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:_____

IN CASE OF EMERGENCY WE CARE MANAGEMENT, LLC MAY CONTACT: NAME:

_____

RELATIONSHIP:

_____

ADDRESS:

_____

PHONE: Home: _____ Work: _____Cell:_____

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 We Care Management’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'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

It is important that you understand our policy and procedures regarding the treatment of minors at the beginning of services so you can make an informed decision about receiving services. This information is in addition to We Care Management, LLC's Services Agreement.

We expect that parent(s) or guardian(s) will be involved in their child's counseling sessions as deemed appropriate by the clinician. All children must be brought to sessions by a parent or guardian and that person must remain at the Center during the time that their child(ren) is being seen.

We ask that a parent or guardian who has the legal authority to do so consent to their child(ren)'s treatment at the Center. We may ask for a copy of a court order to verify that you are the legal parent/ guardian.

Virginia Law allows for either parent to have access to their child's record or information, regardless of whether they have legal custody or not, unless there is a court order limiting access or terminating parental rights. The Center will attempt to notify the parent authorizing treatment if such a request is made, but please understand that we must comply with a legitimate request.

We Care Management, LLC would like you to recognize the importance of the relationship that your child will be developing with their counselor. The trust that is built in the sessions is the foundation for change and growth for your child. Therefore, we ask that by signing this statement you agree not to involve your child's therapist in any type of legal proceeding against a parent or family member. By doing so you would ask the therapist to betray the trust and relationship they have built with your child.

I have read and agree to all the above provisions about seeking services for my child. I certify that I am the legal parent/guardian and have the authority to consent to services.

Parent/Guardian _____ Date: _____

Mental Health Child Packet

Personal/Relationship Background History

Client's Name: _____DOB:____ /____ /_____ Today's Date: ____ /____ /_____

Guardian's Names: Mother: _____Father:_____

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

Family History

Parents With whom does the child live at this time? Are parent's divorced or separated? If Yes, who has legal custody? Were the child's parents ever married? ❑ Yes ❑ No Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ❑ Yes ❑ No If Yes, describe:

Client's Mother Name: Age: Occupation: ❑ FT ❑ PT Where employed: Work phone: Mother's education: Is the child currently living with mother? ❑ Yes ❑ No ❑ Natural parent ❑ Step-parent ❑ Adoptive parent ❑ Foster home ❑ Other (specify):
_____ Is there anything notable, unusual or stressful about the child's relationship with the mother? ❑ Yes ❑ No If Yes, please explain:

How is the child disciplined by the mother? For what reasons is the child disciplined by the mother?

Client's Father

Name: Age: Occupation: ❑ FT ❑ PT Where employed: Work phone: Father's education: Is the child currently living with father? ❑ Yes ❑ No ❑ Natural parent ❑ Step-parent ❑ Adoptive parent ❑ Foster home ❑ Other (specify):
_____ Is there anything notable, unusual or stressful about the child's relationship with the father? ❑ Yes ❑ No If Yes, please explain:

How is the child disciplined by the father? For what reasons is the child disciplined by the father?

Client's Siblings and Others Who Live in the Household

Quality of relationship Names of Siblings Age Gender Lives with the client

❑ F ❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good ❑ F ❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good
❑ F ❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good ❑ F ❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good
Others living in Relationship the household (e.g., cousin, foster child)

❑ F ❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good ❑ F ❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good

❑ F❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good ❑ F ❑ M ❑ home ❑ away ❑ poor ❑ average ❑ good

Family Health History Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply: ❑ mental illness ❑ suicide ❑ alcohol/drug abuse or addiction ❑ other: _____

Comments regarding family health:

_____

_____

_____

_____

Childhood/Adolescent History

Were there any complications during pregnancy or birth? ❑ yes ❑ no If yes, describe:

_____

_____ Any developmental concerns? ❑ yes ❑ no If yes, describe:

_____

_____ Any head injuries ? ❑ yes ❑ no If yes, describe:

_____

_____ Any hospitalizations ? ❑ yes ❑ no If yes, describe, including dates:

_____

Education

Current school: School phone number: Type of school: ❑ Public ❑ Private ❑ Home schooled ❑ Other (specify): Grade: Teacher: School Counselor: In special education? ❑ Yes ❑ No If Yes, describe: In gifted program? ❑ Yes ❑ No If Yes, describe: Has child ever been held back in school? ❑ Yes ❑ No If Yes, describe: Which subjects does the child enjoy in school? Which subjects does the child dislike in school? What grades does the child usually receive in school? Have there been any recent changes in the child's grades? ❑ Yes ❑ No If Yes, describe: Has the child been tested psychologically? ❑ Yes ❑ No If Yes, describe:

Check the descriptions which specifically relate to your child.

Feelings about School Work:

❑ Anxious ❑ Passive ❑ Enthusiastic ❑ Fearful ❑ Eager ❑ No expression ❑ Bored ❑ Rebellious ❑ Other (describe):

Approach to School Work:

❑ Organized ❑ Industrious ❑ Responsible ❑ Interested ❑ Self-directed ❑ No initiative ❑ Refuses ❑ Does only what is expected ❑ Sloppy ❑ Disorganized ❑ Cooperative ❑ Doesn't complete assignments ❑ Other (describe):

Performance in School (Parent's Opinion):

❑ Satisfactory ❑ Underachiever ❑ Overachiever ❑ Other (describe):

Child's Peer Relationships:

❑ Spontaneous ❑ Follower ❑ Leader ❑ Difficulty making friends ❑ Makes friends easily ❑ Long-time friends ❑ Shares easily ❑ Other (describe):

Who handles responsibility for your child in the following areas?

School: ❑ Mother ❑ Father ❑ Shared ❑ Other (specify): Health: ❑ Mother ❑ Father ❑ Shared ❑ Other (specify): Problem behavior: ❑ Mother ❑ Father ❑ Shared ❑ Other (specify):

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, school activities, scouts, etc.)

Activity How often now? How often in the past?

Health

List any current health concerns:

List any recent health or physical changes:

List any allergies:

_____

Current prescribed medications:

Dose

_____

Dates

_____

Purpose

_____

Side effects

_____

Current over-the-counter meds:

Dose

_____

Dates

_____

Purpose

_____

Side effects

_____

Chemical Use History Does the child/adolescent use or have a problem with alcohol or drugs? ❑ Yes ❑ No If Yes, describe:

Counseling/Prior Treatment History

Information about child/adolescent (past and present): Counseling/Psychiatric treatment

_____ Suicidal thoughts/attempts _____

Drug/alcohol treatment

_____

Hospitalizations

_____

Behavioral/Emotional:

Please check any of the following that are typical for your child: ❑ Affectionate ❑ Frustrated easily ❑ Sad ❑ Aggressive ❑ Gambling ❑ Selfish ❑ Alcohol problems ❑ Generous ❑ Separation anxiety ❑ Angry ❑ Hallucinations ❑ Sets fires ❑ Anxiety ❑ Head banging ❑ Sexual addiction ❑ Attachment to dolls ❑ Heart problems ❑ Sexual acting out ❑ Avoids adults ❑ Hopelessness ❑ Shares ❑ Bedwetting ❑ Hurts animals ❑ Sick often ❑ Blinking, jerking ❑ Imaginary friends ❑ Short attention span ❑ Bizarre behavior ❑ Impulsive ❑ Shy, timid ❑ Bullies, threatens ❑ Irritable ❑ Sleeping problems ❑ Careless, reckless ❑ Lazy ❑ Slow moving ❑ Chest pains ❑ Learning problems ❑ Soiling ❑ Clumsy ❑ Lies frequently ❑ Speech problems ❑ Confident ❑ Listens to reason ❑ Steals ❑ Cooperative ❑ Loner ❑ Stomach aches ❑ Cyber addiction ❑ Low self-esteem ❑ Suicidal threats ❑ Defiant ❑ Messy ❑ Suicidal attempts ❑ Depression ❑ Moody ❑ Talks back ❑ Destructive ❑ Nightmares ❑ Teeth grinding ❑ Difficulty speaking ❑ Obedient ❑ Thumb sucking ❑ Dizziness ❑ Often sick ❑ Tics or twitching ❑ Drugs dependence ❑ Oppositional ❑ Unsafe behaviors ❑ Eating disorder ❑ Over active ❑ Unusual thinking ❑ Enthusiastic ❑ Overweight ❑ Weight loss

❑ Excessive masturbation ❑ Panic attacks ❑ Withdrawn ❑ Expects failure ❑ Phobias ❑ Worries excessively

❑ Fatigue ❑ Poor appetite ❑ Other: ❑ Fearful ❑ Psychiatric problems ❑ Frequent injuries ❑ Quarrels

Please describe any of the above (or other) concerns:

How problem behaviors are generally handled?

What are the family's favorite activities?

What does the child/adolescent do with unstructured time?

Has the child/adolescent experienced death? (friends, family pets, other) ❑ Yes ❑ No At what age? If Yes, describe the child's/adolescent's reaction:

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

❑ Yes ❑ No If Yes, describe:

Any additional information that you believe would assist us in understanding your child/adolescent?

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

What are your goals for the child's therapy?

What family involvement would you like to see in the therapy?

Do you believe the child is suicidal at this time? ❑ Yes ❑ No If Yes, explain:

Mental Health Contract

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

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

We Care Management, LLC is not an emergency service, and in an emergency situation, if you cannot reach We Care Management, LLC 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 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 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 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 We Care Management 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 for phone sessions over 10 minutes. 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 staff (including 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

_____ _____/_____/_____

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 We Care Management, LLC to exchange confidential health care information about me with:

Name:_____

Agency/Address:_____

Telephone/Fax:_____

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 for 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: _____