Great Lakes TTC Counseling Services

Mission Statement: To provide cutting edge Evidence Based Treatment to persons afflicted by Mental Illness and Substance Abuse issues. With a strong focus on educating the patient on their illness. To provide to patients in need a Board Certified Psychiatrist for medication management.

Vision Statement, To bring integrated health care to the Northern Michigan Area, working closely with patients in treatment with their PCP and other health care providers to ensure complete treatment, we must all work together to give the proper treatment and support. We provide a psychiatrist on staff to work with our LMSW to provide medication management as well as psychotherapy.

Our Goals, To specialize in adolescent and adult psychiatry, evaluate patients based on their needs, and determine whether medication management is required. To diagnose if symptoms result from medical or mental illness or a combination of both.

We sincerely look forward to working with you to meet all your treatment needs.

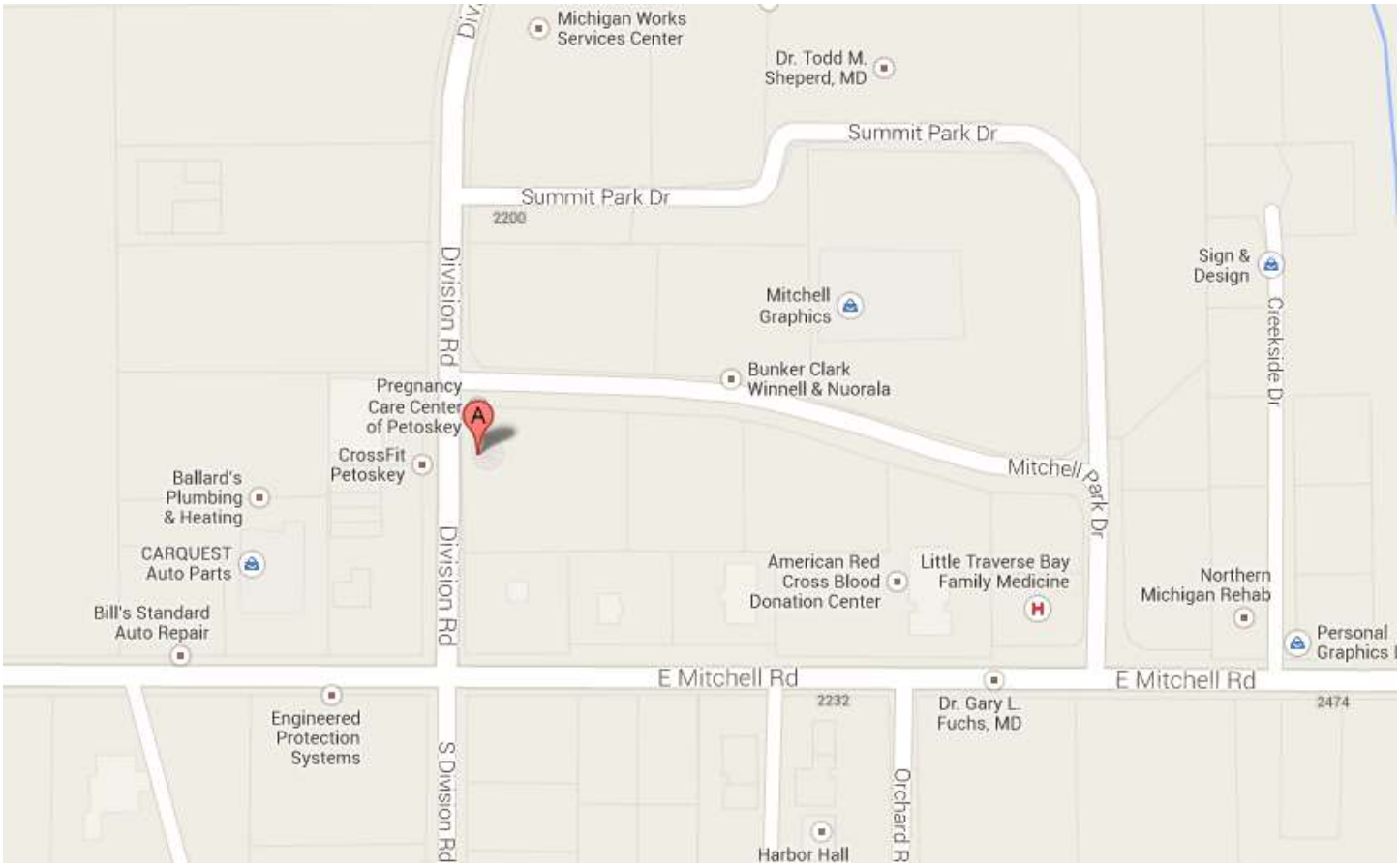
Sincerely,

The Staff Members of Great Lakes TTC, LLC.

Great Lakes TTC, LLC

COUNSELING AND OUTPATIENT MENTAL HEALTH SERVICES

2206 Mitchell Park Drive, Suite 10 • Petoskey, Michigan 49770
231.487.6076 landline • 231.487.6569 fax



Traveling US-31 South to Petoskey:

Take US-31 South to Petoskey until you see Bay View Golf Course on the left, before Bay View Association begins there is a new turning lane to take **LEFT on Division Road** and proceed up hill. At top of hill, **second entrance on left is Mitchell Park Drive**. (Located across street from Old Kilwins Factory if you proceed to light at intersection you have gone too far.) After taking Left on Mitchell Park Drive we are **SECOND drive on right**. There will be a sign at parking lot entrance that says Little Traverse Psychiatric Associates. Business is located in Building B, Suite 10. We occupy the lower left side of building.

Traveling North on US-131 to Petoskey:

Take US-131 to US 31 intersection. Continue north past McLaren Hospital – formerly Northern Michigan Regional Hospital/Burns Professional Building to the SECOND traffic light and **turn right on Mitchell Street**. One of the first buildings you will see on right is 7-Eleven. Continue east on Mitchell St. through all of the traffic lights up the hill. You will come to a 4-way stop sign at top of hill. Go straight through intersection heading East and stay on Mitchell for approximately one-half mile, you will pass Petoskey High School on right. Continue on Mitchell to intersection light at Division Road. **Turn LEFT onto Division Road** and **take second right onto Mitchell Park Drive**. We are **second drive on right**. There will be a sign near parking lot entrance that says Calm Waters. Business is located in Building B, Suite 10. We occupy the lower left side of building.

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly **confidential**. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain that privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and client service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations.
- If we are required by law to treat you; or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice for us upon request.

We are required by law to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Great Lakes TTC
Privacy Officer
2206 Mitchell Park drive, Suite 10
Petoskey, MI 49770
(231) 487-6076

For more information about HIPAA
Or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: 1 (877) 696-6775

Client Information and Policy Statement
Great Lakes TTC, Counseling Services

NEW CLIENTS: As a new client, it is important that we provide you with information relevant to treatment, confidentiality and office policy. The clinician working with you will be pleased to respond to any questions you about these areas during the course of your treatment.

GOALS: Our basic purpose is to improve and maintain the mental health of clients we serve and to provide high quality behavioral health care. The clinician will be using a treatment plan stating goals and outcomes as part of your care. There is an understanding that you the patient will be participate in the formulation of the treatment plan.

CONFIDENTIALITY: Issues discussed with you during the course of therapy are confidential. Meaning that information you share during sessions will not be shared with any other party without your written consent. You should be aware of circumstances when there is an exception to confidentiality. In situations of potential harm to self or others, in suspected abuse or neglect of children, Elders, disabled or other vulnerable persons and in the case where the courts may subpoena records. If an independent evaluation is performed for legal or disability purposes, your information will be given to the organization requesting the evaluation. Insurance companies often request information about your care before they will pay for your treatment. You will be requested to sign a release of information to your insurance company if you want Great Lakes TTC to bill your insurance provider.

FEES: A fee schedule is available upon request. Fees are based on the type of service provided. Services include Individual, marital and family therapy, Administering, scoring, analyzing and reporting diagnostic test, letters, consultations, telephone calls and reviewing records reports. You will be bill for time spent with you and time spent on your behalf. Most insurance companies will not pay for indirect time spent on you, this includes court testimony, letters to employers, Attorneys, as well as some consultation services with family members when you are not present, the patient will be made aware of and authorize these services prior to work being done. The patient is responsible for payment of these items.

PAYMENT FOR SERVICES RENDERED: Payment is expected at the time of service, this includes co-pays, super bills, and fees not covered by patient insurance. If you have insurance coverage with mental health/substance abuse benefits, we ask that you contact your insurance provider to see what benefits they will cover. You will be responsible to pay co-pays and deductibles at the time of service. I will accept cash, check, MasterCard, Visa, Discover and American Express. All service can be super billed through your insurance provider if I am not a provider of your insurance Great Lakes TTC will provide you with a "super bill" to send into your insurance provider for reimbursement. In this case the patient must pay in full for service rendered that day, as reimbursement will be sent to you, Not Great Lakes TTC. Please ask office staff or myself if you have any questions regarding "super bill."

ETHICS AND PROFESSIONAL STANDARDS: All providers are licensed by the State of Michigan. As members of our respective professional associations, we agree to abide by and uphold the most responsible ethical and professional standards possible.

If you are unhappy with your services here, it is important that you try you best to communicate with us the source of your dissatisfaction. Some clients do this in writing if they feel unable to do this directly. If we should not reach an agreeable solution and you need help finding additional or alternate assistance, we will do our best to help you locate a more suitable referral or therapy source.

QUALITY OF CARE: We are committed to quality care. Please complete all necessary forms prior to your appointment and bring them with you at that time.

Quality care includes the active participation of those we serve and a safe working environment for our clients and providers alike. It will be understood that services may be discontinued under the following conditions:

- Violent or threatening behaviors
- Destruction of department property
- Appearing under the influence of alcohol or non-prescribed substances
- Non-payment of fees as agreed upon
- Refusal to participate in treatment plan or assessment

Your provider has the authority to discharge you. You will be notified in writing if such action is considered.

Please sign below to indicate receipt of Notice of Privacy Practices and Client Information and Policy Statement.

Signature of Client _____ Date _____

Doctor/Therapist _____ Date _____

PREPARED BY:_____

MONTH DAY YEAR

MED REC NUMBER

ACCOUNT NUMBER

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	BIRTHDATE
STREET ADDRESS	CITY, STATE	SEX ☐ MALE ☐ FEMALE	
P.O. BOX	COUNTRY, ZIP	SOCIAL SECURITY NO.	
HOME NUMBER ( )	CELL NUMBER ( )	WORK NUMBER ( )	

MARITAL STATUS
☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ MARRIED- SPOUSE:

COMMENTS / MAIDEN OR OTHER NAME

GUARANTOR'S NAME / RESPONSIBLE PERSON	GUARANTOR'S ADDRESS	GUARANTOR'S SOC. SEC. NO.
GUARANTOR'S EMPLOYER	EMPLOYER'S ADDRESS	TELEPHONE
WIFE / MOTHER'S NAME	WIFE / MOTHER'S ADDRESS	SOCIAL SECURITY NO.
WIFE / MOTHER'S EMPLOYER	EMPLOYER'S ADDRESS	TELEPHONE

FATHER / HUSBAND BIRTHDATE / / MOTHER / WIFE BIRTHDATE / /

INSURANCE INFORMATION

GROUP/ PRIVATE INSURANCE	NAME OF SUBSCRIBER	SUBSCRIBER'S EMPLOYER	CONTRACT / POLICY NO.
	INSURANCE NAME	ADDRESS	SUBSCRIBER'S SOC. SEC. NO.

I CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT, AND I WILL NOTIFY **GREAT LAKES TTC** OF ANY CHANGES.

SIGNATURE _____ DATE _____

Guarantor (see above) is the term that is used for the primary person listed on the insurance policy

Counseling and Outpatient Mental Health Services
2206 Mitchell Park, Suite 10
Petoskey, Michigan 49770
Phone: 231-487-6076
Fax: 231-487-6569

INTAKE INFORMATION

Please complete all forms before your appointment and bring them with you. You will not be seen without them.

Purpose of this questionnaire

This questionnaire was developed to obtain a comprehensive picture of you and your background. Your responses, combined with information discussed with your therapist/physician, lead to an assessment of you and your concerns. This will allow us to develop a plan to meet your needs and goals. As you can see the completeness of your responses is valuable to your therapy program.

Please review client information and policy statement and notice of privacy rights. Please discuss any concerns you have regarding confidentiality with myself.

IDENTIFICATION Today's Date _____

Name _____
(First) (Middle) (Last)

Date of Birth _____ Age _____

Address _____
Number and Street Apartment Number POB

Phone (home) _____ (work/cell) _____

Social Security Number _____ Occupation _____

Who is to be notified in case of an emergency? _____

Relationship _____ Phone (home): _____ (work/cell) _____

Who referred you to our practice? _____

What concerns brought you here? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH HISTORY

Allergies _____

_____

Please list all current medications including psychiatric medications, medications for health conditions, vitamins and herbal supplements: (Include inhaled and injected medications such as insulin)

Medication	Dose	How Taken	Purpose	Physician

(Attach additional sheet if necessary)

List any psychiatric medications taken in the past that you no longer take _____

_____

_____

Did you have any side effects or adverse reactions to any medications? _____ If yes, please describe:

_____

_____

_____

_____

EARLY DEVELOPMENT

○Night Terrors	○Bed wetting	○Sleep walking	○Few Friends
○Nail biting	○Speech problem	○Fears	○Run Away
○School failure	○Hyper activity	○Delinquency	
○Happy childhood	○Unhappy childhood	○Drug/alcohol use	
○Sexual abuse	○Emotional Abuse	○Physical abuse	

Was your health during childhood / adolescence good or poor? _____

If poor, explain _____

_____

_____

EDUCATIONAL BACKGROUND

Highest grade completed _____ Year Graduated _____

Degrees received _____ Major _____

Did you ever repeat a grade? _____ Did you ever receive special education? _____

Were you allowed to skip any grades or placed in an accelerated education program? _____

Comments _____

MARITAL / RELATIONSHIP HISTORY

Are you presently married or in any type of long term relationship? _____

How long? _____ Are there any problems in current relationship? _____

If yes, please describe _____

_____

_____

_____

Describe past marriages or long term relationships _____

_____

_____

Please check any conditions that apply to you

◯Chest pain	◯Sleep Apnea	◯Kidney failure	◯TMJ
◯Previous Heart attack	◯Insomnia	◯Arthritis	◯Closed Head Injury
◯Coronary Artery Disease	◯Snoring	◯HIV/AIDS	◯Stroke/TIA
◯Heart Failure	◯Daytime sleepiness	◯Bleeding Disorder	◯Seizures
◯High Blood Pressure	◯Morning headaches	◯Cancer	◯Numbness/tingling
◯Deep Vein Thrombosis	◯Impotence	◯Thyroid	◯Loss of consciousness
◯Elevated cholesterol or Triglycerides	◯IBS	◯Ulcer	◯Headaches
	◯Obesity	◯Diabetes	◯Emphysema
◯Liver problems	◯Hiatal hernia	◯Chronic pain	◯Morning dry mouth

Have you ever been hospitalized or had surgery? _____ Give reasons and approximate dates_____

_____

_____

Describe any serious illnesses or physical limitations you have _____

_____

What illnesses run in your family? _____

_____

Name and phone of family doctor _____

May we contact? _____

FAMILY HISTORY

Describe the home atmosphere in which you grew up. Were there any losses or separations? How was the discipline, religious training, communications? Did you feel secure? _____

_____

_____

_____

_____

_____

_____

FAMILY

	Name	Age	Full, half, step, adopted	Marital Status	Where living	Occupation	History of emotional disorder or substance abuse
Spouse							
Children							
Mother							
Father							
Brothers							
Sisters							

Who currently lives in your household? _____

Were there any suicides in your family? _____ Please describe _____

_____

What is your ethnic/cultueral heritage? _____ Where were you born? _____

Religion? _____ Do you attend services? _____

PSYCHIATRIC HISTORY

Have you ever been treated for a psychiatric disorder, nervous disorder or emotional problem? _____
Individual, marital or family therapy? _____ Drug or alcohol abuse? _____

Date of Treatment	Name of therapist or psychiatrist	Reason for treatment

(Attach additional sheet if needed)

Have you ever been hospitalized for a psychiatric disorder, nervous disorder, emotional problem, alcohol abuse and/or drug abuse? _____

Date of Hospitalization	Name/Location of Hospital	Reason

Please list below alcohol or substances you have used in the past or present

Substance	Age of First use	Date of last use	Amount used	Number of days used in the last 30 days	Longest period of time not used last 180 days

Describe any experience you have had with overdose, withdrawal or adverse drug or alcohol reactions_____

_____

_____

_____

Have you taken any of the medications listed below?

Antabuse/disulfiram _____ Chantix _____ Camprell _____ Buprenorphine/Suboxone_____

Naltrexone _____

WORK EXPERIENCES

Most recent or current job _____ How Long? _____

Have you had difficulty holding a steady job? _____

_____

What job did you hold for the longest? _____ How long? _____

Have you ever been fired? _____

Are you on disability? _____ Are you planning to apply for disability? _____

Have you been disabled in the past for more than 6 weeks? _____

What was the reason? _____

_____

MILITARY HISTORY

Have you ever been in the military? _____ What year? _____

Any combat experience? _____ If yes, describe? _____

_____

_____

_____

Highest rank _____ Rank at discharge _____ Type of discharge _____

LEGAL HISTORY

Have you had any legal / court involvement in the past or present? _____ If yes, describe _____

_____

_____

_____

_____ _____

Signature Date

MEDICAL INFORMATION RELEASE FORM
HIPPA RELEASE FORM

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, medications, appointments, and examinations rendered to me and claims information. This information may be released to (please provide **full** names):

[ ] Spouse _____ DOB: ___/___/___
[ ] Children _____ DOB: ___/___/___
[ ] Other _____ DOB: ___/___/___

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] other _____

The best time to reach me is (day) _____ between _____ & _____

Signed: _____ Date: _____
Witness: _____ Date: _____