Dr. Michael Washburn, Clinical Sexologist
26862 Woodward Ave., Suite 102, Royal Oak, MI 48067
Phone: 248-986-6711 FAX: 248-398-9456

Name: (First and Last)

Address:

Street City State Zip

Name: Spouse/Partner/Significant Other: (First and Last)

Address:

Street City State Zip

Your Email:

Your Phone:	Marital Status:	Gender Identity:
____	½π Married	½π Male (he/him)
½π Cell	½π Separated	½π Female (she/her)
½π Home	½π Divorced	½π Non-Binary
½π Other:	½π Partnered	½π LGBT+
	½π Single	½π Other:____
	½π Other	
D.O.B.:	Partner/Spouse Phone Numbe2qar:	Emergency Contact Number:

Spiritual or Religious Preference? How do you describe this part of you?

Have you previously received any type of mental health services (psychotherapy, counseling services, IP, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

What was the diagnosis or treatment? _____

How did you hear about me?_____

What is happening in your life which resulted in this appointment? _____

_____

_____

GENERAL QUESTIONS:

Did you have any thoughts of suicide or self-harm this week?_____

Do you have any diagnosed physical/mental conditions I should know about?_____

Anything else I should know before our session: _____

Medications Rx [name, dosage, frequency]:	**CREDIT/DEBIT/HSA INFORMATION**:
	Name on Card:_____
	CC #:_____
	Security Code:_____
	Zip Code:_____
	Exp. Date:_____

	(*Your card will only be charged after treatment or in case of no-show. You do not need to pay for your session with this card.)*

Check all that applied to you THIS WEEK…

___Depression
___Low energy
___Low self-esteem
___Poor concentration
___Hopelessness
___Worthlessness
___Guilt
___Sleep disturbance (more/less)
___Appetite disturbance (more/less)
___Thoughts of hurting yourself
___Thoughts of hurting someone else
___Isolation/withdrawal
___Sadness/loss
___Stress
___Anxiety/panic
___Heart pounding/racing
___Chest pains
___Trembling/shaking
___Sweating
___Chills/hot flashes
___Tingling/numbness
___Fear of dying
___Fear of going crazy
___Nausea
___Phobias
___Obsessions/compulsive behaviors
___Thoughts racing
___Preoccupation with sexual thoughts
___Shame
___Loss of control of sexual fantasizing
___Can't hold onto an idea
___Easily agitated
___Excessive/compulsive behaviors
___Delusions/hallucinations
___Not thinking clearly/confusion
___Feeling that you are not real
___Lose track of time
___Unpleasant thought won't go away
___Anger/frustration
___Easily agitated/annoyed
___Defies rules
___Blames others
___Argumentative
___Excessive use of drugs and/or alcohol
___Excessive use of prescription meds
___Blackouts
___Lustful thoughts
___Physical abuse issues
___Sexual abuse issues
___Spousal abuse issues
___I don't give a sh#t attitude
___Other feelings/symptoms

Dr. Michael Washburn, Clinical Sexology

PATIENT'S RIGHTS AND RESPONSIBILITIES

AGREEMENT TO PAY

If the patient is a minor, I/WE understand that I/WE have a right to the information my child shares with MICHAEL WASHBURN and I/WE will use this, and any information shared for the child's best interests.

If, at any time, I/WE am dissatisfied with this therapy, I/WE will fully discuss my views, reasons and plans with MICHAEL WASHBURN (and if the client is a minor, with the client named above) prior to terminating therapy.

I/WE agree that this financial relationship will continue in effect with MICHAEL WASHBURN as long as he provides services or until I/WE inform him in person, by telephone or by mail, that I/WE wish to end it. I/WE agree to pay for services rendered to myself or my child/ward up until the time I/WE terminate the relationship.

I/WE understand that I/WE am responsible for charges for services provided by MICHAEL WASHBURN to me or my child/ward, although other persons or insurance companies may make payments on my account. I/WE also understand I/WE can make payment via., **cash, check, credit cards** (Visa, MC, Discovery or American Express**), and HSA** cards.

I/WE understand that sessions with (MICHAEL WASHBURN, MM, MA, NCC, CSAT, PhD Student/Clinical Sexology) are as follows:

$200.00	Intake (initial appointment) (90791)
$175.00	Individual 50-60 minute session (90837)
$100.00	Individual 30 minute check-in (90832)
$200.00	Marriage/Family 50-60 minute session (90847)
$100.00	Small Group/Processing Group per 2-hour session (90853)
$ 50.00	Cancellation fee if not cancelled prior to 24 hour notice
$175.00	Missed appointment without notification
$300.00	MMPI -2-RF Assessment and Interpretation
$200.00	MCMI-IV Assessment and Interpretation
$100.00ph	Ancillary Services (Letter writing, reviewing documentation, etc.)
$100.00-$500.00	Other Misc. Assessments and Interpretation
$2,000.00	Testifying per court order fee plus $.50 per mile for travel
$500.00	Records fee if subpoenaed (plus $.50 per page to print)
$200.00	Consulting with attorney fee, flat fee, hourly rate
$ ---.--	Attorney fee for my defense at attorney hourly rate

CANCELLATION OR NO-SHOW POLICY

I/WE understand that I/WE must cancel an appointment 24 hours in advance to avoid a cancellation fee of $50.00. I/WE will be charged half of my usual session fee if I/WE cancel between 24 and 2 hours prior to my appointment. I/WE will be charged the full session fee if I/WE cancel less than 2 hours prior to the session or if I/WE fail to show. The session fee is either the amount I/WE self-pay or the amount that the insurance company pays including my co-pay. If for unforeseeable circumstances MICHAEL WASHBURN must cancel within 24 hours a $25 credit will be posted to your account. Please understand that MICHAEL WASHBURN will take into consideration personal and family issues that arise.

I/WE agree to provide my credit card information at the time of intake and for my credit card to be charged the appropriate fee as indicated above in the event of a cancellation or no-show.

CONSENT TO TREATMENT

I/WE have reviewed and fully understand the information provided in the "Privacy Practices" below regarding my rights and responsibilities as MICHAEL WASHBURN'S patient.

I/WE have reviewed and fully understand the information provided in the "Privacy Practices" below regarding the limits of confidentiality of my records.

I/WE understand and agree that I/WE am responsible for all fees and co-payments, payable each time I/WE come to treatment. I/WE am aware that I/WE may terminate my treatment at any time without consequence, but that I/WE will still be responsible for payment for the services I/WE had received. I/WE am aware that if I/WE have not paid for services received, my treatment may be discontinued by MICHAEL WASHBURN.

I/WE am aware that the development and review of my progress, or of a Treatment Plan, is in my best interest and may be required by governmental, funding, accrediting or other agencies and I/WE agree to actively participate in this process.

I/WE am aware that the practice of psychotherapy or counseling is not an exact science and so predictions of the effects are not precise or guaranteed. I/WE acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by MICHAEL WASHBURN.

I/WE understand that I/WE may address any concerns or grievances with MICHAEL WASHBURN or any other representative of my insurance provider at any time. I/WE understand that I/WE may also contact the licensing board (State of Michigan Professional Licensing Board) which regulates MICHAEL WASHBURN'S professional practice.

I/WE am aware that MICHAEL WASHBURN is not responsible for any personal property or valuables I/WE bring into the office.

NOTICE OF PRIVACY PRACTICES

MICHAEL WASHBURN may use and disclose protected health information (PHI), including but not limited to name, address, health history, symptoms, examination and test results, diagnosis and treatment, for payment from third party payors such as health insurance companies or health care operations. I/WE understand that I/WE must consent to this use and disclosure in order to enroll in or receive services through MICHAEL WASHBURN unless I/WE am privately paying for my treatment.

I/WE understand that MICHAEL WASHBURN may use or disclose my PHI (Protected Health Information) without my consent or authorization in the following circumstances

Child or Elder Abuse – If MICHAEL WASHBURN has reasonable cause to suspect child or elder abuse or neglect, he must report this suspicion to the appropriate authorities as required by law.

Adult and Domestic Abuse – If MICHAEL WASHBURN has reasonable cause to suspect you have been criminally abused, he must report this suspicion to the appropriate authorities as required by law.

*Health Oversight and Legal Activitie*s – If MICHAEL WASHBURN receives a subpoena or court order he must turn over your PHI without your authority only after you have been notified.

Serious Threat to Health or Safety – If you communicate to MICHAEL WASHBURN a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If MICHAEL WASHBURN believes that there is an imminent risk that you will inflict serious physical harm on yourself, he may disclose information in order to protect you.

Worker's Compensation – we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law, which provide benefits for work-related injuries or illness without regard to fault.

NOTICE OF PATENT'S RIGHTS

MICHAEL WASHBURN may use and disclose protected health information, including but not limited to name, address, health history, symptoms, examination and test results, diagnosis and treatment, for payment from third party payors such as health insurance companies or health care operations. I/WE understand that I/WE must consent to

this use and disclosure in order to enroll in or receive services through MICHAEL WASHBURN unless I/WE am privately paying for my treatment.

I/WE understand that MICHAEL WASHBURN does not counsel, consult or diagnose using texts or emails. I/WE understand that if we text or email MICHAEL WASHBURN'S reply's are not on a devoted, secured server and we waive our claims of protected information.

I/WE understand that I/WE have a right for my therapist MICHAEL WASHBURN to provide, coordinate, and manage my/our mental health inline with his training and experience.

I/WE understand that I/WE have the right to request restrictions on my PHI. As a patient of MICHAEL WASHBURN, I/WE have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request if it is in conflict with established policy and/or law.

I/WE understand as a patient of MICHAEL WASHBURN that I/WE have the right to receive confidential communications by alternative means and at alternative locations. I/WE have the right to request and receive confidential communications of PHI by alternative means and at alternative location for privacy concerns.

I/WE understand as a patient of MICHAEL WASHBURN I/WE have the right to inspect or obtain a copy (or both) your PHI. If you request a copy of your PHI to be copied or sent to a third party the costs for copying (under 25 pages at .10/over 25 pages at .25 per page) and shipping will be billed to me.

I/WE understand I/WE also have the right to request an amendment to my PHI for as long as the PHI is maintained in the record. We may deny your request. On my request, MICHAEL WASHBURN will discuss with me the details of the amendment process.

I/WE understand that I/WE will be provided with a copy of this document that includes the Notice of Privacy Practices that provides a complete description of potential uses and disclosure of my protected health information. I/WE understand that I/WE have the right to review the Notice of Privacy Practices, which is provided on the website, prior to signing the consent.

I/WE understand that MICHAEL WASHBURN reserves the right to change his privacy practices and will provide a copy of any revised material at my next appointment or will mail one to me upon my request to the address that I/WE have provided.

I/WE understand that I/WE have the right to request that MICHAEL WASHBURN restricts how protected health information is used or disclosed to carry out treatment, payment or health care operations. I/WE further understand that MICHAEL WASHBURN is not required to grant any request to restrict the use or disclosure of information. If, however, MICHAEL WASHBURN agrees to the requested restriction, the restriction is binding on him.

I/WE agree that I/WE have the right to revoke this Consent in writing, except to the extent that MICHAEL WASHBURN has already relied upon it. I/WE understand that if I/WE do revoke this Consent, MICHAEL WASHBURN may choose to discontinue providing me with healthcare treatment and services.

I/WE agree that I/WE have read, agree to and consent to all of the information contained in this form.

_____ _____

Consenting Patient (or Parent/Guardian) Signature & Date *Dr. Michael Washburn, LPC*

_____

Partner/Spouse (or Parent/Guardian) Signature & Date