made well
center for wholeness

Online Therapy Client Intake Form

Demographic Information

Name: _____ Date of Birth: _____

Legal Guardian (if applicable):_____

Address:_____

Phone Number: _____ **Email Address:** _____

How did you hear about us:_____

Services you are interested in receiving? ( ) Online Therapy ( ) Private Yoga Sessions

Average Annual Income: _____ **Reason for needing Tele-Therapy:** _____
_____

Emergency Contact:

Full Name: _____ Phone number: _____

Relationship: _____

Medical/Mental Health History

Main Concern to Address in Treatment:_____
_____

Symptoms you are experiencing:_____
_____

Primary Physician:_____ Phone: _____

Exercise Type and
Frequency:_____

Allergies:_____
_____

Current Medications, Vitamins, or Supplements:_____
_____

Previous diagnoses/treatment:_____
_____

Previous medications:_____
_____

What type of work do you do and how does it impact your concerns:_____
_____

Level of Education. If you are currently a student, please describe:_____
_____

Type and frequency of any alcohol and/or drug use:_____
_____

Caffeine amount and frequency:_____

Family History of Mental Health Issues:_____
_____
_____

Current Relationship Status:
☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership

☐ Boyfriend ☐ Girlfriend ☐ Single ☐ Other:_____

Do you have children, if so what are their names and ages:_____
_____
_____

Anything else you want the provider to know:_____
_____
_____

MADE WELL CENTER FOR WHOLENESS OFFICE POLICIES

COURT: The provider does not make court appearances. They do not assist clients in divorce or custody litigation, writing court reports, making recommendations to the court, or testifying for or against clients in a court of law. If, under some unforeseen circumstance, a provider does go to court on a client's behalf, the rate for each provider is $350 dollars an hour including travel time which is the client's responsibility.

WORKING WITH MINORS: Due to the importance of trust between client and therapist, when the client is a minor child (under 18), we will offer parents general information about the therapeutic process and overall themes, but not specific details about what information is exchanged during each session. If at any time we feel that your child is engaging in dangerous behavior, we will immediately inform you of the situation or have your child do so as a part of the therapeutic process. We will not provide you updates after each session. If you need to speak with your therapist regarding your child, please either call or email to discuss any issues. It is important that your child feel that our office is a safe place where he or she can trust the therapist enough to share the sensitive things that may be underlying the presenting problem. We are sensitive to a parent's need to be involved in the process, however this should be balanced with the child's need for a safe place.

CANCELLATIONS: Missed appointments without at least 24 hours' notice will result in a $50 fee billed to the client. We will attempt to send reminders, but ultimately your scheduled appointments are your responsibility. If you are late 15 or more minutes from the time of your scheduled appointment, the provider has the right to consider this a late cancellation and charge you the $50 late cancellation fee.

TERMINATION: Following 3 no-shows or late cancellations, a patient may be terminated as a client. In addition, any patient who engages in inappropriate behavior in the office will immediately be terminated as a client. If a patient is terminated, we will supply them with appropriate referrals to other agencies that can address their mental health and other need.

RETURNED CHECKS: A $50 fee will be applied for any returned checks written.

DOCUMENT/DISABILITY PAPERWORK FEES: We will do what we can to support our patients and provide you with whatever paperwork you need. Our providers do not fill out disability forms, but we will be able to provide clinical documents to agencies or providers with appropriate written consent. For letters and other paperwork there will be a $25 charge per 15 minutes.

TREATMENT PLAN REQUESTS: Patients have the right to request a copy of their individualized treatment plan. This can be requested in writing to your therapist and will be provided to you within 2 business days.

ELECTRONIC COMMUNICATION: I give the provider permission to contact me via e-mail, phone and mail via the contact information on my intake form. I agree to receive text and email message reminders of appointments at the phone number on my intake form.

INDEPENDENT CONTRACTORS: MADE WELL CENTER FOR WHOLENESS is a group of independent contractors, not employees. Each provider sets their own hours, rates, and services. By signing this form, you are acknowledging that MADE WELL CENTER FOR WHOLENESS is not responsible for any services or behaviors of the contractor you are working with. The contractor is solely responsible for your services and care. However, MADE WELL CENTER FOR WHOLENESS wants to provide the best customer service available, so if you have any questions or concerns please email buffy@madewellcenter.org

PAYING WITH INSURANCE: If you chose to utilize insurance benefits for the cost of counseling or another service, the provider will attempt to verify my insurance benefits, however, any information given to me by the provider is not a guarantee of coverage. I agree to pay the appropriate copays and deductibles at time of service. I give my permission to the provider to bill my insurance company on my behalf for services rendered if the provider is an in-network provider of my policy at the time of services rendered. I understand that the provider will not send billing statements to insurances policies if he/she is out of network, but that I can request he/she print my statements so I can submit the statements to the insurance company myself. I understand that if my insurance does not cover all or part of any service I receive for any reason that the remaining balance will be my

responsibility to pay within 30 days of the services rendered.

PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. We accept cash, checks made out to "Made Well Center for Wholeness" or credit cards. If you do not pay in full at the time of service you can log in to your client portal and make a secure payment via credit card at any time. If you chose not to use insurance benefits or insurance is not available to you for a service you utilize at Made Well Center for Wholeness, you can pay the service rate of $120 per session. Some providers offer sliding scale fees based on yearly salary; please ask for more details. Clients that have outstanding balances for longer than 30 days will not be permitted to schedule further appointments until these balances are paid. Balances remaining after 60 days following reasonable efforts to collect will be turned over to a collections agency unless arrangements are made with your provider to pay the balance.

CAMERA: By signing this intake packet, you are acknowledging that you are aware of and give permission to Made Well Center for Wholeness to have a video camera in the waiting room and hallway. This camera is for security and safety purposed only and will only be reviewed by Made Well Center for Wholeness providers. Footage of you will never be released to anyone outside of Made Well Center for Wholeness under any circumstances outside of police investigation if these circumstances arise.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you can request a copy of HIPPA Notice of Privacy Practices at any time or access a copy on our website at www.madewellcenter.org.

By signing I acknowledge and agree to the above office policies.

_____	_____	
Client Name	Client Signature	Date
_____	_____	
Legal Guardian Name	Legal Guardian Signature	Date

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INFORMED CONSENT TO RECEIVE PSYCHOTHERAPY

GENERAL INFORMATION: The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

THE THERAPEUTIC PROCESS: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY: The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm. 2. If a client threatens grave bodily harm or death to another person. 3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years. 4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses. 5. Suspected neglect of the parties named in items #3 and # 4. 6. If a court of law issues a legitimate subpoena for information stated on the subpoena. 7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

If I decide that another service, provider, or agency will better fit your needs for mental health treatment, I will provide you the names and information to the service I am referring you to.

By signing I acknowledge and agree to the above informed consent for psychotherapy with:

_____ *(Provider's Name and Credentials)*

_____	_____	
Client Name	Client Signature	Date
_____	_____	
Legal Guardian Name	Legal Guardian Signature	Date

TELEMENTAL HEALTH SESSIONS

Made Well Center for Wholeness offers Telemental Health Services for those wishing to utilize them. That means that you can choose to do your session on video chat versus coming into the office. This is completely optional but may be beneficial if you struggle to find childcare, are traveling, or move to another area in North Carolina.

1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The potential benefit of Telemental health services is that I will be able to talk with mental health staff today from this local setting for an evaluation of my needs. When appropriate, I will be able to participate in mental health services.
3. The potential risk of Telemental health services is that there could be a partial or complete failure of the equipment being used which could result in mental health staff's inability to complete the evaluation and/or mental health services.
4. There is no permanent video or voice recording kept of the Telemental health service's session.
5. All existing confidentiality protections apply.
6. All existing laws regarding client access to mental health information and copies of mental health records apply.
7. Dissemination of client identifiable images or information from the Telemental health interaction to researchers or other entities shall not occur without the consent of the client.

By signing this, I consent to Telemental health services with my Made Well Center for Wholeness provider if I chose to. My mental health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above.

_____	_____	_____
Client Name	Client Signature	Date
_____	_____	_____
Legal Guardian Name	Legal Guardian Signature	Date