my therapist to suspect that any child or vulnerable (elderly or disabled) adult Is being abused.
    c. If I file suit for breach of duty or If I commit a crime on the premises of the Clinic.
    d. If a court order, other legal proceedings, or statute requires disclosure.
8. I understand the Clinic policies regarding fees, billing, and missed appointments and agree to the terms of payment. Specifically, I understand that therapy services are charged at the rate of $35 per 50-minute Individual session and $10 per group session. Psychological assessment batteries are billed at a flat (and non-negotiable) rate, all of which must be paid before the formal assessment process may begin.
9. I understand that I will be charged a "failure to cancel" fee (equal to my usual session rate specified above) if I fail to cancel a scheduled appointment at least four hours in advance. I also understand that I may be billed for extensive telephone consultation at the session rate, adjusted for actual time spent.
10. I understand that contraband and weapons are prohibited at the Clinic.
11. I understand that it is not appropriate or effective to conduct assessments or treatment when an individual is intoxicated or otherwise cognitively Impaired. I understand that if my child appears to be impaired, a scheduled session may be rescheduled; should this occur, I will be charged for the original and the rescheduled appointment.

I have read and understand the Consent for Services statement. I have been given a copy of these documents and have been given an opportunity to ask questions about services with the Clinic.

I, _____, agree for my child to receive services at the MSP Clinic. **(Name)**

_____

Client Name

_____

Parent/Guardian A Signature **Date**

_____

Parent/Guardian B Signature **Date**

_____

Therapist Signature **Date**

_____

Supervisor Signature **Date**

Communication

Consent for Telehealth
The Michigan School Psychological Clinic is using video conferencing as an option for conducting remote therapy sessions over the internet through an electronic platform called Zoom where you will be able to speak to and see your therapist on a screen. For more information about ZOOM security and privacy, please see: ZOOMcare.com.

Zoom is an online communication tool allowing for face-to-face video and is **HIPAA compliant**. Zoom requires the use of a browser and may require an app download.

SMS/Email
By signing below, I authorize the Michigan School Psychological Clinic to contact me by automated SMS text messages and email regarding my child's appointment.

I understand that message/data rates may apply to messages sent by the Michigan School Psychological Clinic under my cell phone plan.

My text/mobile phone number is: _____ Parent/Guardian A Initials _____
My text/ mobile phone number is: _____ Parent/Guardian B Initials _____

My email address is: _____ Parent/Guardian A Initials _____
My email address is: _____ Parent/Guardian B Initials _____

I know that I am under no obligation to authorize the Michigan School Psychological Clinic to send me text messages or emails. I may opt-out of receiving these communications at any time by calling (248)919-0063 ext. 200, or by responding STOP. Please allow 2-3 business days for processing.

I understand that text messaging and email is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages and email may include your first and last name, date/time of appointments, name of therapist, clinic phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from the Michigan School Psychological Clinic to the phone number that I have provided.

_____
Client Name

_____
Parent/Guardian A Signature **Date**

_____
Parent/Guardian B Signature **Date**

ACKNOWLEDGEMENT OF COVID-19 PUBLIC HEALTH CRISIS
INFORMED CONSENT FOR IN-PERSON SERVICES

Please initial each of the following to indicate that you understand and agree to these actions:

_____You will only keep your in-person appointment if you are symptom free.

_____You will take steps between appointments to minimize your exposure to COVID-19.

_____If a resident of your home tests positive for the infection, you will immediately let Clinic Staff know and treatment via telehealth will begin.

_____If you have a job that exposes you to other people who are infected, you will immediately inform Clinic staff.

_____You will wait in your car or outside until no earlier than 5 minutes before your appointment.

_____You will wear a mask in all areas of the office (as will all Clinic staff).

_____You will be provided with hand sanitizer as you enter the Clinic.

_____Your temperature will be taken by Clinic staff upon your arrival for each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the Coronavirus, you are aware that the appointment will be canceled.

_____You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where signs prohibit sitting.

_____You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with Clinic staff.

_____Children are only allowed in the Clinic for a scheduled appointment **for the child**. When bringing your child for an appointment, you will ensure that they follow all of these sanitation and distancing protocols.

_____ Only clients may enter the Clinic.

The above precautions may change if additional local, state or federal orders or guidelines are published. If that occurs, we will discuss any required changes.

Informed Consent
This agreement supplements the general informed consent for Clinical services. Your signature below confirms that you have been informed the risk of in-person treatment, agree to assume that risk, and that you agree to follow the terms and conditions outlined in this agreement.

_____
Client Name

_____
Parent/Guardian A Signature **Date**

_____
Parent/Guardian B Signature **Date**

Financial Policies

Fees and Billing
Clients are financially responsible for all charges. Payment for services is expected at the conclusion of each session. If necessary, arrangements for establishing a payment plan with the Clinic can be made by discussing the matter with the Therapist. Please note: With the exception of ABA services, services provided at the Michigan Psychological Clinic are **NOT** reimbursable by insurance. Any claims submitted directly by clients to their insurance companies will be denied.

Clients must make some payment toward their total Clinic bill every three sessions at a minimum.

Clients are considered to have delinquent Clinic accounts and must negotiate a payment plan before scheduling further appointments if: a) they have not made at least one payment at each third session; or b) the account balance exceeds four times the hourly rate. Therapy is billed at the standard rate of $35/hour for individual therapy and $10/hour for group therapy. A full assessment including educational testing is $450.00, and without educational testing is $350.00.

Missed Appointments
Clients are responsible for notifying the clinic office if they must cancel or reschedule an appointment. Clients are strongly encouraged to provide at least 24-hour notice for canceled/ rescheduled sessions to avoid charges for missed appointments

As assessment batteries are billed at a flat rate of $450 if educational testing is included, $350 if not, and not based on time. As a result, the above policies do not apply. With regard to assessments, student therapists will discontinue testing and prepare an abbreviated report if a client no show/no calls two or more times after the first visit. Clients are expected to pay one half of their balance prior to the first testing session, and the remaining half prior to the feedback session.

Fee Establishment

The fee of $_____ per session has been approved by the therapist, Clinic Director, and client parents/guardians.

_____

Therapist **Date**

_____

Clinic Director **Date**

_____

Client Name

_____

Parent/Guardian A Signature **Date**

_____

Parent/Guardian B Signature **Date**

MICHIGAN SCHOOL PSYCHOLOGICAL CLINIC
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about your child may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

When it comes to your child's health information, you have certain rights. This section explains your rights and our responsibilities to assist you.	
Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have a legal guardian or given someone medical power of attorney, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated	• You can complain by contacting us using the information on the last page if you feel we have violated your rights. • You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.	
In these cases, you have both the right and choice to tell us to:	• Share information with family, friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
Your written permission is needed to share your information for:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
Fundraising:	We may contact you for fundraising efforts, but you may tell us not to contact you again.
Highly sensitive information:	Some types of medical information, such as mental health records, are particularly sensitive. Federal or state laws may require us to obtain your written permission or, in some cases, a court order, to disclose that information. Other examples include information dealing with matters such as genetic testing, HIV/AIDS, substance use disorders, or sexual assault.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.		
Treat you	We can use your health information and share it with other professionals who are treating you.	Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Manage our organization	We can use and share your health information to manage our practice, improve your care, and contact you when necessary.	Example: We use health information about you to manage your treatment and services.

Bill for your services	We can use and share your health information to bill and receive payment from health plans or other entities.	Example: For ABA services, we give information about the client to your health insurance plan enable payment for services.
Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety	
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.	
Respond to organ and tissue donation requests	We can share health information about you with organ procurement organizations.	
Work with a medical examiner or funeral director	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.	
Address workers' compensation, law enforcement, and other government requests	• For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services	
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.	
Other reasons for sharing your health information	We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.	

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Our Address and Other Contact Information is Listed Below:
Michigan School of Psychology Clinic
26811 Orchard Lake Road
Farmington Hills, MI 48334

Our Contact Person for Purposes of Privacy Matters is:
Privacy and Security Officer: Jeff Cross
Phone: 248.476.1122
jcross@msp.edu
Effective February 1, 2020

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
By signing this form, you acknowledge receipt of the Michigan School of Psychology Clinic Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change.

_____
Client's Name

_____
Parent/Guardian A Signature **Date**

_____
Parent/Guardian B Signature **Date**