Freedom Wellness Center, PLLC
2816 Veach Road, Suite 208, Owensboro, KY 42303
Phone: 270-228-2991 Fax: 270-228-2994

_____ _____ ___/___/___
First, M.I. *Last* *DOB*

Gender: ☐ Male ☐ Female **Social Security Number.:** _____

Status: ☐ Single ☐ Married ☐ Separated ☐ Widow ☐ Other _____
☐ Dating ☐ LGBT

Client Address: _____
Street City State Zip

Parent/Guardian/Legal Rep.: _____
(If applicable) Name Relationship Address Contact No.

Contact Number(s): _____ _____ _____
Home Cell Work/Other

_____
Email

Contact preference(s): ☐ Home/Cell ☐ Work ☐ Text ☐ Email ☐ May we leave messages?
Preference(s): _____

Emergency Contact: Name: _____ Relationship: _____
Contact info: _____

Were you referred? ☐ **Yes** ☐ **No** **If so, who referred you?:** _____
If not referred, how did you hear about Freedom Wellness Center, PLLC? _____

Payment Source: ☐ Self ☐ Medicaid/MCO ☐ Priv. Insurance ☐ EAP ☐ Health Savings Acct
☐ Other, please specify: _____

PRIMARY INSURANCE INFORMATION (complete only if filing for insurance reimbursement):

Policy Holder: _____
First, M.I. *Last* DOB

Policy Holder ID number: _____

Policy Holder SSN: _____ **(required to submit claim)**

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Copy of medical card and/or insurance card (front/back) **Employer Name:** _____

SECONDARY INSURANCE INFORMATION (complete only if filing for insurance reimbursement):

Policy Holder: _____
First, M.I. *Last* DOB

Policy Holder ID number: _____

Policy Holder SSN: _____ **(required to submit claim)**

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Copy of medical card and/or insurance card (front/back) **Employer Name:** _____

Financial responsbile party: _____
☐ **Self** Name Relationship

_____
Address Contact No.

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Confidentiality Agreement

Your trust is the foundation on which you will receive and accept the help/support you are looking for. It is the cornerstone of making progress and you are given the strictest of confidentiality. Your health information will remain protected according to the law at all costs. Whenever it is necessary to share information with anyone outside Freedom Wellness Center, PLLC, it will be discussed with you.

I understand:

- √ My health information is protected under HIPAA law and that a copy the HIPAA law is available for pick up at the front desk or upon request.
- √ I have the right to request access to and copies of my protected health information (PHI).
- √ My protected health information (PHI) will remain protected according to the law.
- √ I must sign an "Authorization to Release Information" for disclosures of PHI other than for the purposes of treatment, payment, or healthcare operations.
- √ Exceptions to this include there being reasonable cause to believe:
  - ~ *that you intend to hurt yourself or someone else.*
  - ~ *that you are a perpetrator or victim of abuse or neglect.*
  - ~ *that children or elderly persons are being abused or neglected.*
- √ The disclosure of PHI must be limited to the minimum necessary to comply with the request
- √ If subpoenaed to court and ordered by a judge to testify about you, a best effort to protect your right to confidentiality while complying with the court order will be made.

Freedom to Choose

You are free to choose your mental health provider. Knowing this, it is considered an honor to serve you. However, if at any time you believe you are not being supported effectively or making the progress you expect/desire, a sincere and reasonable effort will be made to find another healthcare professional for you.

If you are under 18...

Except for situations such as those mentioned above, specific things you share in a private therapy session that you do not wish to be shared with your parent/guardian will not be shared. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then professional judgment will be used to decide whether you are in serious and immediate danger of being harmed. If it is suspected that certain risk-taking behavior could cause harm, your parent or guardian will be notified.

In addition, even if agreed that certain information will be kept confidential - to not tell your parent or guardian – it is possible that clinical judgement indicates that it is important for them to know what is going on in your life. In these situations, you will be encouraged and advised/supported to tell your parent/guardian in the best manner you see fit. Also, when meeting with your parents, problems/concerns may be shared in general terms, without using specifics, in order to help them know how to be more helpful to you.

Client Signature (age 14 and above)	Parent/Guardian/Legal Rep.	Date

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Treatment Understanding

Welcome to Freedom Wellness Center, PLLC. It is considered a great honor to be afforded the opportunity to work with you during this time of need. Therapy works in part because of clearly outlined rights and responsibilities held by both parties, therapist and client. When you sign this document, it will represent an mutual agreement between us. If you have any questions before signing or in the future, please ask.

CLIENT RIGHTS

- √ To be treated the way you want to be treated: with dignity, respect, fairness, and care.
- √ To confidentiality and to control who does/does not have access to your record (exceptions apply).
- √ To work with a qualified professional.
- √ To be informed and have input in the treatment method(s) used.
- √ To receive treatment in the least restrictive setting, most appropriate to your treatment needs.
- √ To refuse treatment unless ordered to participate by a higher authority such as Court.

CLIENT RESPONSIBILITY

- √ Be involved, participate willingly, and provide input toward your treatment.
- √ Ask questions if you do not understand something about the service(s) being provided to you.
- √ Provide accurate information to help make the best clinical decision(s) necessary.
- √ Arrive on time.
- √ Call ahead if you cannot make your appointment.
- √ Fulfill your financial obligations for the service(s) rendered.

ABOUT YOUR TREATMENT

Psychotherapy has both benefits and risks. *Risks* may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. *Benefits* may include experiencing a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. There are no guarantees about what will happen. Psychotherapy requires a very active effort on your part - in and out of the therapeutic session.

EMERGENCY SERVICES

24 hour emergency services are not offered. In the event of an emergency, please:

1. Call 911, if you are in danger.
2. Call Freedom Wellness Center, PLLC at 270-228-2991 and leave a voicemail. An urgent appointment will be attempted.
3. If you are unable to reach your provider and/or an appointment cannot be made in a timely manner please call the crisis line at 800-433-7291.

BOTTOM LINE

Trust the process - its meant to help you, not hurt you.

You own your success - be involved.

Therapy is not mind reading - speak your mind.

Honesty is the best policy - what's the point in lying to someone that can't say anything anyway.

Client Signature (age 14 and above)	Parent/Guardian/Legal Rep.	Date

*by signing this document, I attest that I have the legal right to consent.

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_____ _____ ___/___/___

First, M.I. *Last* *DOB*

Payment Agreement

PROFESSIONAL FEES

Mental Health Evaluation			*$120*
Includes standard, domestic violence, and substance use evaluations			
**Time producing documents for Court and other referral sources included*			
Psychotherapy	*16-37 minutes = $60*	*38-52 minutes = $90*	*53-75min = $120*
Group therapy, per session			*$25*
Crisis Calls			*$150*
Treatment planning			*$70*
**Includes time outside therapeutic session developing an individualized treatment plan*			
Legal consultations/Court appearances			*$120*
**Pro-rated per hour: includes face to face, written, and/or telephone time incurred*			
Other fees:			
No show or same day cancellations			*$60*
Insufficient funds, per transaction			*$75*
Interpretation, preparation of results			*Prorated*

INSURANCE

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, assistance will be provided to you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and communicating if/when your coverage changes. Due to contractual agreements between Freedom Wellness Center, PLLC and (your insurance), only the "allowed" amount set by (your insurance) is considered for payment. Any amount over the "allowed" amount will be written off.

PAYMENT UNDERSTANDING

- √ Payment is due at the time services are provided unless a payment plan has been arranged.
- √ Accounts are past due after 30 days. Balances not paid within 90 days are considered terminated.
- √ Past due accounts are subject to being sent to collections.
- √ In the event that (the client) changes mental health providers and wishes that records be sent from Freedom Wellness Center, PLLC, the account balance must be paid in full.
- √ A credit card may be kept on file to secure any fees due at the time a service, including "other fees" above.

Office Use Only:

According to your policy, as of _____:

☐	Your policy does cover mental health services	☐	Your policy does not cover mental health services
☐	You have met your deductible	☐	You have not met your deductible
☐	You do not have a deductible	☐	Your copay is $ _____
☐	The total amount due at your first session is	$	
☐	The anticipated amount due once obligations specific to your policy are met is	$	

_____ _____ _____

Client Signature (age 14 and above) **Parent/Guardian/Legal Rep.** **Date**

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

_____ _____ ___/___/___

First, M.I. *Last* *DOB*

The person named above authorizes the discussion/sharing of protected health information by and between:

Freedom Wellness Center, PLLC
2816 Veach Road, Suite 208
Owensboro, KY 42303
270-228-2991 (office)
270-228-2994 (fax)

AND

_____
_____
_____
_____
_____

for the scope and purpose(s) of:

☐ All information regarding evaluation, treatment, progress, discharge, and recommendations related to the patient's condition, concern, or disease.
☐ All information between the dates _____ and _____
☐ Other/specific information: _____

Certain information requires specific authorization before being released. To authorize the release of the following types of information, ***you must initial and date***. Without your initials, such information may not be shared.

☐ Alcohol/Substance use and treatment ☐ Mental health treatment ☐ HIV/AIDS treatment

Client rights:

- ∨ This authorization will expire 1 year from the date signed unless otherwise specified.
- ∨ You have the right to review any information shared before being released.
- ∨ You may refuse to sign the authorization.
- ∨ Individual psychotherapy notes are not protected under HIPAA law and, therefore, are not required to be released.
- ∨ You have the right to have only the minimum necessary disclosed to satisfy the reason for the request.
- ∨ If you are above the age of 14 but under the age of 18, you have the right to decide who and what information is shared.
- ∨ You and (provider) reserve the right to redact any information that may potentially be used against the person named above.

There may be a fee associated for the copying of your records. You are entitled to 1 personal copy free of chage.

_____ _____ _____

Client Signature (age 14 and above) **Parent/Guardian/Legal Rep.** **Date**

*Must sign if 14-17 years of age

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SELF-REPORT

(Completing this helps us get to the point of why you are coming more quickly)
(p.s. Honesty is the best policy...remember, its stays between us anyway)

Chief Complaint (in other words, why now?):

Are you having thoughts of ☐ Suicide? ☐ Harming self? ☐ Harming others? ☐ N/A
Have you used any alcohol, drugs, or abused medication in the last 30 days? ☐ Yes ☐ No

Medical Care:

Do you see a physician/ARNP and/or take medication? ☐ Yes ☐ No
If yes, please list who, what, and when:

Do you believe taking your medication *is* helpful? ☐ Yes ☐ No

Past psychological/psychiatric care:

Have you previously been hospitalized or seen by a mental health provider? ☐ Yes ☐ No
If you answered yes, please list names/locations/dates below:

Have you taken medication for mental health reasons *in the past*? ☐ Yes ☐ No
If yes, please list condition and medication:

Present relationships:

☐ Single ☐ Married ☐ Dating ☐ Widowed ☐ Divorced ☐ Cohabitating
Do you have children? (list names/ages):

How would you describe your relationship with your spouse/partner?

How would you describe your relationship with your parents?

Do you have siblings? (list names/ages):

How would you describe your relationship with your child(ren)?

What kind(s) of support do you/can you rely on? (people, groups, church, things, spirituality, etc)

See Page 2 on back

Past relationships:

Were any of the following done BY YOU	Have any of the following done TO YOU
☐ Abandonment, Neglect, or Rejection	☐ Abandonment, Neglect, or Rejection
☐ Abuse, physical/sexual/emotional	☐ Abuse, physical/sexual/emotional
☐ Aggressiveness (physical or verbal)	☐ Aggressiveness (physical or verbal)
☐ Enabling or Dependence	☐ Enabling or Dependence
☐ Stalking	☐ Stalking

If so, please briefly explain:

Who did you live with growing up? Please briefly describe how this was for you:

Family history:

☐ Addiction (drug/alcohol)	☐ Depression	☐ Suicide, please list:
☐ Addiction (other:_____)	☐ Eating disorder	
☐ ADHD/Impulse control	☐ OCD	
☐ Anxiety	☐ PTSD	
☐ Bipolar	☐ Schizophrenia	

Please list the family members you are referring to in this section:

Social:

Were you or are you bullied?	☐ Yes	☐ No				
Do you have close friends?	☐ Yes	☐ No				
Are you generally respected by others?	☐ Yes	☐ No				
Which type of social setting do you prefer?	☐ Small groups		☐ Large groups		☐ None	

Education:

What is the highest level of education you have completed?

Are/were you in any special education classes? ☐ Yes ☐ No

Occupation:

Are you working? ☐ Yes ☐ No

Have you ever been fired/let go? ☐ Yes ☐ No

If you answered yes, please briefly describe:

If you answered no, are you looking for work?	☐ Yes	☐ No	☐ Disabled			
Are you/Have you been in the military?	☐ Yes	☐ No	☐ Combat?			

Legal:

Have you been arrested or charged with any crime?	☐ Yes	☐ No
Has an EPO or DVO ever been filed against you?	☐ Yes	☐ No
Are you on probation or parole?	☐ Yes	☐ No

Please briefly describe (list charge and year):

Substance Use/Addiction:

Have you ***ever*** used any of the following?				Age began	Last use
Alcohol	Y N	*Last 30 days?*	Y N		
Hallucinogens (LSC, MDMA, etc)	Y N	*Last 30 days?*	Y N		
Inhalents (Aerosols, gases, etc)	Y N	*Last 30 days?*	Y N		
Marijuana	Y N	*Last 30 days?*	Y N		
Methamphetamine or "meth"	Y N	*Last 30 days?*	Y N		
Heroin/Opioids (Oxy, Lortab, etc)	Y N	*Last 30 days?*	Y N		
Sedatives (Xanax, Ambien, etc)	Y N	*Last 30 days?*	Y N		
Stimulants (Cocaine, adderall, etc	Y N	*Last 30 days?*	Y N		

Have you ever felt you ought to cut down on your drinking or drug use?	Yes	No
Have people annoyed you by criticizing your drinking or drug use?	Yes	No
Have you felt bad or guilty about your drinking or drug use?	Yes	No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	Yes	No

Do you gamble? Y N How often? _____

Spiritual Life: God Higher Power Pagan Other, describe:

Any other information you feel is important?

(feel free to write in the space below)