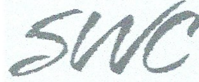

Welcome to Shine Wellness Clinic of Romeo! We look forward to meeting all of your clinical needs. Please fill out the information below to the best of your ability in addition to any other forms attached to this welcome sheet. Do not hesitate to ask any questions or express any concerns you many have. Thank you!

Patient Name: ____ DOB: ________________________

Parent Name (if applicable):______________________________

Address: __________________________City:_______________Zip Code: ____________________

Phone: _______________________ May we Leave a Message? Yes No

May We Communicate Via Text? Yes No

Email: ________________________ May We Communicate Via Email? Yes No

Emergency Contact:

Name: _____________________ Relationship:_____________Contact Number: ________________

(For Staff Only)

Payment for Services: ☐ Photo ID ☐ Insurance Card

Health Insurance or **Cash** (Circle One)?

Health Insurance Company:____________________

Enrollee Number:____________________________Group Number: ___________________________

Deductible:_____________________ Co-Pay: ________________________

Shine Wellness Clinic
215 North Main Street, Floor 3
Romeo, MI 48065

Client Intake Questionnaire

Please make the staff aware immediately of you are unable or have difficulty filling out this packet.
Please note: Information provided on this form is considered confidential.

PERSONAL INFORMATION

Client Name: ____________________ (Preferred Name) _______________ Todays Date: ________
Parent/Legal Guardian (if under 18): ____
DOB: ____________________
Age at time of assessment: ______
Address: ____
Home Phone: ______________________________ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: ______________________ May we leave a message? □ Yes □ No
Email: ___________________________________ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a secured medium of communication.*
Were you referred by a friend, family member or professional? If so, who? _____________________

Marital Status:

□ Never Married	□ Domestic Partnership	□ Married
□ Separated	□ Divorced	□ Widowed

Sexual Identity: □ I prefer not to share this information:
Birth Gender (Circle One): Male Female
Identified Gender (Circle One): Male Female Gender Fluid
Sexual Preference (Circle one): Straight/Heterosexual Gay/Homosexual Bisexual/Curious
Other: ____________________________

Are you currently in the military or a veteran? □ Yes □ No If yes, what branch? ______________

Are you disabled or require any special accommodations that our clinic should be aware of?
□ Yes □ No If yes, please specify what accommodations we can make for you.
-
____
____

Physical Health History

1. How would you rate your current physical health? (Please circle one)

   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: ____________________
____

1. How would you rate your current sleeping habits? (Please circle one)

   Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
____

2. How many times per week do you generally exercise? ________________________________
3. What types of exercise do you participate in? ____
4. Please list any difficulties you experience with your appetite or eating problems including overeating or undereating:
   ____
5. Do you have any concerns that you may have an eating disorder? □Yes □No
6. Are you currently taking any prescription medications? □ Yes □ No
   If yes, please list:
____
____

8. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____

Please rate your pain level on a scale of 1-10. Ten indicates the highest in severity.

1 2 3 4 5 6 7 8 9 10

If yes, do you use prescription medications (prescribed or unprescribed) to manage your pain?

□ Yes □ No If so, what medications do you use?

____
____

Clinical History

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

□ Yes □ No If so, please list previous therapist(s)/practitioner(s):

____

2. Have you ever been prescribed psychiatric medications? □ Yes □ No
If yes, please list and provide dates:

____

3. you ever been hospitalized due to a mental health condition? □ Yes □ No
If yes, please describe:

____

4.Are you currently experiencing overwhelming grief, depression or feeling down more than normal?
□ Yes □ No

If yes, for approximately how long?

____

Please rate your depression and/or grief on a scale of 1-10. Ten indicates the highest in severity.
1 2 3 4 5 6 7 8 9 10

5. Are you currently experiencing anxiety, panics attacks or have any phobias? □ Yes □ No

If yes, when did you begin experiencing this and for how long?

____

____

Please rate your anxiety, panic attacks or phobias on a scale of 1-10. Ten indicates the highest in severity.

1 2 3 4 5 6 7 8 9 10

6. Do you experience any suicidal thoughts, ideation, or behaviors? □ Yes □ No

If yes, please describe: ____

Please rate your intensity of thoughts/behavior in a level on a scale of 1-10. Ten indicates the highest in severity.

1 2 3 4 5 6 7 8 9 10

7. Do you currently or have you in the past used self-harm behaviors (cutting, smacking, bruising scratching, hitting, etc.) to alleviate/cope with your feelings? □ Yes □No

Please explain: ____

Substance Abuse History

1. Do you drink alcohol more than once a week? □Yes, If so, how often?___________ □ No

2. Do you smoke cigarettes or vape nicotine? □ Yes □ No

11. Do you engage in medical or recreational drug use? □Yes □No
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

If so, what substances do you use or have experimented with?

____

____

12. Do you have a concern that you may have a drug or alcohol abuse issue? □ Yes □ No

13. Are you under any court orders or recommendations currently? □ Yes □ No

If so, please explain your current circumstances:

____

____

School/Work History

1.What is your highest level of education? _______________________________

2. Where did/do you attend school?

____

3. Are you currently employed? □ No □ Yes

4. Where do you work?_______________________________

5. Which best describes your current financial status?

□Financial Crisis/Struggle to Meet Basic Needs

□ Financially Stable/ Basic Needs Met

□ Financially Secure

6. Do you enjoy your school/work? Is there anything stressful about your current schooling/work?

____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	___________________
Anxiety	yes / no	___________________
Depression	yes / no	___________________
Domestic Violence	yes / no	___________________
Eating Disorders	yes / no	___________________
Obesity	yes / no	___________________
Obsessive Compulsive Behavior	yes / no	___________________
Schizophrenia	yes / no	___________________
Suicide Attempts	yes / no	___________________

ABUSE AND NEGLECT HISORY:

Have you or an immediate family member experienced childhood or adult abuse or neglect?

Please Circle	List Family Member including Self	
Verbal Abuse	yes / no	___________________
Emotional Abuse	yes / no	___________________
Physical Abuse	yes / no	___________________
Domestic Violence	yes / no	___________________
Sexual Abuse	yes / no	___________________
Neglect (physical, medical, financial, etc.)	yes / no	___________________
Removal from the Parental Home	yes / no	___________________
Witness or forced participation in crimes	yes / no	___________________
Human Trafficking	yes / no	___________________

Trauma History

1. Have you experienced traumatic events not previously addressed in this questionnaire?
   If so, please explain:

   ____

   ____

   ____

2. Have you experienced significant life changes or stressful events recently?

____

____

HOUSEHOLD COMPOSITION:

1. Who reside with you in your home?____
2. Do you have children? □ Yes □ No
   If yes, children's names and ages:

____

____

3. Are you currently in a romantic relationship or marriage? □No □ Yes

If yes, for how long? ________________________

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
1 2 3 4 5 6 7 8 9 10

Additional Information:

1.Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: ____

____

2. What are your favorite past times, hobbies or activities?

____

3. What do you consider to be some of your strengths? ______________________________

____

____

____

4. What do you consider to be some of your weaknesses? ____________________________

____

____

____

5. What would you like to accomplish out of your time in therapy? ______________________

____

Thank you for filling out this questionnaire! Is there anything else that you would like to tell us about yourself?

____

____

____

____

Clinical Notes:

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: ____

Billing Address: ____

______________________ Zip Code: __________

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: ____

Expiration Date: Month: __________ Year: __________

Card Identification Number: ______ (last 3 or 4 digits located on the back of the credit card)

Amount to Charge: $ ______________ (USD)

Is this card linked to an HSA/Flex Spending Account? Yes No

Please let Shine Wellness Clinic know if you wish to change or delete your card at any time.

I authorize Shine Wellness Clinic to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: ____

Date: ____

Print Name: ____

Revised: 6-24

Shine Wellness Clinic, PLLC
215 North Main Street, Floor 3
586-218-6815

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: ____

Date of Birth: ___________________________

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: ____

Date: ___________________________________

Relationship to patient (if signed by a personal representative of patient):

____

Revised June 2024- Client Consent to Psychotherapy:

1. I have read the consent for treatment plan. I have had sufficient time to consider the information and understand that I have the ability to ask any questions I may have.

2. I consent to the use of a diagnosis in billing, and to the release of that information to my insurance company if I request so.

3. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy at Shine Wellness Clinic PLLC.

4. I understand that I can terminate my treatment at any time, and I can refuse any requests or suggestions made by Shine Wellness Clinic professionals.

5. For **CASH FEE** Clients: I agree to pay $____________ per session.

6. I agree to pay $40.00 per session for all "No Show/No Call" of scheduled sessions.

7. (3) Three "No Show/No Call" sessions will result in closure of your case.

8. My case could automatically be closed if no session has been scheduled within 60 days of the last session.

9. I have reviewed and understand the risks/benefits and terms associated with Teletherapy Sessions.

10. I have been provided a copy with the current cash/reimbursable rates established by Shine Wellness Clinic. I understand that it is my responsibility to pay Shine Wellness Clinic the cost of services including insurance deductibles and copays. SWC encourages all patients to know and keep track of their health insurance coverage including deductibles and copays.

11. It is my responsibility to know my next appointment day and time. Text/email reminders are provided by Shine Wellness Clinic as a helpful reminder but not for the patient to solely depend upon. You are encouraged to call/text your clinician if you have forgotten your next appointment date.

12. I agree to cancel/reschedule appointments as early as possible if I or my child is ill with a communicable sickness. This includes the flu, COVID, lice, or any other illness that may compromise the health of professionals or other patients in the office.

__________**Please initial here to acknowledge that you have reviewed and agree to each of the terms listed above.**

Print Client's Name:____

Client Signature:____Date:________________

Parent/Guardian Signature (if applicable):____________________________ Date:________________

Shine Wellness Clinic Therapist:____________________________________ Date:________________

Shine Wellness Clinic, PLLC

215 North Main Street, Floor 3
Romeo, MI 48065

Revised Date: 06/25/2024

Disclosure Statement and Informed Consent to Treatment

Your rights as a Therapy Patient:

Therapy is a collaborative relationship between people that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy—the goal is your well-being. There are also certain legal limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist:

I. Confidentiality: With the exception of certain specific instances described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. I will always act to protect your privacy even if you do permit me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

I consult with various experts in specific fields of mental health so that I can better serve my clients. I also participate in regular group consultation. If there is any reason to believe you might know one of these professionals, I will tell you their name, so you have the option to request I do not consult with them regarding your care.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone who is doing this, I must inform Child Protective Services or the police within 24 hours.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police, the county crisis team or someone who can ensure your safety. I will first explore all other options with you before I take this step.

4. I may use and disclose your health information to bill and collect payment for the services and items you may receive from me. For example, I may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and I may provide your insurer with details regarding your

treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also, I may use your health information to bill you directly for services and items. Usually what is only shared is the type of service I provided as well as a diagnosis from the DSM-IV (See III below).

5. Please keep in mind that although every safeguard possible is in place when using electronic communication such as email, computer, cell phone, or fax, I cannot guarantee there will be no interception. Nor can I protect your name when depositing your check at my bank if you choose to pay by check. I file most insurance claims electronically, sharing your protected health information when required.

6. If you are filing a complaint or are a plaintiff in a lawsuit where you bring up the question of your mental health, you will have already automatically waived your right to the confidentiality of these records in the context of the complaint or lawsuit. Despite this, I will not release information without your signed consent or a court order. We can also discuss obtaining a protective order to help maintain confidentiality of records. Please let me know if you are in this kind of situation so that I can take the upmost care possible to protect your privacy in my records.

7. Testifying & Other Court Procedures: Whenever possible, our agency refrains from becoming involved in the court procedures of our clients or their parents. It is our belief that a therapist's involvement in court testimony or procedures has the potential to have a negative impact on the therapist/client relationship. This is especially true in Friend of Court cases. There may be times when we are subpoenaed by the court or other state agencies. As a rule of law, we must abide by these orders. If a client or guardian is compelled to subpoena one of our clinicians, we reserve the right to charge for our time and professional services. **Our established retaining fee is $450** which is used for case preparation and therapist compensation for up to three hours. This must be paid in full before the hearing date. Each additional hour spent on testimony, travel, hearings and other miscellaneous activities is established at **$150 per hour**.

II. Record-keeping: I normally keep very brief records, noting that you have been here, what we did in the session, and a few words describing the topics we have discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location in my office.

III. Diagnosis: If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party for you so that we can be paid. Diagnoses are the technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All diagnoses come from a published resource guide titled: DSM-V; I have a copy in my office and will be glad to let you read more about what it says about your diagnosis.

IV. Scheduled appointments. I will do my best to have a regularly scheduled appointment time for you. If I need to cancel for some unforeseen circumstance, I will do my best to get a hold of you as soon as possible and do my best to accommodate you. I will tell you in advance of any planned absences.

Your Rights as a Therapy Client

I. You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

II. You have the right and responsibility to decide whether the proposed treatment plan will provide you with the treatment that you want. At any point during treatment, you are encouraged to let me know if something does not feel right, or if you want something else from treatment. Your input into the process of therapy, no matter how hard it is to put into words, is very important.

III. You have the right to confidential and safe treatment. As I said before what you say to me is confidential unless I am concerned about your safety or the safety of another person.

Your Responsibilities as a Therapy Client

I. You are responsible for coming to your sessions on time and at the time we have scheduled. If you are late, we will end on time and not run over into the next person's session. If you miss a session without cancellation, or cancel with less than twenty-four hours' notice, you will be charged a $40 fee.

II. You are responsible for paying for your session or your child's session at the beginning of each session unless we have made other firm arrangements in advance. My fee is typically $125.00 for a 50-minute session. Please let me know if you feel that the fee is unaffordable - I am willing to make some adjustments depending on your personal circumstances. If we decide to meet for a long session, I will bill you prorated on the hourly fee. Emergency phone calls are normally free. However, if we regularly spend more than fifteen minutes weekly on the phone, I will bill you on a prorated hourly basis.

1. Please check with me to see if I can be reimbursed directly by your insurance company. If I am not a preferred provider under your insurance, I will help you as best I can so that you might be reimbursed by your insurance company. In that case, it is your responsibility to pay my fee, and provide me with the correct forms and information necessary for you to be reimbursed, unless otherwise arranged.

2. If you end up having an outstanding bill with me and we have terminated therapy, I expect you to pay resolve any outstanding bills. If you refuse to pay your debt, I reserve the right to give your name and the amount due to a collection agency.

3. Complaints: If you are unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously and with care and respect. If you believe that I have behaved unethically, you have the right to file a formal complaint at: Michigan Department of Licensing and Regulatory Affairs, Phone: 517-373-9196.

Naomi M. Baba: My Training and Approach to Therapy

I am a fully licensed clinical social worker in the State of Michigan (License: 6801091649). I have a Master's in Clinical Social Work from Michigan State University. I have a BA in Social Work from the University of Michigan.

My approaches to therapy are grounded in primary cognitive behavioral treatment. I use a variety of techniques in therapy and will try to find what will work best for you. These techniques may include cognitive reframing, training in mindfulness, distress tolerance, and emotional regulation, awareness exercises, self-monitoring, behavioral analysis, journal-keeping, and monitoring material. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting.

Kimberly Hazel: My Training and Approach to Therapy

I am a fully licensed clinical social worker in the State of Michigan (License: 6801065462) and a Registered Play Therapist and Supervisor by the Association for Play Therapy. I have a Master's in Clinical Social Work from Wayne State University. I have a BA in Sociology & Spanish from Central Michigan University.

My approaches to therapy are grounded in cognitive behavioral treatment, family systems, harm reduction, and are viewed through a lens of human development. I use a variety of techniques in therapy and will try to find what will work best for you. These techniques may include child-centered, and directive play therapy, sand tray therapy, cognitive reframing, training in mindfulness, distress tolerance, and emotional regulation, awareness exercises, self-monitoring, behavioral analysis, journal-keeping, and reading books. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting.

Stephanie Evans: My Training and Approach to Therapy

I am a fully licensed clinical social worker in the State of Michigan (License: 6801085773) and play therapist, with experience working with people of all ages. I received my education through Spring Arbor University with a B.A. in Family Life Education and Wayne State University with a Master of Social Work degree. In 2016, I completed many hours of training for a certificate in play therapy, a technique specialized for children encouraging them to express feelings and emotions with play, a child's first language. I have worked with children, youth, and adults for 14 years, in a clinical capacity. I have compassion for families and understand the importance of strong healthy family ties in raising healthy children, which in turn produces healthy adults.

My approaches to therapy are grounded in cognitive behavioral treatment, family systems, harm reduction, and are viewed through a lens of human development. I use a variety of techniques in therapy and will try to find what will work best for you. These techniques may include child-centered, and directive play therapy, sand tray therapy, cognitive reframing, training in mindfulness, distress tolerance, and emotional regulation, awareness exercises, self-monitoring, behavioral analysis, journal-keeping, and reading books. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting.

Teletherapy Services

Teletherapy can be a convenient and cost-effective service to treat mental health issues. With any service, there are benefits and risks that must be addressed before proceeding with this service. Your clinician will assess the appropriateness of teletherapy sessions if you are interested in this service. Your clinician may decide that teletherapy sessions are not appropriate for your needs. Your clinician will provide you with a clear explanation if this decision is made.

Some Benefits:

1. Privacy by having services in your own home or other locations.
2. Cost-effective by saving gas, time and other resources.
3. Most health insurances allow reimbursement to providers.
4. Patients with disabilities or health issues can more easily access therapy services.

Some Risks:

1. Teletherapy may compromise some privacy to patients. Family members or other household members could overhear conversations during sessions.
2. Social communication platforms could experience security breaches.
3. Not all insurances companies reimburse providers for teletherapy services.
4. Teletherapy services can reduce the overall therapeutic experience.
5. Teletherapy services can reduce the ability for the provider to assess the severity of mental health issues including lethality.

If you request teletherapy services, the following terms must be understood and agreed upon:

- I have reviewed all benefits and risks of teletherapy services.
- I understand and accept that Shine Wellness Clinic is not responsible for compromised privacy, security breaches, reduction in the therapeutic experience or ability to assess the severity of patient's mental health status.
- I understand and accept that I or Shine Wellness Clinic reserves the right to refuse teletherapy services. Shine Wellness Clinic may require in-person sessions to meet patient needs.
- I understand that not all insurance companies reimburse for teletherapy services. The patient is responsible for payment for services.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
- I have had a direct conversation with my clinician, during which I had the opportunity to ask qu estions regarding this service. My questions have been answered and the risks/benefits have been explained. Practical alternatives have been discussed with me in a language in which I can understand.

SHINE WELLNESS CLINIC
BCBS NEW CLIENT RATES
STARTING JULY 2024

CODE	DESCRIPTIONS	SHINE RATE	BCBSM RATE	10%	20%	25%	50%
90791	INTAKE ASSESSMENT	176.00	173.71	17.37	34.74	43.43	86.86
90832	INDIVIDUAL - 16-37 MINUTES	79.00	78.96	7.90	15.79	19.74	39.48
90834	INDIVIDUAL - 38-52 MINUTES	105.00	104.16	10.42	20.83	26.04	52.08
90837	INDIVIDUAL - 53 + MINUTES	154.00	153.55	15.36	30.71	38.39	76.78
90846	CONJOINT THERAPY WITHOUT PATIENT	125.00	124.84	12.48	24.97	31.21	62.42
90847	CONJOINT THERAPY - FULL SESSION	104.00	103.15	10.32	20.63	25.79	51.58
90853	GROUP THERAPY	28.00	27.89	2.79	5.58	6.97	13.95