Grace Wellness Center

Guidance. Empowerment. Freedom.

Counseling Intake Form (Adult)

Date of Intake: ________________________ SS#:___________________________

Name of Caller: _______________________ Relationship to Client: ___________________

Name of Client:____

Address:____

Street City State/Zip

Phone: __________________ Cell: __________________ Email: _______________________

Gender: _________Age: _______Birth date: _________ Marital Status: ________

Insurance Provider: __________________ Primary Insured: _________________

ID Number: _________________________

Insurance Phone #: __________________MH Coverage (Y/N): ____ Co-Pay: ____

Presenting Issues: ____

____

____

Location: _________________________ Counselor:______________________________

Education: Last Grade Completed: __ College: __ Graduate School: ___Occupation:_____

Children: Name: ______________ Age: ____ In/Out of Home His/Hers/Ours/Other

Name: ______________ Age: ____ In/Out of Home His/Hers/Ours/Other

Name: ______________ Age: ____ In/Out of Home His/Hers/Ours/Other

Others living in the home:____

Referred to Grace Wellness Center By:____

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BRIEFLY ANSWER THE FOLLOWING QUESTIONS:

1. Please describe the current problem for which you are seeking counseling:

2. What have you attempted to do to alleviate the problem (if anything)?

3. What do you hope to achieve through the counseling process? Briefly list two or three goals:

4. Have you sought other outside help? If so, from whom?

5. Who is your current Primary Care Physician and when was the last time you saw him/her?

6. Please list any pertinent/relevant medical conditions or medications you are currently taking:

CHURCH AFFILIATION

1. Are you a believer in Jesus Christ? YES NO (Circle one)
2. Please explain how one reaches heaven as you understand in the space provided below:

3. Are you a member of a local church? YES NO (Circle One)
4. If so, how long have you attended this church? _____
5. Do you believe being an active part of a community of believers is important to reach your goals in counseling? Why or why not?

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ASSESSMENT

1. Please check all the following that apply to you at this time:

___ I feel depressed
___ I feel anxious
___ I have mood swings
___ I struggle with my parents
___ I am having marital problems
___ I struggle with my in-laws
___ I have children
___ I struggle as a parent
___ I abuse alcohol
___ I use illegal drugs
___ I use prescription drugs
___ I abuse prescription drugs
___ I view pornography
___ I struggle sexually
___ I feel hopeless
___ I feel fearful
___ I feel angry
___ I struggle with anger
___ I am a poor communicator
___ I feel sad
___ I struggle with bitterness
___ I feel worthless
___ I do not attend church regularly
___ I do not read my Bible often
___ Jesus is important in my life
___ I don't think about Jesus much
___ I strongly fear rejection
___ I have been sexually abused
___ I have been physically abusive
___ I have been verbally abused
___ I have been sexually abusive
___ I have been physically abused
___ I have been verbally abusive
___ I am a respectful wife
___ I am a loving husband
___ I have felt unsafe in past relationships
___ I am currently or have been suicidal or had suicidal thoughts
___ I feel unsafe in one or more current relationships

Is there anything else about your medical history, mental health history, or health and safety issues that you would like to tell us about?

____

____

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Provider/Client Service Agreement and Treatment Contract

Welcome to The Grace Wellness Center. This document addresses many important aspects of therapeutic treatment such as specific information about my services and my practices, as well as more generalized information concerning your rights and privacy as a client as outlined in HIPAA and HITECH laws that most professionals follow. Although this document may be long and have a lot of information that you may have seen before, it is important that you review the entire document, and sign off on the appropriate signature lines. If at any time during treatment you have any questions about this document, we can review it together in session. Signing this document serves as an agreement between us, however we can revisit or discuss aspects of this document at any time during treatment.

Psychological Services:
Therapy is difficult to define concisely, but generally refers to a relationship between a professional and a client that has clearly defined boundaries and rules, with outlined goals to be completed or issues to be discussed during time of treatment. As a client in the therapeutic relationship, you have many rights and responsibilities that may be maintained throughout treatment. I too as the provider must adhere to certain responsibilities, and our respective rights and responsibilities are listed throughout the document.

Risks and Benefits:
Psychotherapy has both benefits and risks associated with treatment. Risks typically center around negative feelings that are brought up in conjunction with discussing situations or memories, such as sadness, guilt, anger, frustration, or stress. Because therapy often deals with discussing somewhat uncomfortable topics, these feelings are prone to arise. The goal would be to work through these feelings together as a team, and minimize the risks while maximizing the benefits gained through therapy. Benefits may include reduction in current symptoms such as feelings of anxiety, anger, or depression. They may also include increased coping skills to handle situations, relationships or feelings occurring presently or in the future. Lastly, therapy may allow you to resolve some past issues or feelings in an effort to move on in your journey. There are no guarantees that these benefits will occur, and if at any time you feel that the risks of therapy are outweighing the benefits, we can discuss and readjust our treatment process.

Therapeutic Style and Appointments
As counselors, we tend to utilize various treatment styles and approaches, often integrating various techniques and tools. Essentially, therapy is centered on you, the client, in an effort to best address your needs. We will be completing a plan of action near the beginning of our relationship that we will be checking in on throughout our work, and this plan will largely be generated by you. If you

have any further or specific questions concerning my treatment style, please feel free to ask me at any time throughout treatment.

Initial intake appointments are typically 60 minutes long, and in this appointment we will review all initial paperwork, and discuss the details of therapy. We will also establish a scheduled appointment time for future dates if possible. Subsequent sessions typically last between 50-60 minutes, and will take place at the same office as the intake, unless noted. *If you cannot attend your allotted time slot, or wish to reschedule, please provide me with 24 hours notice. If you do not provide me with 24 hours notice, barring any unforeseen emergencies, you will be responsible for a "No-Show Fee" that will be determined upon our first session.* Lastly, you are responsible for respecting the time constraints of our sessions. If you are late to a meeting, the scheduled end time will still be upheld.

Professional Fees

The standard fee for the Intake appointment is $130.00 and all subsequent appointments will be charged at $120.00, unless otherwise discussed before treatment. You are responsible for payment at time of service, unless previous arrangements are made, and maybe paid by cash, credit card, or check. If there are other services that you may incur during treatment such as report writing, telephone calls lasting longer than 15 minutes, or attending of meetings you have requested, we will discuss a fee for that before the service is completed. If a court case comes up that requires my involvement with this case, we will thoroughly discuss options and my involvement. If you know of potential court involvement before we begin therapy, please notify me as this deals with your confidentiality. You will be responsible for fees that come with court time if we get to that as well. If your balance exceeds $500 without being paid, we will need to suspend services until the balance is met.

Cash Services (Including Thrive Coaching or Telehealth Counseling):
For those individuals who either do not have insurance or has an insurance plan that may not be accepted by a certain therapist, we offer cash rates that are discounted. The rate for our cash services is $95.00 for a full session, and $50.00 for half of a session. Additionally, we offer a sliding scale option for those who are unable to afford the $95 rate. The sliding scale rate is determined on a case by case situation and each therapist will discuss this rate with you personally. For those who are conducing therapy via phone or online due to the inability to meet face to face, the rates for this type of service is $75.00 for a full session, and $40.00 for half a session. A half session is considered 30 minutes or less, while a full session is considered 31 minutes up to 60 minutes.

Insurance:
If you have health insurance that I participate with as a provider that covers your treatment, we are able to bill our treatment dates to that insurance for reimbursement. With your permission, my

billing associate and I will assist you in understanding the insurance billing process and sending your claims to your insurance to be billed accordingly. We will assist you if possible, but it is ultimately your responsibility to know the details of your Insurance plan such as copayment or coinsurance amount, deductible amount and progress, sessions approved per year, and yearly renewal time. If you choose to utilize insurance, insurance companies do require me to provide them with certain pieces of information in order to be properly reimbursed. Such information typically includes your name, a diagnosis, a date of service, and session length in minutes. Occasionally, insurance companies may need more information such as treatment plans or goals, or copies of records. If the insurance company requires extensive information, you will be made aware of this. Insurance companies are mandated to abide by the same privacy laws outlined in HIPAA and HITECH, but once your information is sent to the company, I am no longer responsible for said information. Occasionally, as a client you may need assistance filing a grievance if your insurance company refuses to pay. If our billing department is able to help you with this, we will do our best. If not, it is your responsibility to contact the appropriate person at your insurance company.

If your insurance requires you to pay an amount such as a copayment, coinsurance, or dollar deductible amount, that will be collected at time of service as well. If you have questions about your insurance plan, we can discuss them at our first meeting. By signing below this segment, you are authorizing me to provide the insurance company with the information needed to properly bill your insurance.

Contacting Me:
As most professionals will be seeing clients most days, it is unlikely that you will be able to reach us immediately by using our work number. If the message is not urgent or emergent, such as calling to cancel, calling to reschedule, or calling to check on an appointment time, you are encouraged to call my work phone and leave a message. I will check this message between client times, and contact you back within 24 hours to confirm the message. If for any reason you cannot contact me directly, or have not heard back from me for a non-urgent matter, you are encouraged to call our main office line (724) 863-7223 and leave a general message or speak to the administrator on call.

Emergencies:
In the event of an emergency, please first either go your emergency room or call 911 and ask to speak to the mental health worker on call. You may also need to contact your Primary Care Physician's office, or, if you feel you are unable to keep yourself safe, contact either **Allegheny County 1-888-796- 8226 (1-888-7-YOU-CAN) or Westmoreland Crisis Mobile / Phone 1-800-836-6010,** depending on your county. I will make every possible attempt to make you aware of unplanned absences on my part. If the absence will be extended, I will also provide you with an interim mental health professional in my practice as a contact for you. You may also contact the main office at 724-863-7223 if appropriate.

Confidentiality
Confidentiality is of utmost importance in a therapeutic relationship, and in order for progress to be made, confidentiality must be upheld and maintained throughout your treatment. Generally speaking, all of our communication is protected by Law and reinforced by the ethics code by which I abide, (specifically outlined in the ACA Code of Ethics, Section B). We operate under the idea of counselor-client privilege and that privilege is to be upheld except in extreme circumstances. In most cases, I am only able to release information about your treatment with your written and signed permission. However, there are some exceptions to this confidentiality and those are as follows:

Intention to Harm oneself or others: If in session it is made evident to me that you intend to harm yourself or harm someone else, I am ethically and legally required to warn appropriate supports in an effort to provide you with as much help as possible. This may include but is not limited to: emergency contacts, the intended victim you are looking to harm, police enforcement, or the hospital. This will be discussed as much as possible between us, but action will be taken appropriately.

Elder or Child Abuse: If it comes to light through our sessions that I believe a child or an elderly person is being abused or has been recently abused, I will need to report that to the appropriate state agency.

Client request: As previously stated, you are able to request copies of your records or request that a release be signed to release your records to various organizations such as other care providing agencies, or disability services. I would warn you however that once your records are out of my possession, I do not have control over their use, so I would discuss all releases with me before completing a request. (Please see the Professional Records section of this document as there are limitations to this request)

Confidentiality and Technology:

Throughout treatment, there are multiple ways in which technology may be incorporated, and the same confidentiality and HIPAA compliance regulations are applicable in those instances as well. I have a work number that you will be provided with for purposes of rescheduling, canceling, or work hour emergencies (emergency procedures have been explained in the previous section). This work phone is kept with me in my office during work hours. I will do my best to keep this confidential, but in the case that the phone would be stolen, I encourage you to leave as little personal information in a message as possible. Email interactions are only for specific purposes and will be discussed in session prior to emailing. Examples can include the following: emailing an invoice, emailing a therapeutic handout previously discussed in session, cancellations or rescheduling, or

emailing links to resources that have been discussed prior. A counseling session will not be conducted via email, nor will any personal health information be shared. Additionally, social networking sites or online chats are forbidden. If by chance you and I are already member of the same online group, no personal information will be shared through these sites, and any communication will be limited to specific topics that the group is participating in. This will need to be discussed in session regarding any benefit or harm that may come about through the online group. Email, text messaging, telephone and video conferencing will only be used to conduct normal and reasonable business transaction. The only exception is when you as the client choose to conduct a session via the phone or online video conferencing technology.

As your therapist, I recognized that certain situations are better suited for face to face interactions, and phone/video conferencing may not be as helpful and potentially more harmful. If this ends up being the case, I will refer you to somewhere local to help accommodate any special needs or disabilities, so you can get the best and most effective help to suit your situation.

Notes are kept on a secured web-based software that is HIPAA compliant, and I am obligated to tell you in the unlikely circumstance that the software would be compromised. The Grace Wellness Center is not responsible for maintaining of security standards for this software, nor are they responsibly for any breach if it were to occur. The video conferencing software (Thera-link) that we use to conduct online therapy sessions is also HIPAA compliant and again, The Grace Wellness Center nor your therapist is responsible for the security of this software in the unlikely event of someone listening in or watching your session. No personal information is stored on the video conferencing software system. Depending on where in the world you live, this HIPAA compliant video conferencing software may not be a viable option due to the encryption process. If this is the case, and you choose to use a non-compliant option, you are fully responsible for any breaches of any kind during that session.

In terms of social media, to keep with the confidentiality of your treatment, I will not be accepting any interactions on any social media sites. This is not personal, but rather to maintain our professional Therapist/Client relationship and increase the benefits of therapy.

Through this informed consent, you acknowledge that all technology, in any form, used for any reason, stands a risk of being "hacked", seen, stolen, or lost. You also acknowledge that most email or phone options are not HIPAA compliant, and confidentiality cannot be guaranteed. While The Grace Wellness Center has taken every possible step to secure all of your information, in the case of a breach due to any type of technological security issue, you hereby waive any claims or legal actions against The Grace Wellness Center and your therapist.

Professional Records

As part of our therapeutic relationship, as well as to uphold requirements from institutions like insurance companies, I am required to keep records of your treatment. You will have a paper file that will be kept in a locked file cabinet in a locked file room of this office which will include your Intake Paperwork, this signed document, the Notice of Privacy Practices document, and any other paper document that I feel is essential to your case. In addition to this file, I will be keeping electronic treatment plans and progress notes stored on a secure medical health record database through a mental health record keeping software entitled Theranest. The notes I keep each week are brief, and are typically a concise summary of what was discussed in session, a general update on your progress and techniques used, as well as a basic plan for the next session. Treatment plans, as discussed, are co-created with you, and re-evaluated every sixty days in an effort to keep them updated. These plans include long term and short term goals, as well as some action steps you may take to complete said goals.

Individual Rights to your Records:
As stated in the federal guidelines of the HIPAA Privacy and Security Act, Code CFR 164.524(a)(1)(i), a patient does NOT have a legal right to view their psychotherapy notes. Psychotherapy notes are defined by HIPAA as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session, or a group, a joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date". Code CFR64.508(a)(2).

If you wish to view your therapist notes that fall out of the guidelines as noted in code CFR 64.508(a)(2), you must present your therapist a written request. Once your therapist receives your written request, they will meet with the Practice Manager along with another clinical director at Grace Wellness Center within 15 days from the day your therapist receives your written request. If during that meeting, it is determined that viewing these notes may cause you harm, your request will be denied and you will receive (in writing) an explanation to the basis of that decision. If during that meeting, it is determined that no additional harm will come from viewing these records, your therapist will gladly provide you with a copy. However, because

some of the language may be unfamiliar to those not in the mental health field, it is recommended that you review them with your therapist, or have them forwarded to another mental health professional before looking at them alone. If you decide to end treatment with your therapist and begin services with another mental health professional, you have the right to request that your records be sent to the new provider.

HIPAA Complaints:
If you feel as if your HIPAA rights have been violated in any way, you may contact the Practice Manager of Grace Wellness Center, Ron Agostoni, directly at 724-515-2422. At that point, an internal investigation will be conducted. Any mishandling of information will be provided to the Office for Civil Rights established by the U.S. Department of Health and Human Services and immediate appropriate disciplinary action will be taken as enforced by Federal Law.

My Professional Affiliations:
As you are aware, I am a counselor in a private practice with multiple co-workers. As is the nature of most mental health practices, outlined in the ACA Code of Ethics Section F, I am involved in both individualized supervision with a Supervisor, and group supervision once a month with other mental health colleagues. During these times, we are encouraged to discuss topics we are seeing in our current cases and receive supervision if necessary. While it is possible that I may discuss your issue, I will do so with the focus being maintaining client confidentiality and use my discretion appropriately. Supervisors and co-workers are held under the same confidentiality codes when it comes to hearing other cases as well.

Other Client Rights and Terminating Therapy:
As a client, we have outlined the many rights you have and are entitled to. In addition to these rights, you are entitled to discuss it with me as your therapist if you are at any time unhappy with what is happening in our sessions. I encourage this discussion either as a way to improve our sessions, or as a venue for me to provide you with a referral for a different therapist. At any time, I will do my best to have various referral sources that may be applicable for you.

You also have the right to terminate counseling at any time. In an ideal situation, therapy ends when the agreed-upon goals are met or at least sufficiently discussed. If you would like to terminate therapy before said goals are completed, I would appreciate a session to discuss termination and properly refer you to another professional. As your therapist, I will not treat or discuss issues outside of my professional ability, and if those would arise, I would be ethically bound to refer you to a more suitable professional. If for any other reason I am unable to complete treatment, this will be discussed as clearly as possible, and various referrals will be offered to you as the client.

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Provider/Client Service Agreement and Treatment Contract

Your signature below indicates that you have READ and REVIEWED this document, and are agreeing to abide by its terms and conditions. This signed form will be saved as a part of your personal file, and can be reviewed and discussed at any point throughout treatment.

Client Signature ______________________________________ *Date:* ___________

Consent to Treatment

______________________________ ______________

Client Signature **Date**

______________________________ ______________

Guardian/ Representative Signature **Date**

____

Relationship to Client if signed by a Guardian

________________________ ______________

Therapist Signature **Date**

Revised August 2018

GRACE WELLNESS CENTER BELIEF STATEMENT

THE BIBLE
The Bible being verbally and plenary inspired by God is inerrant. It is the authority for all matters of faith and practice (2 Timothy 3:16; 2 Peter 1:21; 3:16).

GOD
God is eternal, needing no introduction (Genesis 1:1). God is beyond description or comprehension (Isaiah 55:8-9); I AM Exodus 3:14). There is only one God, but in the unity of the Godhead there are three eternal and coequal Persons, the same in substance but distinct in subsistence (Matthew 28:19; 2 Corinthians 13:14).

JESUS CHRIST
Jesus Christ is 100% man and 100% God (Philippians 2). His purpose in coming to earth is to seek and save that which is lost (Luke 19:10). Salvation was made possible through His death, burial and resurrection (1 Corinthians 15:3-5
.

THE HOLY SPIRIT
The Holy Spirit is God (John 14:16; Romans 8:15; 1 Corinthians 6:11). The Holy Spirit illuminates the minds of the believer (John 16:13-15; 1 Corinthians 2:10-13; 3:2) and convicts the mind of the unbeliever (John 16:7-11).

SALVATION
Salvation is by grace through faith, not of works (John 3; Ephesians 2:8-9; Titus 3:5)

SIN
All men have a sin nature resulting from man's participation in Adam's first sin (Romans 5:12). The sin nature is the capacity and inclination to do those things that can in no way commend us to God (Romans 1:18-3:20; 2 Corinthians 4:4; Ephesians 4:18).

THE CHURCH
The church is an organism of which Christ is the Head and is composed of all regenerated people (Colossians 1:18). As an organization it appears in many different forms.

SANCTIFICATION
Sanctification has three aspects. Positionally, set apart to God (1 Corinthians 6:11; Hebrews 10:10). This is as we are today in the eyes of God. Practically increasingly we are set apart from sin to God in our daily lives (1 Peter 1:16). Potential sanctification is being fully set apart to God when we are brought into perfect accord when we see Christ and become as He is (1 John 3:1-3).

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Policy on Missed Appointments

An appointment is considered "missed" if you fail to cancel the appointment with at least 24 hours notice or do not show up for a scheduled appointment without canceling. Missed appointments are detrimental to your treatment and also place a burden on your counselor, who makes his or her living providing these services, and on Grace Wellness Center's ability to effectively serve all of our clients.

While it is understood that unavoidable situations arise where it is impossible to make an appointment, this time slot was held for you and is unable to be given to another client, which may have needed that appointment, because of the late notice. Your counselor may, on a one time basis, wave this policy for situations beyond your control. However, this is not able to be done on a regular basis because of the above reasons.

If your insurance pays for all or part of your treatment, please be aware that insurance will not cover missed appointments. Therefore, you will be responsible for charges that apply to your missed appointments.

If you miss an appointment, you will be billed at the rate of ***$50.00*** per session (unless otherwise specified by your therapist). This charge must be paid prior to scheduling your next appointment. Payment can be made online through Paypal, by calling the office with a credit card or mailing a check to the office. If you are more than 20 minutes late for your appointment, it is considered a missed appointment and must be rescheduled.

By signing below, I am stating that I understand that I will be charged for missed appointments and must pay that charge prior to scheduling the next appointment.

____________________________ ____________________________

Signature of Client Date

____

Print Name

____________________________ ____________________________

Signature of Staff Date

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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name:____

DOB:____________________

SSN:___________________________

I hereby acknowledge that I have had Grace Wellness Center's Notice of Privacy Practices read and/or explained to me by my Therapist. I also acknowledge that I have been given the opportunity to obtain and/or read over a copy of the Practices myself and will indicate below if I am interested in a copy. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ron Agostoni at (724) 515-2422.

☐ I would like my own copy of the Privacy Practices

____

Signature of Patient/Client **Date**

____

Signature of Parent, Guardian or Personal Representative **Date**

____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

☐ **Patient/Client Refuses to Acknowledge Receipt:**

____

Signature of Staff Member **Date**