Solutions4Wellness, Inc
Mailing Address: 231 N. Main St, Breese, IL 62230 www.Solutions4Wellness.com
Phone: 618.322.6424 Fax: 618.227.8227
Office Locations: 231 N Main Street, Breese, IL 62230 & 3600 S Water Tower Place, Mt. Vernon, IL 62864

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

DEMOGRAPHICS

DATE OR FIRST APPOINTMENT: _____

NAME: _____NICKNAME PREFERRED:_____

AGE TODAY:_____ BIRTH DATE:_____ Gender: ☐ Female ☐ Male

HOME ADDRESS: _____

CITY, STATE, ZIP:_____

E-MAIL: _____ OK TO EMAIL? ☐ YES ☐ NO

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:
*If legal enforcements, such as custody or parenting plans exist, we require a copy of the intact, current legal documents.

_____

_____

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)

IF YES, BRIEFLY EXPLAIN: _____

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

☐ HEALTHCARE/OTHER PROVIDER (name) _____ ☐ INSURANCE COMPANY

☐ INTERNET SEARCH ☐ FRIEND/COWORKER/FAMILY MEMBER (Name): _____

☐ Other, DESCRIBE _____

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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 _____

EMPLOYER/SPONSOR OF PLAN_____

MEMBER ID # _____ GROUP ID# _____

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

NAME _____ DATE OF BIRTH ___/___/___

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 CURRENT MEDICATIONS (if you do not have a copy of them with you to provide today):

Name of Medication	Prescribed for Reason for Use	Dosage amount	Frequency/ How Often Taken	Physician Prescribed by

(ADD ADDITIONAL MEDICATION ON SEPARATE SHEET OF PAPER)

IF HAVE YOU TAKEN PSYCHOTROPIC MEDICATIONS IN THE PAST, PLEASE COMPLETE:

LIST WHAT YOU'VE TAKEN, HOW LONG AGO AND REASON FOR DISCONTINUATION:

_____

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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 LIFE SATISFACTION_____

How much sleep you get each night? _____ Do you typically wake up rested? ☐ YES ☐ NO

How much caffeine do you typically have each day?_____

THERAPEUTIC PREPARATION STATUS

In your own words, what are your primary concerns that lead you to schedule this appointment?

_____

_____

_____

_____

AND/OR YOU MAY USE THIS CHECKLIST FOR EXPLAINING THE 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 ☐ HARMFUL THOUGHTS ABOUT SELF OR OTHERS

☐ OTHER, briefly describe: _____

PLEASE NOTE THAT IF ANSWERING ANY OF THE FOLLOWING QUESTIONS FEELS TO PAINFUL OR CHALLENGING TO ANSWER, SKIP THIS SECTION AND SIMPLY MARK THIS BOX AND MOVE TO THE NEXT SECTION. WE CAN DISCUSS THIS TOGETHER DURING OUR WORK TOGETHER. ☐

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

HAVE YOU PARTICIPATED IN COUNSELING/THERAPY IN THE PAST? ☐ YES ☐ NO

IF YES, PLEASE LIST TO THE BEST OF YOUR KNOWLEDGE:
WHEN: _____ ABOUT HOW LONG DID YOU ATTEND?:_____

What did you find helpful about your treatment? _____

What was not helpful in your treatment? _____

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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: _____

SYMPTOM CHECKLIST (check all that apply or that you have been experiencing):

___Depression	___ Angry or irritable	___Compulsive rituals
___Poor Appetite	___Loses temper easily	___Excessive Distress
___Sleep Changes	___Argues with others	___Risky sexual behaviors
___Hopelessness	___Loose thinking	___History of trauma
___Low Energy	___Racing thoughts	___History of eating disorder
___Low Self-Esteem	___Disorientation or confusion	___Excessive exercise
___Diminished Interest	___Decline in Personal Hygiene	___Vomiting, laxatives, diuretics
___Weight Change	___Anxiety or excessive worry	___Menstrual irregularities
___Fatigue	___Physical aches and complaints	___Avoidance of eating in social situations
___Worthlessness	___Unrealistic worry about the future	___Preoccupation with food
___Suicidal Ideations		___History of weight fluctuations
___Social Problems	___Unrealistic concern about past	___Several failed diets
___Excessive moodiness	___Self-consciousness	___Eating for reasons other than hunger
___Self Harm	___Excessive need for reassurance	___Eating until so full you are uncomfortable
___History of self-harm	___Inability to relax	
___Hx of suicide attempt	___Panic Behavior	___Feeling that your eating is out of control
___Hx of ups and downs	___Difficulty listening	___Secretive eating
	___Difficulty concentrating/memory	___Feeling disgusted or guilty about eating
	___Poor school/work Functioning	___Skipping meals and then overeating

Additional Symptoms/Concerns Not Listed Above: _____

_____

PLEASE NOTE YOUR HISTORY TO USE WITH SUBSTANCES. IF NOT USED, WRITE "NA"

Substance	Age started	Age stopped	Frequency	Amount
Alcohol				
Marijuana				
Cocaine				
Opiates				
Club drugs				
Other				

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Have you experienced Drug/Alcohol use resulting in?

__ Failure in school, work, home __Physically dangerous situations __Legal problems
__ Social/relationship problems __Tolerance/withdrawal __Intoxication

Indicate other family history of Addiction and Mental Health Concerns: _____
_____
_____

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

This Event Occurred:	In the Past Year	This happened in the past	This still affects me	This is part of why I am here
Move to a new home	_____	_____	_____	_____
Divorce/Break-up	_____	_____	_____	_____
Remarriage	_____	_____	_____	_____
Relationship Issues	_____	_____	_____	_____
Family Discord	_____	_____	_____	_____
Adoption/Birth of child	_____	_____	_____	_____
Abuse issues/Violence Exposure	_____	_____	_____	_____
Employment changes	_____	_____	_____	_____
Work/school issues	_____	_____	_____	_____
Homelessness	_____	_____	_____	_____
Financial Problems	_____	_____	_____	_____
Legal issues	_____	_____	_____	_____
Personally having a Serious illness	_____	_____	_____	_____
Someone else having a serious illness	_____	_____	_____	_____
Military Service, My Own	_____	_____	_____	_____
Military Service, Someone else's	_____	_____	_____	_____
Stressful, Demanding Job	_____	_____	_____	_____
Grief issues	_____	_____	_____	_____
Guilt issues	_____	_____	_____	_____
Humiliation or Shame issues	_____	_____	_____	_____
Death in family	_____	_____	_____	_____
Death of someone else close to	_____	_____	_____	_____
Loss of friendship	_____	_____	_____	_____
Foster care	_____	_____	_____	_____
Loss of pet	_____	_____	_____	_____
Self Harming thoughts or actions	_____	_____	_____	_____
Harmful thoughts or actions to others	_____	_____	_____	_____
Other Emotional or Mental Health Concerns (those of your own or someone connected to you)	_____	_____	_____	_____

Other information you believe would be important for me to know about you?

_____
_____

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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 mental health professionals 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.

THERAPIST/PROVIDERS: 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), relationship counseling and techniques to address emotion and subconscious, or unaware thoughts, to include mindfulness, Brainspotting, EMDR(Eye Movement Desensitization and Reprocessing) methodology, which is a form of adaptive information processing when used, may help the brain unblock maladaptive material. I have been advised and understand that treatment approaches that have been researched as effective for trauma also have some studies that indicate they may also be effective in reducing anxiety and other symptoms.

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/counseling 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.

(INITIALS) _____ I read and agree with the Techniques, Rights and Risks and understand the Role and Limits of Treatment.

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 industry standard and usual length of an appointment is 45-53 minutes unless scheduled differently. Other arrangements can be made per request outside of the use of health insurance.

FEES AND FINANCIAL ARRANGEMENTS: 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 $80 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 prior to or at your session.

CANCELLATION POLICY: Solutions4Wellness, Inc. 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 at scheduled times. 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. If you receive automated appointment reminders through text from your therapist, they are typically sent the day before and with at least 24 hours notice. You can cancel using the instructions on the text message within the 24 hour time frame without penalty. If you cancel using this method with less than 24 hours notice, the cancellation fee may also apply.** It is difficult to schedule someone for the appointment with this short notice. Insurance companies do not pay for 'no show' charges or late cancellation fees. We cannot make exceptions to this rule, including for reasons associated with illness, childcare issues, or work conflict.

(INITIALS) _____ I read, agree and understand the Appointments, Fees, Financial Arrangements & Cancellation Policy.

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.

ELECTRONIC COMMUNICATION: As technology has advanced, the use of cellphones, texting, and e-mailing has become more prominent. We 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 at least 24-48 hours to receive a response. Using this technology, 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. Your

participation in the use of electronic communication and agreement to our office policies is your acknowledgment that you understand we cannot guarantee your protected health information shared through electronic communications.

(INITIALS) _____I read, agree and understand the Telephone Call and Electronic Communication Policy.

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.

SOCIAL MEDIA POLICY: Per the NASW Code of Ethics the general public can hold the social work profession accountable for professional practice and consumer protection. It is our primary responsibility as your provider to assure that we keep your best interest in mind and with the quick changing world of social media, provide a clear understanding of our social media policy. We will conduct ourselves on the Internet as a mental health professional and how you can expect us to respond to various interactions that may occur between us on the Internet. As new technology develops and the internet changes, there may be times when we may need to update this policy. If we do so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

SOCIAL MEDIA: FRIENDING: Per the NASW Code of Ethics policies we cannot accept friend or contact requests from current or former clients on social networking sites (ie-Facebook, LinkedIn). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

SOCIAL MEDIA "FOLLOWING AND FANNING": At this time we keep a Professional Facebook and Pinterest Page for Solutions4Wellness, Inc to post psychology and motivational information and news, share blogs and to allow people to share blog posts and practice updates with other Facebook users. As our blogs are published, they will be available on our website, www.Solutions4Wellness.com.
If you, a client, chooses to "like" our professional pages on social media, this may create a greater likelihood of compromised client confidentiality and the NASW's Code of Ethics prohibits soliciting testimonials from clients and we in no way or looking to solicit any endorsement from any current or previous therapy clients. We have no expectation that you as a client will want to follow our blog, Facebook Page or Pinterest page. However, if you use an easily recognizable name and we happen to notice that you've followed us at any of these locations, we may briefly discuss it and its potential impact on our working relationship.

Note that you should be able to subscribe to the page via RSS without becoming a Fan and without creating a visible, public link to my Page. You are more than welcome to do this.

SOCIAL MEDIA: ELECTRONIC COMMUNICATION: We will avoid communication with clients using technology (such as social networking sites, online chat in addition to e-mail, text messages, telephone and video) for personal or non-work related purposes. If communication through any of these electronic means occurs, we will only communicate about business tasks, ie-appointments.

We will never share any identifying or confidential information about our clients on any of these platforms.

(INITIALS) _____I read and agree with and understand the Dual Relationship and Social Media Policies.

MISSED APPOINTMENTS/INACTIVE SERVICES/CLOSURE POLICY: We encourage a pre-planned and prepared finalization to conclude your therapy experience, which is discussed from the beginning of treatment. Although we encourage face to face sessions to provide healthy and therapeutic closure or finalization of services, we realize that a situation may arise in that this may not occur, ie-a client leaves without rescheduling a session or cancels and does not reschedule. In the event you do not have a set appointment or you for some reason, such as cancellation without contacting us to reschedule, it is our policy to allow you to make decisions on your own behalf. We may contact you during the time of your appointment to verify your participation, although we typically do not contact you to reschedule primarily due to potential privacy concerns. If after 60 days of your last appointment, you have not established contact with Solutions4Wellness, Inc or your therapist, we assume that you decided to stop therapy at this time and you will no longer be considered an "Open or Active Client/Case" and at that time your case will automatically, without further notice be considered closed. If your case becomes Inactive/Closed, unless indicated differently, you are welcome to reestablish contact to reopen or resume services with your therapist and the paperwork that is required for a new or returning client will be necessary to complete at this time. This policy is in effect unless other arrangements are made with your therapist, such as an agreement for maintenance sessions that are less than monthly.

(INITIALS) _____I read and agree with and understand the Missed Appointment, Inactive Services and Closure Policy.

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.)

(INITIALS) _____I read and agree with and understand the Litigation Disclosure Agreement Policy.

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.

DUTY TO WARN: I designate the following people to be contacted if I am in danger:

NAME/RELATIONSHIP_____PHONE NUMBER:_____

(INITIALS) _____ I read, agree and understand when to call 911 or go to emergency room but for a non-emergency question, and Telephone Calls

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.**

(INITIALS) _____I read and agree with and understand the Consent to Treat and Confidentiality Policy.

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: _____

IF CLIENT IS A MINOR:

Client's Parent/Guardian Signature: _____ Date: _____

Client's Parent/Guardian Signature: _____ Date: _____

Treating Therapist: _____ Date: _____

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THIS PAGE MAY BE USED TO ADD ADDITIONAL INFORMATION

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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**