Dr. Allen A. Winebarger, PhD
Clinical Psychology Services, pllc

509 Franklin Ave., Grand Haven, MI 49417 ♦ (616) 844-4140 ♦ Fax: (616) 604-1931 ~ clinpsysoffice@gmail.com

Welcome to Dr. Al's Office!

There are several important things to know about the services you will receive from our office. Dr. Allen Winebarger is a licensed clinical psychologist in the State of Michigan and he has the responsibility to ensure you understand all of the information about your rights, his responsibilities and the activities you will participate in while working with him. This letter will briefly describe these. If you have further questions about any of the issues addressed, please discuss them with Dr. Winebarger prior to beginning treatment or disclosing any information about yourself.

Confidentiality: By law and professional ethics, what you share with us as your consultant, remains confidential unless we have permission to share it with a third party. If you wish to communicate with a third party about your situation, we ask that you sign a Release of Information form, which we will keep in your case file. Please refer to our Notice of Privacy Practices for details. Information in your therapy sessions and the written records of those sessions are confidential and may only be revealed **without your written permission** under the following circumstances: 1. When child, dependent or elder abuse are suspected; 2. By a formal court order; 3. When our therapist believes you are in danger or harming yourself or someone else; 4. If you have a medical emergency while at our office; 5. If we believe you have committed, threatened to commit or are about to commit a crime at our facility.

Emergencies (Unscheduled Requests for Consultation): Although we do not maintain a consultant "on call" to meet with you outside of normal business hours, if a situation is sufficiently serious for you to fear impending harm to yourself or others, we ask you to immediately use one of the following options (depending on the situation):

- Contact supportive family or friends.
- Call the local Crisis Help Line at (616) 842-4357.
- Request local police support by calling 911.
- Go to the nearest hospital emergency room.

Michigan state law allows only physicians to admit individuals to hospitals. Therefore, if over the course of your work with us, hospitalization becomes necessary; your primary care physician may be asked to arrange such an admission.

Contacting the Office: We utilize a confidential voicemail and answering service on our business phone, (616) 844-4140. We make every attempt to return calls as soon as possible.

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We ask that the only parties to be present at the scheduled appointment are the patient and/or parents/guardian. **If additional children or parties are present, the appointment will be rescheduled and parties will be charged a cancellation fee.

Name of Client _____

Mailing Address_____City_____Zip_____

Email Address_____

Primary Phone _____ Alt Phone _____

Date of Birth _____Age_____ Gender_____ SSN _____

Family Physician_____ Referral Source_____

Primary Insurance _____

Contract/ID# _____ Group # _____

Subscriber's Name _____ Date of Birth _____

Secondary Insurance _____

Contract/ID# _____ Group # _____

Subscriber's Name _____ Date of Birth _____

Name_____ Age____ Relationship_____ Living at home Yes/No

Family Members: (spouse, children for adults; mother, father, siblings for children)

Name_____Age_____Relationship_____ Living at home Yes/No

Name_____Age_____Relationship_____ Living at home Yes/No

Name_____Age_____Relationship_____ Living at home Yes/No

Name_____ Age_____ Relationship_____ Living at home Yes/No

Presenting Problem(s): Please state in your own words the reasons for which you are requesting counseling:

_____

_____

_____

_____

_____

_____

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Regular Fee Schedule: Fees for the services provided by Dr. Winebarger are $231.00 for the initial diagnostic evaluation and $190.00 per hour for an individual psychotherapy visit, unless otherwise arranged. Fees for testing and report writing are in addition to psychotherapy visits and are additional charges.

NO SHOW/CANCELLATION POLICY: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. The charge for missed appointments without a 24-hour cancellation notice is $35.00. The charge for a No-Show appointment is $50.00. These charges are
Billed out of pocket, not to your insurance carrier. Excessive abuse of scheduled appointments may result in discharge from the practice.

- I agree that it is my responsibility to call my insurance company to determine coverage, benefits and obtain authorization if necessary.
- If I fail to call my insurance company, I will take full responsibility for any charges not covered by my insurance policy.
- I authorize the release of any medical or other information necessary to process insurance claims.
- I authorize payment of medical benefits directly to the provider for services rendered.
- I agree to be financially responsible for all charges incurred at this clinic, including my insurance deductible, co-payment and any services rejected by my insurance company.
- I agree to maintain active insurance coverage for myself/minor child. If there is a lapse in coverage, I agree to pay any charges incurred.
- I agree to be responsible for payments **at the time services are rendered**.
- The parent or guardian who has signed for consent of treatment is responsible for payments for the minor child at the time service is rendered.

Please sign that you have read, understand and agree to the above statements:

Signature of Patient or Responsible Party Date

Patient Name if different than Responsible Party

Printed Name

If you understand and agree with the above, we ask that you sign this document as a statement of your understanding and agreement to comply with our financial fee schedules. This document may be used along with your personal information to collect outstanding fees if not paid in a timely manner. If no attempt to pay for outstanding fees is made, legal recourse may occur.

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SENSITIVE MEDICAL DATA: FOR PROFESSIONAL USE ONLY

MEMO FOR RECORD

Legal Testimony: Given the time constraints, difficulties and issues that can arise because of court proceedings, it is the opinion of this office that we do not engage in legal matters. However, if presented with a Court Order, Dr. Winebarger may be required by law to provide testimony.

Dr. Winebarger will only appear in court if subpoenaed unless his testimony is truly needed. ***Even though you are responsible for the testimony fee, it does not mean Dr. Winebarger's testimony will be solely in your favor.*** He can only testify to the facts of the case and to his professional opinion. Should you decide to have Dr. Winebarger subpoenaed in your case, or for any court and/or custody related services, the following fees are required*:

- Preparation time (including submission of records): $250.00/hr.
- Phone calls: $75.00/15 min. increment
- Depositions: $300.00/hr.
- Time required in giving testimony (to include travel time): $300.00/hr.
- Mileage: $.50/mile
- All attorney fees and costs incurred by Dr. Winebarger as a result of the legal action.
- Filing a document with the court: $100.00
- A written report will not be provided.

If you wish to engage Dr. Winebarger in any of the above services, a retainer of $1,500.00 is due in advance. In addition, all invoices must be paid prior to court dates requiring testimony. If a subpoena or notice to meet an attorney is received without a minimum two (2) working days' notice, Dr. Winebarger may not be able to attend. In such situations, if Dr. Winebarger does choose to attend, there will be an additional $250.00 "express" charge. Also, if the case is reset, with less than 72 business hours' notice, the client will be charged $500.00 (in addition to the retainer).
Please sign that you have read, understand and agree to the above statements:

_____

Signature of Responsible Party

_____

Printed Name

*All of the listed fees are doubled if Dr. Winebarger is scheduled to be out of town or on vacation and must attend to these legal, out of session, requests.

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Client-Consumer Rights: We believe in your right as a client-consumer to have information, to the greatest degree possible, about the method techniques and possible duration of any intervention with us if you find that our services are not what you desire.

We believe that any unprofessional behavior should be reported to:

Michigan Board of Psychology
Department of Consumer and Industry Services
P.O. Box 30018
Lansing, MI 48909-7518

We believe in providing you with quality, scientifically based service. If it appears that you would receive particular benefit from a different type of intervention that we are not trained to provide, we will facilitate the referral that will meet your needs.

Please think about any questions you have regarding this information and talk with us about any other information you need to help us work better together.

By signing below, you express understanding of the above information and consent to treatment based on the limitations described, so please seek clarification of any questions you have prior to signing.

Signature of Patient or Responsible Party Date

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Regarding This Office's Privacy Practices (Please review the Notice of Privacy Practices):

- I understand that my health information may be used and disclosed to carry out treatment, payment or health care operations.
- I understand I have the right to review the Notice of Privacy Practices prior to signing a consent to release information.
- I understand the terms of the Notice of Privacy Practices may change and I may request a revised notice.
- I understand I have the right to request restrictions on uses and disclosures of protected health information for treatment, payment, and health care operations. But that my provider is not required to agree to the restrictions if they would impair our ability to provide necessary services.
- I understand any restrictions agreed upon by the provider will be binding.
- I understand I can revoke this consent in writing except to the extent that the provider has already cited based on my previous consent.

Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Al Winebarger, Clinical Psychologist, has provided information about how we may use and disclose Protected Health Information about you. By signing this form, you are acknowledging receipt of Dr. Winebarger's Notice of Privacy Practices.

Signature of Patient or Responsible Party Date

Witness Date

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NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information that may identify you and that is related to your past, present or future physical or mental health status and to related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the term of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Disclosures Made with Your Written Consent

Following are examples of the types of uses and disclosures of your protected health care information that our office is permitted to make once you have signed our Consent to Release Information form.

- Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party (such as another healthcare provider) that has already obtained your permission to have access to your protected health information.

- Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommended for you such as making determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

- Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of business operation. These activities include, but are not limited to, quality assessment and improvement activities, licensing, and conducting or arranging for other business activities.

We may share your protected health information with third party "business associates" that perform various activities. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Disclosures Made with Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing.

- Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement.

Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

- Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- Abuse or Neglect: We may use or disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect or domestic violence to the government entity or agency if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding. In response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information. If we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

Right to Inspect and Copy: You may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your health care provider and the practice use for making decisions about you.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. Any changes resulting from an amendment to the record do not expunge any prior information or part of the records; it is simply added to it.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. Your request must state a time period, which may not be longer than six years, and may not include dates before April 14, 2023.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. To request confidential communications, you must make your request known at the time of treatment. We will not ask you the reason for your request.

CHANGES TO THIS NOTICE

We reserve the right to revise this notice. We reserve the right to make the revised or changed Notice effective for medical 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 the waiting area of our office. We are required by law to comply with whatever notice is currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or to the Secretary of Health and Human Services. You may file a complaint with us by notifying our privacy contact of your complaint. You will not be penalized in any way for filing a complaint.

Effective Date of this Notice: April 14, 2003

CHILD SYMPTOMS RATING SCALE

Name of Client: _____ Age: _____

Completed By: _____ Relationship: _____ Date: _____

Please rate the following symptoms or behaviors by placing an X in the appropriate box according to degree of severity.

Symptom(s) Behaviors	Not True	Sometimes True	Often True	Very True
1. Failure to give close attention to details or making careless mistakes in schoolwork or other activities.				
2. Difficulty sustaining attention in tasks or play activities.				
3. Not listening to others.				
4. Difficulty following through on or completing tasks such as schoolwork and chores.				
5. Often loses temper.				
6. Often lies to gain favor or avoid obligations.				
7. Is often angry or resentful.				
8. Easily distracted.				
9. Forgetful in daily activities.				
10. Fidgetiness of hands or feet or squirms in seat.				
11. Bullies, threatens of intimidates others.				
12. Runs about or climbs excessively.				
13. Seems to be fatigued or "low energy"				
14. Voices thoughts of suicide.				
15. Often truant from school.				
16. Socially withdrawn.				
17. Steals or destroys property.				
18. Significant change in sleeping. (more/less than usual)				

Parent: _____ Child: _____

Date: _____

GHAC Parent Checklist

Instructions: Below is a list of childhood behaviors. For each item, please indicate how frequently your ***child*** has engaged in these behaviors over the course of the last six months by circling the appropriate number. Please rate all items.

1 = Never/Rarely **2 = Occasionally** **3 = Pretty Often** **4 = Very Often**

1	2	3	4	1. Often loses temper
1	2	3	4	2. Often argues with adults
1	2	3	4	3. Often actively defies or refuses to comply with adult requests or rules (e.g., refuses to do chores at home)
1	2	3	4	4. Often does things to deliberately annoy that annoy other people (e.g., grabs other children's hats)
1	2	3	4	5. Often blames others for his/her mistakes or misbehavior
1	2	3	4	6. Is often touchy or easily annoyed
1	2	3	4	7. Is often angry or resentful
1	2	3	4	8. Is often spiteful or vindictive
1	2	3	4	9. Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities
1	2	3	4	10. Often has difficulty sustaining attention in tasks or play
1	2	3	4	11. Often does not seem to listen when spoken to directly
1	2	3	4	12. Often does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand instructions)
1	2	3	4	13. Often has difficulty organizing tasks and activities
1	2	3	4	14. Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
1	2	3	4	15. Often loses things necessary for tasks or activities (e.g., school assignments, pencils, books, money)
1	2	3	4	16. Is often easily distracted by extraneous (unimportant) stimuli

1 = Never/Rarely			2 = Occasionally	3 = Pretty Often	4 = Very Often
1	2	3	4	17. Is often forgetful in daily activities	
1	2	3	4	18. Often fidgets with hands or feet or squirms in seat	
1	2	3	4	19. Often leaves seat in classroom or in other situations where remaining seated is expected	
1	2	3	4	20. Often runs about or climbs excessively in situations in which it is inappropriate	
1	2	3	4	21. Often has difficulty playing or engaging in leisure activities quietly	
1	2	3	4	22. Is often "on the go" or often acts as if "driven by a motor"	
1	2	3	4	23. Often talks excessively	
1	2	3	4	24. Often blurts out the answers before questions have been completed	
1	2	3	4	25. Often has difficulty waiting his/her turn	
1	2	3	4	26. Often interrupts or intrudes on others (e.g., butts into conversations or games)	
1	2	3	4	27. Often bullies, threatens, or intimidates others	
1	2	3	4	28. Often initiates physical fights	
1	2	3	4	29. Has used a weapon that can cause serious physical harm to others	
1	2	3	4	30. Is physically cruel to people	
1	2	3	4	31. Is physically cruel to animals	
1	2	3	4	32. Steals while confronting a victim (e.g., mugging, purse snatching)	
1	2	3	4	33. Deliberately engages in fire setting with the intention causing serious damage.	
1	2	3	4	34. Deliberately destroys others' property (other than by fire setting)	
1	2	3	4	35. Has broken into someone else's house, building, or car	
1	2	3	4	36. Often lies to obtain goods or favors or to avoid obligations	

1 = Never/Rarely			2 = Occasionally	3 = Pretty Often	4 = Very Often
1	2	3	4	37. Steals items of nontrivial value without confronting the victim	
1	2	3	4	38. Stays out at night despite parental prohibitations	
1	2	3	4	39. Runs away from home overnight	
1	2	3	4	40. Is often truant from school	
1	2	3	4	41. Seems to be sad, down or depressed	
1	2	3	4	42. Reports significant change in sleeping (sleeping more or sleeping less than usual)	
1	2	3	4	43. Seems to be fatigued, or to have "low energy"	
1	2	3	4	44. Voices thoughts of suicide	
1	2	3	4	45. Is tearful	
1	2	3	4	46. Seems to have no interests in things normally enjoyed	
1	2	3	4	47. Voices feelings of worthlessness	
1	2	3	4	48. Seems to lack self-confidence or self-esteem	
1	2	3	4	49. Seems socially withdrawn	

Please describe the strengths of this child.

Please describe your main areas of concern for this child.

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Authorization for Release of Information

Name of Client _____

This is to authorize the exchange of information between:

Dr. Allen A. Winebarger

And the following person(s):

_____

_____

_____

Phone:_____

Fax: _____

Special Instructions: _____

_____

_____

_____

Signature of Client Date

_____

Signature of Parent/Guardian Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information	**Amount to be Charged:** _____
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____	
Cardholder Name (as shown on card): _____	
Card Number: _____	Security Code: _____
Expiration Date (mm/yy): _____	
Cardholder ZIP Code (from credit card billing address): _____	

I, _____, authorize the office of Dr. Al Winebarger 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. Any appointments canceled without 24-hour notice will be subject to a $25 cancelation fee. I understand that this fee is not billable to my insurance and that I will be 100% responsible.

_____

Patient Name

_____ _____

Customer Signature Date

Current Email Address: _____