# THE IMAGINE CENTER FOR PSYCHOLOGICAL HEALTH


## Michael E. Behen, Ph.D., LP

4160 Woodward Ave., 2nd Floor Detroit, MI 48201
315 N. Center Street Northville, MI 48167
42140 Van Dyke Avenue, Ste. 210 Sterling Hts., MI 48314


## Demographic Information

Last Name: First Name:

Date of Birth: Soc. Security #:

Address:

City: State: Zip Code:

Primary Phone: Secondary Phone:

Primary E-mail: Secondary E-mail:

Referred By: Parent/Guardian:

## Insurance Information

Insurance Provider:
Subscriber Name:

Subscriber SSN (if different): Subs. DOB (if different):

Subscriber Address (if different):

City: State: Zip Code:

Subscriber/Member Number: Group #:

Insurance Contact Phone Number:

Insurance Contact Address:

## Emergency Contact Information

Emergency Contact Name: Relationship to Patient:

Emergency Contact Phone Number:

### FOR OFFICE USE ONLY

Prelim Dx: Intake Date:
Authorization #: Assessment Date:

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (HCO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

**Imagine Center for Psychological Health**
**4160 Woodward, Second Floor, Detroit, MI 48201**
**315 N. Center St., Northville, MI 48167**
**42140 Van Dyke, Suite 210, Sterling Heights, MI 48314**
**Phone:** 313 656-4052 **Fax:** 313 656-4053

**Signing this consent permits the following:**

1. **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** may contact my home or other alternative location (by phone, email, or standard mail) and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out HCO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. Correspondence sent via fax or standard mail may contain the full practice name (e.g. The Imagine Center for Psychological Health) on the return address label or letterhead.
2. **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** may release relevant PHI for HCO related to billing and payment receipt.
3. **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D** may release relevant PHI for HCO related to auditing and practice review by the proper institutions.

I have the right to request that **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** restrict how it uses or discloses my PHI to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D** to use and disclose my PHI to carry out HCO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** may decline to provide treatment to me.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Patients Name Print Guardian's Name (if applicable)

## INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a patient of **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** I am eligible to receive treatment. The type and extent of treatment that I will receive will be determined following an initial assessment and thorough discussion. The goal of the assessment process is to determine the best course of treatment for me.

I understand that all information shared during treatment is confidential and no information will be released without my consent unless otherwise stated in the Privacy Practice Notice.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. I understand that **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D., LP** will help me to work though any difficulties that may arise, but will not be held responsible for any negative consequences that are caused by such risks.

If I have any questions regarding this consent form or about the services offered, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by **The Imagine Center for Psychological Health, Michael E. Behen, Ph.D** I understand that I may stop treatment at any time.

_____ _____

Signature of Patient/Guardian Date

_____

Print Patients Name

_____

Print Guardian's Name (if applicable)