NWA PREMIER THERAPY

Your Path To A Better Life

Client Information

Name: _____ Date of Birth: _____

Address: _____

Preferred Pronouns: _____ Administrative Sex: M ___ F ___

Gender Identity: _____ Sexual Orientation: _____

Ethnicity: _____

Preferred means of communication (please check all that apply) Phone _ Email _ Text _

Cell Phone: _____ Alt. Phone: _____

Email Address: _____

Referred By: _____

Emergency Contact: _____ Relation: _____

Phone Number: _____

Employer : _____

Work: Full Time ___ Part Time ___ Student ___ Unemployed ___ Retired ___

May we leave a message for you at home? Yes ___ No ___

Relationship Status:

Single __ Married __ Partnership __ Separated __ Divorced __ Widow(er) ___

Children's names and ages: _____

Who lives in your home: _____

What brings you in for help now?_____

When did this start & how does this affect your life? _____

_____

_____

_____

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Please provide the following information for our records. Leave any question blank that you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

Treatment History

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

Are you currently receiving psychiatric services, professional counseling, or psychotherapy elsewhere? Yes ___ No___
Have you had previous psychotherapy: Yes ___ No ___
If yes, please provide your previous therapist's name: _____

Are you currently taking prescribed psychiatric medication? Yes ___ No ___

If yes, please list: _____

_____
Prescribed by: _____
Prior hospitalization or substance abuse treatment: _____
Date(s): _____
Do you currently have a primary care physician? Yes ___ No ___

If yes, please provide physician's name: _____
Are you currently seeing more than one health specialist? Yes ___ No ___
If yes, please list: _____
Date of last physical: _____

Are you having any difficulty with appetite or eating habits? Yes ___ No ___
If yes, check where applicable: Eating less __ Eating more __ Bingeing __ Restricting __
Have you experienced significant weight change in the last 2 months? Yes ___ No ___
Have you had suicidal thoughts recently? Frequently__ Sometimes__ Rarely__ Never__
Have you had suicidal thoughts in the past? Frequently__Sometimes__ Rarely_ Never__
Do you engage in recreational drug use? Frequently__ Sometimes__ Rarely__ Never__

In the past 2 weeks what were your sleep patterns: Typical ___ Unusual___
Check all that apply to the past 2 weeks: Difficulty falling asleep ___ Nightmares ___ Terrors ___ Frequent waking ___ Early morning waking ___ Tired after sleep ___ Teeth grinding ___ Snoring ___
Do you have any history of trauma (e.g. chronic illness, childhood trauma, sexual, emotional, verbal abuse) Yes ___ No ___
If yes, please explain: _____
_____

Have you ever experienced any of the following:

Depression Yes ___ No___	Repetitive behaviors (e.g. frequent checking, hand washing) Yes ___ No ___
Dramatic mood swings Yes ___ No ___	Homicidal thoughts Yes ___ No ___
Racing thoughts Yes ___ No ___	Fatigue Yes ___ No___
Anxiety Yes ___ No ___	Suicidal attempts Yes ___ No ___
Panic attacks Yes ___ No ___	Seizures Yes ___ No ___
Risky activity (speeding, sexual behavior) Yes___ No___	Difficulty with intimacy/closeness Yes ___ No ___
Irritability Yes ___ No ___	Loss of emotional control Yes___ No ___
Hallucinations Yes ___ No ___	Lack of energy Yes ___ No ___
Impulsivity Yes ___ No ___	Chronic pain Yes ___ No ___
Suspiciousness Yes ___ No ___	Lack of motivation Yes ___ No___
Alcohol/substance abuse Yes ___ No ___	Impatience Yes ___ No ___
Eating disorder Yes ___ No ___	Learning disabilities Yes ___ No ___
Body image problems Yes ___ No ___	Sensory Integration Problems Yes ___ No ___

Hyper focus Yes ___ No ___	Lack of empathy for others Yes ___ No___
Spaciness or fogginess Yes ___ No ___	Daydreaming Yes ___ No ___

Awkwardness in social settings Yes ___ No ___	Emotional reactivity Yes ___ No ___
Fearfulness/Paranoia Yes ___ No ___	Poor concentration Yes ___ No ___
Headaches/Migraines Yes ___ No ___	Anger or rage Yes ___ No ___

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Please check all that apply and list family member relation, e.g. sibling, parent, etc.)

Difficulty		Family Member
Depression	Yes ___ No ___	
Bipolar Disorder	Yes ___ No ___	
Anxiety Disorder	Yes ___ No ___	
Panic attacks	Yes ___ No ___	
Schizophrenia	Yes ___ No ___	
Alcohol/substance abuse	Yes ___ No ___	
Eating disorder	Yes ___ No ___	
Learning disabilities	Yes ___ No ___	
Trauma History	Yes ___ No ___	
Suicide attempts	Yes ___ No ___	
Chronic illness	Yes ___ No ___	

Substance History

Have you ever tried the following? Please check all that apply and date last used

__ Alcohol ___/___	__ Tobacco ___/___	__ Marijuana ___/___	__ LSD ___/___
__ Heroin ___/___	__ Meth ___/___	__ Cocaine ___/___	__ Stimulants ___/___
__ Ecstacy ___/___	__ Methadone ___/___	__ Tranquilizers ___/___	__ Pain Killers ___/___

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Informed Consent

This form is called a Consent for Services (the "Consent"). Your therapist, has asked you to read and sign this Consent before you start therapy. Please review the information. If you have any questions, contact your Provider.

THE THERAPY PROCESS

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies and procedures, talk about fees, identify emergency contacts, and decide if you want health insurance to pay your fees depending on your plan's benefits. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your Provider is practicing under the supervision of another professional, your Provider will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take.

After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

TELEHEALTH SERVICES

To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option. There are some risks and benefits to using telehealth:

Risks

• Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.

• Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.

• Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.

Benefits

• Flexibility. You can attend therapy wherever is convenient for you.

• Ease of Access. You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.

Recommendations

• Make sure that other people cannot hear your conversation or see your screen during sessions.

• Do not use video or audio to record your session unless you ask your Provider for their permission in advance.

• Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

CONFIDENTIALITY

Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary to satisfy the obligation. However, there are a few exceptions.

• Your Provider may speak to other healthcare providers involved in your care.

• Your Provider may speak to emergency personnel.

• If you report that another healthcare provider is engaging in inappropriate behavior, your Provider may be required to report this information to the appropriate licensing board. Your Provider will discuss making this report with you first, and will only share the minimum information needed while making a report. If your Provider must share your personal information without getting your permission first, they will only share the minimum information needed. There are a few times that your Provider may not keep your personal information confidential.

• If your Provider believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your Provider can explain more if you have questions.

• If your Provider has reason to believe a minor or elderly individual is a victim of abuse or neglect, they are required by law to contact the appropriate authorities.

• If your Provider believes that you are at imminent risk of harming yourself, they may contact law enforcement or other crisis services. However, before contacting emergency or crisis services, your Provider will work with you to discuss other options to keep you safe.

RECORD KEEPING

Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all log-ins and actions within the system.

COMMUNICATION

You decide how to communicate with your Provider outside of your sessions. You have several options:

Texting/Email

• Texting and email are not secure methods of communication and should not be used to communicate personal information. You may choose to receive appointment reminders via text message or email. You should carefully consider who may have access to your text messages or emails before choosing to communicate via either method.

Secure Communication

• Secure communications are the best way to communicate personal information, though no method is entirely without risk. Your Provider will discuss options available to you. If you decide to be contacted via non-secure methods, your Provider will document this in your record.

Social Media/Review Websites

• If you try to communicate with your Provider via these methods, they will not respond. This includes any form of friend or contact request, @mention, direct message, wall post, and so on. This is to protect your confidentiality and ensure appropriate boundaries in therapy.

• Your provider may publish content on various social media websites or blogs. There is no expectation that you will follow, comment on, or otherwise engage with any content. If you do choose to follow your Provider on any platform, they will not follow you back.

• If you see your Provider on any form of review website, it is not a solicitation for a review. Many such sites scrape business listings and may automatically include your Provider. If you choose to leave a review of your Provider on any website, they will not respond. While you are always free to express yourself in the manner you choose, please be aware of the potential impact on your confidentiality prior to leaving a review. It is often impossible to remove reviews later, and some sites aggregate reviews from several platforms leading to your review appearing other places without your knowledge.

FEES AND PAYMENT FOR SERVICES

You may be required to pay for services and other fees. You will be provided with these costs prior to beginning therapy, and should confirm with your insurance if part or all of these fees may be covered. You should also know about the following:

No-Show and Late Cancellation Fees

• If you are unable to attend therapy, you must contact your Provider before your session. Insurance does not cover these fees. A charge of $50 will be assessed for non-emergent cancellations. You agree to provide notice of cancellations within 24 hours prior to my appointment. If you fail to provide adequate notice, you will be charged the full fee with the exception of agreed upon emergencies.

Balance Accrual

• Full payment is due at the time of your session. If you are unable to pay, tell your Provider. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service. If you need a referral to another provider please just ask and one will be provided to you.

Administrative Fees

• Your Provider may charge administrative fees for writing a letter or report at your request; consulting with another healthcare provider or other professional outside of normal case management practices; or for preparation, travel, and attendance at a court appearance. Payment is due in advance.

Insurance Benefits

• Before starting therapy, you should confirm with your insurance company if:

• Your benefits cover the type of therapy you will receive;

• Your benefits cover in-person and telehealth sessions;

• You may be responsible for any portion of the payment; and

• Your Provider is in-network or out-of-network.

Sharing Information with Insurance Companies

• If you choose to use insurance benefits to pay for services, you will be required to share personal information with your insurance company. Insurance companies keep personal information confidential unless they must share to act on your behalf, comply with federal or state law, or complete administrative work.

Covered and Non-Covered Services

• As a courtesy, we will contact your insurance provider for an estimate of your benefits, however, you are encouraged to contact them yourself to assure the information regarding expense and coverage.Your insurance plan may cover all or part of the cost of therapy. **You are responsible for any part of this cost not covered by insurance, such as deductibles, copays, or coinsurance. You may also be responsible for any services not covered by your insurance.**

• When your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your session to your Provider. Your Provider will tell you if they can help you file for reimbursement from your insurance company. If your insurance company decides that they will not reimburse you, you are still responsible for the full amount.

Payment Methods

• The practice requires that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

COMPLAINTS

If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

Acknowledgment

I have read and understand the Consent for Services form and that agree to the information therein.

_____ _____

Client Signature Date

Parent or Guardian

I have read and understand the Consent for Services form and that agree to the information therein.

_____ _____

Guardian Signature (if applicable) Date

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Insurance Information

Services are billed by the hour, in accordance with standards of practice. Your insurance is a contract between you and your insurance company. Please present insurance cards to be photocopied.

Primary Insurance Provider: _____
Member ID: _____ Group ID: _____
Policy holder full name: _____
Relationship to client: _____ Policy holder DOB: _____
Policy holder phone number: _____

Policy holder SSN: _____-_____-_____
Policy holder Employer: _____

Secondary Insurance Provider:_____
Member ID: _____ Group ID: _____
Policy holder full name: _____
Relationship to client: _____ Policy holder DOB: _____
Policy holder phone number: _____

Policy holder SSN: _____-_____-_____
Policy holder Employer: _____

Method of Payment

Name on card: _____
Card number: _____
Expiration date: _____ CVV: _____
Billing address attached to card: _____
_____