Wellness Counseling Services, LLC

Patient Registration Form

Patient Name:	**Social Security Number:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Race:**
Sex/Gender/Pronouns:	**Home Phone:**
Ethnicity:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Other Family Members Seeking Counseling

Family Member 2:	**Date of Birth - Family Member 2:**
Family Member 3:	**Date of Birth - Family Member 3:**
Family Member 4:	**Date of Birth - Family Member 4:**
Family Member 5:	**Date of Birth - Family Member 5:**

Insurance Information

Primary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**

Signature of Client **Date**

Wellness Counseling Services, LLC
Client Email and Text Message Informed Consent

You may give permission to Wellness Counseling Services, LLC staff to communicate with you by email and text message. This form provides information about the risks of these forms of communication, guidelines for email/text communication, and how we use email/text communication. It also will be used to document your consent for communication with you by email and text message.

1. **How we will use email and text messaging:** We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be electronically made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Please refer to our Notice of Privacy Practices for Information as to permitted uses of your health information and rights regarding privacy matters.
2. **IN A MEDICAL EMERGENCY, DO NOT USE TEXT MESSAGES, CALL 911. Risk of using email and text messages:**
    a. Emails and texts can be circulated, forwarded, stored electronically, on paper, and broadcast to unintended people.
    b. Senders can easily misaddress an email or text and send the information to an undesired recipient.
    c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
    d. Employers and on-line services have a right to inspect emails and texts sent through their company systems.
    e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
    f. Emails and texts can be used as evidence in court.
    g. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.
3. **Conditions for the use of email and text messages:** WCS cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to:
    a. **IN A MEDICAL EMERGENCY, DO NO USE EMAIL, CALL 911.** Do not email for urgent problems. If you have an urgent problem during regular business hours, please call your Counselor. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.
    b. Emails should not be time-sensitive. While we try to respond to email messages daily, we cannot guarantee that any particular email will be read and responded to within any particular period of time.
    c. Speak to your WCS staff person to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations. Email and text messages may be filed electronically into your medical record.
    d. WCS will not forward your identifiable email/texts without your written consent, except as authorized by law.
    e. You should use your best judgement when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
    f. WCS is not liable for breaches of confidentiality caused by you or any third party.
    g. It is your responsibility to follow up with your staff person if warranted.
4. **Withdrawal of consent:** I understand that I may revoke this consent at any time by so advising WCS in writing.
5. **Client Acknowledgement and Agreement:** I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between WCS staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that WCS may impose to communicate with me by email or text message.

Client Name:_____ Client Signature:_____

Date:_____

Wellness Counseling Services, LLC
CLIENT CONSENT FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the counseling process, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:
All interactions with **Wellness Counseling Services, LLC** including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- Your therapist may consult with counseling supervisor or staff to provide the best possible care. These consultations are for professional and training purposes.
- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.
- A court order, issued by a judge, may require the Wellness Counseling Services, LLC staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify via email, call (843-621-5404), or text, if you will be late. Twenty-four hour notice of cancellation allows us to use the time for others.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the Counseling Services.

Signature of Client Date

Signature of Therapist Date

If other family members are also seeking counseling services please sign below to consent for services. Parents please sign for children 17 and younger.

Signature of Family Member 2 Date

Signature of Family Member 3 Date

Signature of Family Member 4 Date

Signature of Family Member 5 Date

Signature of Therapist Date

Wellness Counseling Services, LLC
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

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 document may be updated without notice so please review it each time your visit us. A copy of this statement is always available upon request. All information revealed by you in counseling or therapy session and most information placed in your counseling file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. **As such, your protected health information cannot be distributed to anyone else without your express informed and voluntary written consent or authorization.** The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your therapist's Professional Disclosure Statement and Consent for Treatment.

1. Use or disclosure of the following protected health information does not require your consent or authorization;
2. Uses and disclosures required by law - *like files court-ordered by a judge*
3. Uses and disclosures about victims of abuse, neglect, or domestic violence - *like the Duties to Warn explained in your therapist's/counselor's Disclosure Statement*
4. Uses and disclosures for health and oversight activities - *like correcting records or correcting records already disclosed*
5. Uses and disclosures for judicial and administrative proceedings - *like a case where you are claiming malpractice or breech of ethics*
6. Uses and disclosures for law enforcement purposes - *like if you intend to harm someone else (see Duties to Warn in your therapist's/counselor's Disclosure Statement)*
7. Uses and disclosures for research purposes - *like using client information in research; always maintaining client confidentiality*
8. Uses and disclosures to avert a serious threat to health or safety - *like calling Probate Court for a commitment hearing*
9. Uses and disclosures for Workers' Compensation - *like the basic information obtained in counseling as a result of your Worker's Compensation Claim*

YOUR RIGHTS AS A COUNSELING CLIENT UNDER HIPAA

- As a client, you have the right to see your counseling file. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.
- As a client, you have the right to receive a copy of your counseling file. This file copy will consist of only documents generated by us. You will be charged copying fees @ $.20/page. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.
- As a client, you have the right to request amendments to your counseling file.
- As a client, you have the right to receive a history of all disclosures of protected health information. You will be charged copying fees @ $.20/page.
- As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment, and operations, If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.
- As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.
- A copy of this notice is available upon request.

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

General Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____
_____
_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____
_____
_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____
_____
_____

5. Are you currently experiencing overwhelming sadness, grief or depression? ▫ No ▫ Yes
If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? ▫ No ▫ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ▫ No ▫ Yes
If yes, please describe: _____

8. How do you identify your sexuality? _____

9. Are you currently in a romantic relationship? ▫ No ▫ Yes
If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

10. Are you currently taking any prescription medication? ▫ No ▫ Yes
If yes, please list (name, dosage, and frequency of use): _____
_____
_____
_____

11. Do you use recreational drugs? Please list: _____
_____

Family Mental/Physical Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	no / yes	
Anxiety	no / yes	
Depression	no / yes	
Bipolar	no / yes	
Domestic Violence	no / yes	
Eating Disorders	no / yes	
Obesity	no / yes	
Obsessive Compulsive Behavior	no / yes	
Schizophrenia	no / yes	
Suicide Attempts	no / yes	

Who lives in your household? And what is your relationship like with these individuals? _____
_____
_____
_____

Siblings or Children (please indicate if a sibling with (S) or child with (C)):

First Name - Last Name	Sex	Age	Relationship to person (full, step, half, foster)
1			
2			
3			
4			
5			
6			

Trauma History

1. Have you experienced any form of trauma (emotion, physical, psychological, spiritual, or sexual) in your past or currently? If so, please describe: _____
_____
_____
_____

2. What significant life changes or stressful events have you experienced recently? _____
_____
_____
_____

Additional Information

1. Are you currently employed? ▫ No ▫ Yes

If yes, name of the place you work and full-time or part-time? _____

2. Is there any cultural factors to take into consideration? _____
_____
_____
_____

3. If you are aware, did you meet your developmental milestones on time? ▫ No ▫ Yes

If not, please describe? _____
_____
_____

2. Are you a student? ▫ No ▫ Yes

Name of School: _____

Grade or Field of Study: _____

If no longer a student, what is the highest level of education completed? _____
_____

3. Who is in your social support network? _____
_____
_____

4. Do you consider yourself to be spiritual or religious? ▫ No ▫ Yes

If yes, describe your faith or belief: _____
_____
_____

5. What do you consider to be some of your strengths? _____
_____
_____
_____
_____

6. What do you consider to be some of your weaknesses? _____
_____
_____
_____
_____

7. List special abilities or talents: (ex. painting, singing, dancing…) _____
_____
_____
_____
_____
_____

8. Do you have any counselor preferences? What are they? _____
_____
_____
_____
_____
_____

9. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

▫ No ▫ Yes, previous therapist/practitioner: _____

If so, was it helpful? ▫ No ▫ Yes, what was helpful? _____

10. What would you like to accomplish out of your time in therapy?
_____
_____
_____
_____
_____
_____
_____
_____
_____

Wellness Counseling Services, LLC and McCall Counseling & Consulting, LLC

Symptom checklist **Instructions. Use checks (✓) to indicate which symptoms you have been experiencing recently.**	**0 — Not at all**	**1 — Somewhat**	**2 — Moderately**	**3 — A lot**	**4 — Extremely**
Depressed Mood					
Anxiety/fears/phobias/panic					
Mood swings					
Marital/relationship					
Parenting/Children Concerns					
Substance use (self)					
Substance use (others)					
Legal problems or arrests					
Irritability (anger)					
Illness in a family member					
Illness in yourself					
Recent loss or death					
Sexual problems					
Sleep Concerns					
Other (list):					

Do you have any current mental health diagnoses? ▫ **No** ▫ **Yes**
If yes, please list:

_____

_____