Client Information

Gateway to Wellness, Tyana Alexander, LPC

PLEASE COMPLETE ALL SECTIONS

Today's Date: ____/____/____

Client's full name: _____

Home address: _____ City:_____ State:____ Zip:_____

Home phone: _____ Cell: _____ Work: _____

Date of birth: ___/___/_____ Age: _____ Gender: _____ Marital Status: _____

Employer: _____

Emergency Contact Name: _____ Phone number: _____

Referred by: _____ Is it OK to send mail Y N

Current Medications: _____

Prescribed by(circle one) Psychiatrist Primary MD Name _____

Insured/Responsible Party Information (PLEASE COMPLETE REGARDLESS OF COVERAGE)

Full Name of Insured: _____ Relationship: _____

Address: _____ Phone: _____

Employer name: _____ Insured date of birth _____

Insurance Company: _____ ID #_____ Group# _____

Secondary Insurance: _____ ID# _____ Group# _____

Billing Policy

- I authorize use of this form on all of my insurance submissions/claims.
- I authorize the release of information to my insurance company(s).
- I understand that I am responsible for the full amount of my bill for services provided.
- I authorize direct payment to my service provider.
- I hereby permit a copy of this to be used in place of an original.

Signature: _____ Date: _____

Print Name: _____

Gateway to Wellness Tyana Alexander, LPC

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, a description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature

_____

Date

Gateway to Wellness Tyana Alexander, LPC

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be charged $50.00 due to your missed appointment.

The cancellation/no show fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

I require a credit card number be kept on file in the event that you same day cancel or no show for your scheduled visit.

Thank you for your consideration regarding this important matter.

Name on Card: _____

Credit card number: _____

Exp. Date: _____ Verification code: _____

Type of Card: Visa Mastercard Discover American Express

By signing below, I authorize Tyana Alexander, LPC to charge the above credit card in the event of a missed appointment.

_____
Client Signature

_____
Date

Gateway to Wellness Tyana Alexander, LPC

Therapeutic Contract

Probable Length of Services: Although some clients elect to pursue long-term in depth treatment, many issues can be resolved within 12-24 sessions. Of course, the success of any treatment depends on the motivation, willingness and dedication of the person being treated. For this reason, I can make no guarantees about treatment length or success.

Risk of Services: As with any change in your life, you should be aware that outcomes of therapy can be unpredictable. However, it has been my experience that the overwhelming majority of willing clients improve their situations through therapy. Treatment is intended to induce change in your life, and when this change occurs it may disrupt your accustomed manner of living and your relationships with others. You should also know that positive change takes work and you may be asked to try things that are difficult for you. Some people reach their goals fairly quickly and without much discomfort, while others need more time and feel more stress through the process. The experience of each individual is impossible to predict as each person has their own unique strengths and problems. Therapy can also provoke feelings of affection and/or anger toward the therapist which will be addressed in session.

My Therapeutic Approach: I believe the therapeutic process is both cooperative and collaborative. I am a process consultant. Because I see the client as the expert, we identify and develop the treatment goals together. I utilize the following therapeutic approaches;

1. Emotionally Focused Individual Therapy, which is process oriented approach that focuses on present process, how inner and relational realities are constructed and confirmed in the present. We will focus on evoking and deepening emotions to create a new experience or second order change rather than symptom modification.

2. Family Systems, which focuses on patterns and communication styles present in your current and past relationships, as well as the roles you play within those relationships. We will also review how one person's growth can effect change in the entire system, even when the others are not participating in the treatment. This is why, not all members of a system need to be present to address relationship issues.

Your Rights: Treatment is entirely voluntary, and you have the right to terminate treatment at any time. I have the right to terminate therapy with you under the following conditions:

1. If I believe that therapy is no longer beneficial to you.

2. If you fail to follow recommended treatment repeatedly.

3. If I believe that you will be better served by another professional.

4. If you have not paid for at least two sessions, unless special arrangements have been made.

5. When you have failed to show up for your last two therapy sessions without a 24-hour notice.

6. If you fail to comply with the 24 hour clean and sober policy for more than two sessions.

7. You are seeing another therapist, and participating in treatment with me would jeopardize our relationship and work with that therapist. (If you are seeing another therapist I will require that you sign a consent form to release information so I can communicate with the other therapist).

If for any reason our services terminate, I will provide you with the names of three other qualified professionals.

Telephone calls: You are welcome to leave messages at any time on my phone. If you need to speak with me regarding a therapeutic issue, I will call you back within 24 hours if it is an emergency and within 48 hours if it is not (please leave message briefly stating nature of call). Remember that, in general, telephone calls are not meant to take the place of an office visit; if you require extended time (15 minutes +) on the phone I will bill you for my time. Most insurance companies do not cover telephone counseling so you will be charged a fee equal to your regular session fee.

In case of an emergency or you are at risk of harming yourself or others please contact the 24-Hour Crisis Lifeline at 988 , or call 911 immediately.

24-Hour Clean and Sober Policy: Therapy can only be effective with a willing and able client. Clients are expected to be sober during our sessions. I assert the right to terminate any session if I believe that a client is under the influence or has used substances within the past 24 hours that impairs his/her ability to participate in treatment. If a session is terminated due to substance use, this is considered a no-show and the client will be charged a fee equal to your regular session fee.

E-mail: I discourage the use of e-mail with established clients because of the risk it poses to confidentiality. If you choose to email, please understand the potential risk.

I acknowledge and consent for treatment with Tyana Alexander, LPC.

_____

Client Signature

_____

Date

Gateway to Wellness Tyana Alexander, LPC

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, hereby, acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____

Signature

_____

Printed Name

_____

Date

Please return the copy of the HIPAA notice if you do not wish to keep it.

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For Office Use Only

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We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ The individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (please specify)

_____

_____