DeLuca Family Wellness Center, Inc.

CLIENT INFORMATION AND INSURANCE: Date:_____

1. Name:_____ 2. Birth Date: ____/ ____/____ 3. Sex: ☐ M ☐ F

4. Address:_____5. Relationship to Insurance Policy Holder:

City:_____ Self ☐ Child ☐

State: _____ Zip Code: _____

6. Social Security Number: _____-_____-_____

7. Parent/Guardian Name: _____

8. Parent/Guardian Phone: _____

9. Parent/Guardian Email: _____

PRIMARY HEALTH INSURANCE INFORMATION:

10. Name of Policy Holder: _____ 11. Date of Birth: _____/_____/_____

12. Address of Policy Holder:_____ 13. Sex: ☐ M ☐ F

14. Phone number of Policy Holder: _____

15. Primary Insurance Company Name: _____

16. Member ID #: _____

17. Employer: _____

18. Is there other health insurance coverage?: Yes ☐ No ☐

SECONDARY HEALTH INSURANCE INFORMATION:

19. Name of Policy Holder: _____ 20. Date of Birth: _____/_____/____

21. Address of Policy Holder: _____ 22. Sex: ☐ M ☐ F

23. Phone number of Policy Holder: _____

24. Secondary Insurance Company Name: _____

25. Secondary Insurance Company Member ID#: _____

26. Employer: _____

27. Who is legal custodian of child?: Parents ☐ Other (Please specify)_____

28. If there was a divorce which state and county has jurisdiction?: _____

39. What type of legal custody was ordered?: Joint ☐ Mother ☐ Father ☐ Other ☐

30. If joint custody exists, **both** parents must consent to non-emergency psychological care.

Child/Adolescent Questionnaire

Client Name: _____

Name and relationship to client of person completing questionnaire:_____

How did you learn about this practice? Friend ☐ Family member ☐ Website ☐ Court/Lawyer ☐

Professional referral ☐ Insurance referral ☐ School referral ☐

What do you think are your child's main struggles? (Include current concerns and stressors).

_____

_____

_____

_____

_____

_____

When did you first notice these difficulties? How did these struggles come to your attention?

_____

_____

_____

_____

_____

MENTAL HEALTH HISTORY:

Has your child been prescribed medications to manage his/her emotions or behavior? Yes ☐ No ☐

If "yes", please state the name of each medication, reason for taking and prescribing physician.

_____

_____

_____

_____

Has your child been in counseling before? Yes ☐ No ☐

If "yes", was that experience… Very positive ☐ Somewhat positive ☐ Negative ☐ Not Sure ☐

If "yes", please list the names of past therapists, reasons for treatment and dates seen.

_____

_____

_____

_____

Has your child made any suicide attempts in the past? Yes ☐ No ☐

Has your child engaged in any self-harm behavior (i.e. cutting or burning)? Yes ☐ No ☐

Has your child ever been hospitalized for mental health treatment? Yes ☐ No ☐

If "yes", please list name of hospital/facility, dates of stay and reason for admission.

_____

_____

_____

_____

_____

FAMILY HISTORY:

Are the child's parents currently…. Living together ☐ Married to each other ☐ Separated ☐ Divorced ☐
Remarried ☐ Widowed ☐ Other ☐
List the names of those currently living in your child's household. Include age, relationship to child and occupation.

Do any family members suffer from substance abuse or emotional problems? Yes ☐ No ☐
If "yes", please describe.

Please describe any additional family stressors that may be contributing to your child's struggles.

PHYSICAL HEALTH:

Name of Pediatrician: _____
Please describe your child's current physical health condition.

List your child's current medications including name, reason for medication and name of prescribing physician.

Does your child use tobacco products? (i.e. cigarettes, snuff, vapes, etc…) Yes ☐ No ☐
Does your child use street drugs, painkillers, tranquilizers, stimulants or sleeping pills? Yes ☐ No ☐
Has your child ever used drugs or alcohol excessively? Yes ☐ No ☐
Do you or others believe that your child has a problem with alcohol or drugs? Yes ☐ No ☐
Has your child received treatment for alcohol or drug abuse? Yes ☐ No ☐
Is your child currently facing or ever faced any criminal charges? Yes ☐ No ☐
If "yes", please describe.

Is your child currently on probation? Yes ☐ No ☐

SCHOOL AND SOCIAL LIFE:

Current grade level _____ Name of School _____
Has your child been diagnosed with a learning or attention disorder? Yes ☐ No ☐
If "yes", please describe.

_____
_____
_____
_____

Does your child currently have an IEP (Individualized Education Plan) or 504 Plan at school? Yes ☐ No ☐
Has your child ever been suspended or expelled from school for behavioral problems? Yes ☐ No ☐
Current grades _____ Typical grades _____

Describe your child's socialization (check all that apply). is popular ☐ makes friends easily ☐ has many friends ☐
has few close friends ☐ has difficulty fitting in ☐
is teased or bullied ☐ is shy or awkward ☐
chooses friends I don't approve of ☐ difficult to get to go to school ☐ underperforms at school ☐

How does your child spend his/her free time? Describe any extracurricular activities and interests.

_____
_____
_____
_____

Is your child involved in any social, religious or community organizations? Yes ☐ No ☐
If "yes", please describe.

_____
_____
_____

Please describe your child's strengths and weaknesses.

_____
_____
_____
_____
_____
_____

Contact Information Permissions:

I authorize DeLuca Family Wellness Center Inc to: (Please indicate YES or NO for each option)
YES ☐ NO ☐ Leave a message on my home telephone voicemail
YES ☐ NO ☐ Leave a message on my work telephone voicemail
YES ☐ NO ☐ Leave a message on my cell telephone voicemail
YES ☐ NO ☐ Leave a message with a family member/friend at my home
YES ☐ NO ☐ Permission to receive a reminder telephone call/text of future appointments

DeLuca Family Wellness Center, Inc.
Payment Responsibility

Name of Client: _____ Date: _____

Person responsible for payment and relationship to client: _____

Social Security Number of Person Responsible for Payment:_____-_____-_____

Birthdate of Person Responsible for Payment: _____/_____/_____

In signing, I agree to be responsible for all charges incurred during my time in counseling. I understand that it is my responsibility to educate myself and know the extent and limits of my insurance benefits. If my insurance does not pay these charges or any part thereof, I agree to be responsible and will pay the incurred fees in a timely fashion. I understand that a third party billing agency, in addition to collections agency services if necessary, may be processing my payments and these agencies are bound by a confidentiality agreement and will only have access to billing information. I agree to the assignment of benefits directly to the provider. Attached is a form for your credit/debit card information should you choose to set up an arrangement to have your payment automatically deducted monthly. Should you choose not to set up automatic deduction, you will be responsible for payment in full, either by cash or check, prior to each visit. Visit fees are as follows: Initial session - $225.00; Individual session - $185.00; Family session - $200.00.

Futhermore, I also understand that in the event I have to miss a scheduled appointment, 24-hour notice must be given or I may be charged a $75.00 cancellation for my missed appointment.

I understand the DeLuca Family Wellness Center, Inc. makes every effort to assist in improving appointment attendance including reminder texts 24-hours prior to each appointment, however, it is my responsibility to manage my appointment times and dates. The 24-hour notice of cancellation can be achieved through telephone, fax or email. I also understand the DeLuca Family Wellness Center, Inc. may use a collection agency and credit bureau to both report and collect any balance outstanding beyond 30 days.

If you have any questions or concerns regarding any of the above, please ask prior to your therapy session beginning.

Please choose one of the following: ☐ Bill my credit/debit card ☐ Cash/Check in advance of session

Agreed upon monthly payment plan amount (if necessary FOR OFFICE USE ONLY): _____

Signature: _____ Date: _____

DeLuca Family Wellness Center, Inc.
Credit/Debit Card Charge Form

Date: _____

Client's Name: _____

Cardholder's Name: _____

Type of Card: Visa☐ MasterCard☐ Am Express ☐ Discover ☐

Card Number: _____

Expiration Date (Month / Year): _____ / _____

Three / Four Digit Security Code: _____

Cardholder's Address: Street: _____
City: _____
State / Zip: _____

Cardholder's Phone Number Associated with card: _____

Cardholder's Email: _____

Printed Name: _____

Signature : _____ Date: _____

DeLuca Family Wellness Center, Inc.

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____and the DeLuca Family Wellness Center, Inc. When the word "you" appears below, it can mean you, your child, a relative or other persons if you have written his or her name below:

_____

When this practice examines, tests, diagnoses, treats or refers you, it will be collecting what the law calls Protected Health Information (PHI) about you. This practice needs to use this information to decide what treatment is best for you and to provide any treatment to you. This practice may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions not limited to but including court or legal purposes. This practice may use or disclose PHI for purposes outside of treatment, payment, and health care operations when appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when asked for information for purposes outside of treatment, payment and healthcare operations, an authorization will be obtained from you before releasing this information. An authorization will also need to be obtained before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes that have been made about your conversations during private, group, joint or family counseling sessions, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

By signing this form, you are agreeing to let this practice use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how this practice can use and share your information. Please read this before you sign the consent form.

If you are concerned about some of your information, you have the right to ask this practice to not use or share some of your information for treatment, payment, or administrative purposes. You will have to request what you want in writing. Although this practice will make every attempt to respect your wishes, it is not required to agree to requested limitations.

After you have signed this consent, you have the right to revoke it, in writing, and this practice will comply with your wishes about using or sharing your information from that time on considering it may already have used or shared some of your information that cannot be changed.

Signature of Client Guardian: _____

Printed name of Client Guardian: _____

Date: _____

Relationship to Client: _____

DeLuca Family Wellness Center, Inc.

Notice of Privacy Practices (1)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

This practice is dedicated to maintaining the privacy of your PHI as part of providing professional care. This practice is required by law to keep your information private. However, this notice cannot cover all possible situations so please talk to DeLuca Family Wellness Center, Inc. about any questions or concerns.

This practice will use the information about your health that is obtained from you or from others mainly to provide you with treatment, to arrange payment for these services, and for other business activities that are called, in law, health care operations. If this practice or you want to use or disclose your information for any other purposes, this will be discussed with you and a written authorization obtained.

While this practice will keep your health information private, there are circumstances where it may disclose PHI without your consent or authorization such as:

1. **Serious Threat to Health or Safety**: Confidential information may be released to protect against a serious threat to your health or safety or the health or safety of another individual or the public.
2. **Child Abuse**: If there is reasonable cause to suspect that a child is abused or neglected or if this practice observes a child being subjected to conditions that are likely to result in abuse or neglect, it is required by law to immediately report these circumstances to the West Virginia State Department of Human Services. If it is believed that a child has suffered serious physical abuse or sexual abuse, it must in addition , be reported to a law enforcement agency.
3. **Professional Health Oversight**: If the West Virginia Board of Examiners in Counseling, its president, or the ethics coordinator issues a subpoena requesting this practice to appear before them and bring documentation, compliance is required. This could include your confidential mental health information.
4. **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made regarding your evaluation, diagnosis or treatment or the records thereof, such information may be privileged under state law, and therefore generally will not be released without your written consent or court order. The privilege would not apply when you are being evaluated for a third party or where evaluation is court ordered.

Initial_____

DeLuca Family Wellness Center, Inc.

Notice Privacy Practices (2)

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. You can ask this practice to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can request this practice to telephone you at home and not at work to schedule or cancel an appointment or to have your bill sent to alternate addresses.
2. You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Access to PHI may be denied under certain circumstances and in some cases you may have this decision reviewed. On your request, the details of the request and denial process will be discussed with you.
3. If you believe the information your record is incorrect or missing important information, you can ask this practice to make some kinds of changes (called *amending*) to your health information. Upon request, this practice will discuss with you the details of the amendment process.
4. This practice is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
5. This practice reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, this practice is required to abide by the terms and conditions currently in effect.
6. If these policies and procedures are revised, you will be furnished with a revised written notice by mail within two weeks of revision.
7. If you are concerned that this practice has violated your privacy rights, or you disagree with a decision that has been made in regard to access to your records, you may contact Matthew J. DeLuca MS,LPC at 304-626-3541 for further information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

The effective date of this notice is: January 1st, 2016. Also, you may have other rights that are granted to you by the laws of our state and these may be the same or different from the rights described above. This practice will be happy to address these situations with you.

Signature: _____ Date: _____

Once we obtain all the information regarding your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your treatment. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

Your signature below indicates that you have read the information in this initial packet and agree to abide by its terms during our professional relationship. Your signature or the signature of your authorized person allows release of information necessary to process insurance claims and authorizes direct payment of health insurance benefits to DeLuca Family Wellness Center, Inc. THIS INFORMATION WILL INCLUDE DIAGNOSIS, DATES OF TREATMENT, AND AT TIMES, TREATMENT PLANS.

HIPAA PATIENT ACKNOWLEDGEMENT

Your signature below indicates:

1. that you have read this Counselor-Client Services Agreement;
2. that you have read the Notice of Privacy Practices and agree to its terms;
3. that you have received copies of the Notice of Privacy Practices form;
4. that you have the right to revoke this consent, in writing, at any time by sending such written notification to this office. Your revocation will not be effective to the extent that your counselor has taken action in reliance on the authorization.

Signature of Parent/Guardian: _____Date: _____

DeLuca Family Wellness Center, Inc.

Telehealth Mental Health Therapy Services Agreement

Client Name: _____ Birthdate: _____/_____/_____

1. Telehealth mental health services are an alternative form of therapy with several limitations. There is a risk of misunderstanding one another resulting from the absence of visual or auditory cues as well as a risk of disruption to the service due to technical difficulties of the devices utilized. I understand these potential risks to using this technology and that my health care provider or I can discontinue the telehealth session if it is deemed that the conferencing connections are not adequate for the situation.
2. My health care provider has explained to me how the video conferencing technology will be used and it will not be the same as a direct client/provider visit due to the fact that I will not be in the same room as my health care provider. I have had the alternatives to a telehealth session explained to me.
3. I agree to inform my provider of my address/location at the beginning of each telehealth session. I understand that notifying my provider of my location is in my best interest in case of an emergency. This may include but is not limited to if I am having suicidal or homicidal ideations or plans, and/or intent to act out my plans; if I am in crisis that cannot be resolved remotely; or if my provider determines I need a higher level of care. I understand that in the event of an emergency, my provider may need to contact emergency services to further assess for safety.
4. There are limitations to confidentiality to be mindful of including that individuals near you may overhear your communications or have access to the platform that you are using. I understand that I am responsible for my surroundings and will make attempts to engage in telehealth sessions privately, in a quiet space and without distractions.
5. I agree to conduct myself in telehealth sessions as I would if in the office participating in a face-to-face session. This included wearing appropriate attire, refraining from substance use and not engaging in sessions while driving.
6. I understand that billing will occur from my provider and that the structure and cost of telehealth sessions are consistent with face-to-face sessions.
7. I agree that I will not record any telehealth sessions.
8. I have had a direct conversation with my provider during which I had the opportunity to ask questions in regard to telehealth sessions.

By signing this form, I certify:

***That I have read or had this form read and/or had this form explained to me.

***That I fully understand its contents as well as the risks and benefits of services

***That I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

_____ Verbal Consent Given _____ _____

Date Time:

_____ _____

Verbal Consent Witness Printed Name Verbal Consent Witness Signature