



KaraLee and Associates, P.C.
1308 S. Main Street, Plymouth, MI 48170
Phone: (734) 451-3440
Fax: (734) 451-8720
www.karaleeandassociates.com

Welcome to KaraLee!

KaraLee Staff: Psychiatrists and therapists at KaraLee are licensed, registered and/or certified by the State of Michigan in their respective treatment professions. Each individual has at least a Master's degree in psychology, social work, or a related field. Appointments with therapists are by appointment only. The best way to contact your therapist is by calling their direct phone number or calling the office and leaving a message in their voicemail box.

Appointments: Appointments with therapists are typically 45 minutes long. Initial evaluations with the psychiatrists are usually 30-40 minutes in length and medication reviews vary between 10-30 minutes long. Missed appointments are not covered by insurance and may be paid out of pocket. There is a \$60 no show fee if there is not 24 hour notice of a cancellation.

Medication & Refills: If an individual is prescribed medication by the psychiatrist, it is their duty to report side effects or reschedule an appointment if their medication supply is running low to ensure they will not run out. **PSYCHIARISTS WILL NOT CALL IN REFILLS.**

Payments & Insurance: Co-payments are due at the time of the appointment. Payments can be made to your therapist or the office manager. If you are unsure about your balance or have any questions regarding billing, you can call our billing company, Health Care Connect at (734) 207-5226.

Patient Responsibilities: Many clients do not realize how crucial their own role is when receiving mental health treatment. You can make a big difference in the outcome of your care by actively participating in your treatment. It maybe very uncomfortable to tell a therapist your personal problems. Such feelings are a natural part of the initial consultation, however, these feelings are usually relieved through the process of clarifying the problem and learning more about it.

Thank you for taking the time to familiarize yourself with our procedures and practices. We appreciate the fact that you have selected KaraLee and Associates to assist you in your care and look forward to our work together.

OFFICE USE ONLY
Co-Pay: \$ _____ # Sessions: _____ Authorization: _____



Client Name:
Therapist:
DX Code:

Registration Information

Patient Name:		Parent Name:		Date:
Address:			State:	Zip:
Home Phone:		Work Phone:		Cell Phone:
Social Security: ____-____-____	D.O.B. ____/____/____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	

INSURANCE INFORMATION

Primary Insurance:		Secondary Insurance:	
Policy #:	Group #:	Policy #:	Group #:
Subscriber Name:		Subscriber Name:	
D.O.B.:		D.O.B.:	
Relationship to Patient:		Relationship to Patient:	
Social Security #:		Social Security #:	
Employer:		Employer:	
Insurance Phone #:		Insurance Phone #:	

APPOINTMENT INFORMATION

Reason for Appointment:		
Appointment Scheduled With:	Date:	Time: AM/PM

BILLING ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have the insurance coverage with _____ and assign directly to KaraLee & Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Signature:	Date:
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MEDICATION RECONCILIATION TRACKING LOG

Please list any prescribed or over-the-counter medication(s) or herbal supplements you currently take.

Patient Name: _____ **D.O.B.** ____ / ____ / ____

Prescribed Medication(s): (i.e. Adderall, Xanax, sleeping aids, birth control, high blood pressure, etc.)

Drug Name	Reason for Taking	Dosage	Amount/Day	Last Taken	Prescribed By (Doctor's Name)

Over-the-Counter Medication(s): (i.e. Advil, Nyquil, Vitamin C, etc.)

Drug Name	Reason for Taking	Dosage	Amount/Day	Last Taken

Miscellaneous Supplements: (i.e. Herbal, whey protein, etc.)

Name	Reason for Taking	Dosage	Amount/Day

Allergies/Side Effects:

Patient/Guardian Signature: _____ **Date:** ____ / ____ / ____

Physician Signature: _____ **Date:** ____ / ____ / ____

Responsible Party Payment Agreement

I understand that I will be responsible for all co-pays, deductibles and appointment fees that are not covered by my insurance company.

Furthermore, I understand that if another individual is court ordered to pay these fees, I will then provide KaraLee and Associates with this individual's written authorization for billing (which includes social security number, current address and signature). It is then the individual's responsibility to seek reimbursement from me either in person or through the Friend of the Court.

If I am unable to provide an alternate payer to KaraLee and Associates or if a collections agency needs to be involved in the collection of due payments, I understand that I am fully responsible for payment of all fees incurred at KaraLee and Associates

Late Cancellation & Missed Appointment Agreement

Mental health care requires the collaborative effort of both and you and your clinician. When you do not come to your scheduled appointment or cancel your appointment without the required 24 hour notice, you miss an opportunity for treatment and deny someone else the opportunity as well. Late cancellations and missed appointments will be charged a \$60 fee, and payment will be expected on or before your next scheduled appointment. Insurance companies do not pay for either later cancellations or missed appointments.

I, _____ have read the late cancellation and missed appointment agreement and agree to abide with this policy. I will be charged a \$60 fee if I miss my therapist or psychiatrist appointment without prior notice.

Acknowledgement of the Notice of Private Practices

I, _____ acknowledge that I have reviewed the Notice of Privacy Practices as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

Patient Name:	
Patient/Guardian Signature:	Date:

CONSENT & AUTHORIZATION OF SERVICES

Client Name:

D.O.B.:

I, the above named client or his/her legal, custodial parent, or legal guardian, acknowledge that I am voluntarily authorizing treatment for myself, or my child/ward at KaraLee & Associates, PC. I have been informed of the purposes of the treatment, the services, which may be provided, and any attendant risks, consequences, and/or benefits. Further, I understand the following:

1. Appropriate professional personnel will provide services. My or my dependent's primary case manager/clinician will be: _____
2. I may contact KaraLee & Associates, PC or the primary clinician as the need arises at the telephone number and addresses provided to me. If the clinician is unavailable, the program or its answering service will arrange for contact as soon as possible by the clinician or professional.
3. Successful termination of treatment is determined when the clinician and the patient agree that the treatment goals have been substantially met.
4. There are fees for the services rendered. I have been informed of those charges and that I am responsible for those charges.
 - a. If I am entitled to healthcare insurance payments for the services received, KaraLee & Associates, PC may assist me, but resumes no responsibility for collecting such insurance payments.
 - b. If the outstanding balance on my account exceeds \$200.00, services may be canceled until the balance is less than that amount. If this is to occur, KaraLee & Associates, PC will inform me no less than 24 hours before the next scheduled appointment.
 - c. I also understand that I am fully responsible for all fees incurred. If payment is not made within 30 days, an interest charge of 2% monthly interest may be added to my account. Failure to pay outstanding balances may result in discharge from treatment.
5. I understand that KaraLee & Associates, PC provides mental health care and/or substance abuse care. All mental health care and/or substance abuse care is provided as agreed upon by the clinician and me. In addition, KaraLee provides psychological. Evaluations for children, adolescents and adults.

Responsibilities:

I understand and acknowledge that persons receiving services have certain responsibilities, including:

- ✓ To help develop a plan of treatment;
- ✓ To sign forms for the release of information pertaining to me or my dependent;
- ✓ To suggest changes for the improvement of services, when appropriate;
- ✓ To attend sessions in good health and alert staff if I contract a contagious disease;
- ✓ To comply with the provision of this Consent and Authorization for Service;
- ✓ To carry out the provisions of my Treatment Plan.

Confidentiality:

No information, written or verbal, concerning the persons receiving service may be released or requested without a dated, signed and witnessed statement made by the

person receiving services or, as appropriate, be his/her legal, custodial parent(s) or legal guardian except in the following instances:

- ✓ In the case of a medical emergency;
- ✓ According to State Law, certain communicable diseases must be reported to the Michigan Department of Community Health;
- ✓ If there is suspected child abuse or neglect and/or elder abuse or neglect that must be reported to either the Department of Social Service or the police department;
- ✓ If there is a legitimate threat to harm another person, the community, or me, the clinician must notify the person and may notify the police department of such intended action.

Confidentiality Rules for Substance Abuse Clients:

Federal law and regulation protect the confidentiality of the records of persons being treated or having been treated for alcohol and/or other drug problems. Generally a program may not say to a person outside of the program that a client attends or has attended the program, or disclose any information identifying a client as an alcohol or drug abuser unless:

- ✓ The person receiving services or, as appropriate, his/her parent(s) or guardian consents in writing;
- ✓ The disclosure is allowed by a court order;
- ✓ The disclosure is made to medical personnel in the event of a medical emergency.
- ✓ In the event of a medical emergency, or to qualify personnel for research, audit, or program evaluation OR
- ✓ The client commits or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal Law and regulation by a clinic is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or Local Authorities.

(Federal laws and regulations regarding confidentiality of records for substance abuse clients are located in 42 U.S.C § 290dd-2 and 42 C.F.R. part 2.)

Discharge/ Termination:

I understand that I may be discharged from services at KaraLee & Associates, PC for the following reasons:

- ✓ My dependent or I complete the planned course of treatment with an acceptable degree of success.
- ✓ I choose to terminate.
- ✓ The clinician feels that termination is the most reasonable option, given my response to treatment.

- ✓ Other circumstances make it necessary to discontinue treatment due to hardships or impracticality, such as job transfer or family relocation.
- ✓ Services cannot be provided in a professional and ethical manner and in compliance with the standards of all regulator bodies.
- ✓ I or my dependent fails to maintain contact with the program for a period of more than 30 days,
- ✓ My dependent or I fail to comply with the provisions or this Consent and Authorization for Services.
- ✓ My dependent or I violate one of the program rules, which identifies that to do, so will result in discharge.

Authorizations to Communicate:

I hereby authorize KaraLee & Associates, PC to communicate with my health insurance company and/ or its agents regarding coverage, which may be applicable to services received by my dependent or myself. I further authorize the clinic to release information to my insurance company or its designated agents about the services rendered and to forward statements of charges and payments, as appropriate, to my health insurance company, its agents, to my home or to the clinic.

- ✓ If my health insurance carrier has the requirement that information regarding any medication prescribed for clients be reported to the client’s primary care physician, I hereby authorize and consent to have this information reported to my primary care physician, _____.
- ✓ I authorize KaraLee & Associates, PC, to contact me by telephone or mail and/or to contact any resources to which I have been referred to KaraLee & Associates, PC. Follow-up contacts will seek information regarding my current condition and activities.

Understanding and Agreement:

By my signature below:

- ✓ I, acknowledge that I have had the opportunity to ask questions and receive answers about the rights and responsibilities of person receiving service listed above.
- ✓ I hereby state that I have read and understand the above information, and agree with all provisions of this Consent and Authorization of services.
- ✓ I hereby request and give my consent for services from KaraLee & Associates, PC. I understand that I maintain the option to terminate this consent at my discretion by notifying KaraLee & Associates, PC of such decision in writing.
- ✓ I attest that I have received a copy of this Consent and Authorization for Services and, if I or my dependent is to receive services for substance abuse, a pamphlet (i.e. “Know Your Rights” that describes my or my dependent’s rights under the Federal Regulations and State Statutes for substance abuse services.
- ✓ I attest that my rights and responsibilities were explained to me by_____

Patient/Guardian Signature:	Date:
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NOT A REQUEST FOR RECORDS

1308 South Main Street, Plymouth, MI 48170
Phone: (734) 451-3440 Fax: (734) 451-8720

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN	
Patient Name:	D.O.B.:

Authorize Do Not Authorize

The release of any information to my physician by KaraLee & Associates, P.C. and

Physician Name:	Phone #:	Fax #:	
Address:	City:	State:	Zip:

To exchange information regarding mental/health/substance abuse treatment. The information exchanged may include diagnosis, medications prescribed and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between KaraLee and Associates and my physician. This release expires upon termination of my treatment with KaraLee and Associates or upon my written request.

Patient/Guardian Signature:	Date:
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Date Admitted/Assessed:	Diagnosis:
TYPE OF TREATMENT & FREQUENCY	
<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly
Medical Concerns (if any):	None Noted <input type="checkbox"/>

Signature of Provider:	Date:
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THERAPY VISIT GOALS

Please list the goals you would like to achieve while in therapy.

Goal #1:

Goal #2:

Goal #3:

Goal #4:

Goal #5:

Patient/Guardian Signature:

Date:

KARALEE CHILD/ADOLESCENT PERSONAL HISTORY

Patient Name: _____ D.O.B.: _____

REASON FOR YOUR VISIT

Problem/Event:

Symptoms:

- Anger Anxiety Appetite Crying Hallucinations Irritable
 Mood Swings Paranoia Racing Thoughts Reduced Concentration
 Sad Sleep Problems Suicidal Voices Worry

FAMILY COMPOSITION

	NAME	AGE	EMPLOYER/SCHOOL	MARITAL STATUS
MOTHER				
FATHER				
STEP-PARENTS				
SIBLINGS				
SIBLINGS				
SIBLINGS				
OTHER RESIDENT				
OTHER RESIDENT				

EDUCATION

School District: _____ School Name: _____

Grade: _____

Has the child ever been afraid to go to school: Yes No

If yes, explain: _____

Has the child ever had any problems with:

- Math Reading Language Speech

Has the child ever had any special education services: Yes No

Has the child received any complaints from their school regarding behavior/achievement:

Yes No Explain: _____

LEISURE TIME

Social time is usually spent: Alone Immediate Family Peers

Does the child isolate him/herself from other people: Yes No

Does the child have a job: Yes No Hours: _____ Position: _____

ADJUSTMENT DIFFICULTIES

- Feels lonely
- Shy with children
- Shy with adults
- Prefers to be alone
- Worries
- Moody
- Sad
- Cries easily
- Expects failure
- Does not share
- Lacks motivation

- Sexual acting out
- Preoccupied with sex
- Tics/twitches
- Compulsive
- Ritualistic
- Sets fires
- Poorly organized
- Clumsy
- Short attention
- Daydreams
- Overactive

- Feelings of guilt
- Defiant
- Aggressive
- Stealing
- Will not admit blame
- Bedwetting
- Unusual thinking
- Destructive
- Lying
- Violent

PERSONAL ADJUSTMENT

How does the child relate to:

Mother: _____
 Father: _____
 Step-Parent: _____
 Siblings: _____
 Authority Figures: _____

BIRTH & DEVELOPMENT

Pregnancy:
 Normal: Yes No Complications: Yes No Explain: _____
 Length of Labor: _____ Premature: Yes No
 Weeks/Weight: _____

- Colic
- Eating issues
- Sleeping issues
- Milk/food allergies

- Overactive
- Underactive
- Infections
- Fussy
- Cried often

- Constipation
- Chronic illness
- High fevers
- Hospitalization
- Surgery

EARLY CHILDHOOD

Indicate age started:
 Single words: _____ months Walking: _____ months Sentences: _____ months
 Toilet train: _____ months Knew #: _____ months Knew letters: _____ months

CURRENT GENERAL HEALTH

Physician: _____

Are the child's immunizations up to date: Yes No
Has the child had an eye exam: Yes No
Has the child had a hearing exam: Yes No
Has she begun menstruation: Yes No Age: _____
 Glasses Hearing deficiency
Present health of the child: Excellent Very good Good Fair Poor
Has the child gained or lost weight in the last 30-60 days: Yes No
Does the child have any diet or nutritional concerns: Yes No
Does the child have any food or medication allergies: Yes No

RELIGION

Mother: <input type="checkbox"/> Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> Other: _____	Father: <input type="checkbox"/> Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> Other: _____
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Does the family practice the above religion: Yes No
How important are the child's religious beliefs: _____

ETHNIC GROUP (OPTIONAL)

Caucasian African-American Native American Hispanic
 Asian-American Other: _____
Would you like the therapist to cover any racial/cultural issues: Yes No

LEGAL HISTORY

Is the child currently facing any pending charges or convictions: Yes No
Has the child ever been or is currently on probation: Yes No
Has the child ever been arrested or spent time in a corrections facility: Yes No
Has the child ever been or is currently a part of a divorce/custody issue: Yes No
Is the child adopted: Yes No Have they been told: Yes No

STOP

Please sign this document while meeting with your therapist.

Signature of Therapist Date

Signature of Client/Guardian Date

Psychiatrist Date