IDENTIFYING INFORMATION

Date:_____ /_____ /__________

Name:____ Date of Birth:_____ /_____ /_________

Address:

____

____

Phone (Home): _________________________ (Work):___________________________ (Cell): ____________________________

The best number to reach you: ____

Your Preferred Email: ____

Do we have your permission to leave a message and identify ourselves?

YES: ❑ Voicemail home ❑ Voicemail Cell ❑ Text ❑ E-mail NO: _______________

Occupation: ____ ❑ Full- time ❑ Part-time ❑ Not Employed

Employer: ____ Job Title: _____________________________________

FINANCIAL

❑ Cash pay ❑ Out of Network Insurance

***For inquiries regarding insurance coverage: We do take out of network insurance and we are willing to help you with completing forms for authorization and reimbursement. Please contact your insurance company regarding the necessary steps to take for out of network authorization and billing.*

Person responsible for payment: ❑ client ❑ parent/guardian

Insurance Company:____

OTHER

How did you hear of us: ❑ Website ❑ Family Member ❑Friend ❑ Online Search ❑Physician ❑Other____

May we thank someone in particular?

____

Sex: ❑M ❑F Height: ____________ Weight ____________

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed _________________Number of Children

Race/Culture(Check all that apply): ❑ African ❑ Hispanic ❑ African American ❑ Native American ❑ Asian Pacific Islander ❑ Asian American ❑ Caucasian ❑ Other:

Religion/Spiritual Orientation: ____

Highest Completed Educational Grade: ____

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

● "PHI" refers to information in your health record that could identify you.

● "Treatment, Payment and Health Care Operations" – Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist. - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

● "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

● "Disclosure" applies to activities outside of this practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

● Child Abuse: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Virginia Department of Child and Family Services.

● Adult and Domestic Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

● Health Oversight: If a complaint is filed against me with the Virginia Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

● Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

● Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

● Worker's Compensation: If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and The Wellness Connection's Duties

Patient's Rights:

● Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

● Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

● Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

● Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

● Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

● Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

We Care Management, LLC's Duties:

● I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

● I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

● If I revise my policies and procedures, I will provide a revised notice in person or through the mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the office administrator to discuss this further.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2013.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that on (date) ____ / ____ / ______, I received the Notice of Privacy Practices from We Care Management, LLC, which sets forth the ways in which my personal health information may be used or disclosed by We Care Management, LLC, and outlines my rights with respect to such information.

____ Patient's signature/Date

Mental Health Adult Packete

Personal/Relationship Background History

Client's Name: _________________________________ DOB: ____ /____ /______ Today's Date: ____ /____ /______

Primary reason(s) for seeking services:

• Anger management • Anxiety • Parenting • Depression

• Eating disorder • Fear/phobias• Trauma • Sexual concerns

• Sleeping problems • Addictive behaviors • Alcohol/drugs • School

• Relationship Issues • Other mental health concerns (specify): ___________________

Please check if there have been any recent changes in the following:

• Sleep patterns • Eating patterns • Behavior • Energy level

• Physical activity level • General disposition • Weight •Nervousness/tension

Who is currently living with you ?

Name:

Age:

Relationship:

Marital Status

(More than one answer may apply)

• Single • Engaged • Living together • Legally married

• Separated • Divorced • Widowed

Your spouse/partner's name: ____ Age:_______

Assessment of current relationship (if applicable): • Good • Fair • Poor

Were there any other marriages for either spouse/partner? • Yes • No

If yes, how many? ___ Self ___ Duration of each (self); ___ Partner ___ Duration of each (partner)

Gross annual income of household: $__________________

Development

Are there special, unusual, or traumatic circumstances that affected your development?

•Yes • No If Yes, please describe: ____

____

Has there been history of child abuse? • Yes • No

If Yes, which type(s)? • Sexual • Physical • Verbal

If Yes, the abuse was as a: • Victim • Perpetrator

Other childhood issues: ____

____

____

Social Relationships

Check how you generally get along with other people: (check all that apply)

• Affectionate • Aggressive • Avoidant • Fight/argue often • Follower

• Friendly • Leader • Outgoing • Shy/withdrawn • Submissive

• Other (specify): _________

Sexual orientation: Comments: ____

Sexual dysfunctions? • Yes • No If Yes, describe: ____

Cultural/Ethnic/Spiritual/Religious

• African • African American • Asian American • Asian • Caucasian

• Hispanic • Native American • Pacific Islander • Other:__________________________

Religious Background:

____________________________________Self_______________________________________Partner

Are there any cultural, ethnic, spiritual, religious or issues your therapist should be made aware of? If yes, please describe: ____

____

Education

Fill in all that apply: Years of education: ______ Currently enrolled in school? • Yes • No

• High school graduate/GED

• Vocational: Number of years: __ Graduated: • Yes • No Major: ___________________________

• College: Number of years: __ Graduated: • Yes • No Major: ___________________________

• Graduate: Number of years: __ Graduated: • Yes • No Major: ___________________________

Other training: _____Special circumstances (e.g., learning disabilities, gifted): ________

Military

Military experience? • Yes • No Combat experience? • Yes • No

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity How often now? How often in the past?

___________________________ ___________________________ _ ___________________________

___________________________ ___________________________ _ ___________________________

___________________________ ___________________________ _ ___________________________

___________________________ ___________________________ _ ___________________________

Medical/Physical Health

• AIDS • Dizziness • Nose bleeds

• Alcoholism • Drug abuse • Pneumonia

• Abdominal pain • Epilepsy • Rheumatic Fever

• Abortion • Ear infections • Sexually transmitted diseases

• Allergies • Eating problems • Sleeping disorders

• Anemia • Fainting • Sore throat

• Appendicitis • Fatigue • Scarlet Fever

• Arthritis • Frequent urination • Sinusitis

• Asthma • Headaches • Smallpox

• Bronchitis • Hearing problems • Stroke

• Bed wetting • Hepatitis • Sexual problems

• Cancer • High blood pressure • Tonsillitis

• Chest pain • Kidney problems • Tuberculosis

• Chronic pain • Measles • Toothache

• Colds/Coughs • Mononucleosis • Thyroid problems

• Constipation • Mumps • Vision problems

• Chicken Pox • Menstrual pain • Vomiting

• Dental problems • Miscarriages • Whooping cough

• Diabetes • Neurological disorders •Other (describe): ____________ _______

• Diarrhea • Nausea ____________________________

List any current health concerns: ____

List any recent health or physical changes: ____

Current prescribed medications:

Dose Dates Purpose Side effects

____ _________ _________ _______

____ _________ _________ _______

____ _________ _________ _______

____ _________ _________ _______

Current over-the-counter medications:

Dose Dates Purpose Side effects

____ _________ _________ _______

____ _________ _________ _______

____ _________ _________ _______

____ _________ _________ _______

Are you allergic to any medications or drugs? • Yes • No

If Yes, please describe:

____

Family History:

Have there been any deaths in the immediate family? • Yes • No

____

Name of Deceased Relationship to you Date Occurred Cause of Death

____

_______________________________ Name of Deceased Relationship to you Date Occurred Cause of Death

Has anyone in your family or your partner's family ever attempted suicide? • Yes • No

If yes, please explain:

____

____

____

Does anyone in your family own weapons? • Yes • No If yes, please list them, and who owns them, where and how are they stored:

____

Type Owner Where/How stored?____

Do you smoke?• Yes • No ____________ Amount Per Day

Please describe any concerns anyone in your family has ever expressed about another family member's use of alcohol:____

____

How much alcohol do you drink and how often? ______Amount/day ______Frequency/day or week

How much does your partner drink and how often? ______ Amount/day______Frequency/day or week

Which of these drugs, if any, have you used: (please check all applicable)

• Marijuana • Methamphetamine • Cocaine • Ecstasy • Heroine • Inhalants

•Other:

____

____

Dates of use: ____ Are you currently drug free?:

____

Has anyone ever expressed concern about the way in which anger is managed in your family?

• Yes • No If yes, please explain or give example(s):_______________________________________

____

Has anyone in the family ever had conflicts that resulted in physical confrontation? For example: pushing, shoving, hitting, and punching. If yes, please explain.

____

____

____

Have you or anyone in your family ever been involved in the court system? If yes, please explain.

____

____

____

____

Counseling/Prior Treatment History:

Who? Self or Your reaction to Yes/ No family member? Where? overall experience?

Counseling/Psychiatric

____

Suicidal thoughts/attempts

____

Drug/alcohol treatment

____

Hospitalizations

____

Involvement with self-help

____

Groups (e.g., AA, Al-Anon,

____

NA, Overeaters Anonymous)

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

• Aggression • Elevated mood • Phobias/fears

• Alcohol dependence • Fatigue • Recurring thoughts

• Anger • Gambling • Sexual addiction

• Antisocial behavior • Hallucinations • Sexual difficulties

• Anxiety • Heart palpitations • Sick often

• Avoiding people • High blood pressure • Sleeping problems

• Chest pain • Hopelessness • Speech problems

• Cyber addiction • Impulsivity • Suicidal thoughts

• Depression • Irritability • Thoughts disorganized

• Disorientation • Judgment errors • Trembling

• Distractibility • Loneliness • Withdrawing

• Dizziness • Memory impairment • Worrying

• Drug dependence • Mood shifts • Other (specify): ____________

• Eating disorder • Panic attacks __________________________________

Do you feel suicidal at this time? • Yes • No

Briefly discuss how the above symptoms impair your ability to function effectively:

____

____

Any additional information that would assist us in understanding your concerns or problems?:

____

____

____

What are your goals for therapy?

____

Welcome to mental health services at We Care Management, LLC. This document contains important information about our business policies and services pertaining to psychotherapy and psychological assessment. Please read it carefully and write down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your clinician will be able to offer you some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your clinician at the We Care Management, LLC. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about your therapist's procedures, you should discuss them with that clinician whenever they arise. If your doubts persist, the We Care Management, LLC will be happy to help you set up a meeting with another mental health professional for a second opinion.

PSYCHOLOGICAL ASSESSMENT

The We Care Management, LLC provides psychological assessment administered and interpreted by licensed psychologists and/or interns supervised by licensed psychologists. Psychological assessment provides the opportunity to evaluate an individual compared against a set of normative samples to make evaluations about how similar or different they are from the normative group. By doing this, assessment provides the opportunity to pinpoint unique strengths and challenges, which can inform therapeutic interventions for treatment planning. You should be aware that psychological assessments only provide a static snapshot of an individual's functioning around the time of the evaluation. As such, information obtained from psychological assessment—while helpful for identifying a diagnosis and making recommendations for treatment—is never the final word on an individual's functioning.

Psychological assessment typically presents a relatively low risk to participants. There may be some discomfort or anxiety about being tested; however, clinicians are trained detect these issues and to support you through the process. It is also important test results and written reports be used with appropriate sensitivity and discretion to ensure patients are not adversely affected by inappropriate use of such information. The procedures for selecting, giving, and scoring the tests, interpreting the results and storing the results, and maintaining privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and the Health Insurance Portability and Accountability Act (HIPAA).

The benefits of completing a psychological assessment potentially include a detailed description of strengths and challenges in the areas covered by the assessment (e.g., intellectual, academic, social-emotional functioning), and specific recommendations for addressing areas of difficulty. For example, this information might be useful to help you qualify for special accommodations in your educational or work environment.

MEETINGS

Psychotherapy:

Clinicians normally conduct an evaluation that will last from 2 to 4 sessions when commencing psychotherapy with clients. During this time, a decision is made regarding whether the clinician is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, clinician and client schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a mutually agreed upon time, although some sessions may be longer or more frequent. Depending on the treatment plan, sessions may also be scheduled on a less frequent basis.

Clinicians may also attend outside appointments or meetings (e.g., IEP's at schools) in support of clients' treatment. Payment may be at the hourly rate agreed upon between client/guardian and clinician or as arranged between client and clinician on an individual basis.

Psychological Assessment:

Psychological assessment can be provided within the context of psychotherapy for treatment planning, or may occur through separate referral. An initial brief phone consult will usually be the first point of contact to discuss your primary concerns and whether we can offer the type of assessment offered appropriate for your needs. If assessment is deemed appropriate and you agree, the next sessions will include interviews, testing and observations. These sessions typically run between 90 minutes and 4 hours. These appointments are arranged between you and the psychologist. Scoring and interpretation is completed outside of testing sessions by a psychologist and usually takes from 1 to several hours, depending on the amount and depth of testing that is done. Once scoring and interpretation is completed the examiner will schedule a feedback session with results and to provide you with answers to any questions you may have.

Attendance:

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours' notice of cancellation. If the clinician is unable to start on time, you will receive the full time

agreed to. If you are late, the clinician will likely be unable to meet for the full time. Note that arriving late for an assessment can be very troublesome because some measures cannot be stopped midway and being late can potentially delay the entire evaluation.

CONTACTING YOUR CLINICIAN

Clinicians are often not immediately available by telephone and typically do not answer phone calls when they are with other clients. When clinicians are unavailable, you may leave a message on the telephone number(s) listed on their professional card. Know that clinicians monitor their calls frequently and will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform your clinician of some times when you will be available. If you are unable to reach your clinician and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your clinician will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

EMERGENCY SERVICES

The We Care Management, LLC is not an emergency service, and in an emergency situation, if you cannot reach We Care Management, LLC or your therapist directly, you should contact your local community health center, another crisis counseling center, or your local hospital emergency room.

PROFESSIONAL RECORDS

The laws and standards of the mental health profession require that the We Care Management, LLC keep treatment records. You have the right to see and get a copy of your medical record. Your mental health provider usually must let you see your medical record or give you a copy of it within 15 days of receiving your written request. You must make your request in writing with an original (not photocopied) signature, and records for non-emancipated minors must be requested by their custodial parents or legal guardians.

Please note, that because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them in the presence of your clinician so you may discuss the contents. We Care Management, LLC is allowed to charge you a fee for copying your record and for the cost of postage if you have the copy mailed to you.

MINORS

For clients under eighteen years of age, please be aware that the law may provide your parents/legal guardian(s) the right to examine your treatment records. It is the We Care Management, LLC's policy to request an agreement from parents that they agree to give up access to your records. If they agree, your clinician will provide them only with general information about your work together, unless your clinician feels there is a high risk that you will seriously harm yourself or someone else. In this case, your clinician will notify them of his/her concern. Your clinician will also provide your parents/legal guardian(s) with a summary of your treatment when it is complete. Before giving them any information, your clinician will discuss the matter with you, if possible, and will do their best to handle any objections you may have with what your clinician is prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist or psychotherapist is protected by law, and the We Care Management, LLC can only release information about our work to others with your written permission.

But there are a few exceptions. In most legal proceedings, you have the right to prevent your clinician from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order the testimony of your clinician if he/she determines that the issues demand it.

There are some situations in which your clinician is legally obligated to take action to protect others from harm, even if he/she has to reveal some information about a patient's treatment. For example, if your clinician believes that a child, elderly person, or disabled person is being abused, he/she must file a report with the appropriate state agency.

If a clinician believes that a client is threatening serious bodily harm to another, he/she is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, the clinician may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in practice. If a similar situation occurs, your clinician will make every effort to fully discuss it with you before taking any action.

Your clinician may occasionally find it helpful to consult other professionals about a case. During a consultation, your clinician will make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. If you don't object, your clinician will not tell you about these consultations unless he/she feels that it is important to your work together.

Confidentiality of E-mail, Cell Phone and Fax Communications: It is important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be easily sent erroneously to the wrong address. Please notify We Care Management, LLC staff or your clinician at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communications devices. Please do not use e-mail of faxes for emergencies or to cancel/reschedule appointments.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have at your next meeting with your clinician. Your clinician will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws

governing confidentiality are quite complex, and We Care Management, LLC clinicians and staff are not attorneys with legal expertise.

PAYMENTS AND BILLING

Psychotherapy and psychological assessment are provided on a fee-for-service basis. This means you pay the clinician directly for services at the time of the appointment (unless other arrangements are made between you and the clinician). Some insurance companies will provide out of network reimbursement for psychotherapy services; however, you are responsible for contacting your insurance to inquire about mental health coverage, to obtain the necessary paperwork, and for billing the insurance company.

Payment schedules for other professional services will be agreed to when they are requested. Below is a payment agreement that itemizes all fees for mental health services that you have agreed to with your clinician. The Payment Contract may be revised at any point during treatment (e.g., with additional services, changes in the financial agreement, etc.). In circumstances of unusual financial hardship, the Wellness Connection may be willing to negotiate a fee adjustment or payment installment plan.

PAYMENT AGREEMENT

I. The person financially responsible for payment on the account is asked to review fees

below, initialing and dating each section pertaining to services client(s) will be receiving.

Person responsible for payment on the account (please print):________________________________

Mailing Address:

____

City:____ State:_________
Zipcode:_____________________________

II. You and your clinician have agreed that you will be provided the following mental health

services (which may be amended at any time during treatment), with said fees as indicated below:

____ Individual/Family/Relationship Psychotherapy: I/we agree to pay a rate of $150 for sessions (defined as 45–50 minutes for assessment, and individual, family and relationship counseling). Initials: ______ Date: ____/____/______

____ Phone consultation/session: I agree to pay a rate of $150, the psychotherapy fee for phone calls of over 10 minutes duration. Initials:______ Date:_____/____/______

____ Ancillary Fees in 15min increments: I agree to pay $ 37.50 per 15 minute increment.

Initials: _______ Date: ____/____/______

____Other: $_______ for ________________________Initials:____ Date:____/____/______

III. Accepted methods of payment include: cash, personal check, and credit card (Visa, etc). As

noted above, once an appointment hour is scheduled you will be expected to pay for it unless you provide 24 hours prior notice of cancellation. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, We Care Management, LLC has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through

small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

*Note: There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

Cancellation Notice

IV. We Care Management, LLC requires a twenty four (24) hour notice if you are unable to attend

your appointment. If twenty four (24) hours' notice is not given, you will be charged the full amount of your appointment.

If you reschedule your appointment prior to the twenty four (24) period the cancellation fee will not apply to you.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that it often involved making a full disclosure with regard to many matters which may be of a confidential nature, we request that your agree that neither you nor your attorney, nor anyone else acting on your behalf call on We Care Management, LLC clinicians to testify in court of at any other proceeding, nor will a disclosure of the psychotherapy records be requested for the purposes of legal proceedings. Court proceedings include but are not limited to: divorce and custody disputes, injuries, lawsuits, etc.

TERMINATION

As discussed above, after the first few meetings, your We Care Management, LLC clinician will assess if psychotherapy and/or assessment services can be of benefit to you. If it is determined that your problems is outside of the clinician's area of expertise, you will be given a number of appropriate referrals. If your clinician assesses that they are not effective in helping you reach your therapeutic goals, your clinician is obliged to discuss it with you and, if appropriate, to terminate treatment. You will also be given a number of referrals in this situation. If you request it, and with your written authorization, your clinician will talk with the therapist of your choice to assist with the transition. You have the right to terminate therapy or the assessment process at any time.

We Care Management, LLC clinicians reserve the right to terminate therapy and/or a therapy session at any time, should the safety of participants or clinicians be deemed compromised in any manner.

DUAL RELATIONSHIPS

Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs the clinician's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature.

I have read the above Outpatient Mental Health Services Contract carefully and I understand and agree to comply with the terms as discussed above. I may request a copy of the agreement.

____ ______/______/__________ Signature of client/parent/guardian Date

Printed Name

____ ______/______/__________ Signature of second client (minor) Date

Printed name (name of minor if applicable)

CREDIT CARD CONSENT FORM

This is to authorize We Care Management, LLC to charge my/our:

o Visa o Master Card o American Express o Discover

Credit Card Number: (Last four digits): ________________________

Expiration Date: _________________

For all services that the individual(s) named below receive from We Care Management, LLC, including all missed sessions that are not cancelled 24 hours before the appointment.

Please print individual(s) receiving services:

____

____

If I dispute any charges made by We Care Management, LLC, I also understand by signing below that I am authorizing We Care Management, LLC to submit a copy of this document and a copy of invoices to my Credit Card Company, bank, and/or merchant services as proof of my authorization for charges to the credit card number on this form. By signing below, I also authorize We Care Management, LLC to discuss any credit card disputes with my Credit Card Company, bank, and/or merchant services, and responsible party.

Please treat this document as a copy of my signature on file. I understand that by signing this form I give authorization to We Care Management, LLC to charge my credit card for services for the above listed individual(s) and agree to abide by the policies identified in the Therapy Agreement.

Signature: _______________________________________ Date:___________________________

Authorization to Release Information

I, ________________________, (Client Name) authorize my therapist, _________________ (Therapist's Name) and/or the staff of the We Care Management, LLC to exchange confidential health care information about me with:

The information may be provided either orally, or in written form, and may include the

Following:____
____

____
____

This disclosure is being made for the purpose of:
____

____
____

As the person signing this authorization, I understand the following:

● I am giving my permission to We Care Management, LLC to disclose and/or receive confidential health care records.

● I have the right to revoke this consent, except to the extent that it has been acted upon. My revocation is not effective until delivered in writing to We Care Management, LLC.

● A copy of this consent, and a notation concerning the persons or agencies to whom disclosure was made, will be included with my original records.

● I understand that neither my therapist nor We Care Management, LLC can guarantee the continued confidentiality of any records released to the person or agency named in this authorization once they are out of We Care Management, LLC's possession.

● I may receive a copy of my confidential health care information if I so request. If my information is shared in common with another person or persons, (for example the records of couple or family treatment), the other person(s) must consent to my receiving a copy of the information that we share in common.

I will be given a copy of this authorization. This authorization expires on (date-not to exceed one year):
____

Signature of Client: ___________________________________ Date: ________________________