Welcome to Blooming Minds Therapy

Thank you for choosing Blooming Minds Therapy for your mental health needs. Sunset Voyage LLC is doing business as Blooming Minds Therapy. Sunset Voyage LLC is owned by Anna Melkumyan, LMSW and employs Treandra Bailey, LLMSW; Mei Bresnahan, LMSW; Cara Vealey, LMSW; Emily Erickson, LMSW; Aaliyah Foreman, LLMSW; Dasianay Ward, LLMSW; Nayla Raad, LLMSW, Ashley Shonibare, LMSW; Joshua Giorio, LPC and Rachael Brunger, LLPC. Limited License Master of Social Work and Professional Counselor (LLMSW and LLPC) are billed under their supervisor, Anna Melkumyan, LMSW or Joshua Giorio, LPC. Blooming Minds Therapy is not affiliated with any medical center or hospital and cannot provide medication or perform medical evaluations. Blooming Mind Therapy is not available for emergency services therefore local Community Mental Health services should be sought out during a crisis.

Detail and Services

Therapy sessions last 45-50 minutes beginning on the hour. Sessions are typically held once per week. Initial sessions are dedicated to assessment, which involves gathering information about you, your history and current life as well as the challenges that brought you to therapy. The initial assessment meeting is charged at $200 to your *insurance provider*. Each following session is charged based on duration of the session: 45 minute sessions are billed at $150 and 53 minute sessions are $175 to your insurance provider.

Private pay rates are $120 per session with a fully licensed therapist and $100 per session with a limited licensed therapist **all payment is due at the time of service.**

Please be aware that by signing this document and becoming a client with Blooming Minds Therapy, you agree to cover any and all costs that your insurance will not or does not cover. Blooming Minds Therapy encourages each client to contact their insurance company prior to services to understand what costs they will cover and to what percentage. All copays and payments towards deductible are due at the time of service.

Additional services that are not covered by any insurance are as follows:
phone consultations $35 per every 15 minutes, report or document writing is charged at $100 per every hour, and no show or late cancellation fees. Blooming Minds Therapy will not provide custody recommendations, emotional support animal documentation, disability evaluations, or appear in court. Additionally, court mandated case will not be accepted due to lack of expertise.

Appointments and Payments

Appointments will be conducted in 45-53 minutes increments once per week or on a bi-weekly basis. If you need to cancel or reschedule an appointment, Blooming Minds Therapy requires a minimum of a 24 hour notice. **If you miss a session without 24 hour notice a $75 fee will be charged.** It is important to note that insurance companies do not provide reimbursement for canceled sessions thus you will be responsible for the portion of the fee as described above. *Payment for any standing balance is expected at each session*, payment plans are available upon request. If no payments are made, external collections services will be contacted to settle the amount owed. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. If excessive absences or reschedules become harmful to ongoing treatment, Blooming Minds Therapy reserves the right to terminate services and will provide a referral to another provider.

Blooming Minds Therapy accepts cash, checks, and credit cards as a form of payment due at the end of each session. Clients will have access to a Client Portal in the event that they would like to make payments online. Credit card information is stored on file to ensure on-time payment and for payments pertaining to late cancellations or missed appointments. Monthly statements are mailed outstanding balances.

In cases where standing balances, $200 or over, are not being paid or there is not an active payment plan in process, treatment will be paused. To prevent an escalation of the balance and possible negative impacts on a client's mental health there will be a pause in services to address payment obligations until either the debt is paid off or a payment plan is set up.

Borrowed Resources

At times, a therapist may feel it is in the best interest of a client to borrow a book, or another resource, in order to help them make progress while not in session. It is understood that borrowing a book, or other items, is temporary and should be returned within an agreed upon time frame. Failure to return the borrowed items will cause the client to be charged the price of replacement in order to replace the missing item.

Telehealth Etiquette

Blooming Minds Therapy provides telehealth treatment to clients only within the state of Michigan to comply with insurance and licensing regulations. Telehealth etiquette requires that clients arrive to appointments on time, are able to ensure their own confidentiality, have reliable connection, refrain from use of alcohol and other controlled substances for the duration of the session and wear appropriate clothing. Telehealth appointments require the same level of engagement as in-person appointments, with limited distractions. If these expectations cannot be met, a therapist may stop the session and reschedule the appointment.

Confidentiality

All information discussed in session is kept confidential, and not released without written permission from the client. There are exceptional circumstances where information is shared with a third part without the client's permission.

These exceptional circumstances include:

1) If Blooming Minds Therapy believes that if you, your child, or someone else is in clear and imminent danger of harm we are legally obligated to inform proper authorities in order to help prevent harm from occurring.

2) If you report information that indicates that someone under the age of 18 years old is being abused or neglected; or information that any disabled adult or elderly person is being abused, neglected, or exploited. Blooming Minds Therapy is legally obligated to notify the proper authorities.

3) If a court subpoena is issued, Blooming Minds Therapy may be required to disclose information about you or your child.

4) Additionally, you are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, client and record information can be released under certain other circumstances, which are outlined in the Notice of Privacy Practice document. You are allowed to revoke any written consent for release of information at any time in writing.

Treatment of Minors

Some therapists at Blooming Minds Therapy provide treatment to minors. It is required that a parent or legal guardian attends the intake appointment with the minor client to assist in the assessment process, scheduling, and providing the completed intake paperwork. In subsequent sessions, a parent or legal guardian is required to stay on premise during the duration of the minor's appointment.

Therapists will often ask a parent or legal guardian to check in with them at the beginning or end of each session to allow time to communicate concerns, updates, treatment coordination, homework assignments and scheduling. Parents and/or legal guardians are always welcome to reach out to the therapist via email or phone call with any additional thoughts, concerns, or information.

Per the agreement upon discretion between the therapist, parent, and/or legal guardian, older teenagers can attend their appointments on their own.

Case Supervision

Blooming Minds Therapy believes in the ongoing growth and development of its therapist through consultation and group supervision. Please be advised that all therapists participate in individual and group supervision to ensure that the best level of treatment is provided to all clients with the most ethical practices.

Confidentiality is maintained in this process to comply with HIPAA requirements.

Termination of Care

Treatment is terminated at the completion of treatment goals or when there is no longer medical necessity for treatment. A planned termination appointment is encouraged to provide closure and to celebrate the completion of treatment.

Therapists and clients reserve the right to terminate treatment prematurely in the event that the therapeutic rapport cannot be established, clinical judgment, a higher level of care or expertise is needed. Repeated missed appointments or a pattern of cancellations can result in termination of treatment due to a lack of progress. Referrals will be provided in these incidents.

To ensure public health and safety, treatment for conditions involving lice, bedbugs, other pests, or contagious diseases shall be provided exclusively through telehealth services

Inactivity in treatment will result in the therapist reaching out to determine if a client would like to terminate treatment and to ensure the clients' safety.

By signing below, I give permission for Blooming Minds Therapy to reach out to the listed emergency contact who resides in the state of Michigan, if I have disengaged from contact abruptly. Along with incidents of a medical or a psychological emergency during session. HIPAA is reinforced during the contact with the emergency contact.

Emergency Contact:__________________________ Emergency Contact Phone Number:_________________

Emergency Contact Relationship:_____________________________

Client Signature:_________________________________Date:_____________________

After reading carefully, please sign the contract below. Anyone over the age of 18 must sign this form in order to be treated by Blooming Minds Therapy. Parents or legal guardians must sign for anyone under 18 years old.

Please sign below to acknowledge that you have read the Notice of Privacy Practices and that a copy of the notice has been provided to you upon your request.
Client Signature:___________________________Date:_________
Parent Signature:___________________________Date:_________

At times there are persons who join the therapy process who are not identified as the "patient", however are important to treatment. By signing below you acknowledge this is a health care setting. The protections in place through our practices HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or Legal Guardian must consent to this participation by signing below.
Signature:___________________________Date:_________
Signature:___________________________ Date:_________

Insurance Consent

By signing below, I give permission for Blooming Minds Therapy to release all required information to a third-party biller that will attain payment from my insurance company for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

Signature of Insured:____________________________Date:________________

Addendum to Consent to Treatment

Blooming Minds Therapy will provide each client with a contact number in which all scheduling can be done via call or text. Phone contact will be exclusively used for scheduling and rescheduling of appointments. Please be aware that all contact will be returned within 72 hours. Please respect normal business hours when calling or texting. This information is a privilege that can be revoked if the therapist deems the client to be abusing the privilege. This definition of abuse is left to the discretion of the therapist and may include, but is not limited to: excessive calls and texts.

Per Social Worker Code of Ethics, no clinical material or relevant discussions can or will be had via email, text message, or phone. Providing this number does not indicate a 24 hour access to Blooming Minds Therapy, nor should it be considered an emergency resource.

In cases of any emergency please contact the following numbers
Community Mental Health agency (listed below), call 911 or go to your local Emergency Room.
Livingston County: (517) 548-0081 Ingham County: (517) 346-8200
Oakland County: (800) 231-1127 Genesee County: (810) 257-3740

HIPAA Privacy Disclosure: Please be advised that communication via cell phone is not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls texts, or emails cannot be guaranteed.
By signing below I understand and accept the conditions above.

Client Signature:________________________________Date:______________

Parent Signature: ______________________________ Date:_______________
(if patient is a minor)

Contact Information

First Name ___________________________________
Last Name ____________________________________
Preferred Name: ______________________________
Date of Birth______________
Address____________________
City___________________ State_____ Zip___________
Please list the most secure number that we can reach you at:
Home:_______________________
Work:_______________________
Cell:________________________
Email address: ______________________________

Pronouns:

Her/She Him/He Them/They

Please list all household member names, date of birth, and relationship to you
____
____
____
____
____

Identifying Race _______________________
Identifying Gender_______________________
Identifying Sexuality_______________________

Relationship Status:

Single Domestic Partner Married

Widow Divorced Polygamous

Appointment reminders

Appointment times are considered “protected health information” under HIPAA. By signing below, I am waiving my right to keep this information completely private so I can receive an appointment reminder via text or email 24 hours prior to my appointment. Reminders are a courtesy only. A no show/late cancellation fee still applies whether or not a reminder is received. Please check if you would like to receive reminders.
___ Via text message on my cell phone
___ Via email message to the address listed above
___ Via automated telephone message to my home phone
___ None of the above. I’ll remember my appointments on my own

Signature:________________________________Date___________

Referral Information

Please let us know how you were referred to us.
□ Family or Friends
□ Physician/Family Doctor
□ Web Search/Internet
□ Other (please specify)___________________________
May we send a general thank-you to this referring source?
□ Yes □ No If yes, where should this be sent?

Insurance Information

Responsible Party Name (who pays the bill):___________________SSN:______-_____-________
Responsible Party Address: ____
Street City State Zip Code
Primary Insurance Company Name:_________________________
Subscriber/Member ID #:______________________________________
Group #:___________________________
Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____
Subscriber name:_________________________ Subscriber birthdate:_______________________
Subscriber Address:____
Secondary Insurance Company Name:____
Subscriber/Member ID #:______________________________________
Group #:______________________
Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____
Subscriber name:_________________________ Subscriber birthdate:_______________________
Subscriber Address:____

Previous Therapy & Medical Information

Have you received therapy services in the past?
_____Yes _____No If yes, when?_______________________
Where or with whom?

____
For what reason?

____
What was most helpful about this therapy experience?

____
What was least helpful about this previous therapy experience?

____

Any current medical concerns:

____
____

Have you ever attempted suicide? □ Yes □ No
If yes, when? _______________

Are you currently having suicidal thoughts? □ Yes □ No

Has anyone in your family ever attempted suicide? □ Yes No

Do you have a history of self-harm? □ Yes □ No

Are you currently engaging in self-harm? □ Yes No

Primary Care Physician _________________________________
Phone / Fax #____
Address____
City_______________ State______ Zip__________

Please list any medications you are taking at this time:

____
Medication Dosage/Frequency Reason for taking

____
Medication Dosage/Frequency Reason for taking

____
Medication Dosage/Frequency Reason for taking

____
Medication Dosage/Frequency Reason for taking

Have you ever been hospitalized for reasons relevant to your attending therapy? □ Yes □ No
If yes, please describe____

Have you ever experienced auditory or visual hallucinations? □Yes □ No

Family Medical History

Which relatives have experienced any mental health or substance abuse related difficulties?

Relationship to you:_________________________________ Mental/substance difficulty:___________________________________

Relationship to you:_________________________________ Mental/substance difficulty:___________________________________

Relationship to you:_________________________________ Mental/substance difficulty:___________________________________

Current Symptoms

__Nervousness
__Shaky/Tremors
__Bowel Disturbances
__Inattention
__Difficulty Relaxing
__Too Much Sleep
__Excessive Worry
__Quick to Anger
__Self-Harming Behaviors
__Fainting
__Crying Spells
__Loss of Interest in Sex
__Abusing Pain Meds
__Body Tension

__Memory Problems
__Mood Swings
__Shy with People
__Excessive Sweating
__Racing Thoughts
__Panic Attacks
__Disinterest in activities
__Isolating From Others
__Heart Palpitations
__Weight Gain _____lbs
__Feeling Out of Body
__Restlessness
__Indecisive
__Unmotivated

__Irritability
__Stomach Trouble
__Dizziness
__Self-critical
__Overeat/Binge
__Weight Loss _____lbs
__Teeth Grinding
__Drink Too Much
__Can't Keep Job
__Lack of Focus
__Illicit Drug Use
__Impulsive
__Too Little Sleep
__Anxiousness

__Nightmares
__Fatigue
__Lonely
__Nausea
__Headaches
__Poor concentration
__Suicidal Thoughts
__Exercise Excessively
__Poor Work Performance
__School Problems
__Negative Body Image
__Inferiority Feelings
__Other: _________

Additional Information

Please describe what brought you to services:

____

____

____

____

Please share anything you think your therapist may need to know to provide the best treatment for your needs.

____

____

____

____

CREDIT CARD AUTHORIZATION FORM

Blooming Minds Therapy, uses an integrated electronic medical record-keeping system for client charts and credit card processing. This form serves as authorization to input your credit card information into our secure system and charge the card when a balance becomes due on the account.

Typical charges that are placed on your credit card include: co-payments, deductibles, document preparation/report writing fees, late cancel and no-show fees, and returned check fees. Should you choose not to pay with a credit card, you may also pay with a check or cash.

Type of Card: Mastercard Visa American-Express Credit / Debit HSA

Name of Cardholder:____

Card No:____

Expiration date:__________ CVV2 (security code):_______

Billing Address: ____

City/State:_________________ Zip Code: ________________

Authorizing Signature:_____________________________________Date:______________

Client name (printed):____

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") and regulations promulgated under HIPAA, including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, therapist or staff review activities, licensing, and conducting or arranging for other business activities. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA **without authorization**. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child or elder abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), a court order, administrative order or similar process.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent (verbal OR written permission) or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena, court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from the U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Office at our central business office at 3496 E Lake Lansing Rd Suite 100, East Lansing, Mi 48823

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set”. A designated record set contains mental health and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you, if the information is contained in separately

maintained psychotherapy notes or if your treatment involves more than one person in the therapeutic environment and a signed release is not obtained by the other party or parties. Our office will charge a reasonable, cost-based fee for copies. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you believe that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care items or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Office, Anna Melkumyan, LMSW, or with the Secretary of the Health and Human Services Department at 200 Independence Avenue S.W., Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**