WETHRIVE
COUNSELING CENTER
Where reNEWment Happens

Confidential Patient Intake Information

Patient Full Name _____ Date_____

Date of Birth ___/___/_____Who Referred you? _____May we thank them? Y N

Address _____City _____State _____ Zip _____

Cell Phone _____Would you like to receive text reminders? Y N

Email _____Would you like to receive email reminders? Y N

Occupation_____ Hours worked per week _____

In School? Y N What level at school _____Degree Pursuing _____

Is religion important to you when seeking a counselor? If so, how? _____

_____

MARITAL STATUS

___Single ___Engaged ___Married ___Separated ___Divorced ___Widowed ___Other

LIVING SITUATION

Who do you currently live with? (Check all that apply)

___Alone ___Spouse ___Parent(s) ___Siblings ___Boyfriend ___Girlfriend ___Children

___Other

MEDICAL INFORMATION

Primary Care Physician/Psychiatrist _____ Phone _____

Would you like me to contact your physician/psychiatrist to coordinate your care? Y N

MEDICATION INFORMATION

Please list all medications you are currently taking_____

_____

_____

Please check all of the symptoms you are currently experiencing

Addiction		Fear of leaving home		Poor decisions	
Adoption		Frequent conflicts		Phobias	
Anger		Head injury		Physical abuse	
Anxiety/Stress/Worry		Hearing/seeing things		Recent Divorce/Separation	
Appetite problems		Headaches/dizziness		Self-harm	
Argumentative		Hypertension		Sadness or crying	
Avoidance of responsibility		Intrusive thoughts		Secrets/hiding things	
Blaming others		Loss of energy		Sexual difficulties	
Concentration/Focus		Lack of Confidence		Sexual abuse	
Death in the family		Legal difficulties		Sleeping problems	
Depression		Medication Issues		Social anxiety	
Disordered eating		Memory issues		Sex preoccupation (pornography)	
Domestic violence		Mood swings		Thoughts of death	
Drug or alcohol use		Nervousness		Tiredness	
Emotional abuse		Nightmares		Trauma (flashbacks)	
Excessive guilty		Obsessions		Veteran/Military	
Employment		Panic		Weight change	
Financial Concerns		Paranoia		Worthlessness	

LEVEL OF DISTRESS

Indicate your level of distress on a 0-10 scale (0 = none; 10 = extreme)_____

Are you currently experiencing any suicidal thoughts? Y N In the past? Y N

Have any family members or friends attempted or committed suicide? Y N

If yes, when and who?

_____

_____

_____

Describe why you are coming to see me now?

_____

_____

_____

_____

What do you hope to gain by coming to see me?

_____

_____

_____

_____

WeThrive Counseling Center
Jenks, OK

Statement of Understanding and Consent for Treatment

Therapy is not like a medical doctor visit; 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. Therapy 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, therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress.

Our policy for after-hours coverage is to leave a message and we will return your call as soon as possible. If you are in need of urgent or emergency services after hours, please call COPES crisis line at (918) 744-4800 or 911.

Please understand that information obtained from you is confidential. Information may not be shared with anyone without your permission except in the following circumstances:

1. When a court order is received.
2. When there is reasonable cause to believe that you will hurt yourself or someone else.
3. When there is reasonable suspicion to believe that abuse/neglect of a child, elderly person or disabled person has occurred.
4. Information necessary for billing purposes to insurance companies.

Your ***INITIALS*** beside each of the following indicates your understanding and consent for treatment:

_____ I understand that I may withdraw consent for treatment at any time.
_____ I understand and have reviewed the statement of financial responsibility.
_____ I have been offered a copy of HIPAA's Notice of Privacy Practices.

I hereby consent for WeThrive Counseling Center to provide my treatment.

_____ _____
Signature **Date**

_____ _____
Clinician Signature **Date**

WeThrive Counseling Center
Jenks, OK

Statement of Understanding and Consent for Electronic Communication

WeThrive Counseling Center, its employees and contractors, utilizes various methods of communication to maintain contact with you including phone and email. Please understand this office is portable and contact with us will be on a cellular phone. We utilize text messaging in very limited circumstances and only for scheduling or basic informational purposes. No clinical information will be discussed via text message or email. If you attempt to discuss clinical matters you will be asked to call or wait until your next session to discuss.

Please be aware that electronic communication via telephone or email may not be secure for either party. Due to the nature of this type of communication, there is a potential for interception or misdirection of your information. Your use of phone or email to communicate protected health information indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information in person to protect your privacy.

As a general rule, WeThrive Counseling Center, its employees and contractors, do not have contact with you outside of the office that is unrelated to mental health treatment. This rule applies to various Internet messaging sites, social networking sites and general emails unrelated to our professional relationship. Please understand that any contacts or requests for contacts will not be confirmed or acknowledged to protect your privacy as well as to eliminate a dual relationship.

Please ***INITIAL*** below:

_____ I understand the risks associated with utilizing any electronic methods of communication and agree to do so at my own risk.

_____ I understand email and text contacts will be scheduling and incidental purposes. All other forms of communication will be made preferably in person or via phone call if emergency arises.

_____ _____

Signature **Date**

_____ _____

Clinician Signature **Date**

WeThrive Counseling Center

Jenks, OK

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. PURPOSE: WeThrive Counseling Center and its professional staff, employees and trainees follow the privacy practices described in this notice. WeThrive Counseling Center keeps your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all professional staff involved in the health care operations of the organization have access to your records.
2. WHAT ARE TREATMENT AND HEALTH CARE OPERATIONS? Your treatment includes sharing information among mental health care providers who are involved in your treatment. For example, if you are seeing multiple providers within WeThrive Counseling Center, they may share information in the process of coordinating your care.
3. HOW WILL WeThrive Counseling Center USE MY PROTECTED HEALTH INFORMATION (PHI)? Your personal mental health record will be retained by WeThrive Counseling Center for at least seven years after your last clinical contact with the organization. After that time has elapsed, the record will be shredded or otherwise destroyed in a way that protects your privacy.
    a. Until the records are destroyed they may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes: Appointment reminders;
    b. Notification when an appointment is cancelled or rescheduled by WeThrive Counseling Center;
    c. As may be required by law;
    d. For public health purposes such as reporting child or elder abuse or neglect;
    e. Mental health oversight activities, e.g. audits, inspections or investigations of administration and management of WeThrive Counseling Center;
    f. Lawsuits and disputes (we will attempt to provide you advance notice of subpoena before disclosing information from your record);
    g. To prevent a serious threat to health or safety;
    h. National security and intelligence activities;
    i. Protection of the President or other authorized persons for foreign heads of state or to conduct special investigations;
    j. To support the operations and functioning of WeThrive Counseling Center. All business associates (e.g. electronic health record vendor and billing department) connected to WeThrive Counseling Center are obligated to protect the privacy and security of your PHI and may not use or disclose your PHI other than as specified in our agreements with them;
    k. Alcohol and drug abuse information has special privacy protections. WeThrive Counseling Center will not disclose any mental health or medical information relating to a client's substance abuse treatment unless: (i) the client consents in writing (ii) a court order requires the disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) it is necessary to report a threat to harm oneself or another or to report abuse or neglect as required by law.
4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES. Except as described previously, we will not use or disclose information from your record unless you authorize (permit) in writing WeThrive Counseling Center to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI). You have the following rights regarding your health information, provided that you make a written request to invoke the right to WeThrive Counseling Center.
    a. Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contact.
    b. Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied. You may request review of the denial by another licensed mental health professional chosen by WeThrive Counseling Center. WeThrive Counseling Center will comply with the outcome of the review.
    c. Right to an electronic copy of mental health records. If your PHI is maintained in an electronic format, you have the right to request that an electronic copy of your record be given to you or another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in that form or format. If it is not readily producible in that form, your record will be provided in either our standard electronic format, or as a readable hard copy. We may charge a fee for transmitting the electronic health record.
    d. Right to request clarification of record. If you believe that the information we have about you is incorrect or incomplete you may ask to add clarifying information. WeThrive Counseling Center is not required to accept the information that you propose.
    e. Right to accounting of disclosures. You may request a list of the disclosures of your mental health information that have been made to persons or entities other than for treatment or health care operations. Right to receive notice of a breach. You have the right to be notified upon a breach of any of your unsecured PHI.
    f. Right to a copy of this notice. You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.
6. PAYMENTS. We may use your health information or share it with your insurance company in order to obtain reimbursement for treatment or care.
7. REQUIREMENTS REGARDING THIS NOTICE. WeThrive Counseling Center is required to provide you with this Notice that governs our privacy practices. WeThrive Counseling Center may change its policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information we have about you as well as any information we receive in the future. Any time you come in to WeThrive Counseling Center, you may ask for and receive a copy of the Privacy Notice in effect at the time.
8. COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with WeThrive Counseling Center or with the Department of Health, Behavioral Health Division of Oklahoma. You will not be penalized or retaliated against in any way for filing a complaint.

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been offered a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by WeThrive and how I may obtain access to and control this information.

_____ _____

Signature **Date**

WeThrive Counseling Center
Jenks, OK

Statement of Financial Responsibility

Fees: We provide services at $150 per 50-minute session and the initial intake session $200. Phone calls, reports, and other services provided outside of regularly scheduled appointments may be billed in 15-minute increments (e.g. 60 minutes will be $150). Participation in legal proceedings is billed at $200 per hour, including commute time, report writing, and other preparations. Payment and insurance copays are due in full by cash, check or debit/credit card ***on the date of service.*** You are responsible for these bills including any portion not covered or reimbursed by your insurance company.

Cancellation Policy: Please call **12 hours in advance** to change or cancel an appointment to allow that time for another client. You are able to leave a message 24 hours a day. If you do not show for an appointment and do not make every effort to call within 12 hours of the session, you will be billed the $100 rate for the session. Health insurance does not cover this fee.

Payment Policy and Agreement: You may leave a credit card on file if you so choose. In the event that your account has not been paid within 90 days, you authorize WeThrive Counseling Center to charge the following account for services according to the financial policies and payment agreement above at which time your account will be charged any unpaid balance.

Type of Card:

___Visa ___ MasterCard ___Amex ___Discover ___FSA/HAS

Account Number _____ Expiration Date_____

Card Holder Name _____ Security Code _____

Address: _____ Zip code _____

Telephone _____ Email for receipt: _____

Card Holder Signature _____

I have read this Statement of Financial Responsibility. I understand that I am responsible for my bill.

_____ _____

Signature **Date**