Premier Wellness Healthcare
103A N Main Street
Bel Air, MD 21014

Adolescent 13-17 Intake Paperwork

Highlighted = Required Information
Patient Name (as listed by insurance):

_____

(Last Name) **(First Name)** **(Middle Initial)**

Preferred Name: _____

Address Line 1: _____

Address Line 2: _____

City/State/Zip Code: _____

Date of Birth: _____ Sex (as listed by insurance): _____

Gender: _____ Preferred Pronouns: _____

Child Phone #: _____ Child Email Address: _____

Employer Name: _____ Employer Phone #: _____

Employer Address: _____

Parent/Guardian Information:

Fathers Name:	Mothers Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone #:	Phone #:
Email:	Email:
DOB:	DOB:

Please bring any court-ordered documents, custody agreements, or other legal paperwork regarding this client.

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Responsible Billing Party

Name:	DOB:	
Address:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
Relationship to Patient:		
Employer:	Occupation:	

__Note__: The parent who brings a child to the office for medical services is responsible **__AT THE TIME OF SERVICE__ for co-payments, deductibles, balances, or for payment in full, in the event the provider of service is non-participating with your insurance carrier.

Emergency Contact

Name: _____ Relationship: _____

Phone number: _____

Primary Insurance Information:

Insurance Company: _____

Claims Address: _____

City/State/Zip: _____ Phone #: _____

ID Number: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Subscriber Sex (as listed by insurance): ____

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Secondary Insurance Information:

Insurance Company: _____

Claims Address: _____

City/State/Zip: _____ Phone #: _____

ID Number: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Subscriber Sex (as listed by insurance): ____

I certify that the demographic and insurance information on this form is current and accurate to the best of my knowledge.

_____ _____

Printed Name of Parent/Guardian Relationship

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

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Medical Providers Information and Release

Primary Care Physician (PCP) Information and Release

Providers Name:

Phone:	Fax:	Email:
Address:		
City:	State:	Zip:

Please select one of the following:

☐I give my consent for my Premier Wellness Healthcare provider to communicate with my PCP: (Includes, but is not limited to, an outpatient notification letter, and contact for coordination of care)

☐I **DO NOT** give consent for my Premier Wellness Healthcare provider to communicate with my PCP.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____

Other Prescribing Provider Information and Release

(E.g. psychiatrist, endocrinologist, pain specialist, other therapists)

Providers Name:

Phone:	Fax:	Email:
Address:		
City:	State:	Zip:

Please select one of the following:

☐I give my consent for my Premier Wellness Healthcare provider to communicate with my provider: (Includes, but is not limited to, an outpatient notification letter, and contact for coordination of care)

☐I **DO NOT** give consent for my Premier Wellness Healthcare provider to communicate with my provider.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____

PWH

Premier Wellness Healthcare
103A N Main Street
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Informed Consent

Welcome to Our Practice

We look forward to seeing you at your scheduled appointment. To save time on the day of the appointment, please read this ***Information Package***, check and sign the consent document, and complete the enclosed registration forms. Please bring the forms and consent document with you to your visit. If you are unable to complete these forms before your visit, please plan to arrive 15-20 minutes before your scheduled time, so that we may answer any questions that you may have about completing the forms.

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, we need to reach a clear understanding of how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

Mental Health Services

Psychotherapy is a constantly evolving practice that comes in many different forms, encompassing a wide array of techniques, expertise, and theories. The therapeutic relationship is defined by both the provider and the patient and is structured around dealing with the issues you wish to address. There are many different methods and approaches your provider may use to deal with your specific needs. Psychotherapy requires an active effort on your part. Premier Wellness Healthcare strives to assist every patient in identifying and solving all difficulties they may face, even the ones they have yet to uncover. For therapy to be successful, you will have to work on things talked about during your session as well as at home. Additionally, you will need to be open and honest about your feelings related to the process of therapy and how it works for you.

Like all things in life, psychotherapy can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience an array of emotions such as guilt, sadness, fear, anger, loneliness, or helplessness. These emotions may be overwhelming at times, and you may want to avoid them, however, they are an important part of your treatment process.

Psychotherapy has been shown to have benefits and has been shown to lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Please be honest about any difficult feelings you may experience, not only those that brought you to therapy but also those that may arise throughout your therapy journey. The therapeutic relationship is a unique opportunity to discuss anything and everything related to interpersonal interactions. If you have questions about procedures, they can be discussed as they arise.

Therapy involves a large commitment of time, money, and energy, so you should be careful about the provider you select. One of the best predictors of successful therapy is the strength of the therapeutic bond between a provider and a patient. If either the patient or provider feels this

is not a good fit, we will work with you to find a suitable provider in our practice or surrounding areas.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. Your provider cannot promise that your behavior or circumstances will change, but they can promise to support you and do their very best to understand you and repeat patterns, as well as to help you clarify what it is that you want for yourself.

Medical Records

If medical records are requested by other parties, such as attorneys, there will be a service charge for printing and/or copying and mailing.

Forms Completion

We reserve the right to charge a fee for the completion of forms, letters, or any other correspondence (disability, FMLA, MVA, etc.). The fees are as follows: Simple/single-page forms: $10 (each form) - Complex/multi-page forms: $25 (each form). These fees must be paid in full at the time the forms are submitted at the practice.
All payments or correspondence should be mailed to:
Premier Wellness Healthcare
103A North Main Street
Bel Air, MD 21014

FMLA Paperwork

FMLA paperwork generally requires a minimum of 1-2 hours to complete, due to the need for supporting clinical documentation. Short-term disability often takes longer to complete and may require additional assessments beyond my regular intake evaluation. The time required to make copies or prepare and send faxes, and any other administrative business (e.g. preparing releases of information or requests for records; phone calls to lawyers, or other non-clinical calls) not directly related to the provision of clinical services, will also be based on the complexity of the documentation request, with a minimum fee of $75.00.

There will be no completion of any FMLA, disability, other paperwork, or letters of support unless your provider has met with you for at least 8 sessions. We also will not complete any FMLA or disability paperwork if we are unable to support the request based on what you have presented at intake and during sessions.

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 requires that PWH provide you with information about how we may use your Protected Health Information (PHI). All of that information is contained in PWH's ***Notice of Privacy Practices*** which you will receive in a separate document. The Notice will tell you:

- How PWH may use and disclose your protected health information.
- Your rights with respect to the information and how you may exercise these rights.
- PWH's legal duties with respect to the information.
- Whom you can contact for further information about PWH's privacy policies.

Confidentiality

In general, the privacy of all communication between a patient and provider, and information can only be released to others with written permission.

In most legal proceedings, you have the right to prevent your provider from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order testimony if they determine that the issue demands it. We will not release any information to a court without a judge's court order.

Limits on Confidentiality

There are very few situations in which we are required to break confidentiality:

- If you inform your provider that you are threatening serious bodily harm to yourself or someone else, your provider must take protective action that may include hospitalization, contacting the police, and/or notifying the potential victim.
- If your provider believes any child under 18, elderly, or disabled person is being abused, neglected, or exploited, they are required to file a report to the appropriate agency, usually the Office of Child Protective Services and law enforcement. Once such a report is filed, your provider may be required to provide additional information. If abuse, neglect, or exploitation occurred in the past, your provider is still required to file a report to the appropriate agency.
- If a judge (court order) requires your provider to testify about you or you are being accused of a crime and use your sanity as a defense. If you are involved in a court proceeding and a request is made for information concerning the professional services provided by Premier Wellness Healthcare, such information is protected by the psychologist-patient privilege law. Premier Wellness Healthcare nor your provider cannot provide any information without you or your legal representative's written authorization, or a judge's court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your provider to disclose information.
- If you file a complaint or lawsuit against Premier Wellness Healthcare or your provider, your records will be used as a defense.
- If a medical emergency arises while you are in session, Premier Wellness Healthcare or your provider will telephone the emergency contact designated on your intake form.
- If you file a worker's compensation claim and your provider is providing services related to that claim, your provider must provide appropriate reports to the Worker's Compensation Commission or the insurer.
- If a government agency is requesting information for health oversight activities, your provider may be required to provide it to them.

The above situations are rare, and your provider will make every effort to fully discuss them with you before taking any action. Let's discuss any concerns that you may have regarding the above. The laws governing confidentiality are complex, and certain situations may require legal advice. If Premier Wellness Healthcare or your provider consults with another professional about a case, they will make every effort to avoid revealing identifying information. The consultant is also legally bound to keep the information confidential. Please also know that Premier Wellness Healthcare is an office with other healthcare professionals where protected information may be shared for administrative purposes and confidentiality is protected.

Designated Spokesperson

Because of privacy rules, providers may not release your health information to anyone without your permission. This includes family members or friends that you may want the provider to keep informed. You may authorize us to share information with specific individuals that you designate as your **Spokesperson(s).** If you provide this authorization, here are some things that you should be aware of:

- We will share information about the services rendered by PWH Providers only, either in person or over the telephone.
- Once this information is released to the spokesperson, it may no longer be protected by federal privacy regulations.
- The designated spokesperson(s), Medical Power of Attorney, Health Care Agent, or other individual allowed by law will be the only individual(s) who may obtain information about you.
- Your spokesperson does not have decision-making abilities unless they are able to do that as outlined in the law.
- The authorization will expire one year after the date on the Patient Consent Signature form.
- You may withdraw this authorization at any time by notifying the PWH Privacy Officer in writing. If you do withdraw the authorization, it will not have any effect on actions taken by PWH before receiving the written request.
- You may refuse to sign this authorization. Your treatment will not be affected in any way by your choice to grant or not grant spokesperson authorization.

Minors

If you are a minor, your parents may be legally entitled to some information about your therapy. Your provider will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Termination

During the initial intake process and the first couple of sessions, we will assess if we can be of benefit to you. If you have requested online counseling, our assessment will include your suitability for psychotherapy delivered via technology. We do not accept patients whom, in our opinion, we cannot help. In such a case, you will be given several referrals that you may contact. If at any point during psychotherapy, your provider assesses that he/she is not effective in helping you reach your therapeutic goals, they are obliged to discuss this with you, up to and

including termination of treatment. In such a case, you would be given several referrals that may be of help to you. If you request and authorize in writing, your provider will talk to the psychotherapist of your choice to help with the transition. If at any time you want another professional's opinion or wish to consult with another provider, we will assist you in finding someone qualified and, if we have your written consent, will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, you will be offered the names of other qualified professionals whose services you might prefer.

Dual Relationships

Not all dual relationships are unethical or avoidable. However, sexual involvement between provider and patient is never part of the therapy process, nor are any other actions or dual relationship situations that might impair my objectivity, clinical judgment, or therapeutic effectiveness or that could be exploitative in nature. In addition, we will never acknowledge working therapeutically with anyone without his/her written permission. In some instances, even with permission, we will preserve the integrity of our working relationship.

If we see each other accidentally outside of the therapy office, your provider will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and your provider does not wish to jeopardize your privacy. However, if you acknowledge your provider first, your provider will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Social Medical and Telecommunication

Due to the importance of your confidentiality and the importance of minimizing dual relationships, your provider does not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc.). Premier Wellness Healthcare and your provider believe that adding patients 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 you meet with your therapist and you can talk more about it.

Electronic Communication

Your therapist cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, your provider will do so. While Premier Wellness Healthcare and your provider may try to return messages in a timely manner, they cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail are considered telemedicine by the State of Maryland. Telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another.

If you and your provider choose to use technology for some or all of your treatment, you need to understand that:

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. All existing confidentiality protections are equally applicable.
3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
4. Dissemination of any of your identifiable images or information from the telemedicine interaction with researchers or other entities shall not occur without your consent.
5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the provider gathers within a session or a series of sessions a multitude of observations, information, and experiences about the patient. The provider may make clinical assessments, diagnoses, and interventions based not only on direct verbal or auditory communications, written reports, and third-person consultations, but also on direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include but are not limited to the provider's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the provider not being aware of what they would consider important information that you may not recognize as significant to present verbally to the provider.

Web Portal Participation

Premier Wellness Healthcare is pleased to offer you the chance to communicate with your provider using ***https://prewellhealth.clientsecure.me/client_portal/client_accesses/sign_in***, our new web portal. ***Simple Practice*** is a safe and secure way for your provider to communicate with you and for you to communicate with your provider. There is no charge for using ***Simple Practice***.

You can use ***Simple Practice*** to:

- Complete intake forms
- Check on upcoming appointments
- View your balance
- Make a payment on your account
- Chat with your provider

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Bel Air, MD 21014

We can use ***Simple Practice*** to:

- Send you the required documents
- Remind you about your appointments
- Reply to any messages you send us
- Answer your questions without playing "telephone tag"

How *Simple Practice* Works

We will use your email address to send you a one-time link to the password-less portal.

1. At the top they should select "Existing Client? Sign In" in green
2. They should then enter the email address PWH has on file and select "send link"
3. The link will go to their email address, they should click their link which will allow them access to their patient portal
    a. This link will only be valid for 24 hours, after 24 hours, the link is no longer accessible, and the patient will need to request a new one-time link following steps 1-3.
    b. The link is only accessible for 1 use

We will use the e-mail address that you give us to send you an e-mail that a message is waiting for you on ***Simple Practice***. No treatment information will be in the e-mail that we send you. When you receive it, you will go to the portal to retrieve the secure message that we left for you. It is as easy as that!

It is up to you to make sure that your e-mail is working, and that our e-mail doesn't end up in your "junk mail" folder. If you stop using e-mail or change your e-mail address, you need to call the practice and let us know right away.

When you use ***Simple Practice*** to send a message to us, someone will answer by the next business day.

Do not use *Simple Practice* to communicate urgent matters!
If you have a problem that needs immediate attention, or you are not certain whether it can wait, call the office.

Printed Name of Parent/Guardian	Relationship
Signature of Parent/Guardian	Date
Printed Name of Patient	
Signature of Patient	Date

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Financial Policy

PWH is committed to providing you with quality and affordable health care. We participate with most insurance plans.

Therapeutic Services and Rates

Initial Intake – 90791 – $250
30 Minute Individual Psychotherapy – 90832 – $100
45 Minute Individual Psychotherapy – 90834 – $125
60 Minute Individual Psychotherapy – 90837 – $175
60 Minute Psychotherapy for Crisis – 90839 – $175
90 Minute Psychotherapy for Crisis – 90840 – $275
Family Psychotherapy without Patient – 90846 – $125
Family/Couples Therapy – 90847 – $175
Group Therapy – 90853 – $100
Interactive Complexity – 90785 – $50
Questionnaire Assessment – 96127 – $25 Each
Psychological Testing - This will be determined before testing.
Late Cancellation – Cancellation less than 24 hours before appointment – $50
No Show – $50

Uninsured Patients

If you are uninsured, payment is expected on the day of your visit. Please refer to the GFE documentation for further information.

Insurance Coverage

We participate with most insurance plans. Please bring a photo ID and your insurance card(s) to each appointment.

It is your responsibility to know and understand the terms of your insurance coverage. Your insurance plan is a contract between you and your carrier. It is your responsibility to know whether your insurance carrier requires a referral and to bring it with you at the time of service. If you present without a referral when one is required, we will ask you to sign a Voluntary Waiver of Insurance Benefits if you want to receive services that day. You will be responsible for the bill. Please contact your insurance carrier with any questions regarding your coverage.

Medicare

If we believe you are receiving a service that Medicare does not consider reasonable or necessary for your condition and for which payment is expected to be denied, you will be notified in writing with the Advance Beneficiary Notice of Non-Coverage (ABN) form. This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal their decision.

HMO/Managed Care Plans

If your insurance is an HMO or Managed Care plan, under the terms of your plan, the provider may not be able to see you without the proper referral or authorization, unless you are willing to sign a *Voluntary Waiver of Insurance Benefits* and agree to pay at the time of service.

Deductibles, Co-pays, and Coinsurance

All co-pays are due at the time of service. Contractually, your insurance company requires us to collect the portion for which you are liable at the time services are rendered. Deductibles and coinsurance amounts will be estimated based on the normal reimbursement from your insurance company, you may receive a bill for the additional amount or a refund if you have overpaid once the insurance processes the claim.

Definitions:

DEDUCTIBLE is the amount the patient is responsible for before the insurance plan starts paying for services. The deductible may not apply to all services.

CO-PAYMENT is a fixed amount set by the insurer that the patient is responsible for paying at the time of service. The co-payment may vary by the type of service, the provider rendering the service, and/or the place in which the service is rendered.

CO-INSURANCE is the patient's cost share, usually calculated as a percentage of the cost of the service. The co-insurance may not be subject to a deductible amount.

Payment for Services

Co-payments/co-insurance and deductibles are due at the time of your appointment. We accept cash, checks, VISA, and MasterCard. If you are unable to pay at the time of service, please refer to the ***Financial Policy*** in this package for options available to you.

A fee of $35 will be assessed for each personal check returned by your bank as non-sufficient funds.

Non-payment / Delinquent Accounts

If you have a balance on your account, you will receive an electronic statement in your Simple Practice Patient Portal and may receive a statement in the mail and/or a phone call about your unpaid balances. If a balance remains unpaid for more than 90 days, the message on your third statement will say that your account is being reviewed for placement with a collection agency. Your account may be assessed a 30% surcharge to cover agency fees. You will be allowed 10 days to send the payment in full. Partial payments or extended payments will not be accepted unless otherwise negotiated with the Billing Department at 888-333-1345.

By signing this I am stating that I have read and understand the Financial Policy set forth by Premier Wellness Healthcare

Printed Name of Parent/Guardian	Relationship
Signature of Parent/Guardian	Date

PWH

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Appointments and Scheduling Policy

It is the policy of the practice to monitor and manage late arrivals, late cancellations, and no-shows. Premier Wellness Healthcare's goal is to provide excellent care to each patient in a timely manner. Please be on time for your appointment. We will do our best to see you at the appointed time and/or advise you of any delays. If it is necessary to cancel an appointment, patients are required to cancel via the patient portal, call, text, email, or leave a message **at least 24 hours** prior to the appointment, so that we may put someone else who needs to be seen in your place.

Late Arrival, Late Cancellation, and No-Show Policy

Definitions:

LATE ARRIVAL is defined as any patient who arrives more than 15 minutes late to their scheduled appointment, with or without informing the provider.
LATE CANCELLATION is defined as any patient who cancels an appointment with less than 24 hours notice.
NO SHOW is defined as any patient who fails to arrive for a scheduled appointment.

Fee

We reserve the right to charge for late arrival, late cancellation, and no-shows. Our fee is $50. These charges will be your responsibility and will be billed directly to you. Payment for missed appointments is expected before your next visit.

Procedure

In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by their provider on the same day, they will be rescheduled for a future visit.

In the event a patient has incurred two (2) documented late cancellations or no-shows and has a standing appointment with their provider, all future appointments will be canceled, and the patient will need to contact Premier Wellness Healthcare to schedule another appointment.

In the event a patient has incurred three (3) documented late cancellations or no-shows, the patient may be dismissed from Premier Wellness Healthcare and provided referrals to other mental health providers in the area.
By signing this I am stating that I have read and understand the Appointments and Scheduling Policy set forth by Premier Wellness Healthcare.

Printed Name of Parent/Guardian	Relationship
Signature of Parent/Guardian	Date
Printed Name of Patient	
Signature of Patient	Date

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Informed Consent for Telehealth

This informed consent for telehealth contains important information focusing on doing psychotherapy using the phone or internet. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telehealth

Telehealth refers to providing psychotherapy services remotely using telecommunication technologies, such as our patient portal, *Simple Practice*. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can help ensure continuity of care if the patient or clinician moves to a different location, takes an extended vacation, or is otherwise unable to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both the provider's and patient's parts to be helpful. Although there are benefits to telehealth, there are some differences between in-person psychotherapy and telehealth, as well as some risks. For example:

- Risks to confidentiality – Because telehealth sessions take place outside the provider's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. Your provider will take reasonable steps to ensure your privacy, but it is equally important that you find a private place for your session where you will not be interrupted. It is also important for you to protect the privacy of your session on your cell phone or other device. You should participate in telehealth only while in a room or other area where other people are not present and cannot overhear the conversation.
- Issues related to technology – There are many ways that technology issues may impact telehealth. For example, technology may stop working during a session, other people might be able to access your private conversation, or stored data may be accessed by unauthorized people or companies.
- Crisis management and intervention – Unusually, your provider will not engage in telehealth with patients who are currently in a crisis requiring high levels of support and intervention. Before engaging in telehealth, we will develop an emergency plan to address potential crisis situations that may arise during your telehealth work.

Electronic Communication

Our practice utilizes Simple Practice for all electronic communication. Simple Practice will require access to a smartphone or computer to complete your audio and video sessions for telehealth sessions. Simple Practice may also be used for form competition and/or secured communication.

For communication between sessions, our office utilizes the Simple Practice chat, telephone, and email. You should be aware Premier Wellness Healthcare cannot guarantee the confidentiality of any information communicated by email or text. Therefore, we do not discuss any clinical information by email or text and prefer that you do not either. Email and text should be limited to administrative matters such as setting and changing appointments, billing matters, and other related issues.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. However, if an urgent issue arises, you should feel free to attempt to reach out to your provider who will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach your provider and feel that you cannot wait for me to return your call, contact your primary care physician, or go to the emergency room and ask for the psychologist or psychiatrist on call. If your provider will be unavailable for an extended period, they will provide you with the name of a colleague to contact in their absence.

Consent to use the Telehealth by Simple Practice Service

Telehealth by Simple Practice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge the following:

- Telehealth by Simple Practice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
- Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Simple Practice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
- The Telehealth by Simple Practice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
- I do not assume that my provider has access to any or all of the technical information in the Telehealth by Simple Practice Service – or that such information is current, accurate, or up to date. I will not rely on my health care provider to have any of this information in the Telehealth by Simple Practice Service.
- To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

Confidentiality

Premier Wellness Healthcare and your provider have a legal and ethical responsibility to make their best efforts to protect all communications that are part of telehealth. However, the nature of electronic communications technologies is such that it cannot be guaranteed that communication will be kept confidential or that other people may not gain access to the communications. Best efforts will be made to use updated encryption methods, firewalls, and backup systems to help keep your information private. You should also take reasonable steps to ensure the security of the communications (for example, only using secure networks for telehealth sessions and having passwords to protect the device you use for telehealth)

The extent of the confidentiality that is outlined in the Informed Consent, Notice of Privacy Practices, and Social Media Policy still applies in telehealth. Please let your provider know if you have any questions about expectations of confidentiality.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telehealth than in traditional in-person therapy. To address some of these difficulties, you and your provider will create an emergency plan before engaging in telehealth services. You will be asked to identify an emergency contact person who is near your location and who your provider or other Premier Wellness Healthcare administrative will contact in the event of a crisis or emergency to assist in addressing the situation. You will be asked to sign a separate authorization form allowing for your provider or Premier Wellness Healthcare administration to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not try to reconnect with your provider and instead call 911 or go to your local emergency room.

If the session is interrupted and you are not having an emergency, please stay in your session as your provider will attempt to reconnect. If after 5 minutes your session does not resume, your provider will reach out directly to provide you with further instructions to finish your session.

Fees

The same fee rates will apply for telehealth as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. **Please contact your insurance company before engaging in telehealth sessions to determine whether these sessions will be covered.**

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. Records of telehealth sessions will be maintained in the same way in-person session records are.

Printed Name of Parent/Guardian	Relationship
Signature of Parent/Guardian	Date
Printed Name of Patient	
Signature of Patient	Date

PWH

Premier Wellness Healthcare
103A N Main Street
Bel Air, MD 21014

Good Faith Estimate

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to provide a good faith estimate of expected charges for items and services to individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing, upon request or at the time of scheduling health care items and services.

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual needs and circumstances, and the type and amount of services that are provided to you.
This estimate is NOT a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.
Disclaimer

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what we agree to in consultation. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. This Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

Services and Charges at Premier Wellness Healthcare

- 90791 – Initial Intake - $250
- 90832 – 30 Minute Individual Psychology - $100
- 90834 – 45 Minute Individual Psychology - $125
- 90837 – 60 Minute Individual Psychology - $175
- 90846 – Family Psychotherapy without patient - $125
- 90847 – Family/Couples Counseling
- 90853 – Group Therapy - $100
- 90839 – 60 Minute Psychotherapy Crisis - $175
- 90840 – 90 Minute Psychology Crisis - $275
- 90785 – Interactive Complexity – 90785 - $50
- 96127 – Questionnaire Assessment – $25 each
- Psychological Testing - Will be determined prior to testing

Additional Charges

- Late Cancellation – Cancellation less than 24 hours before appointment – $50
- No Show – $50
- Medical Records - $10 each
- Complex/Multi-Page Forms- $25 each
- Bounced Check Fee - $35

Premier Wellness Healthcare recognizes every client's therapy journey is unique.
How long you need to engage in therapy and how often you attend sessions will be influenced by many factors including:

- Your schedule and life circumstances
- Therapist availability
- Ongoing life challenges
- The nature of your specific challenges and how you address them
- Personal finances

You and your therapist will continually assess the appropriate frequency of therapy and will work together to determine when you have met your goals and are ready for discharge and/or a new "Good Faith Estimate" will be issued should your frequency or needs change.

Where services will be received:

- Office Location – 103 North Main Street Bel Air, MD 21014
- Online via telehealth

Providers available at Premier Wellness Healthcare:

- Patricia Balducci, LCSW-C – NPI: 1558421909
- Rebecca Cooper, LCSW-C – NPI: 1386119121
- Mara Egorin-Williams, RPA
- Courtney Harris, LCSW-C – NPI: 1265135313
- Luba Popivker, PsyD – NPI: 1215256664
- Lanika Wilson, LMSW – NPI: 1326772815

_____ _____

Printed Name of Parent/Guardian | Relationship

_____ _____

Signature of Parent/Guardian | Date

_____

Printed Name of Patient

_____ _____

Signature of Patient | Date

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Authorization for Release of Protected Health Information to a Spokesperson

Because of privacy rules, providers may not release your health information to anyone without your permission. This includes family members or friends that you may want the provider to keep informed. You may authorize us to share information with specific individuals that you designate as your Spokesperson(s). If you provide this authorization, here are some things that you should be aware of:

- We will share information about the services rendered by PWH Providers only, either in person or over the telephone.
- Once this information is released to the spokesperson, it may no longer be protected by federal privacy regulations.
- The designated spokesperson(s), Medical Power of Attorney, Health Care Agent, or other individual allowed by law will be the only individual(s) who may obtain information about you.
- Your spokesperson does not have decision-making abilities unless they are able to do that as outlined in the law.
- The authorization will expire one year after the date on the Patient Consent Signature form.
- You may withdraw this authorization at any time by notifying the PWH Privacy Officer in writing. If you do withdraw the authorization, it will not have any effect on actions taken by PWH before receiving the written request.
- You may refuse to sign this authorization. Your treatment will not be affected in any way by your choice to grant or not grant spokesperson authorization.

Authorization for Release of Protected Health Information to a Spokesperson
☐ I have read and understood the PWH Spokesperson Information.
☐ I authorize PWH to tell the spokesperson(s) named below about my diagnosis, prognosis, and treatment plans either in person or by telephone.

I authorize the release of information including my diagnosis, medical records, examinations rendered to me, and claims information. This information may be released to:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

- OR IF YOU DO NOT WANT YOUR INFORMATION RELEASED TO ANYONE –

☐ I do NOT want my information released to any spokesperson. This information is not to be released to anyone.

_____ _____
Printed Name of Parent/Guardian Relationship

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

Contact

Should you need to contact me with private health information (PHI) or in general please utilize the following method of contact.

(Choose ONE) this will be entered as your preferred method of contact.

Phone Call (Please list preferred number): _____

Text Message (Please list preferred number): _____

Email (Please list preferred email): _____

I understand that the office will use this as my preferred method of contact.

_____ _____
Printed Name of Parent/Guardian Relationship

_____ _____
Signature of Parent/Guardian Date

_____
Printed Name of Patient

_____ _____
Signature of Patient Date

Reminders

Premier Wellness Healthcare utilizes an appointment reminder service within our *Simple Practice* patient portal. Under this service, you will receive an automated reminder 48 hours (2 days) prior to your appointment. Reminders can be sent to the patient, parent/guardian, spouse, etc. Please mark the corresponding box regarding your preference:

Phone Call (Please list preferred number(s)): _____

Text Message (Please list preferred number(s)): _____

Email (Please list preferred email(s)): _____

By my initials, I acknowledge that I have reviewed the following policy listed below:

_____ Reminders are a courtesy provided by Premier Wellness Healthcare. Missing an appointment due to no reminder will not waive the no-show/late cancellation fee.

_____ In the event that a reminder is not paid, the patient will still be charged the $50 missed appointment/no-show fee if the cancellation has not been made 24 hours in advance.

_____ If a call is unable to be made due to technical difficulties, incorrect phone number, failing to inform Premier Wellness Healthcare of a new or changed phone number, or voicemail is full, the patient will still be charged the $50 no-show/late cancellation fee.

_____ If an appointment is scheduled within the 24-hour timeframe, a reminder phone call will not go out to the patient.

_____ Cancellations can be made by speaking with a receptionist Monday – Friday 8:00 AM – 5:00 PM at 888-333-1345, sending a text to cancel to 888-333-1345, emailing inquiry@prewellhealth.com, or contacting your provider directly.

Please note: This reminder service is a courtesy provided by Premier Wellness Healthcare. It is still the patient's responsibility to keep track of upcoming appointments in the event a reminder is not sent out.

Failure to acknowledge all of the above policies will result in no reminders being sent to the patient.

Your mobile Provider's standard messaging rates still apply

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Credit Card Authorization/Guarantee

- I understand that Premier Wellness Healthcare, LLC will be billing my insurance company for therapy or evaluation services (unless I'm paying out of pocket). I further understand that I am responsible for all patient responsibility fees as determined under my healthcare plans such as deductibles, copays, or coinsurance.

- I understand that Premier Wellness Healthcare, LLC will work with me and my insurance to receive payments promptly. For my convenience, Premier Wellness Healthcare, LLC will wait 90 days to be reimbursed by my insurance carrier for the services provided. However, as insurance companies do not always reimburse promptly or at the rate initially expected, I am giving Premier Wellness Healthcare, LLC permission to charge my credit card for any services that have not been paid for by myself or my insurance carrier within 90 days of billing.

- I authorize Premier Wellness Healthcare, LLC to keep my signature and card information on file with their payment processor, Stripe, through Stripe's encrypted payment gateway to charge therapy session fees (i.e., copays/coinsurance/deductibles).

- I understand that if I miss a scheduled appointment or fail to provide 24 hours' notice of my need to cancel, my credit card will be charged for the full self-pay of the session ($50) as insurance does not reimburse for missed sessions.

- I understand that this authorization is valid until canceled in writing. I understand that charges for ongoing services will normally be posted to my credit/debit/flex card account within 48 hours of each session date. Additionally, I agree that the card listed below and/or the card on file may be charged by Premier Wellness Healthcare, LLC to settle any outstanding balances accrued upon the termination of therapy services.

- I agree that if I have any concerns or questions regarding charges to my card, or if the charge fails to post to my account, I will contact Premier Wellness Healthcare, LLC for clarification.

Autopay

- All clients, new or returning, who have a credit card authorization on file will automatically be enrolled in autopay. If this is an issue, please contact us directly.

Autopay will not be enabled for clients with two insurances. For clients with two insurances, once both insurances have processed, we will charge any remaining patient responsibility.

Printed Name of Parent/Guardian	Relationship
Signature of Parent/Guardian	Date

I authorize Premier Wellness Healthcare, LLC to charge my credit card for recurring payments or copayments for counseling services, as well as for late cancellation and no-show fees as described in the Informed Consent Agreement.

By having your credit card information on file, this will help you with paying your fees promptly and prevent delinquent fees from being forwarded to collections.

Client Name (Please Print): _____

Cardholder Name (As it appears on card): _____

Is this a Flex Spending Account (FSA) or Health Savings Card (HSA)? (Circle one) Yes No

Cardholder Billing Address: _____

City/State/Zip: _____

Credit Card #: _____

Expiration Date: _____ CVV Code: _____

I hereby authorize Premier Wellness Healthcare, LLC to charge the credit card indicated in this authorization form according to the terms outlined on the previous page and in the Informed Consent Agreement. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated on this form.

_____ _____

Signature of **Cardholder** Date

If the above card is attached to either a Flex Spending Account or Health Spending Account, please provide information for a secondary credit card. This account will be charged if the payment is NOT approved by the FSA/HSA and it will also be used for late cancellations or no-show fees as set forms in the Informed Consent Agreement

Cardholder Name (As it appears on card): _____

Cardholder Billing Address: _____

City/State/Zip: _____

Credit Card #: _____

Expiration Date: _____ CVV Code: _____

I hereby authorize Premier Wellness Healthcare, LLC to charge the credit card indicated in this authorization form according to the terms outlined on the previous page and in the Informed Consent Agreement. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated on this form.

_____ _____

Signature of **Cardholder** Date

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Premier Wellness Healthcare
103A N Main Street
Bel Air, MD 21014

Adolescent Intake Questionnaire (Ages 13-17) Parent/Guardian Section

How did you find our practice? (Google, insurance, friend, etc.): _____
Did you contact other practices for an appointment? ☐Yes ☐No

If yes, what made you choose Premier Wellness Healthcare? _____

_____

Your child's current grade? ___ Have they ever repeated a grade? Yes No If so, which? _____

School name: _____

Street Address: _____

School District/County? _____ Phone: _____

General Information

Briefly describe the problem for which your adolescent is seeking counseling.

_____

_____

What would you like to see happen because of counseling? _____

_____

What is most concerning right now? _____

_____

Home Dynamics

Parents are:	**Child lives with: (Check all that apply)**
☐Married ☐Unmarried, Living together ☐Never Married, Living together ☐Separated ☐Divorced ☐Mother Deceased ☐Father Deceased	☐Biological Mother ☐Biological Father ☐Stepparent ☐Adoptive Parent (Specify) _____ ☐Grandparent ☐Legal Guardian (Specify) _____ ☐Other (specify) _____ ☐Split custody (Lives in homes of both divorced parents)

Please describe the current visitation schedule (if any) and type of communication with the child's other parents. _____

_____

_____

Who has legal custody? (Please bring the custody agreement with you for us to scan these documents) _____

Your Child's Family

Biological Father
Name: _____
☐Living Age: _____ Occupation: _____
Frequency of contact with him: _____
☐Deceased Cause of Death: _____
Fathers age at the time of his death: _____ Child's age at the time of his death: _____

Biological Mother
Name: _____
☐Living Age: _____ Occupation: _____
Frequency of contact with him: _____
☐Deceased Cause of Death: _____
Mothers age at the time of her death: _____ Child's age at the time of her death: _____

Siblings: Please list your child's brothers and sisters in the order of birth (including adopted or stepsiblings).

Name of Sibling	**Sex**	**Age**	**Same Father?**	**Same Mother?**	**List any health/behavior/learning problems**	**Lives with child?**
			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No

How well does your child get along with their siblings?
☐ Very Well ☐ Good ☐ Average ☐ Fair ☐ Poor

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Childcare and Discipline

Who is the primary caregiver? ☐Mother ☐Father ☐Both ☐Other: _____

Who is mainly in charge of discipline in the home?

☐ Mother ☐ Father ☐ Both ☐ Other: _____

Please describe any misbehavior patterns in the home and classroom. _____

_____

Please describe discipline techniques used with the adolescent and their effectiveness. _____

_____

Emotional/Behavioral/Chemical Issues (Has your child recently or currently experienced the following?)

Concern	Yes	No	Concern	Yes	No
Recent suicidal thoughts			Difficulty sleeping		
Suicide plans			Depression		
Suicide attempts			Loneliness or hopelessness		
Self-inflicted injury behaviors			Crying often		
A tendency to be shy or sensitive			Frightening dreams or thoughts		
A strong dislike of criticism			Often annoyed by little things		
A frequent loss of temper			Difficulty completing tasks		
Difficulty expressing feelings			Violent or destructive behavior		
Nervousness, anxiety, or worry			Difficulty remembering		
Difficulty relaxing			Difficulty concentrating		
Difficulty making decisions			Mental confusion		
Difficulty making friends			Difficulty with eating		

Has your child ever been in court or picked up by the police? ☐ No

☐Yes, please describe: _____

Do you think your child has tried tobacco, alcohol, or illicit drugs? ☐ No

☐Yes, please describe: _____

Internet/Electronic Communications Usage

Does your child have a cell phone? ☐Yes ☐No

How many hours of screen time (computer, video games, TV) does your child engage in daily?

_____hours

Do you have any concerns with your child using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting, etc. (Select one)? ☐No

☐Yes, please describe: _____

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Peer Relations

Is your child socially: ☐ Outgoing ☐Shy ☐Depends on the situation
Has your child experienced any bullying? ☐Yes ☐No
Is your child involved in any organized social activities? ☐No
☐Yes, please describe: _____

School History

Has your child ever been held back a grade? ☐No ☐Yes, which grade and what was the reason they were held back? _____

What are the grades your child receives at school? _____

Do you feel your child is doing the best they can at school? ☐Yes ☐No

Are there any behavioral problems at school? ☐No ☐Yes, please explain: _____

_____

How many schools has your child attended? _____

Medical History

Does your child have a primary care physician (PCP)? ☐Yes ☐No

If yes, please provide name of PCP: _____

Allergies and Reactions

☐Medication Allergy	Please list/describe:
☐Food Allergies	Please list/describe:
☐Adverse Medication Reaction	Please list/describe:
☐Seasonal/ Environmental Allergy	Please list/describe:

Specify all medications and supplements they are presently taking and for what reason.

Medication/Supplement	Dosage	Reason for Taking

If taking prescription medication, who is their prescribing MD? Type of MD: _____

Name of MD: _____ Phone #: _____

Clinical Mental Health History

Has your child previously seen a counselor? ☐ No ☐Yes

If yes, where? _____

Approximate dates of counseling _____

For what reason did your child attend counseling? _____

Does your child have a previous mental health diagnosis? ☐No ☐Yes, please provide if you recall what it was _____

What did you find **most helpful** for your child in therapy? _____

_____

What did you find **least helpful** for your child in therapy? _____

_____

Psychiatric Hospitalizations:

Has your child previously been admitted? ☐Yes ☐No

When and when were they admitted? _____

Total number of admissions: _____

Outpatient treatment received: _____

_____

Psychiatric Medications:
Has your child taken medication for a mental health concern? ☐Yes ☐No
Please list any medications that have been or are being used for mental health concerns.

Name of Medication	**Dates taken**	**Was it helpful?**

Development

Were there any complications with the pregnancy or delivery of your child? ☐ No
☐Yes, please describe: _____

Did your child have health problems at birth? ☐ No
☐Yes, please describe: _____

Did your child experience any developmental delay (e.g. toilet training, walking, talking)? ☐ No☐Yes, please describe:
_____

Did your child have any unusual behaviors or problems prior to age 3? ☐ No
☐Yes, please describe: _____

Has your child experienced emotional, physical, or sexual abuse? ☐ Not to my knowledge
☐Yes, please describe: _____

Family Concerns (Please check any family concerns that your family is currently experiencing)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol or drug use
	Lack of honesty		Trauma
	Medical concerns		Infidelity (couple)
	Education problems		Divorce/Separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a child
	Inadequate health insurance		Job changes or job dissatisfaction
	Inadequate housing/feeling unsafe		Other

Family Medical History and Conditions

Please select all that apply:	**Please describe the medical conditions this biological family member suffer(ed) from:**
☐Biological Mother	
☐Biological Father	
☐Biological Siblings	
☐Biological Child(ren)	
☐Biological Maternal Grandparents	
☐Biological Paternal Grandparents	
☐Biological Maternal Aunts/Uncles	
☐Biological Paternal Aunts/Uncles	
☐Other:	

☐Client has no information on their biological history

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Family Mental Health History: (Check all that apply.)

Condition/Disorder	Bio Father	Bio Mother	Bio Siblings	Bio Grandparent	Bio Aunt/Uncle
				Please indicate maternal (Mat) or paternal (Pat)	
Alcohol/Drug Addiction	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Anxiety	☐	☐	☐ Bro| ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
ADHD	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Autism Spectrum Disorder	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Bipolar Disorder	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Depression	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Domestic Violence	☐	☐	☐ Bro| ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Eating Disorders	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Epilepsy/Seizure Disorder	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Genetic Disorder/Condition	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Intellectual Disability/MR	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Jail Time/Incarceration	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Language Disorder	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Learning Disability	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Mental Health Hospitalization	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Motor or Vocal Tics/Tourette's	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Obesity	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Obsessive Compulsive Behavior	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Psychosis or Schizophrenia	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Special Education Services	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Speech Difficulties/Therapy	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Substance Abuse Arrests/DWI/DUI	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat
Suicidal Thoughts/Attempts	☐	☐	☐ Bro | ☐ Sis	☐ Mat | ☐ Pat	☐ Mat | ☐ Pat

☐Client has no information on their biological history

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Your Adolescent's Strengths

	Often True	Sometimes True	Seldom True	Cannot Say
Outgoing				
Self-confident				
Seems happy				
Friendly				
Enjoys new experiences or activities				
Even disposition or steady mood				
Expresses feelings				
Affectionate				
Kind or sympathetic to others				
Shares				
Can compromise				
Follows rules easily				
Is forgiving				
Stands up for self when appropriate				
Tolerates criticism				
Recovers easily after disappointment				
Is appropriately cautious				
Creative				
Plays gently with smaller children or animals				
Good sense of humor				
Other				

What activities do you feel your child is successful at when they try? _____

_____

What personal qualities would you say your child has? _____

_____

Who are some of the influential and supportive people, activities (e.g., walking), or beliefs (e.g., religion) in your child's life? (Please describe) _____

_____

Is there anything else you would like me to know? _____

_____

_____

How much are each of the following areas currently a problem for your child?					
	0 – Not at all	1 – A little	2 – Somewhat	3 – Considerably	4 – Terribly
Anxiety	0	1	2	3	4
Physical Problems	0	1	2	3	4
Sleep Problems	0	1	2	3	4
Depression	0	1	2	3	4
Alcohol or Substance Use	0	1	2	3	4
Parent-Child Conflict	0	1	2	3	4
Sibling Conflicts	0	1	2	3	4
Social Relationships	0	1	2	3	4
School Problems	0	1	2	3	4
Sexual Problems	0	1	2	3	4
Spiritual/Religious	0	1	2	3	4
Legal Problems	0	1	2	3	4
Eating Disorder	0	1	2	3	4
Abuse (Physical, emotional, sexual)	0	1	2	3	4

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, the family moved, family financial problems, remarriage, sexual trauma, other losses)? _____

_____

PWH

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Adolescent Intake Questionnaire (Ages 13-17)

General Information

Please provide the following information and answer the questions. Information you provide here is protected as confidential information and will not be shared with anyone unless ordered by a judge. Your parent(s)/guardian(s) are not able to see this document or your answers.

Are you sexually active?(Circle one) Yes No

Briefly describe the problem for which you are seeking counseling. _____

_____

What would you like to see happen because of counseling? _____

_____

Personal Strengths

What activities do you enjoy and feel you are successful at when you try? _____

_____

Who are some of the influential and supportive people, activities (e.g., walking,) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

Counseling History

Have you previously seen a counselor? (Circle one) Yes No

If yes, what did you find most helpful? _____

_____

What did you find least helpful? _____

_____

Chemical Use and History

Do you currently drink alcohol? (Circle one) Yes No

If yes, how often do you drink? (Circle one) Daily Weekly Occasionally Rarely

If yes, how much do you drink? _____ (#) per time.

Do you currently use tobacco? (Circle one) Yes No

If yes, how much do you smoke/chew? _____
Do you currently use any other drugs? (Circle one) Yes No

If yes, what drugs do you use? _____
If yes, how often do you use? (Circle one) Daily Weekly Occasionally Rarely
Have you received any previous treatment for chemical use? (Circle one) Yes No

If so, where did you go? _____

____Inpatient ____Outpatient

Adolescents (Please answer the following with Y/N)
Have you ever used more than 1 chemical at the same time to get high? _____

Do you avoid family activities so you can use? _____

Do you have a group of friends who also use? _____

Do you use it to improve your emotions such as when you feel sad or depressed? _____

Legal Issues

Please list any legal issues that are affecting you or your family at present, or have had a

significant effect on you in the past_____

_____

Family History

Parents are:	**Child lives with: (Check all that apply)**
☐Married	☐Biological Mother
☐Unmarried, Living together	☐Biological Father
☐Never Married, Living together	☐Stepparent
☐Separated	☐Adoptive Parent (Specify) _____
☐Divorced	☐Grandparent
☐Mother Deceased	☐Legal Guardian (Specify) _____
☐Father Deceased	☐Other (specify) _____
	☐Split custody (Lives in homes of both divorced parents)

How often do you see each parent? Mom_____% Dad _____%.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. _____

Family Concerns (Please check any family concerns that you feel your family is currently experiencing)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol or drug use
	Lack of honesty		Trauma
	Medical concerns		Infidelity (couple)
	Education problems		Divorce/Separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a child
	Inadequate health insurance		Job changes or job dissatisfaction
	Inadequate housing/feeling unsafe		Other

Other concerns not listed above _____

Peer Relations

How do you consider yourself socially (circle one): outgoing | shy | depends on the situation
Are you happy with the number of friends you have (circle one)? Yes No
Have you ever been bullied (circle one)? Yes No
Are your parents happy with your friends (circle one)? Yes No

Are involved in any organized social activities (e.g., sports, scouts, music)? _____

School History

Do you like school (circle one)? Yes No
Do you attend regularly (circle one)? Yes No
What are your current grades? _____
Do you feel you are doing the best you can at school (circle one)? Yes No

Is there anything else you would like me to know? _____

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Generalized Anxiety Disorder—Child Aged 11–17

Severe Measure for Generalized Anxiety Disorder —Child Aged 13–17*

Instructions: How often have you been bothered by each of the following symptoms during the past 2 weeks? For each symptom circle the answer that best describes how you have been feeling.

Over the last 2 weeks, how often have you been bothered by the following problems?	**Never**	**Occasionally**	**Half of the Time**	**Most of the Time**	**All of the Time**
Felt moments of sudden terror, fear, or fright	0	1	2	3	4
Felt anxious, worried, or nervous	0	1	2	3	4
Had thoughts of bad things happening, such as family tragedy, ill health, loss of a job, or accidents	0	1	2	3	4
Felt a racing heart, sweaty, trouble breathing, faint, or shaky	0	1	2	3	4
Felt tense muscles, felt on edge or restless or had trouble relaxing or trouble sleeping?	0	1	2	3	4
Avoided, or did not approach or enter, situations about which I worry	0	1	2	3	4
Left situations early or participated only minimally due to worries	0	1	2	3	4
Spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries	0	1	2	3	4
Sought reassurance from others due to worries	0	1	2	3	4
Needed help to cope with anxiety (e.g., alcohol or medication, superstitious objects, or other people	0	1	2	3	4
FOR PROVIDERS USE ONLY					
TOTALS					

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PHQ-9 Modified for Adolescents (PHQ-A)

Severity Measure of Depression – Child Aged 13 – 17

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom circle the answer that best describes how you have been feeling.

During the past TWO (2) WEEKS, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
Feeling down, depressed, irritable, or hopeless?	0	1	2	3
Litter interest or pleasure in doing things?	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
Poor appetite, weight loss, or overeating?	0	1	2	3
Feeling tired, or having little energy?	0	1	2	3
Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
Trouble concentrating on things like schoolwork, reading, or watching TV?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or hurting yourself in some way?	0	1	2	3
FOR PROVIDERS USE ONLY				
TOTALS				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all

☐Somewhat difficult

☐Very difficult

☐Extremely difficult