East Valley Maternal Wellness, PLLC - INTAKE QUESTIONNAIRE

Personal Information

Name: ____ Date: ____________________

Address: ____
Street City State ZIP

SS #: _________________________________ Date of Birth: _____/_____ / __________

Home Phone: ___________________________ Cell Phone: ________________________

How did you hear about us? ____

Are you? *(circle one)* Married Single Divorced Separated Widowed Co-habitating

Not including yourself, list the names, ages, and relationship of individuals who live with you:

Name	Age	Relationship	Name	Age	Relationship
________________	_____	___________	________________	_____	___________
________________	_____	___________	________________	_____	___________
________________	_____	___________	________________	_____	___________

Military service? .... Yes No

If yes, service dates: ___ /___ - ___ /___

Any military problems? .... Yes No

Financial problems? .... Yes No

Legal problems? .... Yes No

Family problems? .... Yes No

Cultural/spiritual problems? .... Yes No

Social support system problems? .. Yes No

Employment problems? .... Yes No

Living/housing problems? .... Yes No

If yes to any of the above, please explain: ________________________________
____
____
____

Are you employed? No Full-time Part-time Where? ___________________________

What is your religious preference? ______________________________________

Is this a source of support for you? Yes No

Briefly explain why you are seeking counseling today: ______________________
____
____
____
____

How long has this been a problem? ______________________________________

Emergency Contact Information

Name: ____ Phone: ______________

Address: ____
Street City State ZIP

Relationship to You: ____

Pregnancy / Postpartum Information

Please indicate if you have ever experienced any of the following. *(check all that apply)*

- ☐ Postpartum depression or anxiety (Me)
- ☐ Postpartum depression or anxiety (Family Member)
- ☐ Abrupt weaning
- ☐ Social isolation or poor support
- ☐ History of premenstrual syndrome (PMS)
- ☐ Mood changes while taking birth control pills or fertility medication
- ☐ Thyroid dysfunction
- ☐ History of infertility
- ☐ History of miscarriage, abortion, or fetal/infant loss

Explain any issues you checked above: ____

____

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____

____

Psychiatric / Medical Information

Have you had any previous psychological consultations? Yes No

Have you ever been hospitalized for psychiatric reasons? Yes No

Are you currently using any other psychiatric/psychological support systems? Yes No

Are you now, or have you ever been, on any psychiatric medications? Yes No

If yes, name of psychiatrist: ______________________________ Phone: ______________

Medication	Dosage	Frequency	Start Date	Side Effects	Helpful?
____________	________	__________	__________	________________	Yes No
____________	________	__________	__________	________________	Yes No
____________	________	__________	__________	________________	Yes No
____________	________	__________	__________	________________	Yes No

Do you have any current or past medical problems? Yes No

Are you currently taking any **non**-psychiatric medications? Yes No

If yes to either question, please explain: ____

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East Valley Maternal Wellness, PLLC
1166 E. Warner Rd. Ste. 101
Gilbert, AZ 85296
(480) 272-0411

CLIENT RIGHTS

Right To Request How We Contact You

It is our normal practice to communicate with you, at your home address and daytime phone number you gave us when you scheduled your appointment about health matters such as appointment reminders, etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right To Release Your Medical Records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right To Inspect And Copy Your Medical And Billing Records

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact your therapist. Under limited circumstances, we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing, and supplies.

Right To Add Information Or Amend Your Medical Records

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement, and our response, will be added to your record. To request an amendment, contact your therapist. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right To An Accounting Of Disclosures

You may request an accounting of disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes, or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period, no longer than six years ago and after June 1, 2007, please submit your request in writing to the therapist you are working with. We will notify you of the cost involved in preparing this list.

Right To Request Restrictions On Uses And Disclosures Of Your Health Information

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to your therapist. However, we are not required to agree to such a request.

Right To Complain

If you believe your privacy rights have been violated, please contact us personally to discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right To Receive Changes In Policy

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from your therapist.

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Michelle Lacy, MA, LPC

INFORMED CONSENT

Thank you for choosing ***East Valley Maternal Wellness***. Today's appointment will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

OUR BACKGROUND

We are board-certified counselors who have special training for the treatment of pregnancy and postpartum-related adjustment problems, and we follow the guidelines of "**Postpartum Support International**". Many of our non-pregnant-and-postpartum clients suffer from anxiety and/or depression and we have extensive experience treating these disorders as well. Our therapists are also well versed working with both adolescents and adults in the areas of substance abuse, grief and loss, trauma, and relationship issues.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for:

- **a.** information you or your child report about physical or sexual abuse of a minor or elderly person. Then, by Arizona State Law, I am obligated to report this to the Child Protective Services or Adult Protective Services,
- **b.** when you sign a release of information to have specific information shared,
- **c.** if you provide information that you are in danger of harming yourself or others,
- **d.** information necessary for case supervision or consultation, and
- **e.** when required by law.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, and we are unavailable, the client or guardian understands that they are to contact the emergency services in the community **(911)** for those services**. *East Valley Maternal Wellness*** will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s): ____ Date: ___/___/______

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I/We consent that ______________________________________ may be treated as a client by
Name of child/adolescent

East Valley Maternal Wellness. At times, it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for your child.

Signature(s): ____ Date: ___/___/______

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/We have read and received a copy of the "**HIPAA Notice of Privacy Practices**" and **"Client Rights**" documents.

Which phone number(s) may we use to contact you? ____________________________________

At which number(s) may we leave a message? ____

Signature(s): ____ Date: ___/___/______

COORDINATION OF TREATMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist to improve your care. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by notifying us in writing. However, a revocation is not valid to the extent that we have already acted in reliance on such authorization**. If you prefer to decline consent, no information will be shared.

____You may inform my physician(s) **____I decline to inform my physician(s)**

Physician Name: ____

Address: ____

Phone: ____

Signature(s): ____ Date: ___/___/______

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Missed Appointment Policy

When you make an appointment with us our time is reserved exclusively for you. If you fail to come to your appointment, our time is lost. Therefore it is common practice to charge the patient for the time reserved, even when they do not come for the therapy appointment.

A "no show/last minute cancellation" fee in the amount of $75 for the lost therapy time will be charged to your credit card on file every time you do not appear for your scheduled session.

"No show" sessions are regularly scheduled sessions for which you fail to appear, and there has been no completed communication informing us of your intent to cancel or reschedule the session. "Last minute cancellations" are appointments cancelled less than 24 hours prior to the scheduled session.

If, for some unexpected reason, you must cancel or reschedule a session, please call us at the above number **no less than 24 hours in advance. Calling the evening before your appointment date may not be sufficient, unless you scheduled a late evening appointment.** Remember, keeping a regular schedule for therapy is an important part of the therapeutic process, so changes and/or cancellations should only occur in the case of true emergencies. Please make every effort to keep our regular schedule. Thank you.

I have read and understood this policy, and I have been provided with a copy of the policy.

Patient Signature: ___________________________ Date: _ _ / _ _ / _ _ _ _

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Collections Policy

It is the policy of East Valley Maternal Wellness, PLLC. to obtain and maintain a valid Visa or MasterCard and authorizing signature. This will remain in your confidential file as a guarantee of payment and allows us to avoid having to take collections actions against any client. ***No charge will be billed to this account unless the owner of the card fails to reconcile debts to East Valley Maternal Wellness, PLLC.*** If you do not wish to complete this form you may seek services elsewhere and I will assist you with a referral.

If you elect to use your insurance or EPA benefits to pay for services you will need to complete this form in its entirety as having benefits is **NOT** a guarantee of payment. If I have a contract with your managed care insurance company/EAP the billing procedures of that company will be followed. Our staff will make several attempts to collect from your insurance company/EAP including a phone call to said company if necessary. However, in the event that any insurance company/EAP obligated by contractual agreement to make payments on your behalf for services provided, refuses to make such payment you will become personally responsible for that amount. I will attempt to notify you of the debt in order to provide the opportunity of calling your insurance company and/or clearing the account. If the account is not cleared within 90 days from date of service you hereby authorize me to collect any outstanding amount on the credit card listed below.

In case you are making payments to East Valley Maternal Wellness by check and the check is returned, the amount will also be billed to your credit card **plus a $25 returned check fee**. In the event charges are billed to this account, you will be sent a copy of the credit card charge and reconciled bill within 7 to 10 business days.

In the event that this policy does not result in the reconciliation of your account East Valley Maternal Wellness, PLLC. reserves the right to send the account to an attorney or collections agency and you will become responsible for any additional fees incurred as a result.

This signed credit card collections policy is for use only for service rendered at the offices of East Valley Maternal Wellness, PLLC.

Client's Name: ________________________________

Type of Card: Visa ____ MasterCard ____

Card Member: _________________________________

Card Number: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ 3digit security code: _ _ _

Expiration Date: _ _ / _ _ _ _

Card Member Signature: _______________________ Date: _ _ /_ _ /_ _ _ _

Therapist Signature: ____________________________________

Michelle Lacy MA, LPC Maria Ward MA, LPC