BIRMINGHAM MAPLE CLINIC
IDENTIFYING DATA
FOR CHILDREN/ADOLESCENTS (UNDER 18)

For office use only: This referral is Direct to Therapist ☐ Clinic Referral ☐ Case #:

DEMOGRAPHIC INFORMATION:

Name of Client:		Age: M/F	BD:
Address:			Therapist:
City, State, Zip:			Date Seen:
Telephone:	School:		Grade:
Father ☐ / Guardian ☐:		Age:	BD:
Address:			
Education:	Occupation:		
Phone: Home:	Work:		Cell:
Mother ☐ / Guardian ☐:		Age:	BD:
Address:			
Education:	Occupation:		
Phone: Home:	Work:		Cell:
Email:		**You have my permission to contact me by email** Yes ☐ No ☐	

Parent's Marital Status:
Mother: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partnered ___ Marriage Date_____ Divorce Date _____
Father: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Partnered ___ Marriage Date_____ Divorce Date _____

FAMILY INFORMATION:

Persons Residing With Client:

Name	Birth Date or Age	Relationship to Client	Education/ Grade	Employer/Occupation School

Immediate Family Members Not Residing With Client:

BIRMINGHAM MAPLE CLINIC
PRIMARY REFERRAL SOURCE

Note: If you were referred to your therapist by the Clinic Director, that is not considered a referral from a BMC therapist. Instead, please indicate who made the **original** referral to Birmingham Maple Clinic. **Please check only one source.**

- ☐ Therapist – Birmingham Maple Clinic (another BMC therapist referred you to this particular therapist at the clinic) (01)
- ☐ Therapist – Other (03)
- ☐ Psychiatrist – Birmingham Maple Clinic (you were referred to the clinic for therapy by a BMC psychiatrist) (02)
- ☐ Psychiatrist – Other (04)
- ☐ Physician – (05)
- ☐ Present/Former Client – (someone else who is/was a client at the clinic) (15)
- ☐ Returning Client – (you have been a client here before) (16)
- ☐ Friend – (17)
- ☐ Family Member – (18)
- ☐ School Counselor – (10)
- ☐ Attorney – (06)
- ☐ Other Professional – (14)
- ☐ Court – (07)
- ☐ Employee Assistance Program – (EAP) – (8)
- ☐ Insurance Company – (09)
- ☐ Religious Institution/Clergy – (12)
- ☐ Agency / Community Organization / Professional Association – (13)
- ☐ Phone Book – (actual paper book) - (19)
- ☐ Advertisement that mentioned Birmingham Maple Clinic – (23)
- ☐ Newspaper / Radio / TV – (24)
- ☐ Workshop / Speech – (given by a therapist from BMC) - (25)

Internet: There are many ways you may have used the internet to arrive at our website. Please indicate **only the first site** you accessed which finally led to our site.

- ☐ Yellowpages.com – (www.birminghammaple.com) – (26)
- ☐ Any other internet source – (21)
  Please name the website that led you to our website: _____

PLEASE ENTER THE SPECIFIC NAME, ADDRESS AND PHONE NUMBER OF THE REFERRAL SOURCE YOU CHECKED ABOVE:

Name: _____ **Phone Number:** _____

Address: _____

_____

Thank you for your cooperation

Updated: 7/26/2006

BIRMINGHAM MAPLE CLINIC FINANCIAL POLICY

As a client at Birmingham Maple Clinic, it is important for you to understand the following information:

- You are responsible for the timely payment of your account. Your co-pay and other charges not covered by insurance are due on the day services are provided.
- **A late fee will be added to all unpaid balances that are 31 days and older.**
  - For delinquent balances under $100, a $5 Late Fee will be added to your account.
  - For delinquent balances over $100, a 5% Late Fee will be added to your account.
  - For delinquent balances over $800, a payment agreement and plan will be required.
  - Terms of payment agreement include:
    - The first payment is due at the time of signing the agreement.
    - Payments must be made monthly with a specified due date or a $25 Late Fee will be added to your account.
    - If payments are not made monthly, your account will be sent to collections.
- We accept cash, check, Visa, MasterCard and Discover. You may keep a credit or debit card on file for your convenience and fees will be charged monthly.
- Payment should be made by the parent/guardian who brings the child to the appointment. We will not become involved in disputes between individuals. It is your responsibility to assure that we receive payment for the services rendered.
- Missed Appointments:
  Unless cancelled 24 hours in advance, our policy is to charge for missed appointments at the usual rate of an office visit. Keep in mind that insurance companies will not cover this cost. Please help us serve you better by keeping all scheduled appointments.
- Regarding Insurance:
  We will verify your insurance following the first visit. Verification of coverage does not guarantee payment. Insurance is a contract between you and your insurance company. We **cannot** be a party to this contract. In most cases, we file insurance claims as a courtesy to our clients. Although we supply factual information to your insurance company when necessary, we will not become involved in disputes between you and the company regarding deductibles, co-payments, covered charges, secondary insurance coverage, usual and customary charges, etc. In the event that a third party payment is denied after the service has been provided, you will still be held responsible for the cost of said service/s.

THANK YOU FOR UNDESTANDING OUR FINANCIAL AND INSURANCE POLICIES.
PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

_____ _____
Client, Parent or Guardian (if under 18) Date Witness Date

_____ _____
Social Security Number Driver's License Number

PERSON RESONSIBLE FOR PAYMENT IF OTHER THAN CLIENT:

Name: _____ Telephone: _____

Address: _____

Employer: _____ Telephone: _____

Employer's Address: _____

Signature of Responsible Party: _____

Birmingham Maple Clinic

2075 W. Big Beaver
Troy, MI 48084
Phone (248) 646-6659
Facsimile (248) 642-8645
www.birminghammaple.clinic

As a convenience to our clients, we can accept payment automatically by charging your Visa/MasterCard on a twice per month basis. If you are interested in making payments with your Visa/MasterCard, please complete the information below.

PREAUTHORIZATION FORM

I _____ do hereby authorize Birmingham Maple
(Please print)
Clinic to charge my **balance due** against my Visa/MasterCard number:

_____ with an expiration date of _____.

My address is _____
Street City Zip

Home # (___) ____- _____ Work # (___) ____-_____ Cell # (___) ____-_____

The 3 digit number from the back of card is _____

_____ _____
Cardholder's Signature Date

☐ Copy of Driver's License required. (Office staff please check)

☐ Copy of Credit Card required. (Office staff please check)

Office Staff Initials _____.

BIRMINGHAM MAPLE CLINIC
INITIATING TREATMENT

You have made a decision to initiate treatment at Birmingham Maple Clinic. It is important for you to understand that you are an active participant in the treatment planning process and should discuss your needs and desires with your therapist. You should always feel comfortable asking your therapist questions about your treatment and the objectives the two of you have established and should expect your therapist to be receptive to these questions.

If during treatment, you feel uncomfortable raising questions with your therapist, or if you feel that the answers you have received are unclear, you may contact the clinic director for further consultation. The clinic director will discuss your concerns with you in a confidential manner and respond to them appropriately. At that time, you may be asked whether you are willing to provide a written statement of your concerns. If you do provide such a statement, you will receive a written response from the Board of Directors.

During the course of your treatment, you are aware that payment is made directly to the provider of services. If the provider's charge exceeds the private insurance carrier payment, you will be responsible for the amount of the difference.

Upon completion of treatment we would like to send you a survey assessing the helpfulness of your therapy. Would you be willing to participate in such a survey? Yes _____ No _____

By signing this document, known as "Initiating Treatment", you are indicating that you have been given the opportunity to discuss your treatment plan and to ask any questions you might have.

******

My treatment plan has been reviewed with me and I have had the opportunity to discuss any questions with my therapist.

_____	_____
Client, Parent or Guardian	Witness
_____	_____
Date	Date

BIRMINGHAM MAPLE CLINIC
HEALTH INFORMATION
FOR CHILDREN/ADOLESCENTS

Name of Client: _____ BD: _____ Date: _____

Date of Last Physical Examination: _____ Name of Physician: _____

Is your child being treated for any illnesses or medical problems by a Doctor? Yes ☐ No ☐
If Yes, please describe below:

Illness or Medical Problem	Treating Physician

Please list all past illnesses and medical problems and the year (or approximate year) in which each started:

Illness or Medical Problem	Year	Treating Physician

Has your child ever been hospitalized or had surgery? Yes ☐ No ☐
If Yes, please explain: _____

Has your child ever had a serious accident, injury or seizure? Yes ☐ No ☐
If Yes, please explain: _____

Has your child ever had significant changes in appetite or weight, an eating disorder or nutritional problems?
Yes ☐ No ☐ If Yes, please explain: _____

Has your child ever used cigarettes, alcohol or drugs? Yes ☐ No ☐
Type: _____ Date of first use: _____ Date of last use: _____ Amount: _____ Frequency: _____
Type: _____ Date of first use: _____ Date of last use: _____ Amount: _____ Frequency: _____
Type: _____ Date of first use: _____ Date of last use: _____ Amount: _____ Frequency: _____

Has your child had sleep problems within the past 6 months? Yes ☐ No ☐
If Yes, please explain: _____

Has your child had previous psychotherapy or counseling? Yes ☐ No ☐

If yes, please explain: _____

Date/s: _____ Name of Therapist: _____

Date/s: _____ Name of Therapist: _____

DEVELOPMENTAL HISTORY (To be filled out by parent or guardian)

Were there any problems or complications during pregnancy? Yes ☐ No ☐

If Yes, please explain: _____

Were there any problems or complications at birth? Yes ☐ No ☐

If Yes, please explain: _____

Were there any problems or complications during infancy? Yes ☐ No ☐

If Yes, please explain: _____

- Age baby crawled: _____
- Age baby walked: _____
- Age baby spoke first words: _____
- Age child was weaned: _____
- Age child was toilet trained: _____
- Additional information : _____

Did your child attend pre-school? Yes ☐ No ☐

Age of your child during attendance: _____

Did your child make friends in preschool: Yes ☐ No ☐

Did your child experience behavior or emotional problems during preschool? Yes ☐ No ☐

If Yes, please explain: _____

Did your child experience any medical problems between ages 0-5? Yes ☐ No ☐

If Yes, please explain: _____

Were there any significant family or environmental changes during your child's first 5 years?

Yes ☐ No ☐ If Yes, please explain: _____

At what age did your child begin Kindergarten? _____

Were there any educational or social problems in Kindergarten? Yes ☐ No ☐

If Yes, please explain: _____

MEDICATIONS:

List current medications (including seizure related medications) and reason for taking

_____

_____

_____

_____

_____

ALLERGIES:

Include allergies to medications

_____

_____

_____

_____

_____

FAMILY HISTORY:

If any blood relative has suffered any of the following, please check the appropriate box and indicate which relative.

- ☐ Heart Attack _____
- ☐ Stroke _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Lung Disease _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ Thyroid _____
- ☐ Learning Disabilities _____
- ☐ Arthritis _____
- ☐ Glaucoma _____
- ☐ Hypertension _____
- ☐ Allergies _____
- ☐ Alcohol / Drug Problems _____
- ☐ Mental / Emotional Problems _____
- ☐ Migraines _____
- ☐ Alzheimer's / Dementia _____
- ☐ ADHD / ADD _____
- ☐ Other _____

****

Name of relative or responsible party we may contact in case of an emergency:

_____ _____

Name Relationship

_____ _____

Address Telephone

BIRMINGHAM MAPLE CLINIC

JOINT NOTICE OF PRIVACY PRACTICES

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.

Effective Date: September 11, 2003

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or otherwise maintained by Birmingham Maple Clinic. Your other non-Birmingham Maple Clinic doctor may have different policies or notices regarding that health care provider's use and disclosure of your medical information created in a non-Birmingham Maple Clinic office or clinic.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Maintain the privacy of your medical information that identifies you;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE

This Notice will cover Birmingham Maple Clinic and those medical providers, who, while not necessarily legally affiliated with us, may provide you with care or treatment at Birmingham Maple Clinic. Together, Birmingham Maple Clinic and these medical providers are part of the "Birmingham Maple Clinic Organized Health Care Arrangement" (referred to as an "OHCA"). This Notice describes privacy practices of those participating in the Birmingham Maple Clinic OHCA. This Notice covers:

- Any health care professional authorized to enter information into any medical record established and maintained by Birmingham Maple Clinic.
- All departments and units of Birmingham Maple Clinic.
- All employees, staff, volunteers and other Birmingham Maple Clinic personnel.
- The individual health care providers of Birmingham Maple Clinic.
- Bradley S. Klein, D.O., P.L.C.
- Jeffrey A. London, M.D., P.C.

In addition, Birmingham Maple Clinic and the Birmingham Maple Clinic OHCA may share your medical information with each other for treatment, payment or health care operations purposes described in this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information. For each category we explain what we mean and give some examples. Our records contain information regarding your mental health or may contain information on substance abuse; those records may be subject to additional restrictions, which we will comply with, under state law. Also, if you are a minor, certain specific information that relates to mental health, substance abuse, pregnancy or sexually transmitted diseases, may be protected by additional restrictions under state law, which we will comply with. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use health information about you to provide you with treatment, health care or other related services. We may disclose your health information to doctors, nurses, aids, technicians or other employees who are involved in taking care of you. Additionally, we may use or disclose your health information to manage or coordinate your treatment, health care or other related services. For example: The therapist or psychiatrist treating you may need to know if you have an illness or disease or are currently taking prescription medication for the treatment of an illness or disease, because this may affect the type of therapy you are provided and your recovery. In addition, we may need to tell another healthcare provider this information so that we can arrange for appropriate care for you. We also may need to disclose information about you to people outside Birmingham Maple Clinic who may be involved in your care, such as, family members.

- **For Payment**. We may use and disclose your health information to bill and collect for the treatment and services we provide to you. We may send your health information to an insurance company or other third party for the payment purposes including to a collection service. We may also disclose your health information to another health care provider or payor of health care for the payment activities of that entity. For example: We may give your health plan or insurance company information about a treatment or service you have received, or are going to receive so that we can be reimbursed for providing that treatment or service. We may also contact your health plan or insurance company for prior treatment authorizations and referrals.

- **For Health Care Operations**. We may use and disclose your health information for health care operations. These uses and disclosures are necessary to run Birmingham Maple Clinic, to make sure you receive competent, quality health care, and to maintain and improve the quality of health care we provide. We may also provide your health information to various governmental or accreditation entities to maintain our license and accreditation. For example: We may use your health information to:
  - Evaluate the performance of our staff in caring for you;
  - Assess the quality of care and outcomes in your case(s) and similar cases compared against other therapists and psychiatrists in the area, state, or nation;
  - Learn how to improve our facilities and the services we provide; or
  - Determine how to continually improve the quality and effectiveness of the health care we provide.

- **Incidental Uses and Disclosures.** We may occasionally inadvertently use or disclose your health information when such use or disclosure is incident to another use or disclosure that is permitted or required by law. For example: While we have safeguards in place to protect against others overhearing our conversations that take place between therapists, psychiatrists or other personnel, there may be times that such conversations are in fact overheard. Please be assured, however, that as much as possible, we have appropriate safeguards in place in an effort to avoid such situations.

- **Disclosures to You.** Upon a request by you, we may use or disclose your health information in accordance with your request.

- **Limited Data Sets.** We may use or disclose certain parts of your health information, called a "limited data set," for purposes of research, public health reasons or for our health care operations. We would disclose a limited data set only to third parties that have provided us with satisfactory assurances that they will use or disclose your health information only for limited purposes.

- **Disclosures to the Secretary of Health and Human Services.** We might be required by law to disclose your health information to the Secretary of the Department of Health and Human Services, or his/her designee, in the case of a compliance review to determine whether we are complying with privacy laws.

- **De-Identified Information.** We may use your health information, or disclose it to a third party whom we have hired, to create information that does not identify you in any way. Once we have de-identified your information, it can be used or disclosed in any way according to law.

- **Disclosures by Members of Our Workforce.** Members of our workforce, including employees, volunteers, trainees or independent contractors, may disclose your health information to a health oversight agency, public health authority, health care accreditation organization or attorney hired by the workforce member, to report the workforce member's belief that we have engaged in unlawful conduct or that our care or services could endanger a patient, workers or the public. In addition, if a workforce member is a crime victim, the member may disclose your health information to a law enforcement official.

- **For Public Health Purposes.** We may disclose health information about you for public health activities. These activities may include the following:
  - To prevent or control disease, injury or disability;
  - To report reactions to medications or problems with products; or
  - To avert a serious threat to health or safety. Any disclosure, however, would only be to someone able to help prevent or lessen the threat or to law enforcement authorities in particular circumstances.

- **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws.

- **About Victims of Abuse.** We may disclose your health information to notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **As Required By Law.** We will disclose your health information when required to do so by federal, state or local law or regulation.

- **Judicial Purposes.** We may disclose your health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process issued by a Court.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official, if such disclosure is:

  - Required by law;
  - In response to a Court issued; Order, Subpoena, Warrant, Summons or similar process;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About criminal conduct at Birmingham Maple Clinic; or
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime, a suspect, fugitive, material witness, or missing person.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, only if you have agreed in writing to such a release, except that your consent will not be required if the information disclosure has been ordered by a court of law.

- **Coroners, Medical Examiners and Funeral Directors**. In certain circumstances, we may disclose health information to a coroner or medical examiner. This may be necessary, For example, to identify a deceased person or determine the cause of death. We may also release health information about individuals to funeral directors as necessary to carry out their duties.

- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all individuals who received one medication or treatment to those who received another. All research projects, however, are subject to a special approval process. This process includes evaluating a proposed research project and its use of health information, trying to balance the research needs with your need for privacy of your health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. Additionally, when it is necessary for research purposes and so long as the health information does not leave Birmingham Maple Clinic, we may disclose your health information to researchers preparing to conduct a research project, For example, to help the researchers look for individuals with specific health needs. Lastly, if certain criteria are met, we may disclose your health information to researchers after your death when it is necessary for research purposes.

- **Military and Veterans**. If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may disclose your health information as authorized by and to the extent necessary to comply with workers' compensation laws or laws relating to similar programs.

- **Communications Regarding Our Services or Products.** We may use and disclose your health information to make a communication to you to describe a health-related product or service of Birmingham Maple Clinic In addition, we may use or disclose your health information to tell you about products or services related to your treatment, case management or care coordination, or alternative treatments, therapies, providers or settings of care for you. We may occasionally tell you about another company's products or services, but will use or disclose your health information for such communications only if they occur in person with you. We may also use and disclose your health information to give you a promotional gift from us that is a minimal value.

- **Treatment Alternatives, Appointment Reminders and Health-Related Benefits**. We may use and disclose your health information to tell you about or recommend possible treatment alternatives or health-related benefits or services that may be of interest to you. Additionally, we may use and disclose your health information to contact you by mail or phone to provide appointment reminders. If you do not wish us to contact you about treatment alternatives, health-related benefits or appointment reminders, you must notify us in writing, and state which of those activities you wish to be excluded from

- **Individuals Involved in Your Care or Payment for Your Care**. We may release health information about you to a family member, other relative, or any other person identified by you who is involved in your health care. We may also give information to someone who is involved with or helps pay for your care. We may also tell your family, friends, personal representative or other person responsible for your health care your condition and that you are at the Hospital.

- **Third Parties.** We may disclose your health information to third parties with whom we contract to perform services on our behalf. If we disclose your information to these entities, we will have a written agreement with them to safeguard your information.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization.

You understand that we are unable to take back any disclosures we have already made under the authorization, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. For example: You could ask that we not use or disclose information about your condition to a certain person to whom disclosure would otherwise be permitted. Also, we will honor a valid Court Order that you provide to us, which restricts disclosure of information about a child to a non-custodial parent.

  We will comply with your request unless the information is needed to provide you emergency treatment, is required by law or a third party payment contract.

  To request restrictions, you must make your request in writing and submit it to the individual at the address identified at the end of this Notice. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you or your responsible party about your health care in an alternative way or at a certain location.

  To request confidential communications, you must make your request in writing and submit it to the individual at the address identified at the end of this Notice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to Inspect and Copy**. You have the right to inspect and copy health information that may be used to make decisions about your care.

  To inspect and copy health information that may be used to make decisions about you, you can submit your request in writing to the individual at the address identified at the end of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend**. You have the right to ask us to amend your health and/or billing information for as long as the information is kept by us.

  To request an amendment, your request must be made in writing and submitted to the individual at the address identified at the end of this Notice. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for us;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - We believe is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request a list of certain disclosures that we have made of your health information.

  To request this list of disclosures, you must submit your request in writing and submit it to the individual at the address identified at the end of this Notice. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (*For example; on paper or electronically*). The first list you request within a twelve-month period will be free. For additional lists, during such twelve-month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

  To obtain a paper copy of this Notice, contact us in writing and submit it to the individual at the address identified at the end of this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in a clear and prominent location to which you have access. The Notice is also available to you upon request. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, if we revise the Notice, you may request a copy of the revised Notice then in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Birmingham Maple Clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Privacy Officer at the address listed at the end of this Notice. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

If you have any questions about this Notice, please contact:

Privacy Officer – Birmingham Maple Clinic, Inc.
950 E. Maple Road
Birmingham, Michigan 48009

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have received Birmingham Maple Clinic's Notice of Privacy Practices ("Notice").

_____ Date:_____

Signature (Patient or Authorized Representative)

_____

Printed (Patient or Authorized Representative)

Birmingham Maple Clinic

2075 W. Big Beaver Rd.
Suite 520
Troy, MI 48084
Phone (248) 646-6659
Fax (248) 642-8645
www.birminghammaple.com

For Parent to Complete

We hope that your experience at Birmingham Maple Clinic was beneficial to your child. You have indicated that you are willing to participate in a study on psychotherapy. We hope that you will find a few minutes to complete the attached questionnaire.

The purpose of this study is to look at the effect of psychotherapy on different aspects of your life at different points in time. The Council On Accreditation, which certifies our clinic, requires that we monitor therapy outcome, but we also believe that this information is important to gather in order to provide the best possible services. Please take a few minutes to read this form and before returning the questionnaire, sign where indicated at the bottom of this page. We do appreciate your participation and hope you find your answers to these questions interesting and useful to you.

INFORMATION ABOUT YOUR PARTICIPATION

Your participation and confidentiality during this study will be protected, as every questionnaire will be identified by number and not name. The only place your name will appear is on a master list which will be separate from the questionnaire, locked and accessible only to the psychologist listed below.

You may refuse to participate at any time, discontinue at any time or skip any questions that make you uncomfortable. Please feel free to ask questions concerning the study at any point. You may contact: Nancy Dolin Dietrich, Ph.D. or Janet Jordan, M.A. at (248) 646-6659.

Once all the data is collected, the results will be tallied and the conclusions shared with the Council On Accreditation. No identifying information will appear on this report. It is possible that the data will be used to provide material for professional journals or further research in this area, again with no names used.

INFORMED CONSENT

I have read the above information, understand the conditions for my participation as stipulated above and agree to participate in this study.

Signature Date

Thank you very much for your participation in this important study. Our hope is that this contribution will help add to the knowledge and understanding of the effects of psychotherapy. Please return this letter and questionnaire in the enclosed self-addressed stamped envelope.

Youth Outcome Questionnaire (Y-OQ®2.01)

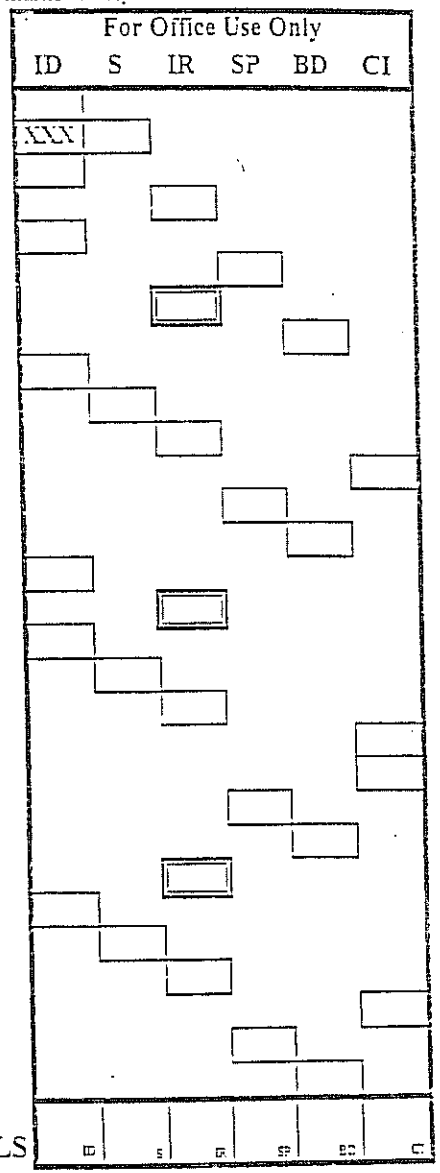
ID# _____ Today's Date _____

PURPOSE: The Y-OQ®2.01 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common in children and adolescents. You may discover that some of the items do not apply to your child's current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®2.01 you will see that you can easily make your child look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking for your child.

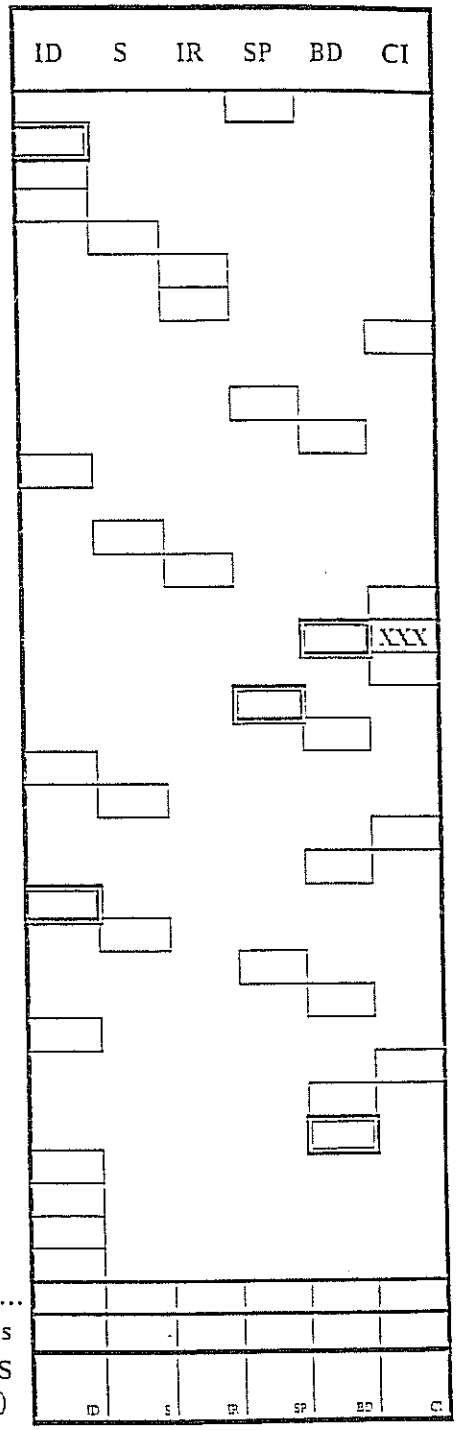
DIRECTIONS:
- Read each statement carefully.
- Decide how true this statement is for your child during the past 7 days.
- Check the box that most accurately describes your child during the past week.
- Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

My Child:	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. Wants to be alone more than other children of the same age	☐0	☐1	☐2	☐3	☐4
2. Complains of dizziness or headaches	☐0	☐1	☐2	☐3	☐4
3. Doesn't participate in activities that were previously enjoyable	☐0	☐1	☐2	☐3	☐4
4. Argues or is verbally disrespectful	☐0	☐1	☐2	☐3	☐4
5. Is more fearful than other children of the same age	☐0	☐1	☐2	☐3	☐4
6. Cuts school or is truant	☐0	☐1	☐2	☐3	☐4
7. Cooperates with rules and expectations	☐ 2	☐ 1	☐ 0	☐-1	☐-2
8. Has difficulty completing assignments, or completes them carelessly	☐0	☐1	☐2	☐3	☐4
9. Complains or whines about things being unfair	☐0	☐1	☐2	☐3	☐4
10. Experiences trouble with her/his bowels, such as constipation or diarrhea	☐0	☐1	☐2	☐3	☐4
11. Gets into physical fights with peers or family members	☐0	☐1	☐2	☐3	☐4
12. Worries and can't get certain ideas off his/her mind	☐0	☐1	☐2	☐3	☐4
13. Steals or lies	☐0	☐1	☐2	☐3	☐4
14. Is fidgety, restless, or hyperactive	☐0	☐1	☐2	☐3	☐4
15. Seems anxious or nervous	☐0	☐1	☐2	☐3	☐4
16. Communicates in a pleasant and appropriate manner	☐ 2	☐ 1	☐ 0	☐-1	☐-2
17. Seems tense, easily startled	☐0	☐1	☐2	☐3	☐4
18. Soils or wets self	☐0	☐1	☐2	☐3	☐4
19. Is aggressive toward adults	☐0	☐1	☐2	☐3	☐4
20. Sees, hears, or believes things that are not real	☐0	☐1	☐2	☐3	☐4
21. Has participated in self-harm (e.g. cutting or scratching self, attempting suicide)	☐0	☐1	☐2	☐3	☐4
22. Uses alcohol or drugs	☐0	☐1	☐2	☐3	☐4
23. Seems unable to get organized	☐0	☐1	☐2	☐3	☐4
24. Enjoys relationships with family and friends	☐ 2	☐ 1	☐ 0	☐-1	☐-2
25. Appears sad or unhappy	☐0	☐1	☐2	☐3	☐4
26. Experiences pain or weakness in muscles or joints	☐0	☐1	☐2	☐3	☐4
27. Has a negative, distrustful attitude toward friends, family members, or other adults	☐0	☐1	☐2	☐3	☐4
28. Believes that others are trying to hurt him/her even when they are not	☐0	☐1	☐2	☐3	☐4
29. Threatens to, or has run away from home	☐0	☐1	☐2	☐3	☐4
30. Experiences rapidly changing and strong emotions	☐0	☐1	☐2	☐3	☐4
SUBTOTALS					



My Child:	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
31. Deliberately breaks rules, laws, or expectations	☐0	☐1	☐2	☐3	☐4
32. Appears happy with her/himself	☐ 2	☐ 1	☐ 0	☐-1	☐-2
33. Sulks, pouts, or cries more than other children of the same age	☐0	☐1	☐2	☐3	☐4
34. Pulls away from family or friends	☐0	☐1	☐2	☐3	☐4
35. Complains of stomach pain or feeling sick more than other children of the same age	☐0	☐1	☐2	☐3	☐4
36. Doesn't have or keep friends	☐0	☐1	☐2	☐3	☐4
37. Has friends of whom I don't approve	☐0	☐1	☐2	☐3	☐4
38. Believes that others can hear her/his thoughts, or that s/he can hear the thoughts of others	☐0	☐1	☐2	☐3	☐4
39. Engages in inappropriate sexual behavior (e.g. sexually active, exhibits self, sexual abuse towards family members or others)	☐0	☐1	☐2	☐3	☐4
40. Has difficulty waiting his/her turn in activities or conversations	☐0	☐1	☐2	☐3	☐4
41. Thinks about suicide, says s/he would be better off if s/he were dead	☐0	☐1	☐2	☐3	☐4
42. Complains of nightmares, difficulty getting to sleep, oversleeping, or waking up from sleep too early	☐0	☐1	☐2	☐3	☐4
43. Complains about or challenges rules, expectations, or responsibilities	☐0	☐1	☐2	☐3	☐4
44. Has times of unusual happiness or excessive energy	☐0	☐1	☐2	☐3	☐4
45. Handles frustration or boredom appropriately	☐ 2	☐ 1	☐ 0	☐-1	☐-2
46. Has fears of going crazy	☐0	☐1	☐2	☐3	☐4
47. Feels appropriate guilt for wrongdoing	☐ 2	☐ 1	☐ 0	☐-1	☐-2
48. Is unusually demanding	☐0	☐1	☐2	☐3	☐4
49. Is irritable	☐0	☐1	☐2	☐3	☐4
50. Vomits or is nauseous more than other children of the same age	☐0	☐1	☐2	☐3	☐4
51. Becomes angry enough to be threatening to others	☐0	☐1	☐2	☐3	☐4
52. Seems to stir up trouble when bored	☐0	☐1	☐2	☐3	☐4
53. Is appropriately hopeful and optimistic	☐ 2	☐ 1	☐ 0	☐-1	☐-2
54. Experiences twitching muscles or jerking movement in face, arms, or body	☐0	☐1	☐2	☐3	☐4
55. Has deliberately destroyed property	☐0	☐1	☐2	☐3	☐4
56. Has difficulty concentrating, thinking clearly, or attending to tasks	☐0	☐1	☐2	☐3	☐4
57. Talks negatively, as though bad things are all his/her fault	☐0	☐1	☐2	☐3	☐4
58. Has lost significant amounts of weight without medical reason	☐0	☐1	☐2	☐3	☐4
59. Acts impulsively, without thinking of the consequences	☐0	☐1	☐2	☐3	☐4
60. Is usually calm	☐ 2	☐ 1	☐ 0	☐-1	☐-2
61. Will not forgive her/himself for past mistakes	☐0	☐1	☐2	☐3	☐4
62. Lacks energy	☐0	☐1	☐2	☐3	☐4
63. Feels that he/she doesn't have any friends, or that no one likes him/her	☐0	☐1	☐2	☐3	☐4
64. Gets frustrated and gives up, or gets upset easily	☐0	☐1	☐2	☐3	☐4



TOTAL =

Birmingham Maple Clinic

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www.birminghammaple.com

For 14 to 17 Year Old Adolescent to Complete

In an attempt to assess the value of treatment, we administer this questionnaire to compare how you feel at the beginning of treatment, the end of treatment and six months following completion of treatment. With your cooperation, we will be able to measure behavioral and emotional change as a result of your treatment experience.

Please complete this questionnaire. If you have any questions regarding a particular item, do not hesitate to ask your therapist. We appreciate your cooperation as we continue to strive to improve the quality and effectiveness of treatment at Birmingham Maple Clinic.

Youth Outcome Questionnaire-Self Report (Y-OQ®-SR 2.0)

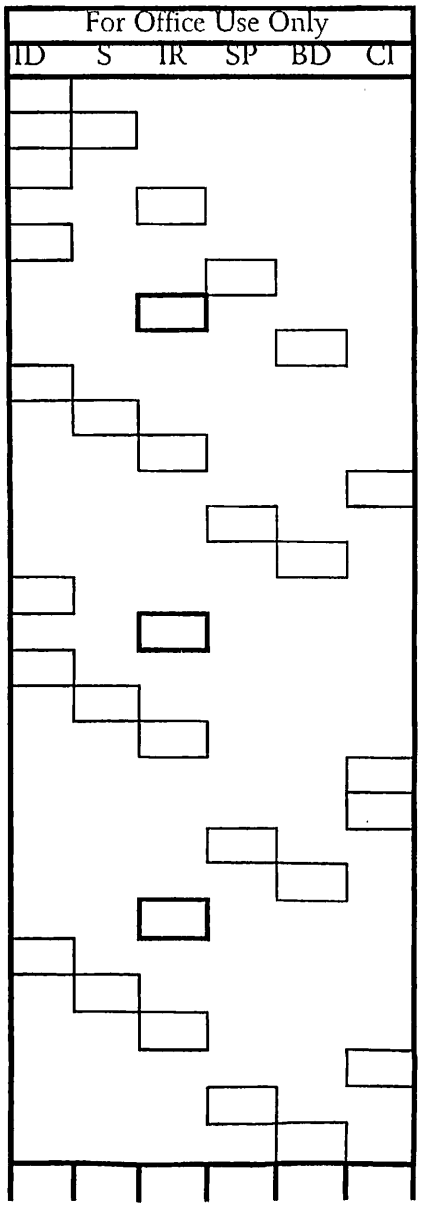
ID #_____ Today's Date_____

PURPOSE: The Y-OQ®-SR 2.0 is designed to describe a wide range of trublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®-SR 2.0 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

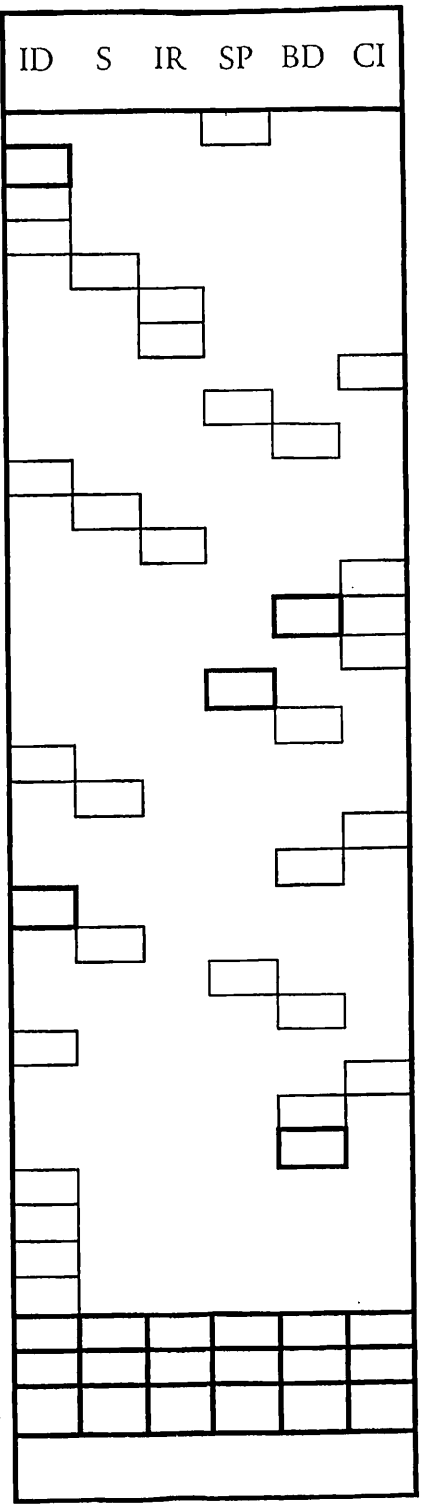
DIRECTIONS: *Read each statement carefully. *Check the box that most accurately describes the past week.
*Decide how true this statement is during the past 7 days. * Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I want to be alone more than others my same age.	0	1	2	3	4
2. I have headaches or feel dizzy.	0	1	2	3	4
3. I don't participate in activities that used to be fun.	0	1	2	3	4
4. I argue or speak rudely to others.	0	1	2	3	4
5. I have more fears than others my same age.	0	1	2	3	4
6. I cut classes or skip school altogether.	0	1	2	3	4
7. I cooperate with rules and expectations of adults.	2	1	0	1	2
8. I have a hard time finishing my assignments or I do them carelessly.	0	1	2	3	4
9. I complain about things that are unfair.	0	1	2	3	4
10. I have trouble with constipation or diarrhea.	0	1	2	3	4
11. I have physical fights (hitting, kicking, biting, or scratching) with my family or others my age.	0	1	2	3	4
12. I worry and can't get thoughts out of my mind.	0	1	2	3	4
13. I steal or lie.	0	1	2	3	4
14. I have a hard time sitting still (or I have too much energy).	0	1	2	3	4
15. I feel anxious or nervous.	0	1	2	3	4
16. I talk with others in a friendly way.	2	1	0	1	2
17. I am tense and easily startled (jumpy).	0	1	2	3	4
18. I have trouble with wetting or messing my pants or bed.	0	1	2	3	4
19. I physically fight with adults.	0	1	2	3	4
20. I see, hear, or believe in things that are not real.	0	1	2	3	4
21. I have hurt myself on purpose (for example, cut, scratched, or attempted suicide).	0	1	2	3	4
22. I use alcohol or drugs.	0	1	2	3	4
23. I am disorganized (or I can't seem to get organized).	0	1	2	3	4
24. I enjoy my relationships with my family and friends.	2	1	0	1	2
25. I am sad or unhappy.	0	1	2	3	4
26. I have pain or weakness in muscles or joints.	0	1	2	3	4
27. I have a hard time trusting friends, family members, or other adults.	0	1	2	3	4
28. I think that others are trying to hurt me even when they are not.	0	1	2	3	4
29. I have theratened to, or have run away from home.	0	1	2	3	4
30. My emotions are strong and change quickly.	0	1	2	3	4
SUBTOTALS					



	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
31. I break rules, laws, or don't meet others' expectations on purpose.	☐0	☐1	☐2	☐3	☐4
32. I am happy with myself	☐2	☐1	☐0	☐-1	☐-2
33. I pout, cry, or feel sorry for myslef more than others my age.	☐0	☐1	☐2	☐3	☐4
34. I withdraw from my family and friends	☐0	☐1	☐2	☐3	☐4
35. My stomach hurts or I feel sick more than others my same age.	☐0	☐1	☐2	☐3	☐4
36. I don't have friends or I don't keep friends very long	☐0	☐1	☐2	☐3	☐4
37. My parents or guardians don't approve of my friends.	☐0	☐1	☐2	☐3	☐4
38. I think I can hear other people's thoughts or that they can hear mine	☐0	☐1	☐2	☐3	☐4
39. I am involved in sexual behavior that my friends or family would not approve of.	☐0	☐1	☐2	☐3	☐4
40. I have a hard time waiting for my turn in activites or conversations	☐0	☐1	☐2	☐3	☐4
41. I think about suicide or feel I would be better off dead.	☐0	☐1	☐2	☐3	☐4
42. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early	☐0	☐1	☐2	☐3	☐4
43. I complain about or question rules, expectations, or responsibilities.	☐0	☐1	☐2	☐3	☐4
44. I have times of unusual happiness or excessive energy	☐0	☐1	☐2	☐3	☐4
45. I'm generally okay with frustration or boredom.	☐2	☐1	☐0	☐-1	☐-2
46. I am afraid I am going crazy	☐0	☐1	☐2	☐3	☐4
47. I feel guilty when I do something wrong.	☐2	☐1	☐0	☐-1	☐-2
48. I demand a lot from others or I am pushy	☐0	☐1	☐2	☐3	☐4
49. I feel irritated.	☐0	☐1	☐2	☐3	☐4
50. I throw-up or feel sick to my stomach more than others my age	☐0	☐1	☐2	☐3	☐4
51. I get angry enough to threaten others.	☐0	☐1	☐2	☐3	☐4
52. I get into trouble when I'm bored	☐0	☐1	☐2	☐3	☐4
53. I'm hopeful and positive.	☐2	☐1	☐0	☐-1	☐-2
54. Muscles in my face, arms, or body twitch or jerk	☐0	☐1	☐2	☐3	☐4
55. I destroy property on purpose.	☐0	☐1	☐2	☐3	☐4
56. I have a hard time concentrating, thinking clearly, or sticking to tasks.	☐0	☐1	☐2	☐3	☐4
57. I get down on myself and blame myself for things that go wrong.	☐0	☐1	☐2	☐3	☐4
58. I have lost a lot of weight without being sick	☐0	☐1	☐2	☐3	☐4
59. I act without thinking and don't worry about what will happen.	☐0	☐1	☐2	☐3	☐4
60. I am calm	☐2	☐1	☐0	☐-1	☐-2
61. I don't forgive myself for things I've done wrong.	☐0	☐1	☐2	☐3	☐4
62. I don't have much energy	☐0	☐1	☐2	☐3	☐4
63. I feel like I don't have any friends or that no one likes me.	☐0	☐1	☐2	☐3	☐4
64. I get frustrated or upset easily, and give up	☐0	☐1	☐2	☐3	☐4



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Understanding Your Health Insurance Benefits: A Guide for Patients

In this ever changing world of health insurance it is imperative that you know and understand your health plan. You may ask yourself "how can I possibly handle that?". It's actually quite simple if you start with the basics. Below you will find a brief guide to give you an introduction to health insurance.

Where do I obtain information about my health plan?

Each subscriber in a health plan receives a policy handbook upon signing up for his or her insurance. If you receive health care benefits through your employer, they can provide you with a copy. Covered benefits vary from policy to policy and from insurance carrier to insurance carrier. It's important that you read through your most recent handbook and know your policy, making notes of any questions you have.

If I have questions about my policy where can I get them answered?

If your insurance is provided through your employer the human resources' staff can assist you. If you purchased your insurance, the agent who sold you your policy should be able to answer your questions. Or you may contact your insurance carrier directly at any time. Typically their contact information is listed on the reverse side of your insurance card.

How will I know if my policy changed?

Your insurance carrier must notify you in advance of any changes in your policy. It is your responsibility to keep current of those changes.

Isn't my doctor's office responsible for knowing my benefits?

No. Medical providers are not responsible for knowing your policy and what is covered or not covered. Patient benefits vary widely with hundreds of different plans available in today's market. Physician offices bill your insurance as both a courtesy and convenience to you as a patient. However, your benefits are your responsibility to know and understand.

Why does my doctor's staff need to know my social security number?

Your doctor can legally request your social security number, and requires it to administer aspects of your health plan, such as obtaining prior authorizations for medical services. Every doctor's office is required by law to maintain a high level of security over patients' personal information. This information is never sold or provided to unauthorized individuals.

What are Prior Authorizations?

Many health plans require permission in advance of a patient receiving particular medical services in order for the service to be paid. Your medical provider usually will call to obtain authorization for a service, but it is your responsibility to know if your insurance requires prior authorizations.

What does participating provider or preferred provider mean?

This means that your medical care provider has a contract in place with your insurance carrier to provide health care services to you for a pre-determined fee schedule. Deductibles and co-payments still apply.

What are Deductibles, Co-payments and Co-insurance?

Deductibles: This is a set dollar amount that is required annually to be paid by the insured. The insurance will not pay any of your claims until this amount is paid by the patient. The medical provider must collect in full and is not allowed to adjust off any portion of this payment.
Co-payments: A set dollar amount that you are required to pay according to your insurance policy at each office visit.
Co-insurance: The portion of medical expenses that you are responsible for after the deductible is met and the insurance has paid its portion. For example, your policy may read 80/20, meaning that your insurance will pay 80% of the claim and you will be responsible for the remaining 20%. Your policy manual can provide you with this information.

Your insurance company determines the amount you pay. Again, medical providers are not allowed to adjust off your co-payments or deductibles. It is your obligation to pay these amounts.

How can I find out if something is a covered service?

You can review covered benefits in your policy handbook or contact your customer service representative. They are responsible for helping you understand your policy. Additionally, review the explanation of benefits that your insurance carrier sends you after you have received medical services. This will explain your charges and how it was reviewed and paid according to your policy by the insurance carrier. Any dollar amounts you owe will match the statement you receive from the medical provider, as the medical provider obtains their information from the insurance carrier.

When is payment expected?

Payment for services received is expected at the time of service. In most instances, you should be prepared to pay for your office visit the day you visit your physician. If you have any questions about your physician's payment policy you should ask the office staff prior to receiving treatment.

We hope you found this guide informative and helpful in navigating through the basics of health insurance. We understand that navigating your health insurance policy can be difficult, but it's an important step to being a responsible consumer of health services.

This information has been brought to you by the:

OAKLAND COUNTY MEDICAL SOCIETY

The Voice of Your Local Physicians Since 1851

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Dear Parents:

Whether your child is just entering therapy or has been in therapy for some time, you may wonder how best to help them. And you likely have questions, hopes and expectations regarding your child's therapeutic outcome.

To assist you in this process, BMC is offering an informational meeting- specifically for parents of children in treatment- facilitated by clinic staff.

If you might be interested, please call or visit the front office to leave your name. You will be contacted for the next scheduled session, generally held on Wednesday evenings.

Sincerely,

BMC Staff