Wellness Counseling & Therapy Services
Don't Let Your Mind Be An Obstacle

www.wellnesscounselingclinic.com
Phone: 630-214-4000
Email: info@wellnesscounselingclinic.com

## CLIENT INTAKE FORM

Date: _____/____/ _____

### GENERAL INFORMATION

Client's Last Name: _____First Name: _____ MI _____

Guardian/Parent(s) (if under 18): _____

Client's Date of Birth: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (House)_____(Cell)_____ (Email)_____

May Wellness Counseling & Therapy Services, Inc. communicate with you via SMS text messages and emails regarding your appointments, treatment, and other related information?

☐ YES. And I understand and acknowledge that there may be risks associated with sending information in an unencrypted email or text message such that the information may be read by an unintended third party; however, Wellness Counseling & Therapy Services, Inc. ensures that it take steps to send only limited information to you via email and text.

☐ NO. I do not wish to be contacted by SMS text message or email.

How were you referred to Wellness Counseling? ☐ Insurance ☐ EAP ☐ School ☐ Friend ☐ Psychology Today

☐ Good Therapy ☐ Yelp ☐ Physician _____ ☐ Other _____

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### EMPLOYMENT/EDUCATION

Current Employment: _____ Student ☐ Yes ☐ No

Job Title: _____ Number of months/years at current job: _____

Highest education completed: ☐ High school/GED ☐ Some college ☐ College Graduate/other

Current Grade in School (Children and Adolescents Only): _____ School: _____

### FAMILY INFORMATION

Relationship Status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If you have children or siblings, please list their names and ages:

Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

Emergency Contact (Name/Phone/Relationship to you):
_____

**MEDICAL/PSYCHOLOGICAL HISTORY**

Date of last physical: _____/____/ _____

Are you experiencing any physical illnesses or symptoms at this time? ☐ Yes ☐ No

List any major surgeries or illnesses: _____

List current medication(s) and dosage(s): _____

Have you received psychotherapy or counseling in the past? ☐ Yes ☐ No If yes, when _____

Name of therapist: _____

Name of agency: _____

Have you ever been on any psychiatric medication? ☐ Yes ☐ No If yes, when? _____

Name of medication(s) and dosage(s): _____

Name of psychiatrist: _____ Name of agency: _____

**CURRENT SYMPTOMS**

What is your reason for seeking counseling now? _____

Please check any of the following symptoms/conditions you or your child is experiencing at this time:

| | | |
|---|---|---|
| ☐ Suicidal thoughts<br>☐ Fatigue<br>☐ Sadness<br>☐ Anxiety<br>☐ Racing thoughts<br>☐ Irritability<br>☐ Poor appetite<br>☐ Difficulty sleeping<br>☐ Weight loss/gain<br>☐ Rapid Heart beat<br>☐ Dizziness<br>☐ Stomach trouble<br>☐ Headaches | ☐ Sleep disturbances<br>☐ Learning difficulties<br>☐ Self-esteem<br>☐ Co-dependency<br>☐ Hyperactivity<br>☐ Impulsivity<br>☐ Loss of hope<br>☐ Anger<br>☐ Poor concentration<br>☐ Stress<br>☐ Loneliness<br>☐ Nightmares<br>☐ Muscle tension<br>☐ Too much energy | ☐ Financial issues<br>☐ School problems<br>☐ Domestic Violence<br>☐ Substance use/abuse (self)<br>☐ Substance use/abuse (family or friend)<br>☐ Partner relationship issues<br>☐ Coping with divorce<br>☐ Grief and loss<br>☐ Sexual problems<br>☐ Others (List)<br><br>_____<br><br>_____ |

| | | |
|---|---|---|
| ☐ Sexual, physical, emotional abuse<br>☐ Self-injury<br>☐ Mood instability<br>☐ Parenting issues | ☐ Flashbacks<br>☐ Frequent worrying<br>☐ Work/job problems | _____ |

What would you like to see happen as a result of counseling?

_____

_____

_____

**BILLING & INSURANCE INFORMATION**

Will you be using insurance? ☐ Yes ☐ No

Insurance Company: _____ID#: _____

Group#: _____ Provider Services phone #: _____

Subscriber Relationship to Client: ☐ Self ☐ Spouse ☐ Parent (Please complete below if other than self)

Subscriber Name: _____ Subscriber's Date of Birth: ____/____/_____
Address of Subscriber (If different than above):

_____

City: _____ State: _____ Zip: _____

**SECONDARY INSURANCE (if applicable)**

Insurance Company: _____ ID#: _____

Group#: _____ Provider Services phone #: _____

Subscriber Relationship to Client: ☐ Self ☐ Spouse ☐ Parent (Please complete below if other than self)

Subscriber Name: _____ Subscriber's Date of Birth: ____/____/_____

Address of Subscriber (If different than above): _____

City: _____ State: _____ Zip: _____

**CANCELLATION & RETURNED CHECK POLICIES**

• Due to the nature of counseling services, we never overbook our schedules; therefore, we request 24-hour notification of cancellation so that others may utilize that time. As a result, we charge a **$75 cancellation fee** when we do not receive this notice within 24 hours of your scheduled appointment time. Insurance companies will not cover payment for missed appointments. Full payment for the missed session is due within one week.

• There will be a $25 services charge on all returned checks.

## CONFIDENTIALITY

The confidentiality of your personal and health information is important to us. Legal and ethical standards require us to maintain confidentiality. Please review the attached HIPAA Notice of Privacy Practices form to understand how we will keep your health information confidential, and how we may use and disclose your health information as permitted or required by law. If your counselor receives clinical supervision, she or he will inform you of that specific process. If you are here with family members, your therapist will discuss expectations and limitations of confidentiality.

## NOTICE OF PRIVACY PRACTICES

### HIPAA NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Wellness Counseling & Therapy Services, Inc. (WCTS) respects client confidentiality and only uses and discloses protected health information (PHI) about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes policies related to the uses and disclosures of your health information.

**USES AND DISCLOSURES OF YOUR PHI THAT DO NOT REQUIRE YOUR PRIOR AUTHORIZATION**

In order to effectively provide you care, there are times when Wellness Counseling & Therapy Services, Inc. will need to use and disclose your PHI for certain purposes without your authorization. Typically, we use and disclose your PHI in the following ways:

**Treatment:** Wellness Counseling & Therapy Services, Inc. may use or disclose your PHI to provide, manage or coordinate your treatment, care or related services, which could include consultants and potential referral sources.

**Payment**: Wellness Counseling & Therapy Services, Inc. may use and disclose your PHI to obtain payment for services provided. This may include contacting your insurance company or a third party to verify coverage and/or benefits, to process your claims, and to collect payment. For example, Wellness Counseling & Therapy Services, Inc. may disclose the minimum amount of your PHI to a collection agency to obtain payment for services provided which have not been paid. With all uses and disclosures related to payment, we will use and disclose only the minimum necessary amount to achieve the intended purpose.

**Healthcare operations:** Wellness Counseling & Therapy Services, Inc. may use and disclose your PHI as necessary to support our business activities including, but not limited to, quality assessment activities, employee review and training activities, licensing and other legal activities, and conducting or arranging for your treatment. For example, we may disclose your PHI to an attorney if a legal matter related to Wellness Counseling & Therapy Services, Inc. arises. With all uses and disclosures related to health care operations, we will use and disclose only the minimum necessary amount to achieve the intended purpose.

**WE MAY ALSO USE AND DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION, FOR THE FOLLOWING PURPOSES:**

**Victims of Abuse or Neglect**: We may use and disclose PHI about you if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

**To Avert a Serious Threat to Health or Safety**: We may use and disclose your PHI when necessary to prevent a serious threat or death to your health and safety or the health and safety of the public or another person.

**To Communicate with Individuals Involved in Your Care or Payment for Your Care**: We may disclose your PHI to a family member, close personal friend, or any other person you identify as being directly related with the involvement in your care or payment related to your care. Additionally, we may disclose PHI to your "personal representative." If a person has the authority by law to make health care decisions for you, we will generally regard that person as your "personal representative" and treat him or her the same way we would treat you with respect to your PHI.

**Worker's Compensation:** To the extent necessary to comply with law, we may disclose your PHI for worker's compensation or other similar programs established by law.

**Public Health**: We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including the FDA. In certain circumstances, we may also report work-related illnesses and injuries to employers for workplace safety purposes.

**Health Oversight Activities:** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

**Law Enforcement**: We may disclose your PHI for law enforcement purposes as required or permitted by law, or if a crime is committed on the premises of Wellness Counseling and Therapy Services.

**Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute with certain satisfactory assurances.

**WE MAY USE AND DISCLOSE YOUR PHI ONLY WITH YOUR PRIOR AUTHORIZATION, FOR THE FOLLOWING PURPOSES:**

**Other Uses and Disclosures:** We will obtain your written authorization before using or disclosing your PHI for purposes other than those described in this Notice or otherwise permitted by law. You may revoke your authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI.

**YOUR HEALTH INFORMATION RIGHTS**

You have a right to the following:

**Obtain a copy of this Notice upon request**: You may request a copy of this Notice at any time. You may obtain a copy at the site where you obtain health care services from us or by contacting the Privacy Officer.

**Request a restriction on certain uses and disclosures of PHI**. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Officer. We are not required to agree to the restrictions, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations and the PHI pertains solely to a health care item or service for which you, or a person on your behalf, has paid in full out-of-pocket.

**Inspect and obtain a copy of PHI:** With a few exceptions, you have the right to access and obtain a copy of the PHI that we maintain about you. If we maintain an electronic health record containing your PHI, you have the right to request to obtain the PHI in an electronic format. To inspect or obtain a copy of your PHI, you must send a written request to the Privacy Officer. You may ask us to send a copy of your PHI to other individuals or entities that you designate. We may deny your request to inspect and copy in certain limited circumstances, for which we will explain the denial. If you are denied access to your PHI, you may request that the denial be reviewed by another person within Wellness Counseling.

**Request an amendment of PHI:** If you feel that the PHI we maintain about you is incomplete or inaccurate, you may request that we amend it. To request an amendment, you must send a written request to the Privacy Officer. You must include a reason that supports your request. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it, and you have the right to send us a statement of disagreement of why you disagree with our denial. Your statement of disagreement will be kept and filed with the rest of your PHI that we maintain about you.

**Request communications of PHI by alternative means or at alternative locations**. You have the right to request that we communicate with you about your PHI in a certain way or at a certain location. For example, you may request that we contact you at a different residence or post office box. We will accommodate all reasonable requests. Please note if you choose to receive communications from us via e-mail or other electronic means, those may not be a secure means of communication and your PHI that may be contained in our e-mails to you will not be encrypted. This means that there is risk that your PHI in the e-mails may be intercepted and read by, or disclosed to, unauthorized third parties. To request confidential communication of your PHI, you must submit a request in writing to the Privacy Officer.

**Notification of a Breach**: You have a right to be notified following a breach of your unsecured PHI, and we will notify you in accordance with applicable law.

**Contact:** You may submit written requests to the Privacy Officer at info@wellnesscounselingclinic.com or by telephone at 331-704-0884. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer of Wellness Counseling & Therapy Services, Inc. or with the Secretary of Health and Human Services at the Office for Civil Rights at 200 Independence Avenue SW, Washington, DC 20201. There will be no retaliation for filing a complaint.

## ACKNOWLEDGEMENT OF RECEIPT:

I acknowledge that I received WCTS currently effective HIPAA Notice of Privacy Practices, and that WCTS must provide me with an electronic copy of the HIPAA Notice of Privacy Practices should I request it.

## CLIENT OR AUTHORIZED PERSON'S SIGNATURE

- I authorize the release of any medical or other information necessary to process this claim.
- I authorize payment of medical benefits to Nabeela Choudry, LCPC on behalf of Wellness Counseling & Therapy Services, Inc. for services rendered.

• **I accept the financial responsibility of any balance remaining on my account after my insurance company has Processed the claim. I also accept the financial responsibility if my insurance does not cover the services rendered or I don't have an insurance plan.**

Signature of Client (or authorized person) _____ Date: _____/____/ _____

If authorized signer, relationship to client_____ Date: _____/____/ _____