The Wellness Center RI, LLC

New Client Intake Form

Client Name:_________________________________Date of Birth____/____/_____Age____

Gender: ○Male ○ Female ○Transgender Not Listed:____________________________

Please note: The following information is only collected to obtain Government grants in order to fund additional services for clients and the list is not our opinion but rather according to the U.S. Governement Census list, we apologize for any personal difference and appreciate your understanding. Please check one category from race and another from ethnicity.

Race: ○White ○Black ○American Indian or Alaskan Native ○Asian ○Native Hawaiian or Pacific Islander

Ethnicity: ○Hispanic or Latino ○Jewish ○Arab/Middle Eastern ○Carribean

Address____Floor_____

City_____________________ State_____ Zip Code__________ SSN_____________________

Home Phone________________________ Cell Phone________________________________

Emergency Contact Person #1______________________________Phone________________

Emergency Contact Person #2______________________________Phone________________

Insurance# 1___________________________ Insurance#2___________________________

Marital/Relational Status_______________Name of Spouse/Partner___________________

Your Employer(s)____

Occupation_______________________________________ Yearly Salary:$_______________

Physician________________________________Address_____________________________

I certify this information is true & correct to the best of my knowledge. I will notify The Wellness Center RI, LLC of any changes in the above information as soon as possible to avoid my case closing prematurely.

Client's (guardian) Signature: _____________________________ Date: ________________

Staff Signature:____Date__________________

Policy effective upon review with client.

Revised 01/2016

The Wellness Center RI, LLC
400 Reservoir Ave Ste.2K Prov., RI 02907

Informed Consent for Treatment Agreement:

SERVICES OFFERED: We offer a variety of services, which include, but are not limited to individual, family, couples, and group psychotherapy. We also offer some psychological evaluations and consultations.

APPOINTMENTS: Appointments are times that are reserved for you. It is important that if circumstances arise which require you to change an appointment, we ask that you provide us with at least 24 hours notice. This will allow us to offer your time to another patient. *On the third no show or late cancelled appointment the charge is $80.00. Fees for missed appointments are not billable to your insurance company.* In addition to the fee, The Wellness Center RI, LLC will discuss your commitment to treatment and possible termination of services. **Initial Here:______**

COST FOR SERVICES: Co-payments and deductables are not covered by insurance and due at the time of service. We accept cash, check and credit card. A service charge may be added for any outstanding balances unpaid after 30 days from the date of service or for returned checks or credit cards. The fees for our service vary by the service provided. Generally Intakes are $100-$150 and sessions are $80-$100 unless otherwise written agreements are made between the client and The Wellness Center RI, LLC. **Initial Here:______**

HEALTH INSURANCE: Many health insurance policies cover the services that our group offers. Many policies have co-payments and some have annual deductibles, or other limits. It is up to you as the policyholder to read your policy carefully and be aware of what is or is not covered. We recommend that you call your insurance company directly to ask about your benefits. We will make our best effort to obtain reimbursement information for you. If your services are covered, we will bill your insurance company directly. If you do not have insurance, payment is expected on the day services are rendered. **Initial Here:______**

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. Please read the Notice of Privacy Practices for more information. **I have received a copy of the Privacy Practice Initial Here:______**

CLIENT RIGHTS:

While you are receiving services through The Wellness Center RI, LLC you retain certain legal rights, including each of the rights listed below. Your exercise of these rights may be subject to reasonable limitations if permitted or required by law, but only with notice to you of the reasons for the limitation and in accordance with your treatment or individual service plan. If you are a minor or you have a court appointed legal guardian, your rights may be exercised by your parent or guardian on your behalf, again subject to any limitations permitted or required by law. The Wellness Center RI, LLC staff can help you understand and exercise these rights, so please take time to read each statement and ask questions if needed.

- You have the right to be treated with dignity, respect and without discrimination.
- You have the right to be informed of what to expect during the treatment process and participate in the individual service plan.
- You have the right to request to be reassigned to another staff member for treatment purposes.
- You have the right to be referred to an alternate treatment setting, if The Wellness Center RI, LLC is unable to provide appropriate treatment.
- You have the right to file a complaint. If you are unable to resolve your problems with any staff member, you can file a complaint with The Wellness Center's Clinical Director (401) 461-9355, without fear of repercussions or reprisals.
- You have the right to review your record when appropriate, with a clinician, upon written request. We retain the right to withhold services if appropriate services cannot be provided by The Wellness Center RI, LLC.
- You have the right not to be photographed, observed, videotaped or audio-taped without your full knowledge and consent.
- You have the right to end treatment at any time for any reason.

I have been informed of my rights as a client. In addition, the nature and purpose of my treatment, risks, benefits and alternatives have been explained to me. I have received a copy of these rights. I hereby give permission to The Wellness Center RI, LLC to retain records related to me where appropriate. **Initial Here:______**

EMERGENCY:

If there is an emergency during therapy, or in the future after termination, where The Wellness Center RI, LLC becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the person whose name you have provided on the biographical sheet. **Initial Here:______**

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. The Wellness Center RI, LLC has no control over, or knowledge of, what insurance companies do with the information s/he submits or who has access to this information.
Initial Here:______

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on The Wellness Center RI, LLC to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. **Initial Here:______**

CONSULTATION: The Wellness Center RI, LLC consults regularly with other professionals regarding their clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained. E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and faxes that go through them. While data on The Wellness, LLC's server is encrypted, e-mails and faxes are not. It is always a possibility that efaxes, texts, and email can be sent erroneously to the wrong address and computers. Unencrypted email or text provides as much privacy as a postcard. Please notify The Wellness Center RI, LLC if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages, or faxes. If you communicate confidential or private information via unencrypted e-mail, texts or fax or via phone messages, we will assume that you have made an informed decision, we will view it as your agreement to take the risk that such communication may be intercepted, and we will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies. **Initial Here:______**

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of The Wellness Center RI, LLC profession require that we keep treatment records *for at least 7 years or 3 years after becoming an adult*. Unless otherwise agreed to be necessary, The Wellness Center RI, LLC retains clinical records only as long as is mandated by Rhode Island law. If you have concerns regarding the treatment records, please discuss them with The Wellness Center RI, LLC. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when The Wellness Center RI, LLC assesses that releasing such information might be harmful in any way. In such a case, The Wellness Center , LLC will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, The Wellness Center RI, LLC will release information to any agency/person you specify unless The Wellness Center RI, LLC assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couples and family therapy, The Wellness Center RI, LLC will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment. **Initial Here:______**

EMERGENCY COMMUNICATION: If you need to contact The Wellness Center RI, LLC between meetings, please leave a message at (401) 461-9355 and your call will be returned as soon as possible. The Wellness Center RI, LLC checks messages a few times during the daytime Monday-Saturday only. If an emergency situation arises and you need to talk to someone right away call 911. Please do not use phone, email or faxes for emergencies. **Initial Here:______**

CLOSINGS OR DELAYS: Due to inclement weather The Wellness Center RI, LLC may delay regularly scheduled opening times, close early or close for the entire day. During adverse weather changes please call our office and the voicemail will prompt any changes.

SOCIAL NETWORKING AND INTERNET: We do not accept friend requests from current or former clients on social networking sites, such as Facebook, twitter etc. We believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, we request that clients not communicate via any interactive or social networking web sites with The Wellness Center RI, LLC.

OTHER SERVICES: We are sometimes requested to complete paperwork or deliver services that are outside the realm of the medical record or coordination of care. Some examples include letter for attorney, disability questionnaires, and school consultations/observations. These services are not covered by insurance and are charged at an hourly rate of $80. **Initial Here:____**

I have read the above Informed Consent Agreement for Services and Treatment carefully; I understand them and agree to comply with them:

Client's Name or Guardian(print) ____

Signature ____ Date __________________

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Permission to provide Mental health related services to Minors:

I, ____, give permission, for my

child ____, to receive services from The Wellness Center.

Parent or legal guardian Signature:__________________________Date________________

- -

Staff Witness: ___________________________________ Date ______________________