**West End Counseling & Wellness, LLC**

CLIENT DEMOGRAPHIC INFORMATION FORM

NAME:_______________________________________ Preferred name/nickname:_________________________

DATE OF BIRTH:_______________ Age: ________ Marital Status: ____________ Ethnicity: ______________

Sex at Birth:_________________ Gender:__________________ Preferred Pronouns:____________________

Home Address:___________________________________________________________________________

City:_____________________________ State:______ Zip:_______ Religion:________________________________

**Home phone** ______-______-_________ Messages Okay? Yes No

**Cell phone** ______-______-_________ Messages Okay? Yes No Text Okay? Yes No

**Email address** ____________________________________________ Messages Okay? Yes No

(Email is used to send appointment reminders, and occasionally to notify you of upcoming WECW programs)

**Emergency Contact:** ________________________ Relationship ______________ Phone: ____________________

**How did you learn about West End Wellness?** ___ Website: __________________ ___Relative/ friend

___ Physician _______________ ___Insurance Company Other:_________________________________

Check one: ____ I will self-pay

_____ I will use insurance (please fill in insurance information below)

**Primary Insurance Company**: ___________________________________________________________________

Name of Insured (Policy Holder) ___________________________ Employer: ____________________________

ID # (on card): _________________________________ Group #: _____________________________________

Insured's Date of Birth:____________ Insured's Sex:______ Insured's Relation to Client: ________________

Insured's Address: ___________________________________________________________________________

Insured's Phone Number:________________________1-800 Number on Card _________________________

**Secondary Insurance Company:** ________________________________________________________________

Name of Insurec (policy holder) ______________________________ Employer: _______________________

ID # (on card): _________________________________ Group #: _____________________________________

Insured's Date of Birth:____________ Insured's Sex:______ Insured's Relation to Client: ________________

Insured's Address: ___________________________________________________________________________

Insured's Phone Number:________________________1-800 Number on Card _________________________

# West End Counseling & Wellness, LLC

INFORMED CONSENT TO TREATMENT

***Welcome to our practice! Please review the important below – your signature is requested in 4 sections.***

## CONFIDENTIALITY

Information you share in the course of treatment is kept strictly confidential and will not be shared with others without your written consent to release information. There are just few exceptions to this confidentiality:

- If your counselor assesses that you or someone else poses a serious risk of harm to themselves or others, they may need to disclose relevant information to County Crisis Intervention, a hospital, relative, or others, in order to ensure all parties' safety.
- If you disclose information regarding the abuse, neglect or exploitation of minors, elderly, or individuals with disabilities, as a mandated reporter in PA, your counselor may need to make a report to Childline.
- If you become involved in legal proceedings, it is possible that a court order may be issued for the release of your mental health record.
- If you are pursuing careers in particular fields, such as law enforcement or the military, you may be required by your prospective employer or agency to allow them access to your mental health information as a condition of employment.

Your counselor may consult with other licensed mental health clinicians employed at West End Wellness in order to provide you with the best treatment possible. You can rest assured that these individuals are bound by the same confidentiality standards as outlined above.

## THE COUNSELING PROCESS

During the first session, your counselor may ask many questions in order to gather information about your concerns and your history. The initial session/s will allow you and your counselor to get to know each other and to decide together if you are a "good fit", and what the best course of treatment may be for you. If either you or your counselor determines that there is not a good fit, your counselor will gladly provide a referral to another treatment provider.

### BENEFITS AND RISKS OF TREATMENT

Research indicates that counseling is an effective treatment for many mental health concerns, and may help you to increase self-awareness, solve problems, learn new skills, enhance relationships, and feel more optimistic, confident, and fulfilled. As with any intervention, counseling also has some risks, including the potential to increase your awareness of painful feelings or experiences. This is often a natural part of your journey to healing, ultimately helping you to find new perspectives, learn new coping skills, and make life-enhancing changes. Keep your counselor informed about how counseling is impacting you, so that they can provide you with the best treatment possible.

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*Sometimes in the waves of change we find our true direction.*

## MISSED APPOINTMENTS

Missed or cancelled appointments without 48 hours notice will be charged at the full session rate, and will not be reimbursable through insurance. An exception may be made for family emergencies, health crises, or dangerous weather. If you arrive late for an appointment, you will still be charged the full session rate.

## FEES AND PAYMENT POLICY

In order to facilitate payment, clients are required to keep a credit card on file with WECW. While we try to assist in verifying client's insurance coverage*, ultimately it is the client's responsibility to know and verify their coverage prior to starting treatment.* You agree to pay at each session any co-payments, co-insurance and deductibles, or charges for services not covered by insurance. You are responsible for paying the bill in full unless special arrangements are approved by WECW. Please call the number on the billing statement to pursue such arrangements. Late fees of 1.5% will be charged on balances that are still unpaid starting 30 days after the first statement. After 90 days, if the insurer has not paid WECW for the services received, you will be responsible for payment of those services. In these instances, WECW will provide you with a statement for services rendered for your use in pursuing reimbursement with your insurance company. WECW accepts cash, checks and credit.

## EMERGENCIES

If you are experiencing a mental health crisis and are unable to reach your counselor, please call your county crisis intervention center, call 911, or go to the nearest hospital emergency room. Each county has a mental health crisis intervention center that is open 24/7, 365 days per year, with crisis workers expressly available to assist. They are there to listen, problem solve, and if you don't feel safe, to arrange for you to access hospital evaluation. The number for Lehigh County Crisis Intervention is: 610-782-3127. Feel free to enter it into your cell phone now for easy access later.

___________________________________________________________

***My signature below indicates I have read, understand, and agree to these terms:***

_________________________________ __________________

**Client Signature** **Date**

_________________________________ __________________________________ __________________

**Guarantor Signature** **Guarantor's Relationship to Client** **Date**

*A client's Guarantor is the person with legal authority to act on behalf of a minor, incapacitated, or otherwise legally dependent client, including the authority to consent to medical services. By signing this form as "Guarantor"on behalf of the client, your represent to WECW that you have such authority and that you accept financial responsibility for services rendered.

***See over***

## West End Counseling & Wellness, LLC

1011 Brookside Rd., Suite 122, Allentown, PA 18106
Privacy Officer: Dr. Lisa P. Coulter Phone: 610-569-0252 Email: westendwellnessllc@gmail.com

# NOTICE OF PRIVACY PRACTICES

(Effective Date: August 15, 2018)

*This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information.* ***PLEASE REVIEW IT CAREFULLY***.

**YOU HAVE THE RIGHT TO**:

- **Get an electronic or paper copy of your medical record**. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee for this service.
- **Ask us to contact you in a specific way** (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to correct health information** about you that you think is incorrect or incomplete. We may decline your request, but will tell you why in writing within 60 days.
- **Ask us to limit what information we use and share** for treatment, payment, or for our operations. This request must be in writing, and we may decline your request if it would affect your care.
- **Have us share your information with others involved in your care.**
- **Get a list of those with whom we've shared information** for six years prior to the date you ask, including what we shared and why.
- **Get a paper copy of this privacy notice at any time** by contacting the privacy officer noted above.
- **File a complaint if you feel your rights have been violated**. Where feasible, please discuss any complaint with your counselor or practice director first. If you are not satisfied you have the right to complain to the U.S., Department of Health and Human Services. We will not retaliate against you for filing a complaint.

**OUR RESPONSIBILITIES ARE TO:**

- **Maintain the privacy and security of your protected health information as required by law**.
- **Inform you promptly if a breach occurs** that may have compromised the privacy or security of your information.
- **Follow the privacy practices** described in this notice and offer you a copy of it.
- **Refrain from using or sharing your information other than as described here** unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by letting us know in writing.

**HOW WE MAY USE OR DISCLOSE YOUR INFORMATION**:

- **To treat you**, including coordinating care or consulting with other professionals who are treating you.
- **To run our practice,** including improving your care, reviewing treatment practices, and contacting you.
- **To bill for your services**, including verifying insurance and coverage, processing claims, and collecting fees.
- **We can change the terms of this notice**, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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***My signature and date below indicates that I reviewed and was offered a copy of this notice and consent to the terms as noted above:***

__________________________________ __________________
**Client Signature** **Date**

_________________________________ _____________________________ __________________
**Representative Signature** **Relationship to Client** **Date**

## CREDIT CARD AUTHORIZATION NOTICE

Clients are required to keep a credit card on file with WECW in order to facilitate payments. By allowing us to swipe/enter your credit card and signing this authorization, you authorize West End Counseling & Wellness, LLC to charge your credit card for any unpaid amount that WECW or your insurer determines are your responsibility for services provided by WECW.

WECW will notify you before charging any amount in excess of your session copay/co-insurance amount to your credit card and will provide 30 days for you to respond before charging your card. Notice will be provided via US mail unless you authorize electronic notice by completing the section below

A copy of this authorization is available upon request. You may revoke this authorization by writing to WECW, Client Accounts Department, 1011 Brookside Rd., Ste. 122, Allentown, PA 18106.

### Agreement

**I, the undersigned, am an authorized user of the credit card that I provide. I hereby authorize WECW to charge my credit card for balances due for services provided by WECW. I agree to pay all amounts charged pursuant to this authorization in accordance with the issuing bank cardholder agreement.**

________________________________ ______________________________ _________________

**Authorized User Signature** **Printed Name** **Date**

### AUTHORIZATION FOR ELECTRONIC COMMUNICATIONS

**Your signature below indicates that you understand that:**

By signing below, you authorize WECW to use unencrypted electronic mail and /or text messaging to notify you of upcoming charges to your credit card

- Email and text notifications will include your name, phone number, email address, date of service, balance and last four digits of your credit card number. They will not include medical information.
- You may revoke this authorization of electronic communications by sending a written request to 1011 Brookside Rd., Suite 122, Allentown, PA 18106, Attn: Privacy Officer
- Your right to receive medical services will not be affected if you refuse to sign this authorization.

________________________________ ______________________________ _________________

**Authorized User Signature** **Printed Name** **Date**

*If you would like a copy of this information, please let you counselor know. Electronic copies are available are on our website at westendwell.com.*