Mind Health
GROUP

PATIENT INFORMATION

First Name:	MI:	Last Name:	Suffix:
Home Address:		Apt #: | City: | State:	Zip Code:
Date of Birth: | Age:	Sex: [ ] Male [ ] Female	Social Security#:	
Marital Status: [ ] Single [ ] Married [ ] Other	Employment Status: [ ] Employed [ ] Unemployed	Employer Name:	Title/Position:
Home Phone #: ( ) Permission to leave message at this #? [I Y [I N	Cell Phone #: ( ) Permission to leave message at this #? I I Y [I N		
Email Address:		Permission to send email? [ ] Y [ ] **N**	

REFERRING PHYSICIAN INFORMATION

First Name:	Last Name:	Address:	Phone #:	Fax #:

PRIMARY CARE PHYSICIAN INFORMATION ***IF DIFFERENT FROM THE ABOVE***

First Name:	Last Name:	Address:	Phone #:	Fax #:

IN CASE OF AN EMERGENCY

First Name:	Last Name:	Relationship: [I Spouse f I Parent [I Other:
Home Phone #: ( )	Cell Phone #: ( )	Work Phone #: ( )

PRIMARY INSURANCE COMPANY INFORMATION

Insurance Company Name:	Identification/Contract Number:		Group #:
Address:	City:	State:	Zip: | Phone#:
Policy Holder **(if other than patient):**	Date of Birth:	Sex: [ ] Male [ ] Female	Relationship to Patient: [ ] Spouse [ ] Parent [ ] Other
Social Security#:	Employer:		
Date of Accident:	Accident Type: I I No Accident [I Auto [ ] Work I I Other:		

SECONDARY INSURANCE COMPANY INFORMATION

Insurance Company Name:	Identification/Contract Number:		Group #:
Address:	City:	State:	Zip: | Phone#:
Policy Holder **(if other than patient):**	Date of Birth:	Sex: I] Male [ ]Female	Relationship to Patient: f 1 Spouse f 1 Parent I] Other
Social Security#:	Employer:		

_____ _____

Patient/Guardian Signature Date

Mind Health
GROUP

20010 Farmington Road, Livonia, Michigan 48152

AUTHORIZATION TO DISCLOSE AND EXCHANGE INFORMATION

Patient Name: DOI: DOB: __ __ __ ___

I, __, (name of patient), do hereby authorize **MIND HEALTH GROUP** to disclose, obtain, or otherwise exchange health information about me, as specified below, to:

- **Any** third-party payer or insurance company; including Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, worker's disability compensation insurers, health maintenance organizations, preferred provider organizations, and managed care plans which are responsible in whole or in part for paying my bill;
- **Any** health care facility, physician, medical case manager, or mental health professional which is currently treating me or to which I am referred or transferred for continuity of care;
- **Any** attorney working on my behalf, or on behalf of Mind Health Group; for collection purposes; or for continuity of care with current treating providers listed below. I understand that fax data transmissions and email of notes and reports will be included in this release of information;
- Other (specify or write "None"). Release any/all records to:

Name: __ Relationship: Phone: __
Address: __ City, State, Zip: __
Fax:
Name: Relationship: _ Phone: __ __ __
Address: City, State, Zip: __
Fax: _

Specific information to be disclosed, obtained, or exchanged includes, but is not limited to:

☐ Psychological and Neuropsychological services and tests ☐ Mental Health records
☐ Outpatient therapy notes ☐ Hospital and ER records ☐ Billing records
☐ Other: __ __ __ ___

□ **If you decline this release please check the box. Please know that we will not be able to release or obtain information without a new release being filled out and signed. We cannot accept verbal authorizations.**

By signing this authorization form, I understand that:

- This consent will terminate after one (1) year
- I have the right to revoke this consent upon notification of the releasing provider in writing. Revocation will not apply to information that has already been disclosed.
- Any disclosure of information has the potential for redisclosure and the information may not be protected by federal confidentiality rules.

_____

Signature of client or legal guardian Date

_____

Witness Date

Mind Health
GROUP
20010 Farmington Road, Livonia, Michigan 48152

CONSENT FOR TREATMENT: AUTHORIZATION

I,_____, am voluntarily seeking services from Summit Psychiatric Services, PLC whose services may include Intake Evaluation, Medication Review, Group Therapy and/or Individual Psychotherapy.

It is understood that:

1. No promises or guarantees shall be offered to the patient concerning treatment services.
2. This is only an Initial Evaluation with no agreement toward on-going care and management. The doctor also reserves the right to cease on-going treatment of any patient who is non-compliant with his/her recommendations
3. Customary and standard treatment will be offered to the patient.
4. The treatment plan shall be developed with the patient's understanding and approval.
5. **Prescription refills can be requested during normal office hours and it may take up to 48 hours to fill the request.**
6. Information shall be considered confidential but may be released to the client's insurance company or auditing agencies to determine that client is receiving quality treatment.
7. Confidentiality may be breached, and information may be released if it is determined that the patient is a danger to self or others or is involved in child abuse.

Authorization of Payment to Summit Psychiatric Services, PLC from the client:

1. The patient is responsible for paying Summit Psychiatric Services, PLC every time services are rendered, unless previous arrangements are made. As a courtesy, the office will submit any claims to your insurance carrier. I understand that I must assume responsibility for any charges not approved or paid for by my insurance company. If you are a Self-Paying Patient these rates may not apply to you.

Intake Evaluation	**$350.00**
Medication Review (E&M 20-30minute)	**190.00**
Extended Visit- Individual - Full	**150.00**
Extended Visit- Individual – Half	**125.00**

Fees are subject to change without notice.

2. The patient is responsible for all missed appointments. **There is a missed appointment charge of $100.00 for all appointments canceled less than 48 hours prior to the appointment time. If you have requested an extended session (Medication Review E&M or Full Extended visit session, the fee will be equal to the session fee or $125.00 - whichever is lower).**

3. Summit Psychiatric Services, PLC accepts cash, checks, Visa, American Express, Discover or Mastercard for payment.
4. The patient will be charged a **$35.00** fee for any returned checks.
5. I have received a notice of the Privacy Practices (HIPAA).

Mind Health
GROUP

Please note, If you are receiving services as a "self pay" patient our fee(s) per session are as follow:
Psychiatric Evaluation = $300
Psychiatric Evaluation No Show Fee = $125
Medication Management = $125
Medication Management No Show Fee = $100
Psychological Testing and/or Assessment Services = $70
Psychological testing and or assessment fees include the time spent with the patient, the time needed for scoring and studying the test results, and the time needed to write a report on the findings.

Credit Card Authorization
Credit Card Information:
Card Type: Circle One MasterCard VISA Discover AMEX
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
CVV (3 digit code) _____
Cardholder ZIP Code (from credit card billing address): _____

I, authorize Mind Health Group to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.
By completing the section below, I agree and allow Mind Health Group, and its divisions, agents, and/or representatives to keep my credit card information on file for future payments. I understand that my information will be kept confidential to the greatest extent possible, while allowing designated agents, assigns, employees, and/or representatives collect payment for services rendered. Please complete all fields. This authorization will remain in effect until you are no longer rendering services with us at Mind Health Group.
My signature below signifies that I accept responsibility for payment of services rendered, and that I assume responsibility for any charges not approved or paid for by my insurance company, and for all No Show Fees and Cancellation Fees. It also signifies that I have received a notice of the Mind Health Group Privacy Practices (HIPAA form).

My signature below signifies that I accept responsibility for payment of services rendered.

_____
Patient's Name

_____ _____
Patient's/Parent's/Guardian's Signature Date

Mind Health
GROUP
20010 Farmington Road, Livonia, Michigan 48152

INSURANCE AND PAYMENT AUTHORIZATIONS AND AGREEMENTS

PLEASE READ THE ENTIRE DOCUMENT CAREFULLY AS IT CONTAINS LEGALLY ENFORCABLE RIGHTS.

Authorization to Obtain and Release Information

I hereby authorize Mind Health Group to (1) Obtain or release any information from/to insurance companies necessary to provide payment for treatment; (2) process insurance claims generated during the course of treatment. I authorize a photocopy of my signature for use in processing insurance claims.

Patient/Responsible Party hereby specifically agrees and acknowledges that Mind Health Group is acting as patient/responsible party's ***attorney in fact*** for purposes of obtaining any and all documents from insurers, including independent medical examinations, and collecting monies for bills incurred by patient for treatment and services rendered by Mind Health Group. Patient/responsible party directs the insurance company, including auto insurer or workmen's compensation insurer, to pay Mind Health Group; Amounts incurred pursuant to this agreement can only be satisfied by payment directly to Mind Health Group with a check naming them as payee under their written designation and agreement. Mind Health Group will maintain exclusive right to payment through their written acknowledgement of checks, acceptance and satisfaction by Mind Health Group. Patient agrees to endorse over to Mind Health Group any insurance payments made directly to patient.

Patient/Responsible Party also understands and agrees to be responsible for the total amount for services rendered and that Mind Health Group is entitled to full payment whether from their insurance or themselves.

Lien In Favor of Mind Health Group for Charges Incurred and Services Rendered

I hereby agree and acknowledge that Mind Health Group shall have an exclusive lien enforceable by direct action against my insurance company with a right to intervene in any related lawsuit or action, for any and all amounts due for treatment services rendered and that such lien may be enforced to collect on my behalf.

I promise my complete cooperation and instruct my attorney to withhold from any and all judgments, settlements or other recoveries, all monies incurred and due for treatments provided by Mind Health Group in the exact amount of the bill without reduction for fees, such as collections or attorney fees. It is my express agreement, with knowledge that I am responsible for full payment of charges for services rendered, that Mind Health Group shall be paid in full prior to any distribution of any proceeds to me and before any disbursement of any attorneys' fees pursuant to my agreement with my attorney.

I hereby also agree and acknowledge that in the event of litigation to resolve any payment disputes regarding my account, Mind Health Group reserves the right to litigate the full fee based on its established fee schedule, and any write-down or discounts previously listed or otherwise granted to the patient or insurance company shall be disregarded and rescinded. Mind Health Group shall also be entitled to all costs and attorney fees incurred in any attempts, including litigation, to collect any and all charges incurred by patient.

Michigan No-Fault Assignment

I, __ _____ (Assignor), do hereby assign my right to collect No-Fault insurance benefits, for unpaid services rendered by Mind Health Group (Assignee) to date, to Mind Health Group. This is an assignment for services already rendered only; this is not an assignment of benefits for services rendered in the future or after the date of this document. Assignor agrees that as consideration for this assignment, Assignee assumes the burden, otherwise born by the Assignor, to pursue payment for services rendered by Assignee, from the insurance company or payor entity responsible to pay for such services. This assignment shall be irrevocable unless terminated by mutual agreement of Assignor and Assignee in writing.

Mind Health
GROUP

Authorization of Payment to Mind Health Group

It is my responsibility to provide Mind Health Group with accurate and up to date insurance information, as well as alert Mind Health Group to any changes in benefits. I understand that Mind Health Group will first attempt to bill any insurances provided. Patient/Responsible Party agrees to be wholly responsible for any copay, coinsurance, deductible amounts, or additional subscriber liability due to non-coverage. The Michigan statute of limitations for collection allows Mind Health Group to send a bill for up to seven (7) years and at any time Mind Health Group may turn any unpaid balances over to a collection agency.

Patient Signature Date

Patient's Responsible Party or Guardian (if applicable)/Relationship to patient Date

Witness Date

Mind Health
GROUP
20010 Farmington Road, Livonia, Michigan 48152

MEDICATION CONSENT

Patient Name _____ _____

I am a patient of Summit Psychiatric Services, PLC DBA Mind Health Group. I understand that the doctor may put me on various medications. If the doctor prescribes medication for me, I understand he/she has given me an overview of the most common side effects. Additionally, I understand there may be other risks if I take the medication(s), which are believed to be small or not known. Most known side effects are listed in the Physician Desk Reference that I can obtain and read either from my doctor, a pharmacy, or a library. I also know that I can read the package insert and discuss any questions. No one has given me a promise or guarantee of what will happen if I take the medication(s).

I understand that I cannot drink alcohol while taking prescription medications. I also understand that it is sometimes dangerous to stop taking a medication too quickly, and that I may have to continue to take the medication(s) for a while, during a weaning period.

IF FEMALE: I will inform my doctor if I am pregnant or plan to become pregnant, since medication might have ill effects. To my knowledge:

____ I am not pregnant now ____ I am pregnant ____ I plan to become pregnant

All my questions about the medication(s) have been answered. I know I can ask the doctor questions I may think of later and he/she will answer them. Additionally, I know that I can read the Physician Desk Reference that is at the doctor's office to ascertain all known information regarding medication(s) prescribed for me. I can also ask my pharmacist to provide me with a package insert describing all known side effects. The doctor will discuss any off-label prescriptions with me, and I agree to off label use.

I have been informed to exercise caution when taking medications with respect to complicated tasks such as driving or operating heavy equipment, and any other task that requires mental alertness and motor coordination. I have also been informed to allow at least 8 hours of sleep if I am placed on a sleeping medication.

If I miss an appointment it is my responsibility to contact the office for a new appointment and a refill, if my prescription will run out prior to my next appointment.

I voluntarily consent to take the medication(s) and I understand that I have the right to withdraw my consent and stop taking the medication at any time . **If I stop the medication(s), I will inform the physician so I may receive instructions on discontinuing the medication safely. Anticonvulsant, Benzodiazepine and Opioids cannot abruptly be stopped, due to severe side effects and possible seizure, which can lead to death, also all other medications cannot be stopped abruptly due to the possible return of symptoms or profound withdrawal states.** I give consent to the doctor to change the amounts, times, combinations, and the ways the medication(s) are given as he/she thinks is best.

_____ _____

Patient/Parent/Guardian Witness

_____ _____

Date Date

Mind Health
GROUP

20010 Farmington Road, Livonia, Michigan 48152

Controlled Medication Office Policy

Our Office Policy for those of you who are being prescribed either Benzodiazepines, or Psychostimulants:

1. If you are requesting any changes in your medications, you must schedule an appointment and turn in the remaining pills to our office at that time.
2. A Michigan Automated prescription system can determine who provides these medications. I must be the only physician to do so. You are not allowed to receive the same medications or any medications from the same category from any other physician while you are under the care of this office. If it is determined that you have done so you will be discharged from the practice immediately.
3. All patients are subject to random urine screening. Any positive drug screening for controlled medications that are not prescribed by a physician or positive for illicit drugs that patient will be discharged or the controlled medications that we provide will be discontinued.
4. If the medications that we prescribe do not show in your urine screen or oral mouth swab, we will no longer prescribe those medications to you and if these are the only medications, we are prescribing you may be discharged from our practice.
5. No lost or stolen prescriptions of any controlled medications will be replaced, even if a police report is provided. It is the patient's responsibility to keep these medications in a safe place. No controlled medications will be refilled early. You will only get a refill on controlled medications when it is due.
6. Please be aware that we are not a Clozapine prescriber.
7. Our office will prescribe only psychiatric medications. Pain, erectile dysfunction and acid-reflex medications will not be prescribed by our office.
8. We will no longer prescribe controlled medications for patients whose primary address is out of state.
9. If you request any of your prescriptions to be mailed to your home and you then state you did not receive them, we will no longer mail any prescriptions to you and you must come in every month to pick up your prescription
10. I have read and received the new policy letter for Benzodiazepines, Psychostimulants and Medications that you are being prescribed.

I have read and received the new policy letter for Benzodiazepines, Psychostimulants and Medications that you are being prescribed.

Patient Signature*

Witness (by office staff only)

For those of you who are being prescribed either Benzodiazepines (Xanax, Klonopin, Valium, Ativan) or Psychostimulants (Adderall, Amphetamines, Vyvanse, Dexedrine, Ritalin, Concerta, Daytrana, Focalin):

Mind Health
GROUP

20010 Farmington Road, Livonia, Michigan 48152

MEDICATION/PSYCHIATRIC HISTORY

Patient's Name: _____ **DOB:** _____

Please list ALL medications and doses you are currently taking:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Please list all psychiatric medications you have previously been prescribed and the reason they were discontinued (such as "ineffective" or "side effects")

NAME OF MEDICATION	REASON DISCONTINUED/SIDE EFFECT
1	
2 3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	

Have you ever been hospitalized for a psychiatric condition? (circle one) YES NO If yes, please list hospitalizations:

_____

_____

_____

_____

_____

_____

Are you currently in psychotherapy? (circle one) YES NO

If yes, who is your therapist? (NAME & Phone)__ _____ ____

Mind Health
GROUP

20010 Farmington Road, Livonia, Michigan 48152

Marketing Authorizations Form

Section A: Email Updates

☐ Check Here to receive HIPAA-Protected emails for coupons, services, groups, and events you might be interested in. Protected Health Information (PHI) may be used to better select recipients. If you choose to opt-in, you can unsubscribe at any time. Making this selection DOES NOT authorize Mind Health Group to release your PHI for marketing purposes.

Section B: Image and Protected Health Information:

Check the boxes below that indicate if and how Mind Health Group may use or distribute your Protected Health Information (PHI):

☐ Distribution to Reporters, Journalists, and other media professionals for local, state, and national media outlets including print publications, broadcast television, and radio stations, internet, and social media sites. I understand that media representatives are not covered by federal privacy regulations and my Protected Health Information may be disclosed and no longer protected by these regulations.

☐ Distribution by the Mind Health Group Marketing Department or anyone authorized by Mind Health Group on channels controlled by Mind Health Group for marketing and promotion purposes.

By signing below and selecting boxes from Section B, I specifically authorize the use and/or disclosure of the following: all photography, video, audio, and/or printed testimonials by me; information about my specific injuries and/or medical condition(s); my prognosis, my age, my city, country or state of residence; the date and time of my expected or actual discharge from a program; information necessary to conduct an interview with me. I understand any and all reproduction of materials, including my image, voice, condition (as outlined above) or personal testimony remains the property solely and completely of Mind Health Group to be used exclusively for the promotion of Mind Health Group and its family of services without compensation to me.

I further understand that my refusal to sign and/or select any of the above options will not affect my ability to obtain treatment, payment, or my eligibility for benefits. Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing. I understand that information released between the effective date of this authorization and the date of the revocation may still be used in the public domain.

Print Client Name: _____ Date: _____

Date of Birth: _____ Phone Number: _____

Email: _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Mind Health
GROUP
20010 Farmington Road, Livonia, Michigan 48152

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Resident Name: Medical Record No._____

Address: _____

Mind Health Group Name: Mind Health Group

I have been given a copy of Mind Health Group's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that Mind Health Group's has the right to change this *Notice* at any time. I may obtain a current copy by contacting Mind Health Group Privacy Official, or by visiting the Mind Health Group's web site at www.mindhealthgroup.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Signature of Participant or Personal Representative Date

_____

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Mind Health Group Use Only: Complete this section if you are unable to obtain a signature.

1. If the participant or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____

Signature of Mind Health Group Representative Date

_____

Print Name

FILE ORIGINAL IN RESIDENT'S BUSINESS OFFICE RECORD.

Mind Health
GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Mind Health Group is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact CHIEF OPERATIONS OFFICER.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to Mind Health Group, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate health professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. 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 into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan your meals. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside Mind Health Group who may be involved in your medical care after you leave a Facility. This may include family members or visiting nurses to provide care in your home.
- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations**. We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all participants receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many participants to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of Mind Health Group including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of Mind Health Group. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of participants. We may disclose your age, birth date and general information about you in Mind Health Group newsletter, on activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions. If you are receiving therapy services, we may post your photograph and general information about your progress.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates**. There are some services provided in our Facility through contracts with business associates. Examples include medical directors, outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Providers**. Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs, hospice caregivers, pharmacies, psychologists, LCSWs, and suppliers (e.g., prosthetic, orthotics).
- **Treatment Alternatives**. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders**. 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.
- **Fundraising Activities**. We may use health information about you to contact you in an effort to raise money as part of a fundraising effort. We may disclose health information to a foundation related to Mind Health Group so that the foundation may contact you in raising money for Mind Health Group. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services at Mind Health Group.
- **Facility Directory**. We may include information about you in Mind Health Group directory while you are a resident. This information may include your name, location in Mind Health Group, your general condition (e.g., fair, stable, etc.) and your religion. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in Mind Health Group and generally know how you are doing.
- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Organ and Tissue Donation**. If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- **Military and Veterans**. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **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 participants who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with participants' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose

health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.

- **Workers' Compensation**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting** Federal and state laws may require or permit Mind Health Group to disclose certain health information related to the following:
- *Public Health Risks*. We may disclose health information about you for public health purposes, including:
  - Prevention or control of disease, injury or disability
  - Reporting births and deaths;
  - Reporting child abuse or neglect;
  - Reporting reactions to medications or problems with products;
  - Notifying people of recalls of products;
  - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
  - Notifying the appropriate government authority if we believe a resident 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.
- *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- *Judicial and Administrative Proceedings:* 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, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect or domestic violence.
- **Law Enforcement**. We may disclose health information when requested by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at Mind Health Group; and
  - 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.
- **Coroners, Medical Examiners and Funeral Directors**. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents, health information necessary for your health and the health and safety of others.

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 permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, 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 with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of Mind Health Group, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.
You must submit your request in writing to DIRECTOR OF ADMINISTRATIVE SERVICES. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for Mind Health Group.
You must submit your request in writing to DIRECTOR OF ADMINISTRATIVE SERVICES. In addition, you must provide a reason for 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 Mind Health Group; or
- Is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to DIRECTOR OF ADMINISTRATIVE SERVICES. Your request must state a time period which may not be longer than six years from the date the request is submitted 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, 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 Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You must submit your request in writing to DIRECTOR OF ADMINISTRATIVE SERVICES. 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, for example, disclosures to your spouse.

- **Right to Request Alternate Communications**. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

You must submit your request in writing to DIRECTOR OF ADMINISTRATIVE SERVICES. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.
- *You may obtain a copy of this Notice at our website, www.lifeskillsvillage.com.*

To obtain a paper copy of this Notice, contact *DIRECTOR OF ADMINISTRATIVE SERVICES*.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed 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 Mind Health Group and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting Mind Health Group administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Mind Health Group or with the Secretary of the Department of Health and Human Services. To file a complaint with Mind Health Group, contact CHIEF OPERATIONS OFFICER. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Mind Health Group
20010 Farmington Rd
Livonia, MI 48152
248.471.7171 Phone