Client Demographic Form

Please PRINT

MRN **Date**

CLIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Social Security Number** | **Gender** ⑨ Male ⑨ Female

Marital Status ⑨ Married ⑨ Single ⑨ Divorced ⑨ Life Partner Separated ⑨ Widowed ⑨ Other | **Language** other than English

Race (Optional) ⑨ Black – Non Hispanic ⑨ American Indian/ Alaskan Native ⑨ Hispanic ⑨ Asian/Pacific Islander ⑨ White – Non Hispanic ⑨ Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ⑨ Cell ⑨ Pager ⑨ Fax

Email Address | **Employment Status** ⑨ Active Duty Military ⑨ Employed Full-Time ⑨ Not Employed ⑨ Student Full-Time ⑨ Child ⑨ Employed Part-Time ⑨ Retired ⑨ Student Part-Time ⑨ Disabled ⑨ Homemaker ⑨ Self Employed ⑨ Other

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

How did you hear about us? ⑨ Billboard ⑨ Employer ⑨ Family Member ⑨ Friend ⑨ Health Fair Event ⑨ Insurance ⑨ Magazine ⑨ Mail ⑨ News ⑨ Physician ⑨ Website ⑨ Other ⑨ Radio ⑨ Yellow Pages ⑨ Television

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ⑨ Self (If self, skip to Emergency / Next of Kin) ⑨ Spouse ⑨ Parent ⑨ Other

Last Name | **First Name** | **Middle Initial**

Date of Birth | **Social Security Number**

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ⑨ Cell ⑨ Pager ⑨ Fax

Employer | **Employment Status** ⑨ Active Duty Military ⑨ Employed Full-Time ⑨ Not Employed ⑨ Student Full-Time ⑨ Child ⑨ Employed Part-Time ⑨ Retired ⑨ Student Part-Time ⑨ Disabled ⑨ Homemaker ⑨ Self Employed ⑨ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** ⑨ Cell ⑨ Pager ⑨ Fax

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name______________________ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**________

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. **Questions about anxiety.**		**NO**	**YES**
a.	In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐

If you checked "NO", go to question #5.

b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. **Think about your last bad anxiety attack.**		**NO**	**YES**
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?...	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. **Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?**		**Not at all**	**Several days**	**More than half the days**
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐

If you checked "Not at all", go to question #6.

b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

		NO	YES
6. Questions about eating.			
a.	Do you often feel that you can't control what or how much you eat?	☐	☐
b.	Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.			
c.	Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?		NO	YES
a.	Made yourself vomit?	☐	☐
b.	Took more than twice the recommended dose of laxatives?	☐	☐
c.	Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d.	Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO" go to question #11.		

10. Have any of the following happened to you more than once in the last 6 months?		NO	YES
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b.	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c.	You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d.	You had a problem getting along with other people while you were drinking.	☐	☐
e.	You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Substance Use

Client's Name______________________________________

Date ______________________________________

a. Substance Use History (Note: AOD is an acronym for Alcohol and Other Drugs)

Category of Drug	First use?	Pattern of use over time?	Frequency of use in past month?	Date/Amount of most recent use?
Alcohol				
Caffeine				
Marijuana/Cannabis				
CNS Stimulants or "Uppers" e.g. Cocaine, Ritalin Methamphetamine				
Anxiolytics/Sedatives/Hypnotics				

Category of Drug	First use?	Pattern of use over time?	Frequency of use in past month?	Date/Amount of most recent use?
or “Downers” Barbituates Secobarbital/ Quaaludes Benzodiazepines Valium (diazepam) Xanax (alprazolam) Rohypnol				
Opiates or “Painkillers” Heroin/Morphine/ Methadone/Oxycodone				
Hallucinogens LSD/PCP/Ecstasy				
Inhalants/aerosols				
Steroids				
Cigarettes/Nicotine/Tobacco				

Have you ever used any of these drugs in combination?

____

AUTHORIZATION FOR APPOINTMENT REMINDERS

________________________________ {*name of clinic/practitioner*} offers the option to receive an appointment reminder ____ hours or ____ day before your scheduled appointment by email and/or by phone. If you choose the reminder by phone, you have the option of a text message or a computer-generated voice message.

Please select ONE of the following options:

Phone Reminder (*choose one*):

Text Message. I authorize ________________ {*name of clinic/practitioner*} to send text message appointment reminders to me on my cell phone number. Text message charges from my cell phone provider may apply. Example of text message: "*Do not reply – reminder – You have an appointment MON 01/11 at 4:00 PM. If you have any questions, please call us at (   ) _______________ {phone number} – Thank you,* ________________ {*name of counselor}"*

Cell phone number to send text messages to: (   ) ________________________

Automated Voice Messages. I authorize ________________ {*name of clinic/practitioner*} to send computer-generated voice phone message appointment reminders to me on my provided phone number. Example of message: *"Hello. This is a reminder of your appointment on Monday, January 11, scheduled for 4 PM with ________________ {name of counselor}. If you need to reschedule or have any questions, feel free to call us at (   ) _______________ {phone number}. Once again, your appointment is scheduled for Monday, January 11, at 4 PM with __________ {name of counselor}. Thank you."*

Phone number for the automated system to call: (   ) ________________________

Email message: I authorize ________________ {*name of clinic/practitioner*} to send email message appointment reminders to me on my provided email address. Example of email message from __________@______________________.com. "*This is a reminder of your appointment on Monday, 01/11/2022, scheduled for 4:00 PM with ___________ {name of clinic/practitioner}. If you have any questions regarding your appointment, please feel free to contact us at (   ) _______________ {phone number}. Thank you."*

Email address to send reminder messages: ____

None of the above: I will remember my appointments on my own.

FINANCIAL POLICY

Below are the terms of agreement regarding payment for sessions with ________________________ (*therapist/practice name*).

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes with the therapist or mental health professional.

2. If I, the client, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees will be charged, and I will be responsible for payment.

3. I understand if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.

4. Services including phone calls, emails, record reviews, and professional consultations at times other than the scheduled therapy session are the client's responsibility. These services will be billed per quarter of an hour.

5. I authorize my health insurance to provide payment of benefits to __________________________ (*therapist's/practice's name*).

6. I understand records of my treatment may be shared with __________________________ (*client's insurance company*) when necessary to process claims.

7. I understand I am responsible for payment if my insurance company declines payment.

I have reviewed this document and understand the above statements.

____

Signature Date

____

Printed name

CLIENT RIGHTS

As a client, when you enter a therapist-client professional relationship, you have certain rights.

I, ____________________________ (*therapist name*), will do my best to honor your rights and give you the best treatment possible. You, as a client, have the following rights. To:

- be an active participant in decisions regarding your treatment and the scope of treatment
- be informed of where to access emergency attention if the practice does not offer these services
- be informed of the practice's policy for financial responsibility
- express grievances and concerns regarding treatment
- receive truthful communication from your therapist
- be assured that your therapist is practicing within their scope of experience, license, and education
- receive services, including evaluations and treatments, within a reasonable time frame
- be treated and receive services in the absence of bias regarding age, race, religion, gender, national origin, or sexual preference
- be treated courteously by all professionals within the practice
- know that all professionals involved in your case maintain confidentiality
- have all professionals adhere to the ethical standards of the professional organizations to which they are licensed and affiliated
- terminate treatment or request a change of service provider

I, ____ (*client name*), understand my rights described above.

Client printed name: ____ Date: _______________

Client signature: ____

THERAPY CONSENT, POLICIES, & AGREEMENT

PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborative identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 45-50 minutes depending upon the nature of the presenting challenges and any insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS:
Regular, consistent attendance and participation is required in order for the therapeutic process to work. Most clients are seen weekly or every other week. Therapy sessions are 45 to 50 minutes in length. Regular attendance can assist clients in reaching goals and maintaining gains in treatment. The following attendance policy reflects the needs of the client as well as the needs of your therapist.
Once a therapy session is scheduled, that time slot is reserved specifically for you. As a Mindful Life Transformations/Blended Recovery client, we expect you to attend sessions scheduled by your therapist except in the event of sickness or emergency.

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In the event of sickness or emergency, we require cancellation to be made *at least 24 hours in advance* to the scheduled appointment. Although 24 hours is the minimum, if you need to cancel or reschedule, please give me as much notice as possible.
Please note that No-Contact Absences or Late Cancellations (less than 24 hours' notice for absence) for initial appointments with new clients may not be rescheduled, they will be looked at on a case-by-case basis. Established self-pay and private insurance clients (clients that has attended 6 regularly scheduled sessions in a row) will be subject to a fee of $40 dollars for each no-contact absence or late cancellation that occurs. This must be paid prior to scheduling the next appointment. This fee is waived for TennCare clients in compliance with TennCare regulations. **Two** no-contact absences or late cancellations during a **two-month (60 day)** period or **two consecutive** no-contact absences or late cancellations may result in discharge from the practice. I can assist you with referrals to other agencies should this event occur.

FEES: The fee for each 45-50-minute therapy session is $ 120 or your insurance copay, unless you are on a sliding scale (see sliding scale agreement). Payment is due at the time of service. Acceptable forms of payment are exact-amount cash, or credit/debit card. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if more than two sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed. If you request any letters, forms, or any other paperwork to be completed, such as FMLA or disability forms, please be advised that there is a fee for paperwork. My fee is $120 per hour. FMLA paperwork generally requires a minimum of 30 minutes to complete, due to the need for supporting clinical documentation. Short-term disability often takes longer to complete and may require additional assessments beyond my regular intake evaluation. The time required to make copies or prepare and send faxes, and any other administrative business (e.g. preparing releases of information or requests for records; phone calls to lawyers or other non-clinical calls) not directly related to the provision of clinical services, will also be assessed based on a rate of $120, with a minimum fee of $25.00.

I will not complete any FMLA, disability, other paperwork, or letters of support unless I have met with you for at least 6-8 sessions. I will also not complete any FMLA or disability paperwork if I do not believe I can support it based on what you have presented at intake and during sessions.

I also charge for telephone calls longer than 10 minutes. My fees for telephone calls are $120.00 per hour; a 30-minute call will be $75.00. Please be advised that insurance companies have never reimbursed therapists for crisis phone calls; it is one of the reasons why clients are referred to crisis services. The cost for phone calls for sliding scale clients will be discussed on a case-by-case basis.

In-home/on-site therapy services offer people comfort and flexibility. They are offered at a regular hourly rate. Cost for travel is based on the regularly hourly rate and is determined by the time it takes to travel from the office to client's home or requested place of session and return trip. Time is configured by tracking and logging actual time via internet sites such as Google, Bing, Waze, etc. to determine travel time.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of $120 an hour to include travel time, court time, preparing documents, etc.

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COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $3 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PART II: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when a your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if the there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about an you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.

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- **<u>Couples Counseling & "No Secret" Policy</u>:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **<u>Dual Relationships & Public</u>**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **<u>Social Media</u>**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **<u>Electronic Communication</u>: If you need to contact me outside of our sessions, please do so via phone.**
  - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.
  - **Do not use e-mail for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.
- **<u>Sessions Outside the Office</u>:** From time to time, clients like to meet in an alternate location (i.e. their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

PART III: REASONS I DO NOT ACCEPT INSURANCE

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

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1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (ie: divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples therapy.

Why Clinicians Do Not Take Insurance: These involve enhanced quality of care and other advantages:

1. You are in control of your care, including choosing your therapist, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren't billable by insurance, such as learning how to cope with life changes, gaining more effective communication techniques for your relationships, increasing personal insight, and developing healthy new skills.

After reading my position on why I don't accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Robert Wade, LMSW**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Robert Wade, LMSW** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Robert Wade, LMSW** of Mindful Life Transformations. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Robert Wade, LMSW** of Mindful Life Transformations may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Robert Wade, LMSW to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Robert Wade, LMSW** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

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Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

*Witness – **Robert Wade, LMSW*** *Date*

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CLIENT COPY

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*Witness – **Robert Wade, LMSW*** *Date*

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