Journey Wellness & Consulting Group, LLC.
364 E. Main Street Ste 184
Middletown, DE 19709
Phone: (302) 723-8859 Fax: (302) 351-7176
Info@JourneyWellnessDelaware.com

Intake Form

Name: _____

Client's Gender Assigned at Birth: _____ Affirmed Pronouns:_____

Birth Date: _____

Client Address:

_____

_____

Client's Phone: _____ Email: _____

Client's Insurance Carrier: _____ Insurance #:_____

Parent/Insurance Subscriber (if not client. Please include address if not the same as client) :

_____

What are you seeking help with/for:

_____

_____

_____

Current medications, if any:

_____

_____

Current Diagnoses (if any):

_____

_____

Additional Comments (if any):

Credit Card Authorization Form

We ask for a credit card to keep on file in the event of missed appointments (no show/no call/no email in less than 24 hours), or copays/deductibles. Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon services and/or purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

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Telehealth Disclosure

Telemedicine Informed Consent

I _____ hereby consent to engage in telemedicine (e.g., internet, email or telephone based therapy) with Journey Wellness & Consulting Group, LLC (Journey Wellness) as a mode of my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic

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storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that, despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with California law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

_____ _____Date
Signature of Patient or Legal Guardian, if applicable

_____ _____Date
Print Name of Patient or Legal Guardian, if applicable

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INFORMED CONSENT FOR TREATMENT

I hereby provide my consent to accept psychiatric, mental health, or alcohol and drug abuse treatment as described to me by the clinicians at Journey Wellness & Consulting Group, LLC. (JWCG).

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Journey Wellness & Consulting Group, LLC. (JWCG).
2. I acknowledge that I have been given information regarding my rights and responsibilities as a participant.
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services from Journey Wellness & Consulting Group, LLC.
5. I understand that I am responsible to pay a copay and that it is payable each time I come for treatment. If changes in fees or co-pays should happen, Journey Wellness & Consulting Group, LLC. will notify me immediately regarding my responsibility.
6. I understand that I may address any concerns or grievances with my therapist or any other representative of my behavioral health member services team.
7. I am freely choosing to enter treatment, and I understand that I may discontinue treatment at any time.
8. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives. I may stop services at any time, however I am still responsible for paying for services I have received.

_____ _____
Signature of Client/Parent or Legal Guardian Date

MINOR (Emancipated Minors Only):

Due to the following reason _____, I have the legal capacity under applicable _____ (State)law to apply for consent to such treatment and services mentioned in this form, without parental consent.

_____ _____
Signature of Participant Date

PARENT OR GUARDIAN OF MINOR CHILD:

I, _____, do hereby state that I am the parent or legal guardian of the participant _____; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____ _____
Signature of Participant/ Parent or Legal Guardian Date

_____ _____
Witness Date

*As witness, I acknowledge that the above information has been signed by the client and services will be rendered as described in the policies and procedures forms.

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Patient Notice of Privacy for Protected Health Information

The Notice of Privacy Practices provided by **Journey Wellness & Consulting Group, LLC.** describes such uses and disclosures more completely.

I hereby give my consent for **Journey Wellness & Consulting Group, LLC.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Journey Wellness & Consulting Group, LLC.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Journey Wellness & Consulting Group, LLC. (using above contact information).**

With this consent, **Journey Wellness & Consulting Group, LLC.** may call my home or other alternative provided contact and leave a voice mail or personal reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance concerns, and information pertaining to clinical care.

With this consent, **Journey Wellness & Consulting Group, LLC.** may use my mailing address to assist the practice in carrying out TPO, such as appointment reminder cards and patient statements (marked "Personal and Confidential").

With this consent, **Journey Wellness & Consulting Group, LLC.** may e-mail to my provided contact, items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that **Journey Wellness & Consulting Group, LLC.** restricts use or disclosure of my PHI to carry out TPO.
The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Journey Wellness & Consulting Group, LLC.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Journey Wellness & Consulting Group, LLC. may decline to provide treatment to me.

_____ _____Date
Signature of Client/Parent or Legal Guardian

_____
Print Name of Signature of Client/Parent or Legal Guardian

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CLIENT SERVICE AGREEMENT

HIPAA NOTIFICATION

Welcome to Journey Wellness & Consulting Group, LLC. (JWCG). This document contains important information about: our professional services, business policies, and Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations.

PSYCHOTHERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as: sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals. Therapy often leads to: a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. To be most successful, you will have to work on things discussed outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, you will be offered you some initial impressions of what work with your therapist might include. You and your therapist will then discuss treatment goals and create an initial treatment plan. You should evaluate this information and make an assessment about whether the therapeutic relationship between yourself and your therapist is a good fit for you.

APPOINTMENTS

Appointments are 45-75 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. If you need to cancel or reschedule a session, we ask that you provide a 24 hour notice. If you miss a session without canceling, or cancel with less than 24 hour notice, JWCG's policy is to collect the amount of **$35.00 unless we agree that you were unable to attend due to circumstances beyond your control**. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Thus, you will be responsible for the portion of the fee as described in this agreement. If possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time. If you are late, your appointment will still need to end on time.

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PROFESSIONAL FEES

The standard fee for the sessions are $175.00 and $225 for couples and families. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by cash, PayPal,/Square, or credit card. If you refuse to pay your debt, JWCG reserves the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, JWCG will charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as: report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of your therapist. If you become involved in a court case, we recommend that you discuss this fully with your therapist before you waive your right to confidentiality. If your case requires JWCG participation, you will be expected to pay for the professional time required even if another party compels your therapist to testify.

INSURANCE

For JWCG to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will assist you, to the extent possible, in filing claims and ascertaining information about your coverage, but *you are responsible for knowing your coverage and for letting us know if/when your coverage changes.*

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. *It may be necessary to seek approval for more therapy after a certain number of sessions.* While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow JWCG to provide services to you once your benefits end. If this is the case, JWCG will do our best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize JWCG to provide them with a clinical diagnosis. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. JWCG has access to a copy and will be glad to let you see it to learn more about your diagnosis, if applicable. Sometimes JWCG will provide additional clinical information such as treatment plans, summaries, or copies of the entire record (in rare cases). By signing this Agreement, you agree that JWCG can provide requested information to your carrier.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by credit card or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be

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paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with us until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once JWCG has all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above, unless prohibited by my provider contract.

If JWCG is not a participating provider for your insurance plan, JWCG will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, JWCG can attempt to refer you to another mental health professional.

PROFESSIONAL RECORDS

JWCG is required to keep appropriate records of the psychological services provided. Your records are maintained in a secure location digitally and in the office. JWCG keeps records noting date of visit, reasons for seeking therapy, the goals and progress set for treatment, your diagnosis, topics discussed, medical, social, and treatment history, records JWCG receives from other providers, copies of records, and billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with your clinician, or have them forwarded to another mental health professional to discuss the contents. If JWCG refuses your request for access to your records, you have a right to have this decision reviewed by another mental health professional, which will be discussed with you upon request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

JWCG policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is JWCG policy not to provide treatment to a child under age 13 unless s/he agrees that information can share information considered necessary with a parent. For children 14 and older, JWCG requests an agreement between the client and the parents allowing therapists to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless therapist feels there is a safety concern (see also above section on Confidentiality for exceptions), in which case every effort to notify the child of intentions to disclose information ahead of time and make every effort to handle any objections that are raised.

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CONTACTING YOUR THERAPIST

Therapists may often not immediately available by telephone. Calls can not be answered when therapist is with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible; it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from your therapist or and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please do one of the following:

- Contact Crisis Intervention Services: Northern Delaware 302-577-2484 or 800-652-2929;
- Southern Delaware 302-577-2484 and 800-345-6785
- Go to your local hospital Emergency Room
- Call 911 and ask to speak to the mental health worker on call

Your therapist will make every attempt to inform you in advance of planned absences.

OTHER RIGHTS

If you are unhappy with your therapeutic process, talk with your therapist or contact the office so that your concerns can be addressed. Such comments will be taken seriously and handled with care and respect. You may also request a referral to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about therapist specific training and experiences.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this agreement (Policies & Procedure Form /Client Service Agreement) and the Notice of Privacy Practices and agree to their terms.

Patient's or Patient's Representative Signature: _____ Date: ___/___/___

Print Patient's or Patient's Representative Name: _____

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AUTHORIZATION TO OBTAIN AND/OR DISCLOSE PROTECTED INFORMATION

Client's Name: _____ Date of Birth: _____

I authorize the use of disclosure of the above named individual's information as described below:

The following organization is authorized to **OBTAIN and/or DISCLOSE (*CIRCLE ONE OR BOTH)*** the selected information to the person listed below:

Journey Wellness & Consulting Group, LLC.

The type of information to be used or disclosed is limited to the following:

- ☐ Verbal Only
- ☐ Admission & Discharge Dates Only
- ☐ Educational Records
- ☐ Attendance
- ☐ Classroom Attendance
- ☐ Classroom Behavior
- ☐ Progress Notes
- ☐ Individual Education Plan
- ☐ Psychoeducational/Therapy Transcripts
- ☐ Psychological Evaluations
- ☐ School Visit(s)
- ☐ Other: _____

I understand that the information in my health record may include information related to sexually transmitted diseases, including HIV/AIDS. It may also contain information about treatment for alcohol and drug abuse.

The information may be obtained from or disclosed to the following individual or organization:

CHECK ONE: REFERRAL SOURCE ☐ THERAPIST ☐ PSYCHIATRIST ☐ CCCP ☐ PCP ☐
SCHOOL/WELLNESS CENTER ☐ PROBATION ☐ EMPLOYER ☐ FAMILY MEMBER ☐ **OTHER** ☐

_____
(Individual or Organization) (Address/phone)

for the purpose of:_____Coordination of Care_____

This Authorization to Release Protected Health Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), standards for privacy of individually identifiable health information standards, 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereof. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present it to the Department of Health Information Services at Rockford Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in 60 days.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

Guardian/Parent Signature:_____ Date:_____

Therapist Signature:_____ Date:_____