**Welcome to The Wellness Tree**

**The Wellness Tree P.L.C is a full-service psychiatry and counseling practice. We treat patients of all ages and offer integrative mental health care. We provide high quality care with an emphasis on mind, body and spirit. We offer extended hours to assist with your needs. Our hours are Monday - Wednesday 9am – 9pm Tuesday -Thursday - Saturday - Sunday**

**9am – 5pm.**

**Patient Information If under 18, parent information required for email and phone number**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name as it appears on INS (Last, First)** | **SSN Number** | **Date of Birth**  | **Sex****M \_\_\_\_****F \_\_\_\_** |
| **Address** | **City, State, Zip Code** |
| **Home Phone** | **Cell Phone** | **Work Phone** | **Marital Status** |
| **If Under 18 Parent Name**  | **Email Address** |
| **Race (Please Check)** **American Indian** **African American** **Asian** **White** **Hawaiian**  **Other \_\_\_\_\_\_\_\_\_\_\_\_** | **Ethnicity: (please check)** **Hispanic or Latino** **Not Hispanic or Latino**  | **Language (Please Check)**  **English**  **Spanish** **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |

**RESPONSIBLE PARTY FOR BILLING ACCOUNT**

|  |  |  |
| --- | --- | --- |
| **Name (Last, First)**  | **Relationship** | **Phone Number** |

**EMERGENCY CONTACT INFORMATION**

|  |  |  |
| --- | --- | --- |
| **Name (Last, First)** | **Relationship** | **Phone Number** |

**PRIMARY INSURANCE INFORMATION**

|  |  |
| --- | --- |
| **Insurance Provider** | **Member ID#** |
| **Policy Holder Name**  | **Relationship to Patient** | **Date of Birth** |
| **Address (if different from above)** | **City, State, Zip code** |

**SECONDARY INSURANCE INFORMATION**

|  |  |
| --- | --- |
| **Insurance Provider**  | **Member ID#** |
| **Policy Holder Name**  | **Relationship to Patient**  | **City, State, Zip Code**  |
| **Address (if different from above)**  | **City, State, Zip Code** |

**CONSENT TO DISCUSS MEDICAL INFORMATION AND/OR RELEASE MEDICAL RECORDS**

|  |  |  |
| --- | --- | --- |
| **Name (Last, First)** | **Relationship** | **Phone Number** |
| **Name (Last, First)** | **Relationship** | **Phone Number** |

**I authorize and request my insurance company to pay directly to The Wellness Tree for any health benefits resulting from care received at that facility. I understand that my insurance company may not cover all services rendered on behalf of me or my dependents and I agree to assume responsibility for any services not covered. I consent to the release to my insurance company for any medical record necessary to resolve claims for services rendered. I understand that co-pays, deductibles, co-insurance and any services not covered by an insurance company are DUE IN FULL AT TIME OF SERVICE.**

|  |  |
| --- | --- |
| **Signature** | **Date** |

**Mental Health History:**

Have you ever seen a mental health provider for any reason? (This includes a therapist or prescriber)?

\_\_\_\_ Yes \_\_\_\_ No

**Medical History:**

Do you have any medical illnesses? If yes, please list:

Problem Year Diagnosed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations:**

Dates Reason Hospital

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List ALL prescribed and over-the-counter drugs, such as vitamins and inhalers:**

Name the Drug Strength Frequency Taken

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you experienced any allergies to Medications?**

Name the Drug Reaction you Had \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise Habits:**

\_\_\_\_ Sedentary \_\_\_\_ Mild Exercise \_\_\_\_ Occasional Vigorous Exercise \_\_\_\_ Regular Vigorous Exercise

Caffeine Intake: \_\_\_\_ none \_\_\_\_ coffee \_\_\_\_ tea \_\_\_\_ cola #cups/cans/day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Intake: Do you drink alcohol? \_\_\_\_ yes \_\_\_\_ no If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How many drinks per week? \_\_\_\_\_\_ Are you concerned about this? \_\_\_\_ yes \_\_\_\_ no

 Have you ever experienced a blackout from drinking alcohol? \_\_\_\_ yes \_\_\_\_ no

 Are you prone to “binge” drinking? \_\_\_\_ yes \_\_\_\_ no

 Have you received treatment for drug or alcohol addiction? \_\_\_\_ yes \_\_\_\_ no

 If yes: \_\_\_\_ # times in Outpatient \_\_\_\_ # times in inpatient

Do you use tobacco or nicotine? \_\_\_\_ yes \_\_\_\_ no

If yes, do you \_\_\_\_ Vape (amt /day) \_\_\_\_\_\_\_

 \_\_\_\_ Smoke Cigarettes \_\_\_\_\_\_\_\_\_\_\_ # of packs/day

 \_\_\_\_ Chew - #/day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Pipe - # per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Cigars - #/day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 # of years used: \_\_\_\_\_\_\_\_\_\_\_\_\_ or year quit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use recreational or street Drugs? \_\_\_\_ yes \_\_\_\_ no

Have you ever given yourself drugs with a needle? \_\_\_\_ yes \_\_\_\_ no

**Payment Policy**

All co-pays, deductibles, and co-insurances will be collected at time of service, this reduces the cost of delivering care to you. Visa, Mastercard, Discover, AmEx and most HSA cards are accepted. If you anticipate a billing problem, please contact our office prior to your appointment so that satisfactory arrangements can be made. **NOTE**: a fee of $35 will be added to unpaid balances that require **collection and/or legal services.**

 Initial\_\_\_\_\_\_\_\_\_\_

**Cancellations Policy**

No-Show and same day cancellations cause unnecessary hardship on the practice to provide care to the community. Therefore, we require 24hr notice for any and all cancellations or reschedules unless the circumstances are completely UNCONTROLLABLE then special arrangements may be approved by management.

* 1st cancellation within the 24hr period or a no show YOU WILL be charged $95 for counseling and $150 for Psychiatric appointments.
* 2nd cancellation within the 24hr period or a no show YOU WILL be charged $95 for counseling and $150 for Psychiatric appointments.
* 3rd cancellation within the 24hr period or a no show YOU WILL be charged $95 for counseling and $150 for Psychiatric appointments AND you will be DISCHARGED FROM THE PRACTICE.

If you are using EAP services and no show or late cancel 3x consecutively, you will be discharged, and the EAP company will be notified.

 Initial\_\_\_\_\_\_\_\_\_\_

**Form rules and fees**

Therapy Support Animal Request are $35 for provider to complete and sign per request. ALL FLMA, Disability, and Leave of Absence forms will NOT be completed until 4 appointments are completed. The fees for completing forms are based on complexity of paperwork, highest complexity will be $150 lowest complexity will be $25. Clinicians and Provider MUST be given 14 business days to complete paperwork.

 Initial\_\_\_\_\_\_\_\_\_\_

**Prior Authorizations**

Prior Authorizations for medications that are not life threatening can take up to 10 to 14 days to be approved, these are the time frames instituted by your insurance plans.

 Initial\_\_\_\_\_\_\_\_\_\_

**Prescription and Refill Request**

Non-Controlled medication refill request MUST come directly from your pharmacy, controlled medication may be called into the office. If a Rx is needed, please anticipate your need and allow 5 to 7 days for the request to be completed. You MUST have attended your last scheduled appointment and have an upcoming appointment with your provider to receive a refill, if you missed an appointment you MUST schedule with provider as soon as possible and may be given a short script.

 Initial \_\_\_\_\_\_\_\_\_\_

**Insurance Information Changes**

Please be aware that it is your responsibility to notify us of any name, address and insurance changes which may have occurred since your last visit here. If claims are denied as a result of incorrect insurance information given to us by the patient and claims go beyond the insurance timely filing limits, then charges would become the responsibility of the patient.

It is your responsibility to know your insurance benefits The Wellness Tree DOES NOT guarantee that our services are a covered benefit or covered under your policy’s “office visit” charge and/or co pay and may be applied to deductible, co-insurance and/or a not covered service. You have the right to refuse any and all services provided by The Wellness Tree.

 Initial \_\_\_\_\_\_\_\_\_\_

**Office Communication**

Staff are often not immediately available by telephone. Please contact (480) 219-9421 when you need a call back from your provider. This number is answered by confidential voice mail that is monitored frequently. We will make every effort to return your call on the same day that you place it, with the exception of Fridays and holidays. If you are difficult to reach, please inform us of sometimes if you will be available. If we are unavailable for an extended time, it is recommended you contact Maricopa County Crisis line at 1-800-631-1314, 911, or head over to the nearest emergency room immediately in case of an emergency.

 Initial\_\_\_\_\_\_\_\_\_\_

# PATIENT RIGHTS

# By signing you acknowledge you were offered a copy the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191

# Client/Parent or Guardian Initial \_\_\_\_\_\_\_\_\_\_ Spouse/Other/Parent or Guardian Initial \_\_\_\_\_\_\_\_\_\_\_

**Courteous Care**

The Wellness Tree staff strives to give quality and courteous care.

We ask that you please remember every patient is a priority and we do our best to adhere to scheduled appointment times BUT emergencies do arise, and your patience is greatly appreciated during these times. We will do all we can to meet your expectations. Patients who exhibit ABUSIVE LANGUAGE, RUDE or INNAPROPRIATE BEHAVIOR will be asked to seek care elsewhere.

With my signature, I acknowledge that I have read the above information, or it has been read to me. I acknowledge that I have received answers to my questions I may have had and that I understand the content of the information above and agree to abide by its terms during our professional relationship.

Your signature also indicates that you consent to treatment for yourself and/or your child (children).

**Signature of Patient or Parent/ Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Spouse or Other Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Credit Card on File Authorization Form**

**Please complete this form for The Wellness Tree to keep your credit card on file for future payments, patient balances and other expenses incurred as a recipient of services with The Wellness Tree. You may elect to provide us with credit card information separately for each payment, however we require you to maintain a valid credit card on file, should you retain an outstanding balance, no-show, or provide cancellation in less than 24 hr.**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardholder Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Card Type: \_\_\_\_\_\_\_\_Visa \_\_\_\_\_\_\_\_ MasterCard**

**Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Security Code: \_\_\_\_\_\_\_\_\_\_ (3 digit code on back)**

**Cardholder Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Billing City/State/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardholder E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize The Wellness Tree to charge the above credit card account for balances owed for services provided at their office. I agree to update any information regarding this account as changes occur. I also authorize The Wellness Tree to contact the cardholder, if different from the patient, or the patient, about declined payments, or needing an alternative payment type if new or updated credit card is required.**

 **\_\_\_\_\_ (Initial Here)**

 **I also agree, that should my account become delinquent in my account, my account will be sent to collections, and I agree that my balance along with a 50% fee of my total balance to cover collections processing fees will be applied to my account.**

 **\_\_\_\_\_ (Initial Here)**

**Cardholder Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name of Cardholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tele mental Health Informed Consent:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to participate in tele mental health

with, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as part of my psychotherapy. I

understand that tele mental health is the practice of delivering clinical health care services via

technology assisted media o rother electronic means between a practitioner and a client who are

located in two different locations. I understand the following with respect to tele mental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to

future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with tele mental health,

including but not limited to, disruption of transmission by technology failures, interruption and/or

breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All

information disclosed within sessions and written records pertaining to those sessions are

confidential and may not be disclosed to anyone without written authorization, except were the

disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information

(PHI) also apply to tele mental health unless an exception to confidentiality applies (i.e., mandatory

reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional

health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic

symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be

determined that tele mental health services are not appropriate and a higher level of care is required.

6) I understand that during a tele mental health session, we could encounter technical difficulties

resulting in service interruptions. If this occurs, end and restart the session. If we are unable to

reconnect within ten minutes, please call me at\_480-219-9421\_ to discuss since we may

have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or

appropriate authorities in case of an emergency.

**Emergency Protocols**

I need to know your location in case of an emergency. You agree to inform me of the address

where you are at the beginning of each session. I also need a contact person who I may contact on

your behalf in a life- threatening emergency only. This person will only be contacted to go to your

location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and my emergency contact person’s name, address, phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read the information provided above and discussed it with my therapist. I understand

the information contained in this form and all of my questions have been answered to my

satisfaction.

Signature of client/parent/legal guardian­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Signature of therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Informed Consent to Treatment**

 1. I will be given a clear description from my service provider regarding the problems, diagnosis, personal strengths/limitations, and treatment interventions proposed.

 2. I will be given a clear recommendation for the types of treatment recommended, such as individual counseling/therapy, group counseling/therapy, family/couples counseling/therapy, addictions counseling, and/or psychiatric services, seminars or other educational opportunities available to me. Times, dates, and session length will be discussed with my assigned Staff Clinician(s).

 3. I voluntarily agree to undergo behavioral health treatment and understand that I may end treatment at any time. I understand that my Staff Clinician may want to discuss this with me, but that I reserve the right to stop treatment. Furthermore, I understand that my Staff Clinician may make diagnostic and treatment recommendations with which I do not agree (e.g., modality of treatment, duration of treatment, frequency of visits, etc.).

 4. I understand that my Provider cannot guarantee results (e.g., less depressed, improved marital satisfaction, etc.) of services received. However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing behavioral health treatment. This will be discussed with my Staff Clinician.

 5. I understand that there may be some risks in participating in behavioral health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on an issue; re-uniting with family members; or being inconvenienced due to costs/fees of counseling. I am aware that I can discuss any unforeseen risks vs. benefits with my Staff Clinician at any time. In the case of psychiatric care, medications, side effects, and alternative treatments will be discussed.

 6. I understand that I have the right to an interpreter (sign or language) if necessary.

 7. I understand that in the case of an emergency, I am to immediately dial 911, go to the closest hospital emergency room, or contact the County Crisis Line in the county where I am located:

* 1-800-631-1314 and 602-222-9444 (Maricopa County)
* 1-800-796-6762 or 520-622-6000 (Pima County)
* 1-866-495-6735 (Graham, Greenlee, Cochise, and Santa Cruz Counties)
* 1-800-259-3449 (Gila River and Ak-Chin Indian Communities)
* 1-866-495-6735 (Yuma, LaPaz, Pinal and Gila Counties)
* 1-877-756-4090 (Mohave, Coconino, Apache, Navajo, and Yavapai Counties)

Emergencies are generally life-threatening in nature. I have discussed with my Provider how to access this service.

 8. I understand that if I have a grievance with my Provider, I will first attempt to communicate this directly to him/her. In the event that the grievance is not satisfactorily resolved, I understand I can write a letter to the CEO or Director of Operations regarding my concerns.

 9. I understand that this “Informed Consent/Limits of Confidentiality Form” is not intended to be “all inclusive” of aspects of my behavioral health treatment. It is only intended to provide some useful information before deciding to engage in behavioral health treatment.

10. I understand that due to licensure constrictions all LMSW and LAC therapist are being supervised by a LCSW or LPC, and I understand this would allow the supervisor access to my records and the supervisor is held to the same HIPAA compliant contract as my LMSW or LAC. I knowing and willing accept this and agree to continue with.

**Limits of Confidentiality**

1. The information that you share with your Provider is considered to be confidential. In most cases, information cannot be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include:

2. Suicide: if you are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be “confidential”. Actions may be taken to ensure your safety.

3. Homicide: if you are assessed to be a danger to others; cannot guarantee their safety; and have immediate, specific plans to cause fatal injury/harm to another person, this information is not considered to be “confidential”. Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim.

4. Court order/subpoena: Your Staff Clinician (s) can be required to relinquish a copy of your written Clinical Health Record to the appropriate Courts. Staff Clinicians can also be subpoenaed to testify in court without your consent.

5. Child abuse/neglect: Arizona Law requires your Staff Clinician to report to the appropriate authorities (i.e. Child Protective Services) any suspicion or evidence of child abuse or neglect. This law also applies to past incidents of abuse or neglect.

6. Elder abuse/neglect: Arizona Law requires your Staff Clinician to report to the appropriate authorities any suspicion or evidence of elder abuse/neglect.

7. Laws regarding minors in mental health services: certain information may be shared with parent/legal guardians at the discretion of the Staff Clinician(s).

**Report Child Abuse or Neglect**

**Arizona Adult Probation**

**602-506-7249**

**Arizona Child Abuse Hotline**

**1-888-SOS-CHILD (1-888-767-2445)**

A report of suspected child abuse, neglect, exploitation, or abandonment is a responsible attempt to protect a child. Arizona law requires certain persons who suspect that a child has received non-accidental injury or has been neglected to report their concerns to DCS or local law enforcement (ARS §13-3620.A). YOU may be a child’s only advocate at the time you report the possibility of abuse or neglect. Children often tell a person with whom they feel safe about abuse or neglect. If a child tells you of such experiences, act to protect that child by calling the toll-free **Arizona Child Abuse Hotline at 1-888-SOS-CHILD** (1-888-767-2445). To learn more about Mandated Reporting, select "Who must report?" from the following list.

8. Confidential information may also be used in several ways within The Wellness Tree without your written permission for coordinating services and delivering quality care. You may be informed if this is the case. These may include:

 1. Consultations and case conference with other Staff Clinicians at The Wellness Tree.

 2. In supervisory meetings with student interns at The Wellness Tree, if applicable.

 3. With providers in other services here at The Wellness Tree.

 4. For billing purposes: a diagnosis is given to your third-party payor (insurance, EAP, Medicare, and/or private insurance companies/HMO’s where applicable for reimbursement purposes.

**Other Notes on Your Privacy:**

1. Video and audio taping: **occasionally**, Mental Health Providers may want to make an audio/video recording of your sessions. Your written permission is required prior to this happening and will be discussed if your provider has an interest in doing so. YOU HAVE THE RIGHT TO REFUSE THIS.

I have reviewed this” Informed Consent to Treatment/Limits of Confidentiality” information.

I have been given the opportunity to ask questions about this information. A copy of this information is available upon request.

By signing this, I acknowledge my understanding of this information.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff Clinician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTIFICATION OF SUPERVISOR PARTICIPATION

All Wellness Tree LMSW’s (Licensed Master’s Social Workers) and LAC’s (Licensed Associate Counselors) recognized by the Arizona Board of Behavioral Health Examiners (AzBBHE). Both LMSW’s and LACs are accruing hours and working toward independent licensure as a Licensed Clinical Social Worker (LCSW) and Licensed Professional Counselor (LPC). All LMSW’s are employees of The Wellness Tree and work under the supervision of Samantha Manchik, LCSW and Stephanie Bilandzija, LCSW, who are AZBBHE approved clinical supervisors. All LACs are employed by The Wellness Tree and are under the supervision of Jennifer Menichello LAC who is an AZBBHE approved clinical supervisors. As the clinical supervisors, Ms. Manchik, Ms. Bilandzija and Ms. Menichello will have access to your records and information.

In accordance with the supervision requirements set forth by the AzBBHE, the LMSW may discuss information regarding patients with her/his supervisor, for the purpose of receiving consultation and clinical supervision. Occasionally, your social worker may also participate in clinical staffing’s or group supervision, in which they discuss and review cases with other professional colleagues for the benefit of continued professional growth and professional consultation and review. Names are not used during supervision and staffing’s, to protect the confidentiality of the client (except when confidentiality is limited, such as a duty to report, duty to warm, danger to self or others, etc.).

Any questions or concerns pertaining to therapeutic services can be discussed directly with Denise Stewart. If you prefer, you can contact the clinical supervisors directly to discuss questions or concerns. They can be reached at 480-219-9421, via e-mail at SBilanzija@wellnesstreeaz.com, SManchik@wellnesstreeaz.com and JMenichello@wellnestreeaz.com or in writing to the following address:

Attn: Clinical Supervisor

The Wellness Tree

3210 S Gilbert Rd Ste 1

Chandler Az, 85286

This clinical supervision will remain in effect while the LMSWs and LACs remains employed The Wellness Tree, or until they obtain their LCSW or LPC. If you have questions about the clinical supervisor’s participation, you may contact Ms. Bilandzija, Ms. Manchik or Ms. Menichello by calling, e-mailing or sending a request, in writing, to the above address.

