Clinic Standards and Practices

STOP AND READ BEFORE COMPLETING

Please note that we only accept patients 8 years of age and up for Medication Management/Psychiatric Services.

Talk Therapy Services accept both adults and minors 8 & up depending on staffing availability.

A list of accepted insurances can be found on our website: www.heliospsych.com

Please be sure to check with your insurance that these services are covered.

Please note that insurance will not cover multiple service appointments on the same day. If you are seen for multiple services, they will need to be scheduled on different days.

If you do not have any insurance or have insurance other than a Medicaid plan, and would like to pay out of pocket, we do offer CASH payment. Patients who opt for CASH payment must pay for services prior to the appointment.

Prior to scheduling an Intake appointment, the following is required:

- ☐ **Intake forms filled out completely**
- ☐ **Picture of all insurance cards (front & back)**
- ☐ **Picture of patient's and/or legal guardian's ID (front & back)**
- ☐ **Additional forms/documents as necessary**
    - **Hospital Discharge paperwork**
    - **Any & all court ordered documents**
    - **Legal guardianship papers**

They can be emailed to: intake@heliospsych.com or faxed to 586-863-4004 Attention: Intake Department

If you have any questions regarding this information, please call our office at 586-863-4000 and select Option 3 for the Intake Department prior to completing the attached forms.

Clinic Standards and Practices continued

****We are now requiring that patients who will need a controlled substance prescription be seen in person at least once prior to getting that prescription.**

Appointment requirements:

- **For Minors:**
  - **A parent or legal guardian must be present for all medication management appointments.**
  - **A parent or guardian must accompany and be available during all therapeutic appointments. However, aside from the initial intake or evaluation appointment, it is not necessary for the parent/guardian to be physically present during the session.**

· Children under the age of 13 cannot be left unattended in the Helios Psychiatry & Counseling lobby at any time.

In this packet you will receive the following:

Notice of Privacy Policies and Practices

Client Financial Responsibilities

Client Bill of Rights

Code of Conduct for Patients

Discharge Policy

****Follow up with the office if you have any additional questions or concerns.**

I _____ have read and understand the policies provided. I have been encouraged to ask any questions about the forms.

Helios Psychiatry and Counseling reserves the right to modify these policies.

Patient Legal Name: _____ Patient DOB: _____

Patient or Legal Guardian's signature:

_____ Date Signed: _____

Adult Patient Initial Intake Form
Demographics

Patient's Legal Name: _____ DOB: _____

Street Address: _____

City: _____ State: MI ZIP: _____

Phone #1: _____ Phone type: [ ] Cell [ ] Landline

Phone #2: _____ Phone type: [ ] Cell [ ] Landline

Email Address: _____

Phone# for reminders: _____ Reminder type: [ ] Text [ ] Call [ ] Either

How did you hear about Helios Psychiatry?: _____

Patient's Social Security number: _____

Primary Insurance: _____

Name of Insurance Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's Address: _____

Subscriber ID: _____Group#:_____

Secondary Insurance: _____

Name of Insurance Subscriber: _____

Subscriber's Date of Birth: _____

Subscriber's Address: _____

Subscriber ID: _____Group#:_____

Preferred Pharmacy: _____

Pharmacy Phone #: _____

Pharmacy Address and/or cross streets: _____

Emergency Contact Name: _____

Emergency Contact - Relationship to Patient: _____

Emergency Contact Phone #: _____

(Note: if you want us to receive calls from your emergency contact, they should also be listed on your Release of Information form)

Does the patient have a legal guardian? _____

If yes, Enter full name of legal guardian: _____

Email Legal Guardianship Court documents to intake@heliospsych.com

Patient Preference Sheet

Patient's Preferred Name: _____

Pronouns:_____

What Service Options are you looking for: *Select all that apply*

- ☐ Psychiatric Medication Management
- ☐ Psychotherapy / Talk Therapy
- ☐ General Evaluation for Diagnosis
- ☐ Both Medication Management and Talk Therapy
- ☐ Special Request-_____

What is your Preferred method of Receiving Communication from Helios?

- ☐ Phone Call
- ☐ Text
- ☐ Any of the above

Do you give Helios Psychiatry & Counseling staff permission to leave detailed voicemails?

- ☐ Yes, I consent to Helios staff leaving detailed voicemails on the contact number provided.
- ☐ No, please leave a generic voicemail & I will return your call.

Type of Visits:

- ☐ In office (select location):
- ☐ Telehealth
- ☐ No preference

Location:

[ ] Troy [ ] Chesterfield

Appointment Time Preference: *(Select all that apply)*

- ☐ Morning
- ☐ Afternoon

Provider Preferences:

- ☐ Female
- ☐ Male
- ☐ No preference

Life Experience Areas: (*Check all that apply - for Therapy only*)

[ ]-Addiction [ ]-Relationship Issues [ ]- Aging Parents Concerns

[ ]-Parenting Concerns [ ]-Organizational Skill Building

[ ]-Chronic Illness/ Pain [ ]-End of Life [ ]-Career Concerns

[ ]-LGBTQi + Concerns [ ]-Trauma Processing [ ]- Grief & Loss

Provider Preference Requests*:

**At Helios we do our best to match patients with providers who meet the requested preferences, however, we can not guarantee that we will have available staff. Waitlist options may be available.*

Helios Psychiatry and Counseling
Psychiatric Intake

Patient Legal Name: _____ Date of Birth: _____

Age: ____ Sex: _____ Race: _____

What brings you in for an assessment? _____

Past Psychiatric History:

Have you ever been in a psychiatric hospital/ward? [ ] Yes [ ] No

How many times?: _____

When was the first time?: _____

When was the last time?: _____

Have you ever attempted suicide? [ ] Yes [ ] No

How many times?: _____

When was the last time?: _____

How have you attempted?: _____

Have you seen a psychiatrist before? [ ] Yes [ ] No

When was the last time?: _____

Psychiatrist Name: _____

Do you currently have a therapist? [ ] Yes [ ] No

Name of current therapist: _____

And phone number: _____

Your Medical History:

(Check all that apply)

____ Heart Disease
____ Diabetes
____ Asthma/COPD
____ Fibromyalgia
____ Thyroid Issues
____ Stroke
____ Hypertension/high blood Pressure
____ High cholesterol/lipids
____ Cancer: Specify: _____

Other Medical conditions:

_____ _____
_____ _____
_____ _____

List any surgeries you've had & dates:

_____ _____
_____ _____
_____ _____

Helios Psychiatry and Counseling
Psychiatric Intake

Patient Legal Name: _____

Who is your primary care doctor? _____ Office phone & fax: _____

Do you have any known drug allergies? [ ] Yes [ ] No

If yes, please list them: _____

Please list all medications you take, including over the counter meds/supplements/vitamins:

Medications	Dose	When taken?	Used for?

Helios Psychiatry and Counseling
Psychiatric Intake

Family Psychiatric History: (list diagnoses)

Mother: _____

Father: _____

Brother: _____

_____

_____

Sister: _____

_____

_____

Grandmother: _____

_____

Grandfather: _____

_____

Anyone else?: _____

_____

Any Suicides in the family? ____ Who?: _____

Social History:

Marital Status: **[ ] Married** **[ ] Divorced** **[ ] Widowed** **[ ] Single**

Please list the ages & sex of your children:

_____ _____

_____ _____

_____ _____

Who do you live with? _____

Which option best describes your social situation?

[ ] Supportive social network **[ ] Few Friends** **[ ] No Friends**

Education Level: [ ] High School Diploma **[ ] Some College** **[ ] College Grad**

[ ] Post Graduate Degree **[ ] GED** **Less than High School(Grade completed: ____)**

Occupation: _____

Do you have any legal problems? ____

Note: If you are on a court order, please email a copy to intake@heliospsych.com. This is required prior to getting scheduled.

Helios Psychiatry and Counseling
Psychiatric Intake

Patient Legal Name: _____

Substance Use History:

How frequently do you drink alcohol?: _____

How much do you drink at a time?: _____

Have you used street drugs within the past month?: [ ] Yes [ ] No

Which?: _____

Do you have a history of abusing street drugs or alcohol?: [ ] Yes [ ] No

Alcohol: Age 1st used: _____ Age last used: _____

Cocaine: Age 1st used: _____ Age last used: _____

Marijuana: Age 1st used: _____ Age last used: _____

Heroin: Age 1st used: _____ Age last used: _____

Amphetamines: Age 1st used: _____ Age last used: _____

Benzodiazepines: Age 1st used: _____ Age last used: _____

Other: _____ Age 1st used: _____ Age last used: _____

Do you, or have you taken more of your prescription medications than you are/were supposed to?: [ ] Yes [ ] No

Have you ever been in treatment for any substances?: [ ] Yes [ ] No

If yes, when & where? _____

_____

Patient Questionnaire

Patient Name: _____Patient DOB: _____

****This must be completed by the patient**

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please only select one answer per question. Failure to complete this form may delay scheduling your appointment.	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed, or hopeless:	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much:	0	1	2	3
4. Feeling tired or having little energy:	0	1	2	3
5. Poor appetite or overeating:	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down:	0	1	2	3
7. Trouble concentrating on things, such as reading The newspaper or watching television:	0	1	2	3
8. Moving or speaking slowly that other people could have noticed? Or the opposite –being so fidgety or restless that you have been moving around a lot more than usual:	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way:	0	1	2	3

GAD - 7

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge:	0	1	2	3
2. Not being able to stop or control worrying:	0	1	2	3
3. Worrying too much about different things:	0	1	2	3
4. Trouble relaxing:	0	1	2	3
5. Being so restless that it is hard to sit still:	0	1	2	3
6. Becoming easily annoyed or irritable:	0	1	2	3
7. Feeling afraid as if something awful might happen:	0	1	2	3

Mood DQ

	Yes	No
1. Has there ever been a period of time when you were not your usual self and…		
… you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
…you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual and found you didn't really miss it?		
…you were much more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had much more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
…spending money got you or your family into trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		

3. How much of a problem did any of these cause you–like being unable to work; having family, money or legal troubles; getting into arguments or fights?

No Problem [ ] Minor Problem [ ] Moderate Problem [ ] Serious Problem [ ]

	Yes	No
4. Have any of your blood relatives (ie children, siblings, parents, grandparents, aunts, uncles) had bipolar disorder?		
5. Has a health professional ever told you that you have bipolar disorder?		

Please review and the following medication list and completed as appropriate

Generic Name	Trade Name	Date tried	Reaction
Aripiprazole	Abilify		
Amphetamine salts	Adderall		
Zolpidem	Ambien		
Amobarbital	Amytal Sodium		
Clomipramine	Anafranil		
Disulfiram	Antabuse		
Hydroxyzine	Atarax, Vistaril		
Lorazepam	Ativan		
Dexmethylphenidate	Attenade, Focalin		
Dextromethorphan/buproprion	Auvelity		
Diphenhydramine	Benadryl		
Buspirone	BuSpar		
Acamprosate	Campral		
Carbamazepine	Carbatrol, Equetro, Tegretol		
Citalopram	Celexa		
Varenicline	Chantix		
Melatonin	Circadin		
Clozapine	Clozaril, Fazaclo		
Xanomeline/tropium chloride	Cobenfy		
Methylphenidate	Concerta, Daytrana, Methylin, Ritalin		
Duloxetine	Cymbalta		
Valproic Acid	Depakote, Depakene		
Trazodone	Desyrel		
Dextroamphetamine	Dexedrine, Dextrostat		
Methadone	Dolophine		
Venlafaxine	Effexor		
Amitriptyline	Elavil		
Lithium salts	Eskalith, Lithobid		

Gepirone	Exxua		
Iloperidone	Fanapt		
Ziprasidone	Geodon		
Triazolam	Halcion		
Haloperidol	Haldol		
Guanfacine	Intuniv		
Paliperidone	Invega, Sustenna		
Clonidine	Kapvay		
Clonazepam	Klonopin		
Lamotrigine	Lamictal		
Lurasidone	Latuda		
Escitalopram	Lexapro		
Chlordiazepoxide	Librium		
Phenobarbital	Luminal		
Eszopiclone	Lunesta		
Fluvoxamine	Luvox		
Pregabalin	Lyrica		
Thioridazine	Melleril		
Phenelzine	Nardil		
Thiothixene	Navane		
Gabapentin	Neurontin		
Desipramine	Norpramin		
Armodafinil	Nuvigil		
Doxylamine	NyQuil, Unisom SleepTab		
Pimozide	Orap		
Nortriptyline	Pamelor		
Tranylcypromine	Parnate		
Paroxetine	Paxil		
Promethazine	Phenergan, Promethegan		
Desvenlafaxine	Pristiq		
Fluphenazine	Prolixin		

Modafinil	Provigil		
Fluoxetine	Prozac		
Mirtazapine	Remeron		
Temazepam	Restoril		
Naltrexone	ReVia, Vivitrol		
Risperidone	Risperdal, Consta		
Ramelteon	Rozerem		
Asenapine	Saphris		
Quetiapine	Seroquel		
Doxepin	Sinequan		
Zopiclone	Somnol		
Zaleplon	Sonata		
Esketamine	Spravato		
Trifluoperazine	Stelazine		
Atomoxetine	Strattera		
Buprenorphine	Subutex, Suboxone		
Olanzapine/fluoxetine	Symbyax		
Chlorpromazine	Thorazine		
Imipramine	Tofranil		
Topiramate	Topamax		
Perphenazine	Trilafon		
Oxcarbazepine	Trileptal		
Vortioxetine	Trintellix		
Diazepam	Valium		
Midazolam	Versed		
Vilazodone	Viibryd		
Cariprazine	Vraylar		
Lisdexamfetamine	Vyvanse		
Bupropion	Wellbutrin		
Alprazolam	Xanax		
Sertraline	Zoloft		

Zuranolone	Zurzuvae		
Olanzapine	Zyprexa		
Ketamine			
Transcranial Magnetic Stimulation (TMS)			
Electroconvulsive Therapy (ECT)			

Additional notes/meds: _____

_____

HELIOS
PSYCHIATRY & COUNSELING

Release of Information Form

I _____ hereby authorize Helios Psychiatry and Counseling to release information contained in client records and/or communicate with the following individual(s) and/or organization(s) and only under the conditions checked below:

Name of person/organization:

Name: _____ Phone#: _____

Relationship: _____

Request is invalid unless one or more of the following is selected:

[ ] Disclose Entire Record Or

[ ] Diagnosis [ ] Drug/Alcohol History [ ] Treatment Summary

[ ] Attendance [ ] Mental Status Exam [ ] Permission to schedule

[ ] Progress [ ] Physical Exam [ ] Prognosis

[ ] Discharge Summary [ ] Other: _____

Name of person/organization:

Name: _____ Phone#: _____

Relationship: _____

Request is invalid unless one or more of the following is selected:

[ ] Disclose Entire Record Or

[ ] Diagnosis [ ] Drug/Alcohol History [ ] Treatment Summary

[ ] Attendance [ ] Mental Status Exam [ ] Permission to schedule

[ ] Progress [ ] Physical Exam [ ] Prognosis

[ ] Discharge Summary [ ] Other: _____

*Without expressed revocation, this consent expires 90 days after discharged from treatment.

**This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

Name of Patient: _____ Patient's DOB: _____

Patient/Guardian Signature: _____ Date Signed: _____

Printed Name of Legal Guardian (if applicable): _____

Medical Coordination of Care
Release of Information Request

I, _____, hereby authorize

Name of other Healthcare provider, etc: _____

Phone #: _____

Fax#: _____

To release information contained in client records to:

Helios Psychiatry and Counseling
30472 23 Mile Road (Main office) Phone: 586-863-4000
Chesterfield MI 48047 Fax: 586-863-4004

Must check one or more of the following to be valid:

[ ]	Disclose entire record	OR		
[ ]	Diagnosis	[ ] Drug/Alcohol History	[ ] Treatment Summary	
[ ]	Attendance	[ ] Mental Status Exam	[ ] School Records	
[ ]	Progress	[ ] Physical Examination	[ ] Prognosis	
[ ]	Discharge Summary	[ ] Other: _____		

Purpose of Disclosure:

[ ]	Continuity of Treatment	[ ] PO/Attorney/Court	[ ] Provision of Mental
[ ]	Aftercare Planning	[ ] Billing Purposes	Health Services

*Without expressed revocation, this consent expires 90 days after discharged from treatment.
**This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

Patient's Legal Name: _____ DOB: _____

Signature of Patient or Legal Guardian: _____
Date signed:_____

Helios Psychiatry & Counseling
Notice of Privacy Policies and Practices

The following notice describes how your medical information may be used and made known, and how you can get access to this information. Please review the information carefully. Helios maintains HIPAA compliance.

- Your private healthcare information may be released to other healthcare professionals within Helios Psychiatry and Counseling for the purpose of providing appropriate care.
- Your private healthcare information may be released to your insurance company for the purpose of Helios Psychiatry and Counseling receiving payment for providing you with needed healthcare services.
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be shared with your PCP for coordination of care.
- Covered entities & business associates may be able to access your private healthcare information.
- With exception of the above, your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by Helios Psychiatry and Counseling to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- Helios Psychiatry & Counseling may order blood work and/or urine drug screenings to ensure we are providing the most complete care possible. Refusal to comply may result in discontinuation of services.
- You have the right to limit the use of your private healthcare information. However, the agency may choose to refuse your limitation if it is in conflict with providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
    - Preferred method requested may be subject to Medical Record charges. Please see Helios Psychiatry & Counseling Patient Financial Responsibilities.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Helios Psychiatry and Counseling is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- Helios uses Doxy.me, Doximity and Google Meet for telehealth appointments, all of which are a secure telemedicine virtual platform that is HIPAA compliant.
- Patients utilizing telehealth services must ensure they are in a safe, private location & have a secure WIFI connection. If you are in your vehicle, the vehicle must remain in park for the duration of the session.
- Helios Psychiatry and Counseling will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information.
- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to Helios Psychiatry and Counseling:

Helios Psychiatry and Counseling
ATTN: Office Manager
30472 23 Mile Road, Chesterfield, MI 48047

**All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency. For further information about this Privacy Notice, please call us at 586-863-4000.

HELIOS PSYCHIATRY & COUNSELING
PATIENT FINANCIAL RESPONSIBILITIES

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with a billing support specialist. We provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- It is the patient's responsibility to contact their insurance carrier to review and confirm coverage for behavioral health services. Staff will work with patients on obtaining authorizations for select insurance carriers. A quote of benefits is not a guarantee of benefits or payment. Helios Tax ID# 46-2781294.
- Helios Psychiatry & Counseling requires that any known patient responsibility, such as insurance co-payments, be paid at the time of service unless alternative financial arrangements have been established in advance. In instances where the exact patient responsibility is not immediately determinable, the remaining balance will become due upon receipt of the Explanation of Benefits (EOB) from your insurance provider. Any credit can be applied to future services. All accounts sent to collections are subject to the following additional fees: Amounts under $1000 will incur a $50 fee. Amounts over $1000 will incur a $100 fee.
- Please note, most insurances will not cover two behavioral health sessions in the same day. Helios policy states no more than one service can be scheduled per day for an individual patient.
- Helios offers a cash payment option if you do not have insurance or do not want to utilize your insurance to cover services. If CASH paying, you must fill out a Cash Waiver Form which can be sent to you upon request. Please contact our Intake Department.
- For any forms to be completed by a Helios Psychiatry & Counseling provider, please allow at least 5-7 business days for forms to be completed, and additional time if they need to be returned via mail. Please ensure that all patient information is complete including insurance information. Fees will be assessed as follows:

  1 to 2-page form: $30

  3 or more pages: $60

- Medical records request – Paper copies will be charged as follows:
  - Initial Fee $26.74
  - Per page (1-20) $ 1.34
  - Per Page (21-50) $ 0.67
  - Per Page (51+) $ 0.27
  - Medical Statement Questionnaire form $30.00
- Payment must be received in advance.
- Active Balance Policy: We will not schedule patients who carry a balance larger than $300, unless a payment plan has been set up with our Patient Support Specialist and is being adhered to. Payments must be made in a timely manner.
- If a patient has an outstanding balance and makes a payment, the payment will be applied to the oldest outstanding balance.

***Patients may incur a $75 fee for a no show or late cancellation, which is less than 48 hour's notice prior to the scheduled appointment start time.

Revised 2026.1.19

Client Bill of Rights

- Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or disability. The personal dignity of each client is recognized and respected in all care or treatment provided.
- Each client has the right to accept or refuse all or part of his/her care and/or have the expected consequences explained.
- Each client has the right to exercise personal privacy by designating release of information, and to be informed of the possible consequences of that action.
- Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service.
- Each client has the right and expectation to participate in the development of treatment plan and implementation.
- An individualized treatment which includes:
    - Personalized treatment goals
    - Services provided in the least restrictive environment possible, related to the patient's level of care needs
    - Definition of clinical services to be offered
    - Treatment plans will be reviewed periodically or as needed
- The client has the right to request referrals for services not offered through Helios or to support the discharge process.
- The client will be informed of his/her rights in a language they can understand.
- Each client has the right to refuse to participate in any research projects without compromising their access to the organization's resources.
- Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
- Patients have the right to report grievances and concerns to management staff.

Recipients have rights protected by state and federal law and promulgated rules. For information contact:

Helios Psychiatry and Counseling

Office Manager
30472 23 Mile Road
Chesterfield, MI 48047

Helios Psychiatry & Counseling
Code of Conduct for Patients

To provide a safe and healthy environment for staff, visitors, patients and their families, Helios Psychiatry and Counseling expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- Treat staff & fellow patients with dignity and respect
- Bring grievances or concerns regarding services or care directly to our management team
- Arrive on time to any appointments
- Utilize appointment time appropriately
- Follow Helios Psychiatry & Counseling cancellation policy
- Questions about your billing can be addressed first with our Reception staff, and then with a Billing Support Specialist
- High balances will be investigated. Unless an agreed upon payment plan is set up and adhered to, there may be a disruption of services if the amount reaches $300 or more.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Minors are expected to be supervised at all times by parent/guardian.
- Helios does accommodate trained service animals only in accordance with ADA.
    - Helios requests appropriate documentation prior to bringing in a service animal.
    - Please speak to our administrative team regarding a Helios Service Animal Contract, if applicable under ADA guidelines
    - Emotional Support animals are not permitted.

The following behaviors are prohibited & can lead to discharge from the clinic:

- Bringing firearms or any weapon onto any Helios properties
- Intimidating or harassing staff or other patients
- Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication
- Physically assaulting or threatening to inflict bodily harm to another person or property
- Making verbal threats to harm another individual or destroy property
- Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Revised 2026.1.22

Helios Psychiatry & Counseling Discharge Policy

- Helios Psychiatry & Counseling reserves the right to discharge any client who does not comply with practice policies and procedures.
- Helios Psychiatry & Counseling reserves the right to discharge any client who is not committed to and/or neglects personal responsibility in achieving mutually determined treatment goals.
- Discharge due to No-Call-No Show (NCNS)/Late Cancellations
    - A late cancellation is defined as any cancellation within 48 hours of the start of the appointment time. It is at the discretion of the provider to determine whether or not circumstances warrant an excused NCNS or cancellation.
    - Three unexcused no call no shows or late cancellations within a service line in a 6-month period may result in discharge from the practice and/or that designated service line.
    - All unexcused NCNS or late cancellations are subject to a cancellation fee. After 3 NCNS or late cancellations, all late fees must be paid prior to scheduling further appointments.
- A client who has an outstanding balance for 3 months or more, with the exception of having made incremental payments or maintaining compliance with a payment plan, is subject to being sent to collections as well as discharge from Helios Psychiatry & Counseling.
- Clients who have been sent to collections more than once may not be eligible to restart services with Helios Psychiatry & Counseling.

Any client discharged from Helios Psychiatry & Counseling, either partially or fully, has the option to contact front desk staff for other local provider information. Despite being discharged from therapeutic or medication management services at Helios, we sincerely wish for your continued success in your mental health journey.

Patient Name: _____

Signer Name: _____

Signature: _____ Date Signed: _____

Revised 2026.1