Solutions4Wellness, Inc
Mailing Address: PO Box 141, Carlyle, IL 62231 www.Solutions4Wellness.com
Phone: 618.322.6424 Fax: 618.227.8227

Office Locations:
- ❑ Solutions4Wellness, 4977 Old US 50, Aviston, IL 62216
- ❑ @ Integrity Clinical Network, 4230 Lincolnshire, Suite D, Mt. Vernon, IL 62864

Today's Date:_____

Please complete so we may better serve your needs. More info here, will allow more time in session.

DEMOGRAPHICS

NAME: _____BIRTH DATE:_____

HOME ADDRESS: _____

CITY, STATE, ZIP:_____

E-MAIL: _____

CELL PHONE:_____OK TO LEAVE MSG? ☐ YES ☐ NO

OKAY TO RECEIVE APPOINTMENT REMINDERS BY TEXT? ☐ YES ☐ NO

HOME PHONE:_____OK TO LEAVE MSG? ☐ YES ☐ NO

WORK PHONE:_____OK TO LEAVE MSG? ☐ YES ☐ NO

ADD TO EMAIL LIST FOR OCCASIONAL UPDATES FROM SOLUTIONS4WELLNESS, INC? : ☐ YES ☐ NO

RELATIONSHIP STATUS

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ OTHER

IF CLIENT IS A MINOR:
LIST PARENT/ GUARDIAN NAMES, RELATIONSHIP STATUS AND CONTACT INFORMATION:

_____

_____

ARE YOU A PARENT? ?☐ YES ☐ NO ☐OTHER (please explain)_____
WHO DO YOU CURRENTLY LIVE WITH? _____

_____

EMPLOYMENT/EDUCATION/LEGAL STATUS

☐ WORK FULL-TIME ☐ WORK PART-TIME ☐ OTHER
Name of Employer: _____HOW LONG?_____
☐ STUDENT, FULL-TIME ☐ STUDENT, PART-TIME School Name:_____

ARE YOU INVOLVED IN ACTIVE LEGAL ENFORCEMENTS? ☐YES ☐ NO (i.e. Court/Restraining order)

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HEALTH/MEDICAL/LIFESTYLE/ACTIVITY STATUS

Primary Care Physician:_____ Phone: _____

Date of last medical exam:____/____/____

LIST Other Healthcare Providers (ie. Psychiatrist, Chiropractor, etc, include phone numbers, if possible)

_____

_____

Do you want us to coordinate care with any of these providers? ☐ YES ☐ NO ☐ Unsure

PLEASE LIST ANY MEDICAL PROBLEMS: _____

_____

_____

_____

PLEASE LIST ALL MEDICATIONS: _____

_____

_____

_____

DO YOU USE ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH?_____

DO YOU USE TOBACCO? ☐ YES ☐ NO IF YES, HOW MUCH?_____

OTHER SUBSTANCE USE (NOT A PART OF A MEDICAL TREATMENT PLAN) ☐ YES ☐ NO

IF YES, WHAT AND HOW MUCH?_____

On a scale of 1 to 10, with 1 being VERY BAD/MAJOR CONCERN and 10 being VERY GOOD/NO CONCERNS, rate how you experience the following:

SLEEP QUALITY _____

PHYSICAL ACTIVITY LEVEL _____

STRESS LEVEL _____

DIET/NUTRITION _____

OVERALL LEVEL OF HEALTH _____

OVERALL QUALITY OF LIFE/SATISFACTION WITH LIFE _____

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LIFE CHANGES, TRANSITIONS, STRESSORS: Have you/your family had these experiences?

Event	Experienced In the past year	Occurred, but not in the past year	Event	Experienced In the past year	Occurred, but not in the past year
1. Move to new home			12. Legal issues		
2. Divorce/break-up			13. Serious illness		
3. Remarriage			14. Guilt issues		
4. Relationship issues			15. Grief issues		
5. Family discord			16. Humiliation issues		
6. Adoption/Birth of child			17. Death in family		
7. Abuse issues			18. Loss of friend		
8. Employment changes			19. Foster care		
9. Work/school issues			20. Loss of pet		
10. Homelessness			21. Other Emotional or Mental Health Concerns (those of your own or someone connected to you)		
11. Financial Problems			22. Other significant events, not listed have impacted me		

AREA WHICH BEST DESCRIBES YOUR REASON FOR CONTACTING US:
"I'M LOOKING FOR HELP WITH OR RELIEF FROM (MARK ALL THAT APPLY)....

☐ STRESSORS LISTED ABOVE ☐ PERSONAL REASONS NOT LISTED IN STRESSORS
☐ RELATIONSHIP ☐ FAMILY ☐ HEALTH (___MY OWN or _____ SOMEONE ELSE'S)
☐ LIFE TRANSITION ☐ EMPLOYMENT ☐ BURNOUT ☐ FINANCIAL ☐ ANXIETY ☐
DEPRESSION ☐ OVERWHELM ☐ OTHER, briefly describe: _____

_____

HAVE YOU SOUGHT OUT HELP FOR THIS/THESE CONCERNS FROM OTHER PROFESSIONALS?
☐ YES ☐ NO
HAVE YOU RECEIVED ANY RELIEF OR IMPROVEMENT REGARDING THIS/THESE ISSUES?
☐ YES ☐ NO

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HAVE YOU PARTICIPATED IN COUNSELING/THERAPY IN THE PAST?

☐ YES ☐ NO

IF YES, PLEASE LIST WHO, HOW LONG AGO AND HOW HELPFUL IT WAS FOR YOU:

_____

HOW MOTIVATED ARE YOU TO OBTAIN RELIEF/RESOLVE FROM WHAT IS CONCERNING YOU?

☐ I DON'T REALLY SEE IT AS A PROBLEM, I'M HERE BECAUSE SOMEONE WANTS/INSISTS I NEED TO BE

☐ I REALIZE SOMETHING IS OFF, BUT I'M NOT SO SURE WHERE TO START

☐ I KNOW I NEED HELP, BUT I'M NOT REAL SURE IT WILL HELP

☐ I WANT HELP, BUT I'M NOT SURE HOW/WHERE TO START

☐ I'M DOING IT, JUST NEED SOME ASSISTANCE

☐ NONE OF THE ABOVE FIT, THIS IS WHERE I'M AT: _____

_____

HOW WERE YOU REFERRED TO US OR DID YOU HEAR ABOUT US?

☐ HEALTHCARE/OTHER PROVIDER (name) _____

☐ INSURANCE COMPANY ☐ INTERNET SEARCH

☐ COWORKER (name)_____ ☐ FAMILY MEMBER (name)

☐ Other, DESCRIBE _____

HEALTH INSURANCE INFORMATION

****A COPY OF YOUR INSURANCE CARD AND YOUR STATE ISSUED ID WILL BE NEEDED TO KEEP ON FILE. PLEASE HAVE THIS READY**.

HEALTH INSURANCE PLAN _____

MEMBER ID # _____ GROUP ID# _____

IF YOU ARE NOT PRIMARY CARDHOLDER, PROVIDE PRIMARY INSURED'S :

NAME _____ DATE OF BIRTH ___/___/___

EMPLOYER_____

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INFORMED CONSENT FOR TREATMENT, CONTRACT, FINANCIAL AGREEMENT & OFFICE POLICIES

Welcome to Solutions4Wellness,Inc. Solutions4Wellness,Inc is an agency that employs Licensed Clinical Social Workers or other therapists who engage in the practice of mental and behavioral health services through the delivery of counseling and psychotherapy. Additional services provided by Solutions4Wellness,Inc include psycho-educational classes, groups, workshops, consultation and Critical Incident Stress Management services which includes personal and clinical information that is confidential.

Therapists We are Licensed Clinical Social Workers in the State of Illinois and oblige by the National Association of Social Worker's Code of Ethics and will use these legal and ethical standards with all clients, no matter what service they receive with the same obligations that she would a counseling or therapy client.

Techniques: We utilize an intuitive approach to wellness, incorporating a variety of method and techniques. In which the providers are trained. There are options available should it be decided not to use one specific technique. Techniques include talk therapies to address behavioral and cognitive psychological processes, including CBT (Cognitive Behavioral Therapy), Gottman Method of couples counseling, as well as techniques to address emotion and subconscious, or unaware thoughts, to include mindfulness and EMDR(Eye Movement Desensitization and Reprocessing) methodology, which is a form of adaptive information processing when may help the brain unblock maladaptive material. I have been advised and understand that EMDR is a treatment approach that has been widely validated by research on PTSD. Some studies indicate that EMDR is also effective in reducing anxiety and other symptoms. Additional trainings have included Brainspotting, DNMS, and PSYCH-K, which utilizes muscle testing in which the therapist applies light pressure to the hand or wrist area. For anyone unfamiliar, but interested in these processes, it will be further explained and demonstrated.

Rights and Risks: Please ask questions about any aspect of the therapy, coaching or educational process. You need to be willing to discuss what troubles you and be open to change. If you are engaging in counseling services, you may remember unpleasant events, arouse intense emotions, and/or alter close relationships. The purpose of counseling is to facilitate your process. If a court or state agency referred you, you have the right to divulge only what you want to be included in a report.

Limits of Treatment: Your participation in psychotherapy is voluntary and you have the right to withdraw from treatment without adversity at any time. We encourage you to let your therapist know you wish to stop sessions so the last session is tailored to providing closure. There are rare circumstances in which a therapist may be obligated to make a unilateral decision to terminate therapy with a client. In such cases, the therapist will attempt to find a suitable referral. The therapist cannot be responsible as to whether this referral is accepted.

Dual Relationships: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves relationships that impair the provider's objectivity, clinical judgment or can be exploitative in nature. Our providers extend this to all professional relationships, including coaching, consulting, education and mentoring. We will assess carefully before entering into non-exploitative dual relationships with clients. You may bump into someone you know in the waiting room or into a provider in the community. We will never acknowledge working with anyone without his/her permission. Many clients choose us as their provider because we are known to them before entering into a professional relationship as the consumer /client is personally aware of our professional work and achievements. Nevertheless, we will discuss with you, the client/s, the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to your provider if the dual or multiple relationship becomes uncomfortable for you in any way. We will always listen carefully and respond accordingly to

your feedback and will discontinue the dual relationship if we finds it interfering with the effectiveness of the our work together or the welfare of the client and of course you can do the same at any time.

Appointments: All office visits are by appointment only. Your scheduled time is dedicated to your well-being as with other clients and their scheduled time. The usual length of an appointment is 45-50 minutes unless scheduled differently.

Fees and Financial Arrangement Options: Payments are required at your session, so please have your check, cash, or credit card ready. Private pay is one option to pay for service fees. Options to obtain reimbursement include: HSA (Health Savings Account) receipt for reimbursement, In-Network Insurance, Out-Of-Network Insurance and EAP (Employee Assistance Program). Once the options have been explained, you will be asked to indicate how you will choose to pay for your fees and your portion of the payment is due at the time of service. Your indication of your payment choice will be acknowledged on the Financial Agreement Form.

Our providers are In Network Providers for some insurances. If we are In-Network for your insurance, it is your responsibility to verify your benefits and seek pre-authorization and at the time of service, you are responsible for your portion of the fee, including co-pays and deductibles. For those Out of Network, your insurance may pay for sessions at at Out of Network Rate and your are responsible for the full fee at the time of service. If you utilize insurance benefits, either In Network or Out of Network, it is your responsibility to seek pre-authorization and verify benefits. We will work with you to help you seek the use of these resources, although it is ultimately your responsibility to verify your benefits and seek pre-authorization prior to appointments. An Insurance Verification form for your convenience is provided for you to use in verifying your insurance.

As a courtesy, we may also verify your benefits and electronically submit your billing, although this does not guarantee payment from the insurance company. If your health insurance does not pay your claim within 30 business days, we may ask and you agree to pay the unpaid fees and any overpayment from your insurance after that point would be returned to you.

*Insurance companies have implemented many changes over the last few months so we strongly encourage you to contact them regarding your benefits.

Returned checks will incur a minimum fee of $25 plus the original amount of the check.

Service fees begin at $100 and vary depending on the service time. Discounts for private pay day of service payment options are available. The service and it's corresponding fee will be explained at your session.

Cancellation Policy: Christina R. Diesen, MSW, LCSW has the policy of charging for missed appointments and late cancellations (less than 24 business hours before scheduled appointment). **Business hours are typically Monday through Friday 9:00 AM to 6:00 PM. As long as you contact the office at 618-322-6424 within 24 business hours, there is no charge. If you give a cancellation notice 23 business hours or less from your scheduled time, a fee of $30 will be assessed to your account and is not payable by your insurance company.** It is difficult to schedule a new appointment with this short notice. Insurance companies do not pay for 'no show' charges or late cancellation fees. We can make no exceptions to this rule, including for reasons associated with illness, childcare issues, or work conflict.

Telephone Calls: Calls over five (5) minutes are billed at $25, per 15-minute increments. If your therapist is not able to respond to your question in a way that best serves you at that initial phone call, she will inform you of scheduling a telephone or individual session. Your therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays.

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Electronic Communication: As technology has advanced, the use of cellphones, texting, and e-mailing has become more prominent. I do not provide psychotherapy through text or e-mails. Any psychotherapy issue must be communicated through face-to-face communication or via telephone. Any e-mails or text messages sent to the therapist will be responded to at the therapist's convenience and it may take 24-48 hours to receive a response. We cannot guarantee your privacy under your protected health information and ask that these means of communication be used ONLY for business purposes, such as arranging or rescheduling appointments or communication regarding payment.

Emergencies: **In a crisis, the best number to call is 911 or go to the nearest emergency room**. Once the doctor has seen you, please call to inform your therapist. Please leave a message, if we cannot answer.

Consent to Treat and Confidentiality: I have read and/or received a copy of Solutions4Wellness, Inc's Privacy Policy (Notices of Policies and Practices to Protect the Privacy of Patient's Health Information) and I may request a copy. I am in agreement with the above policies. If desired, I discussed these policies with my therapist and all questions were answered to my satisfaction. **I understand that in the event of nonpayment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I realize that my account may be sent to a collection agency after it is 60 days past due. The only information shared with a professional collection service is my contact information, date of birth, services rendered, dates of treatment and charges incurred. All clinical notes will not be shared in order to collect a debt.**

LITIGATION DISCLOSURE AGREEMENT: If you are involved in litigation or become a party to litigation, you agree that you will not call your therapist at Solutions4Wellness, Inc to testify or release records of service.

As a treating therapist, the role is to provide treatment and not make recommendations to courts in legal matters. It is our policy not to testify in court cases because experience has shown that the professional relationship is often harmed when therapists testify. However, we will always respond according to the law. In domestic litigations, such as divorce and custody disputes, courts can appoint professionals who have no prior contact with a family to conduct custody evaluations and to make recommendations to the court.

We agree the goal is to provide treatment to help improve client emotional and mental health needs of and to maintain and protect their right to confidentiality.

By signing below, you are consenting to treatment by a contracted therapist of Solutions4Wellness, Inc and you agree not to call your treating therapist or any contracted therapist of Solutions4Wellness, Inc as a witness in litigation matters. You also agree not to requests any letters of support or therapy notes for judges or attorneys to review or utilize in any litigation matter. (Conjoint and Family session, all adults sign.)

Duty To Warn: I designate the following people to be contacted if I am in danger:

NAME/RELATIONSHIP_____PHONE NUMBER:_____

I have read, understand and agree to the stipulations of the Informed Consent, Treatment Agreement, Contract and Financial Agreement and The Litigation Disclosure Agreement and I have asked for clarity on any part that I did not clearly understand to include:

Client Signature (age 12 & over): _____ Date: _____
Client Signature (age 12 & over): _____ Date: _____
Treating Therapist: _____ Date: _____

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Payment/Insurance Verification Form

Choosing to bill for counseling sessions through your insurance carrier is an important decision you must make. According to federal regulations, you may choose to 'opt', pay out-of-pocket, and **NOT bill through your insurance policy**. Clients who 'opt' are private pay clients. Should this be your preference, Solutions4Wellness, Inc would **NOT have the authorization to share your records with your insurance company**. The decision made at the outset of services regarding payment of services is changeable at any time by completing a new form and updating your file. However, the fee or payment option is not retroactive and only changes for subsequent sessions.

Here is an example. Let's say you opt to be a "private pay client" in January, and pay for services at $150.00 per session for 4 weeks. You cannot change your status from private pay client to Insurance Client for those January dates of service. If you decide to bill insurance for your February sessions, you would need to complete a new form expressing that preference, and your rates would reflect that change for your February sessions and all subsequent sessions as long as that is your expressed preference. Keep in mind if you choose to use insurance benefits, the insurance company will have instant access to your records. In addition, you will be responsible for deductibles and co-pays for subsequent sessions.

Knowing your out-of-pocket expenses prior to receiving services is your right and your responsibility.

Select a box:

- ❑ I choose to be designated as a **private pay client** at Christina R. Diesen, MSW, LCSW. I will pay for sessions out-of pocket with cash, check, or credit card, in accordance with my signed contract for services. I do not authorize Christina R. Diesen, MSW, LCSW, its agents or employees, to share my private information with my insurance company.

- ❑ I choose to bill my insurance company for mental health services. I understand that if my provider at Solutions4Wellness, Inc is in-network with my carrier, my rates may be discounted in accordance with their business contract. I understand that if y provider at Solutions4Wellness, Inc is out of network with my insurance company, I am responsible for co-pays, deductible payments, or any portion of the session fees not covered by my plan. I grant this permission to be effective as of the date of my signature and witnessed by a representative of Solutions4Wellness, Inc

INITIAL _____ I understand that Solutions4Wellness, Inc and my insurance company can terminate network contracts at any time and neither is required by law to inform me of this change. However, Christina Diesen will make every effort to communicate any contractual change via letter, telephone call or in person. This change will affect my financial responsibility for subsequent sessions.

I authorize the release or exchange of information from Solutions4Wellness, Inc of my insurance company, EAP, managed care group, and/or other paying organization to facilitate payment and continued coverage under the mental health benefit of my policy. I consent to have Solutions4Wellness, Inc submit claims on my behalf to my insurance company, EAP, managed care group, or other paying organization and receive payment according to the guidelines of my policy. I understand that I am responsible for payment for services rendered by Solutions4Wellness, Inc regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form may result in nonpayment by my insurance company. I agree to notify Solutions4Wellness, Inc as soon as I am aware of any changes in my health condition or health plan coverage.

_____ _____

CLIENT OR PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

EMPLOYEE/AGENT SIGNATURE **DATE**