The Anxiety & Stress Relief Center, PLLC
Mailing Address: 110 N. Main St, Breese, IL 622331 Phone: 618.322.6424, Fax: 618-227-8227 E-Mail: office@solutions4wellness.com

DATE OF FIRST APPOINTMENT: _____

DEMOGRAPHICS

NAME: _____NICKNAME PREFERRED:_____

AGE TODAY: _____ BIRTH DATE:_____ Gender: ☐ Female. ☐ Male

HOME ADDRESS: _____

CITY, STATE, ZIP:_____

E-MAIL: _____ OK TO EMAIL? ☐ YES ☐ NO

CELL PHONE:_____ OK TO LEAVE MSG? ☐ YES ☐ NO

OKAY TO RECEIVE APPOINTMENT REMINDERS BY TEXT? ☐ YES ☐ NO

HOME PHONE:_____ OK TO LEAVE MSG? ☐ YES ☐ NO

WORK PHONE:_____ OK TO LEAVE MSG? ☐ YES ☐ NO

ADD TO EMAIL LIST FOR OCCASIONAL UPDATES FROM SOLUTIONS4WELLNESS, INC?: ☐ YES ☐ NO

RELATIONSHIP STATUS

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ OTHER

*If legal enforcements, such as custody or parenting plans exist, we require a copy of the intact, current legal documents.

_____

_____

ARE YOU A PARENT? ☐ YES ☐ NO ☐ OTHER (please explain)_____

WHO DO YOU CURRENTLY LIVE WITH?_____

_____

EMPLOYMENT/EDUCATION/LEGAL STATUS

☐ WORK FULL-TIME ☐ WORK PART-TIME ☐ DISABLED ☐ OTHER

Name of Employer: _____ LENGTH OF TIME @ THIS POSITION?_____

☐ STUDENT, FULL-TIME ☐ STUDENT, PART-TIME School Name: _____

ARE YOU INVOLVED IN ACTIVE LEGAL ENFORCEMENTS? (i.e. Court/Restraining order) ☐ YES ☐ NO
IF YES, BRIEFLY EXPLAIN:

_____

_____

PLEASE NOTE ANY OTHER CIRCUMSTANCES THAT MAY OR WOULD BE HELPFUL FOR YOUR PROVIDER TO KNOW, SO THEY CAN BEST ASSIST YOU WITH A FULL PICTURE:

_____

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HOW WERE YOU REFERRED TO US OR DID YOU HEAR ABOUT US?

☐ HEALTHCARE/OTHER PROVIDER (name) _____ ☐ INSURANCE COMPANY

☐ INTERNET SEARCH ☐ FRIEND/COWORKER/FAMILY MEMBER (Name): _____

☐ Other, DESCRIBE _____

HEALTH INSURANCE INFORMATION

****A COPY OF YOUR INSURANCE CARD, YOUR STATE ISSUED ID & A FORM OF PAYMENT WILL BE NEEDED**

IF USING HEALTH INSURANCE (Currently In-Nework with Aetna, BCBS, Health Link, Medicare, Mercy Managed Care). This means if you have and use one of these insurance companies, we will bill your insurance and then determine your portion of the fee. You may be asked to keep a card on file (HSA & FSA cards are welcome) to pay for the balance you owe for sessions, once your portion of the fee is determined.

All other insurance is considered Out-Of-Network, in that you will be expected to pay for your session at the time of service (typically $150, as most sessions are 55 minutes) and if you choose, a receipt to provide to your insane for any benefits can be provided.

HEALTH INSURANCE _____ EMPLOYER/SPONSOR_____

MEMBER ID # _____ GROUP ID# _____

(Please note that the primary cardholder will likely be able to see the charges if they look in the insurance portal or call the insurance company.)

If you are not the primary cardholder Please provide the following to bill insurance: Provide primary cardholder's:

Name:_____ Card Holder's Date of Birth _____/_____/_____

Address if different than previously listed for client: _____

HEALTH/MEDICAL/LIFESTYLE/ACTIVITY STATUS

Primary Care Physician:_____ Phone: _____

Date of last medical exam:____/____/____

LIST Other Healthcare Providers (i.e. Psychiatrist, Chiropractor, etc, include phone numbers, if possible) _____

_____

_____

Do you want us to coordinate care with any of these providers? ☐ YES. ☐ NO ☐ Unsure

PLEASE LIST MEDICAL PROBLEMS OR DIAGNOSIS THAT YOU HAVE HAD OR ARE CURRENTLY EXPERIENCING :_____

_____

_____

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PLEASE LIST ALL CURRENT MEDICATIONS (if you do not have a copy of them with you to provide today):

Name of Medication	Prescribed for Reason for Use	Dosage amount	Frequency/ How Often Taken	Physician Prescribed by

(ADD ADDITIONAL MEDICATION ON SEPARATE SHEET OF PAPER)

If you have taken psychotropic medications in the past, please list what you have taken, how long ago and reason for discontinuation: _____

_____

_____

How much sleep you typically get each night? _____ Do you typically wake up rested? ☐ YES ☐ NO

How much caffeine do you typically have each day? _____

Is sleep a part of why you're here or as a contributing factor for why you're seeking help? ☐ YES ☐ NO

THERAPEUTIC PREPARATION STATUS

In your own words, what are your primary concerns that lead you to schedule this appointment?

_____

_____

_____

And/or you may use this checklist for explaining the area which best describes your BIGGEST REASON(S) for contacting us: "I am looking for help with or relief from (mark all that apply)…

☐ BOTHERED FROM PAST EVENT(S)/EXPERIENCES ☐ HEALTH (___My own or ____someone else)
☐ LIFE TRANSITION ☐ BURNOUT ☐ FINANCIAL ☐ ANXIETY ☐ DEPRESSION ☐ HARMFUL THOUGHTS ABOUT SELF OR OTHERS ☐ RELATIONSHIP ISSUES ☐ EMPLOYMENT ☐ OVERWHELM/ NOT SURE. ☐ PERSONAL REASONS NOT ALREADY LISTED/OTHER (please briefly describe):

_____

_____

We ask for the following additional information to save time in your session, although we want to be respectful & sensitive to your concerns and know it might be too much to complete in this way. So complete what works for you now and we can take care of the rest when we're together.

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IF ANSWERING ANY OF THE FOLLOWING QUESTIONS ARE TO DIFFICULT ANSWER, FEEL FREE TO SKIP ANY ITEMS AND SIMPLY MARK THIS BOX AND MOVE TO THE NEXT SECTION.

WE CAN DISCUSS THIS TOGETHER DURING OUR WORK TOGETHER. ☐

HAVE YOU SOUGHT HELP FOR THIS/THESE CONCERNS FROM OTHER PROFESSIONALS? ☐ YES ☐ NO

HAVE YOU RECEIVED ANY RELIEF OR IMPROVEMENT REGARDING THIS/THESE ISSUES? ☐ YES ☐ NO

HAVE YOU PARTICIPATED IN COUNSELING/THERAPY IN THE PAST? ☐ YES ☐ NO
IF YES, PLEASE LIST TO THE BEST OF YOUR KNOWLEDGE:

WHEN: _____ ABOUT HOW LONG DID YOU ATTEND?:_____

What did you find helpful about your treatment? _____

What was not helpful in your treatment? _____

HOW MOTIVATED ARE YOU TO OBTAIN RELIEF/RESOLVE FROM WHAT IS CONCERNING YOU?

☐ I DON'T SEE IT AS A PROBLEM, I'M HERE BECAUSE SOMEONE WANTS/INSISTS I NEED TO BE
☐ I REALIZE SOMETHING IS OFF, BUT I'M NOT SO SURE WHERE TO START
☐ I KNOW I NEED HELP, BUT I'M NOT REAL SURE IT WILL HELP
☐ I WANT HELP, BUT I'M NOT SURE HOW/WHERE TO START
☐ I'M DOING IT, JUST NEED SOME ASSISTANCE
☐ NONE OF THE ABOVE FIT, THIS IS WHERE I'M AT: _____

ADDITIONAL SYMPTOM CHECKLIST (check all that apply or that you have been experiencing):

___Excessive Distress	___History of trauma	___Excessive need for reassurance	___Vomiting, laxatives, diuretics
___Sleep Changes	___Self Harm	___Difficulty listening	___Preoccupation with food
___Low Energy	___History of self-harm	___Difficulty concentrating/ memory	___Several failed diets
___Fatigue	___Past suicide attempt	___School/Work Difficulty	___Eating for reasons other than hunger
___Physical aches and complaints	___Panic Behavior	___Menstrual irregularities	___Feeling that your eating is out of control
___Inability to relax	___Loose thinking	___Risky sexual behaviors	___Secretive eating/only in private
___Self-consciousness	___Racing thoughts	___Poor appetite	___Feeling disgusted or guilty about eating
___Low Self-Esteem	___Disorientation or confusion	___Weight changes	___Skipping meals and then overeating
___Worthlessness	___Decline in Personal Hygiene	___History of eating disorder	
___Hx of ups and downs	___Unrealistic concern about past	___Excessive exercise	
___Excessive moodiness	___Social Problems		
	___Argues with others		

Additional Symptoms/Concerns Not Listed on Symptom Checklist: _____

_____

PLEASE NOTE YOUR HISTORY TO USE WITH **SUBSTANCES**. IF HAVE NOT USED, WRITE "NA"

Substance	Age started	Age stopped	Frequency	Amount
Alcohol				
Marijuana				
Cocaine				

Opiates				
Tobacco				
Other				

Have you experienced Drug/Alcohol use resulting in?
__ Failure in school, work, home __Physically dangerous situations __Legal problems
__ Social/relationship problems __Tolerance/withdrawal __Intoxication ___ Rehab Program
Indicate other family history of Addiction and Mental Health Concerns: _____

_____

LIFE CHANGES, TRANSITIONS, STRESSORS: Have you/your family had these experiences?

This Event Occurred:	**In the Past Year**	**This happened in the past**	**This still affects me**	**This is part of why I am here**
Move to a new home	_____	_____	_____	_____
Divorce/Break-up	_____	_____	_____	_____
Remarriage	_____	_____	_____	_____
Relationship Issues	_____	_____	_____	_____
Family Discord	_____	_____	_____	_____
Adoption/Birth of child	_____	_____	_____	_____
Abuse issues/Violence Exposure	_____	_____	_____	_____
Employment changes	_____	_____	_____	_____
Work/school issues	_____	_____	_____	_____
Homelessness	_____	_____	_____	_____
Financial Problems	_____	_____	_____	_____
Legal issues	_____	_____	_____	_____
Personally having a serious illness	_____	_____	_____	_____
Someone else having a serious illness	_____	_____	_____	_____
Military Service, My Own	_____	_____	_____	_____
Military Service, Someone else's	_____	_____	_____	_____
Stressful, Demanding Job	_____	_____	_____	_____
Grief issues	_____	_____	_____	_____
Guilt issues	_____	_____	_____	_____
Humiliation or Shame issues	_____	_____	_____	_____
Death in family	_____	_____	_____	_____
Death of someone else close to	_____	_____	_____	_____
Loss of friendship	_____	_____	_____	_____
Physical Injury	_____	_____	_____	_____
OTHER:	_____	_____	_____	_____

Other information you believe would be important for me to know about you?

_____

_____

You may notice overlap in questions or see some repetition or similarities on the next several pages. The following items are taken from current research results to best assess and develop a treatment plan with you that more fully addresses your concerns, so we do ask that if possible you complete this before your session or we can do it together. We're happy to answer any questions and will talk to you about your results.

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BRAIN HEALTH QUESTIONNAIRE:

How do you feel NOW or more so than not, for the next #1-70 statements:

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

____ 1. Frequent feelings of nervousness or anxiety
____ 2. Panic attacks
____ 3. Avoidance of places due to fear of having an anxiety attack
____ 4. Symptoms of heightened muscle tension (sore muscles, headaches)
____ 5. Periods of heart pounding, nausea, or dizziness (not w/ exercise)
____ 6. Tendency to predict the worst
____ 7. Multiple, persistent fears or phobias (dying, doing something crazy)
____ 8. Conflict Avoidance
____ 9. Excessive fear of being judged or scrutinized by others
____ 10. Easily startled or tendency to freeze in intense situations
____ 11. Seemingly shy, timid, and easily embarrassed
____ 12. Bites fingernails or picks skin Office Use: Total 3/4 on 1-12 (PA): ___

____ 13. Persistent sad or empty mood
____ 14. Loss of interest or pleasure from activities that are normally fun
____ 15. Restlessness, irritability, or excessive crying
____ 16. Feelings of guilt, worthlessness, helplessness, hopelessness
____ 17. Sleeping too much or too little, or early morning waking
____ 18. Appetite changes/ weight loss or weight gain through overeating
____ 19. Decreased energy, fatigue, feeling "slowed down"
____ 20. Thoughts of death or suicide, or suicide attempts
____ 21. Difficulty concentrating, remembering, making decisions
____ 22. Physical symptoms; headaches, chronic pain, digestive problems
____ 23. Persistent negativity or low self esteem Office Use: Total 3/4 for 13-24(PD) ____
____ 24. Persistent feeling of dissatisfaction or boredom Total 3/4 1-24 (MAD): ____

____ 25. Excessive or senseless worrying
____ 26. Upset when things are out of place or don't go according to plan
____ 27. Tendency to be oppositional or argumentative
____ 28. Tendency to have repetitive negative or anxious thoughts
____ 29. Tendency toward compulsive behaviors
____ 30. Intense dislike of change
____ 31. Tendency to hold grudges
____ 32. Difficulty seeing options in situations
____ 33. Tendency to hold on to own opinion and not listen to others
____ 34. Needing to have things done a certain way or you become upset
____ 35. Others complain you worry too much. Office Use: Total 3/4 for 25-36
____ 36. Tendency to say no without first thinking about the question (OFAD) ____

How do you feel NOW or more so than not,

0=Never 1=Rarely 2=Occasionally 3=Frequently 4=Very Frequently

____ 37. Periods of abnormally happy, depressed or anxious mood
____ 38. Periods of decreased need for sleep, energetic on much less sleep
____ 39. Periods of grandiose thoughts and ideas (feeling very powerful)
____ 40. Periods of increased talking or pressured speech
____ 41. Periods of too many thoughts racing through your mind
____ 42. Periods of increased energy level
____ 43. Periods of poor judgment that leads to risk-taking behaviors
____ 44. Periods of inappropriate social behavior
____ 45. Periods of irritability or aggression
____ 46. Periods of delusional or psychotic thinking. Office Use: Total 3/4 for 37-46 (CAD): ____

____ 47. Short fuse or periods of extreme irritability
____ 48. Periods of rage without being provoked
____ 49. Often misinterprets comments as negative when they are not
____ 50. Periods of spaciness or confusion
____ 51. Periods of panic or fear for no specific reason
____ 52. Visual or auditory changes (seeing shadows or hearing sounds)
____ 53. Frequent periods of déjà vu (feeling you've been somewhere you have never been)
____ 54. Sensitivity or mild paranoia
____ 55. Headaches or abdominal pain or uncertain origin
____ 56. History of head injury or family history of violence/ explosiveness
____ 57. Dark thoughts, may be homicidal or suicidal
____ 58. Periods of forgetfulness or memory problems Office Use: Total 3/4 for 45-58 (TLAD): _____

____ 59. Trouble staying focused
____ 60. Spaciness or feeling like you're in a fog
____ 61. Overwhelmed by tasks of daily living
____ 62. Feels tired, sluggish, or slow moving
____ 63. Procrastination, failure to finish things
____ 64. Chronic boredom
____ 65. Loses things
____ 66. Easily distracted
____ 67. Forgetful
____ 68. Poor planning skills
____ 69. Difficulty expressing feelings
____ 70. Difficulty expressing empathy for others Office Use: Total 3/4 for 59-70 (UAD): _____

FOR OFFICE USE: (PAD)____ (PD)____ (MAD)____ (OFAD)____ (CAD)____ (TLAD)____ (UAD)____

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MODIFIED HCL-32 QUESTIONNAIRE For the next 32 statements, please try to remember **a period when you were in a "high" state.** How did you feel then?	**I have experienced this or felt this way at some point, even if not currently**	**This had an adverse effect on me on at least one occasion**
1. I need less sleep		
2. I feel more energetic and more active		
3. I am more self-confident		
4. I enjoy my work more		
5. am more sociable (make more phone calls, go out more)		
6. I want to travel and/or do travel more		
7. I tend to drive faster or take more risks when driving		
8. I spend more money/too much money		
9. I take more risks in my daily life (in my work and/or other activities)		
10. I am physically more active (sport etc.)		
11. I plan more activities or projects.		
12. I have more ideas, I am more creative		
13. I am less shy or inhibited		
14. I wear more colorful and more extravagant clothes/make-up		
15. I want to meet or actually do meet more people		
16. I am more interested in sex, and/or have increased sexual desire		
17. I am more flirtatious and/or am more sexually active		
18. I talk more		
19. I think faster		
20. I make more jokes or puns when I am talking		
21. I am more easily distracted		
22. I engage in lots of new things		
22. I engage in lots of new things		
23. My thoughts jump from topic to topic		
24. I do things more quickly and/or more easily		
25. I am more impatient and/or get irritable more easily		

CONTINUED: please try to remember **a period when you were in a "high" state.** How did you feel then?	**I have experienced this or felt this way at some point, even if not currently**	**This had an adverse effect on me on at least one occasion**
26. I can be exhausting or irritating for others		
27. I get into more quarrels		
28. My mood is higher, more optimistic		
29. I drink more coffee		
30. I smoke more cigarettes		
31. I drink more alcohol		
32. I take more drugs (sedatives, anti-anxiety pills, stimulants		
FOR OFFICE USE: (HCL-32)	Experienced: ___	Adverse ___

DSM-5-TR Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None,** Not At All	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	OFFICE USE: **Highest** Domain clinician
I.	1 Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV,	6 . Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11.Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None,** Not At All	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	OFFICE USE: **Highest** Domain clinician
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII	19. Not feeling close to other people or enjoying your relationships with them? Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

	INTERPERSONAL RELATING ASSESSMENT	YES	NO
	Do you often put others' needs before your own, even to your detriment?	Yes	No
	Do you feel responsible for solving other people's problems or managing their emotions?	Yes	No
	Do you have difficulty saying "no" when others ask for help?	Yes	No

B.	Do you frequently sacrifice your own desires or well-being to please others?	Yes	No
	Do you feel guilty or anxious when prioritizing your own needs?	Yes	No
	Do you struggle with low self-esteem or feelings of inadequacy?	Yes	No
	Are you uncomfortable expressing your true feelings or asking for help?	Yes	No
E.	Do you feel rejected or unworthy when significant others spend time away from you?	Yes	No
	Do you feel that your sense of self-worth depends on others' opinions of you?	Yes	No
	Have you ever been in a relationship where you felt compelled to "fix" or "rescue" the other person?	Yes	No
R.	Do you often stay in unhealthy or one-sided relationships out of fear of abandonment?	Yes	No
	Do you minimize, deny, or alter how you truly feel to avoid conflict?	Yes	No
	Do you struggle to identify what is "normal" in relationships or question your own mental state?	Yes	No
C. P..	Do you have difficulty adjusting to changes in routines or life circumstances?	Yes	No
	FOR OFFICE USE: IRA B: _____ E: _____ R: _____ C/P: _____		

FOR OFFICE USE:

BHQ :(PAD)____ (PD)____ (MAD)____ (OFAD)____ (CAD)____ (TLAD)____ (UAD)____

HCL-32 Experienced: ____ Adverse Effect: ____

DSM-5-TR CC ADULT: I _____ II_____ III _____

IV _____ V _____ VI _____ VII _____ VIII _____IX _____ X _____ XI _____ XII _____ XIII _____

IRA B:_____ E: _____ R: _____ C/P: _____

Notes-Clinical Impressions:

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INFORMED CONSENT FOR TREATMENT, CONTRACT, FINANCIAL AGREEMENT, OFFICE POLICIES

Welcome to The Anxiety & Stress Relief Center, PLLC. We are an agency that employs licensed mental health professionals who engage in the practice of mental and behavioral health services through the delivery of evaluation of mental health needs and the delivery of counseling and psychotherapy services and includes personal and clinical information that is confidential. Please read this form carefully and ask any questions you may have.

This document will be an official agreement once you sign it.

THERAPIST/PROVIDERS: We are licensed in the State of Illinois and Missouri and oblige by the National Association of Social Worker's Code of Ethics and will use these legal and ethical standards with all clients.
TECHNIQUES: Our providers are trained in multiple evidence-based therapy methods to support your wellness journey. We offer: talk therapy approaches, relationship counseling methods, trauma and emotional processing Techniques as well as nervous system regulating approaches and psychoeducation. Your provider will assess your status ongoing and make recommendations for which method to utilize for your treatment. These approaches can help address behavioral patterns, thought processes, emotional challenges, physical symptoms, and unprocessed trauma. While many of these methods were initially developed for trauma treatment, research suggests they may also be effective for anxiety and other symptoms. We can adjust or change techniques based on your comfort level and response to treatment
RIGHTS AND RISKS: We encourage you to ask questions about any aspect of professional treatment. You need to be willing to discuss what troubles you and be open to change. The therapeutic process, while beneficial, may involve temporary discomfort or challenging periods before improvement occurs. During counseling, you may remember unpleasant events, experience intense emotions, or notice changes in your relationships as you develop new patterns of thinking and behaving. It's natural to feel more emotionally vulnerable or even temporarily worse while working through sensitive issues – this is often a normal part of the healing journey. The purpose of counseling is to facilitate your process of growth in a supported environment, where your therapist will help you develop coping strategies and move at a manageable pace. You have the right to ask questions, voice concerns, take breaks, decline discussing certain topics, request changes to your treatment approach, or terminate therapy at any time.

LIMITS OF TREATMENT: Your participation in psychotherapy/counseling is voluntary and you have the right to withdraw from treatment without adversity at any time. We encourage you to let your therapist know you wish to stop sessions so the last session is tailored to providing closure. There are rare circumstances in which a therapist may be obligated to make a unilateral decision to terminate therapy with a client. In such cases, the therapist will attempt to find a suitable referral. The therapist cannot be responsible as to whether this referral is accepted.

REASONABLE ALTERNATIVES: I understand that my therapist has discussed various treatment options with me, which may include: different therapy approaches, individual or group therapy, medication management, referrals to specialists, self-help resources or support groups, alternative treatment settings or intensities, tele-health or in-person sessions, varying session frequencies and the option of no treatment, There is the opportunity to discuss these alternatives, including their potential benefits and risks at any point in therapy.

CONSENT FOR IN-PERSON SERVICES AND RISKS: In-person services may transition to telehealth due to COVID-19 resurgence (or any other infectious disease), government restrictions, health concerns, or illness. By attending in-person sessions, you assume the risk of coronavirus exposure and waive claims against the practice and provider for related damages. This exposure risk may result from actions, omissions, or negligence of the practice, providers, staff, and other clients. **YOUR RESPONSIBILITIES:** You agree to follow precautions based on local, state, or federal guidelines. Your provider will discuss any necessary changes with you. You agree to follow precautions and understand they are subject to change according to published local, state or federal orders or guidelines. If that happens, we will talk to you about any necessary changes.

PRACTICE RESPONSIBILITY TO MINIMIZE YOUR EXPOSURE: The Anxiety & Stress Relief Center, PLLC and its staff have also taken steps to reduce the risk of spreading the coronavirus. Please let us know if you have questions about these efforts. The Anxiety & Stress Relief Center, PLLC and Christina Diesen, LCSW cannot guarantee that you will not become infected with COVID – 19 if you choose to enter the office building for an in person session.

APPOINTMENTS: All office and online visits are by appointment only. Your scheduled time is dedicated to your well-being as with other clients and their scheduled time. The industry standard and usual length of an appointment is 45-53 minutes unless scheduled differently. Other arrangements can be made per request outside of the use of health insurance.

FEES AND FINANCIAL ARRANGEMENTS: Payments are required at your session, so please have your check, cash, or credit card ready. We request that you keep a card on file in, although if this is an issue, we can discuss other arrangements. Private pay is one option to pay for service fees. Options to obtain reimbursement include: HSA (Health Savings Account) receipt for reimbursement, In-Network Insurance, Out-Of-Network Insurance (where you may be able to seek reimbursement) and EAP (Employee Assistance Program). Once the options have been explained, you will be asked to indicate how you will choose to pay for your fees and your portion of the payment is due at the time of service. Your indication of your payment choice will be acknowledged on the Payment/Insurance Verification Form.

Our providers are In Network Providers for some insurance carriers and if we are In-Network for your insurance, it is your responsibility to verify your benefits and seek pre-authorization and at the time of service, you are responsible for your portion of the fee, including co-pays and deductibles.

If you utilize insurance benefits, either In Network or Out of Network, it is your responsibility to seek pre-authorization and verify benefits. An Insurance Verification form can be provided for you to use in verifying your insurance. As a courtesy, we may electronically submit your billing, although this does not guarantee payment from the insurance company. If your health insurance does not pay your claim within 30 business days, we may ask and you agree to pay the unpaid fees and any overpayment from your insurance after that point would be returned to you. *Insurance companies implement changes often so we strongly encourage you to contact them regarding your benefits.
IF USING *AETNA, BLUE CROSS BLUE SHIELD, HEALTH LINK, MEDICARE OR MERCY MANAGED CARE* HEALTH INSURANCE (Currently In-Network Plans), we will bill your insurance and then determine your portion of the fee. We ask for you to keep a card on file (HSA & FSA cards are welcome) to pay for the balance you owe for sessions, once your portion of the fee is determined.

All other insurance is considered Out-Of-Network. You will be expected to pay for your session at the time of service (typically $150, as most sessions are 55 minutes). For those Out of Network, your insurance may pay for sessions at an Out of Network Rate. If you choose, upon request, receipts are available for you to submit to your insurance for any reimbursement between you and your insurance company.

Other service fees begin at $40 (1 hour group) and vary depending on the service time. Discounts for private pay day of service payment options are available upon request.. The service and its corresponding fee will be explained prior to or at your session.
RETURNED CHECKS will incur a minimum fee of $25 plus the original amount of the check.
TELEPHONE CALLS: Calls over five (5) minutes are billed at $25, per 15-minute increments. If your therapist is not able to respond to your question in a way that best serves you at that initial phone call, she will inform you of scheduling a telephone or individual session. Your therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays.

CANCELLATION POLICY: The Anxiety & Stress Relief Center, PLLC has the policy of charging for missed appointments and late cancellations (less than 48 hours before scheduled appointment). **Business hours are typically Monday through Thursday at scheduled times. As long as you contact the office, or cancel via Jituzu within 48 hours, there is no charge. If you give a cancellation notice 47 business hours or less from your scheduled time, a fee**

of $50 will be assessed to your account and is not payable by your insurance company. If you receive automated appointment reminders through text from your therapist, they are typically sent two days before and with at least 48 hours notice. You can cancel using the instructions on the text message within the 48 hour time frame without penalty. If you cancel using this method with less than 48 hours notice, the cancellation fee may also apply. It is difficult to schedule someone for the appointment time with this short notice. Insurance companies do not pay for 'no show' charges or late cancellation fees. We cannot make exceptions to this rule, including for reasons associated with illness, childcare issues, or work conflict.

MISSED APPOINTMENTS/INACTIVE SERVICES/CLOSURE POLICY: We encourage a pre-planned and prepared finalization to conclude your therapy experience, which is discussed from the beginning of treatment. Although we encourage face to face sessions to provide healthy and therapeutic closure or finalization of services, we realize that a situation may arise in that this may not occur, i.e.-a client leaves without rescheduling a session or cancels and does not reschedule. In the event you do not have a set appointment or you for some reason, such as cancellation without contacting us to reschedule, it is our policy to allow you to make decisions on your own behalf. We may contact you during the time of your appointment to verify your participation, although we typically do not contact you to reschedule primarily due to potential privacy concerns. If after 60 days of your last appointment, you have not established contact with The Anxiety & Stress Relief Center, PLLC or your therapist, we assume that you decided to stop therapy at this time and you will no longer be considered an "Open or Active Client/Case" and at that time your case will automatically, without further notice be considered closed. If your case becomes Inactive/Closed, unless indicated differently, you are welcome to reestablish contact to reopen or resume services with your therapist and the paperwork that is required for a new or returning client will be necessary to complete at this time. This policy is in effect unless other arrangements are made with your therapist, such as an agreement for maintenance sessions that are less than monthly.

ELECTRONIC COMMUNICATION: We do not provide psychotherapy through text or e-mails. Any psychotherapy issue must be communicated through face-to-face communication or via telephone or tele-health platform. Any e-mails or text messages sent to the therapist will be responded to at the therapist's convenience. Using this technology, we cannot guarantee your privacy under your protected health information and ask that these means of communication be used ONLY for business purposes, such as arranging or rescheduling appointments or communication regarding payment. Your participation in the use of electronic communication and agreement to our office policies is your acknowledgment that you understand we cannot guarantee your protected health information shared through electronic communications.

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves relationships that impair the provider's objectivity, clinical judgment or can be exploitative in nature. Our providers extend this to all professional relationships. We will assess carefully before entering into non-exploitative dual relationships with clients. You may bump into someone you know in the waiting room or into a provider in the community. We will never acknowledge working with anyone without their permission. Many clients choose us as their provider because we are known to them before entering into a professional relationship as the consumer /client is personally aware of our professional work and achievements. Nevertheless, we will discuss with you, the client/s, the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your responsibility to communicate to your provider if the dual or multiple relationship becomes uncomfortable for you in any way. We will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if we find it interfering with the effectiveness of our work together or the welfare of the client and you can do the same at any time.

SOCIAL MEDIA POLICY: Per the NASW Code of Ethics the general public can hold the social work profession accountable for professional practice and consumer protection. It is our primary responsibility as your provider to assure that we keep your best interest in mind and with the quick changing world of social media, provide a clear understanding of our social media policy. We will conduct ourselves on the Internet as a mental health professional and how you can expect us to respond to various interactions that may occur between us on the Internet. As new technology develops and

the internet changes, there may be times when we may need to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy. SOCIAL MEDIA: FRIENDING: Per the NASW Code of Ethics policies we cannot accept friend or contact requests from current or former clients on social networking sites (i.e.-Facebook, LinkedIn). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. Should anyone that becomes a client have a preexisting connection on a social media account with the provider, the dynamics of this will be discussed and may potentially disconnect in this manner. SOCIAL MEDIA "FOLLOWING AND FANNING": At this time we have a Facebook and Pinterest Page found at the nonclinical business named Solutions 4 Wellness, Inc. to post psychology and motivational information and news, share blogs and to allow people to share blog posts and practice updates with other Facebook users. If you, a client, chooses to "like" our professional pages on social media, this may create a greater likelihood of compromised client confidentiality and the NASW's Code of Ethics prohibits soliciting testimonials from clients and we in no way or looking to solicit any endorsement from any current or previous therapy clients. We have no expectation that you as a client will want to follow our blog, Facebook Page or Pinterest page. However, if you use an easily recognizable name and we happen to notice that you've followed us at any of these locations, we may briefly discuss it and its potential impact on our working relationship. Note that you should be able to subscribe to the page via RSS without becoming a Fan and without creating a visible, public link to our Page. SOCIAL MEDIA: ELECTRONIC COMMUNICATION: We will avoid communication with clients using technology (such as social networking sites, online chat in addition to e-mail, text messages, telephone and video) for personal or non-work related purposes. If communication through any of these electronic means occurs, we will only communicate about business tasks, i.e.-appointments. We will never share any identifying or confidential information about our clients on any of these platforms.

LITIGATION DISCLOSURE AGREEMENT: If you are involved in litigation or become a party to litigation, you agree that you will not call your therapist at The Anxiety & Stress Relief Center, PLLC to testify or release records of service. As a treating therapist, the role is to provide treatment and not make recommendations to courts in legal matters. It is our policy not to testify in court cases because experience has shown that the professional relationship is often harmed when therapists testify. However, we will always respond according to the law. In domestic litigations, such as divorce and custody disputes, courts can appoint professionals who have no prior contact with a family to conduct custody evaluations and to make recommendations to the court. We agree the goal is to provide treatment to help improve client emotional and mental health needs of and to maintain and protect their right to confidentiality. By signing below, you are consenting to treatment by a contracted therapist of The Anxiety & Stress Relief Center, PLLC and you agree not to call your treating therapist or any contracted therapist of The Anxiety & Stress Relief Center, PLLC as a witness in litigation matters. You also agree not to requests any letters of support or therapy notes for judges or attorneys to review or utilize in any litigation matter. (Conjoint and Family session, all adults sign.

LIMITS OF CONFIDENTIALITY: As your therapist, I am committed to protecting your privacy. However, there are certain situations where I may be required by law to disclose information without your consent:

1. If you present an imminent risk of serious harm to yourself or others.
2. In cases of suspected abuse, neglect, or exploitation of a child, elderly person, or person with disabilities.
3. If you are involved in a court proceeding and information is requested by a valid court order.
4. In the event of your death or disability, with the written consent of your personal representative or beneficiary or as determined by legal statutes.
5. If you file a complaint or lawsuit against this agency or provider.
6. When required by law to report information related to the investigation of child, elder, or dependent adult abuse
7. To appropriate persons in the case of a health emergency.

In all other situations, I will obtain your written permission before disclosing any information about you.
Please note that in group therapy settings, while I am bound by confidentiality, other group members are not legally required to maintain confidentiality, although the parameters of explaining and requesting each member to maintain privacy will occur at the onset of a group. as as needed. If you have any questions about confidentiality, please feel free to discuss them with me.

EMERGENCIES: **In a crisis, the best number to call is 911 or go to the nearest emergency room**. Calling 988 for assistance is one additional option. Once the doctor has seen you, please call to inform your therapist. Please leave a message, if we cannot answer.

DUTY TO WARN: I designate the following people to be contacted if I am in danger:

NAME/RELATIONSHIP_____ PHONE NUMBER:_____

PLEASE INITIAL EACH SECTION TO VERIFY THAT YOU HAVE READ, ASKED ANY QUESTIONS FOR CLARITY AND ARE IN AGREEMENT WITH EACH SECTION OF THIS INFORMED CONSENT.

_____ CONSENT TO TREAT AND CONFIDENTIALITY: I acknowledge that I have received a copy of The Anxiety & Stress Relief Center, PLLC's Notice of Privacy Practices. I have had an opportunity to review it and discuss any questions with my therapist. I understand that I may request an additional copy at any time. My signature below indicates my receipt and review of this Notice

_____ I understand that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I realize that my account may be sent to a collection agency after it is 60 days past due. The only information shared with a professional collection service is my contact information, date of birth, services rendered, dates of treatment and charges incurred. All clinical notes will not be shared in order to collect a debt.

____ I have read, understand and agree to the stipulations of the Informed Consent, Treatment Agreement, Contract and Financial Agreement and The Litigation Disclosure Agreement and I have asked for clarity on any part that I did not clearly understand.

____ I agree to waive all rights and claims against The Anxiety & Stress Relief Center, PLLC and my provider both jointly and severally from damages arising from me assuming the risk of exposure to the coronavirus or other infectious disease by coming int the office for in person sessions.

____ I HAVE READ THE STATEMENT OF UNDERSTANDING/INFORMED CONSENT, AND AGREE TO COMPLY WITH ALL OF THE POLICIES AND PROCEDURES OF THE PRACTICE OF THE ANXIETY & STRESS RELIEF CENTER, PLLC

_____ I have been offered and received a copy of this informed consent to refer back to. I don't have to accept the copy. If a copy, either digital or paper is overlooked at the intake process, I agree to ask for it.

Client PRINTED NAME:_____

Client Signature (age 12 & over): _____ Date: _____

IF CLIENT IS A MINOR:
Client's Parent/Guardian Signature: _____ Date: _____

Client's Parent/Guardian Signature: _____ Date: _____

Mailing Address: 110 N. Main St, Breese, IL 622331 Phone: 618.322.6424, Fax: 618-227-8227 E-Mail: office@solutions4wellness.com

Treating Therapist Signature: _____ Date: _____

Christina Diesen, LCSW

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The Anxiety & Stress Relief Center, PLLC
Mailing Address: 110 N. Main St, Breese, IL 622331 Phone: 618.322.6424, Fax: 618-227-8227 E-Mail: office@solutions4wellness.com

PAYMENT/INSURANCE VERIFICATION FORM

Choosing to bill for counseling sessions through your insurance carrier is an important decision you must make. According to federal regulations, you may choose to 'opt', pay out-of-pocket, and **NOT bill through your insurance policy**. Clients who 'opt' are private pay clients. Should this be your preference, The Anxiety & Stress Relief Center, PLLC would **NOT have the authorization to share your records with your insurance company**. The decision made at the outset of services regarding payment of services is changeable at any time by completing a new form and updating your file. However, the fee or payment option is not retroactive and only changes for subsequent sessions.

Knowing your out-of-pocket expenses prior to receiving services is your right and your responsibility.

Please select only one of the options below: (PICK OPTION 1 + A, 1 + B OR OPTION 2)

☐ **OPTION 1:** I choose to be designated as a **private pay client** at The Anxiety & Stress Relief Center, PLLC. I will pay for sessions out of pocket with cash, check, or credit card, which I will keep a card updated on file with a HIPPA complaint payment platform with The Anxiety & Stress Relief Center, PLLC, in accordance with my signed contract for services. I understand that my provider **is either not** in network with my insurance, is in-network and I am requesting to not use my insurance or I do not have insurance to bill, and I choose to be designated as a **private pay client**. I understand that I am responsible for co-pays, deductible payments, or any portion of the session fees not covered by my plan. I grant this permission to be effective as of the date of my signature and witnessed by a representative of The Anxiety & Stress Relief Center, PLLC. As a courtesy we may be able to submit electronic billing to your insurance provider. How you choose to proceed with this is:

CHOOSE 1 OPTION:

☐ **A.** I do not authorize the Anxiety & Stress Relief Center, PLLC, its agents or employees, to share my private information with my insurance company. OR, I do not have health insurance to submit claims to on my behalf. I can receive a super bill to submit for out of network coverage if I request one. OR, if

☐ **B.** I authorize the Anxiety & Stress Relief Center, PLLC, its agents or employees, to share my private information with my insurance company on my behalf to save me from submitting the claims as an out network benefit. I understand that this does not in any way constitute an agreement between the Anxiety a& Stress Relief Center, PLLC and my health insurance.

☐ **OPTION 2:** I choose to **bill my insurance company** for mental health services. I understand that if my provider at The Anxiety & Stress Relief Center, PLLC is in-network with my carrier, my rates may be discounted in accordance with their business contract. I understand that The Anxiety & Stress Relief Center, PLLC and my insurance company can terminate network contracts at any time and neither is required by law to inform me of this change. However, The Anxiety & Stress Relief Center, PLLC will make every effort to communicate any contractual change via letter, telephone call or in person and understand that this change will affect my financial responsibility for subsequent sessions. I authorize the release or exchange of information from The Anxiety & Stress Relief Center, PLLC to my insurance company, EAP, managed care group, and/or other paying organization to facilitate payment and continued coverage under the mental health benefit of my policy. I consent to have The Anxiety & Stress Relief Center, PLLC submit claims on my behalf to my insurance company, EAP, managed care group, or other paying organization and receive payment according to the guidelines of my policy. I understand that I am responsible for payment for services rendered by The Anxiety & Stress Relief Center, PLLC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify The Anxiety & Stress Relief Center, PLLC as soon as I am aware of any changes in my health condition or health plan coverage.

CLIENT PRINTED NAME: ___ _____

_____ _____

CLIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

EMPLOYEE/AGENT SIGNATURE **DATE**

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name: _____Date of Birth: _____

I hereby acknowledge that I have receive and have been given an opportunity to read a copy of Anxiety and Stress Relief Center, PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or of my privacy rights, I can contact Christina Diesen, Privacy Officer at (618) 322-6424 or office@solutions4wellness.com.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent/Guardian Date

_____ Patient/Client Refuses to Acknowledge Receipt of Privacy Practices

_____ _____
Signature of Staff Member Date