Lotus Wellness Center

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INITIAL PAPERWORK

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. ***Please fill out this form and bring it to your appointment.***

DATE: _____Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)
Birth Date: _____/_____/_____ Age: _____

Gender: _____Male _____Female_____Non-binary Preferred gender pronouns: _____

Marital Status: Never Married Married Separated Divorced Widowed Domestic Partner

Address: _____
(Street and Number) (City) (State) (Zip)

Home phone: _____ May we leave a message? Yes No

Cell/Other phone: _____ May we leave a message? Yes No

E-Mail: _____ May we email you? Yes No
**Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by: _____

INSURANCE INFORMATION

** *Please provide a copy of insurance card in addition to completing information.*

- Person responsible for bill: _____ Birth date: ___/____/____
  Address (if different):_____

- Insurance company: _____
  Subscriber's name: __ _____ Birth Date: ____/____/_____
  Relationship to patient: _____
  ID number: _____ Group no.: _____

- Secondary Insurance company: _____
  Subscriber's name: _____ Birth Date: ____/____/_____
  Relationship to patient: _____
  ID number: _____ Group no.: _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. **I agree to pay for services rendered, in full at the time of service, unless other arrangements are made in advance.** Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services, which may not be available at the time of leaving the office. We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for psychiatric care is a contract between you and the carrier. You should direct any questions and/or complaints regarding coverage to your insurance carrier. **If at any time, your health insurance coverage changes, please notify our office immediately or you will be held accountable for all charges at the time of services rendered.** Any account exceeding 90 days without a payment or arrangement shall be considered delinquent and can be subject to legal actions or assignment to a collection agency. **Co-payments and outstanding balances are due at the time of service. In case of no insurance, payment in full will be due at the time of service. For individual counseling services, initial evaluations are $150, and follow-ups are $100 for a self-pay client. Please inquire regarding self-pay rates for all other services.**

_____ *Initial*

NON-PAYMENT

If you are unable to make a payment on your bill, please contact our office for possible payment arrangements. If your bill is 90 days overdue without payment, you will not be able to schedule further appointments, and your bill may be subject to late fees or turned over to collections for non-payment.

_____ *Initial*

NOTICE OF PRIVACY PRACTICES

I hereby authorize Lotus Wellness Center, PC to release any and all information to insurance companies or associations, employee groups, government agencies or their third party payors and their agencies or employees, as may be necessary for the completion of all my claims. **By signing below, you agree that you received, read and understand our Privacy Practices. If you choose to keep information confidential from insurance, we can discuss self-pay rates.**

_____ *Initial*

***APPOINTMENTS**

Expected length of services to be provided is often difficult to predict and this factor will be discussed with you prior to initiation of the services. Counseling sessions are **typically 45-50 minutes** in length and in order to see the most progress, clients are encouraged to begin with weekly or biweekly sessions.

_____ *Initial*

***APPOINTMENT CANCELLATION POLICY**

Because my clinician holds your appointment slot open for me, I understand that the office requests more than 24 hours notice be given for cancellations. **I understand that failure to cancel with at least 24 hours notice will result in a $50 fee.** Charges for missed appointments are not covered by insurance. I understand that this charge will be directly billed to me, and must be paid prior to the next appointment. Recurrent no-shows may result in a discharge from care.

_____ *Initial*

***INITIAL CONSULTATION**

The initial consultation, otherwise known as the intake interview is an important and mandatory procedure for all new clients, which provides you and your clinician the opportunity to get to know each other and determine if you are a good treatment match. During this time, the individual's background, therapeutic concerns and goals, schedule availability and financial resources are discussed and an initial treatment plan is agreed upon. Details of confidentiality and fees are also discussed. I understand the importance of this initial meeting.

_____ *Initial*

LETTERS/FORMS

Lotus Wellness Center PC does not provide disability letters, companion pet letters, or letters regarding your ability to work, or any letters that would inform providers of your mental health history. You must discuss these needs with your medical, psychiatric or primary care provider.

_____ *Initial*

***INSURANCE POLICY**

This office accepts most major insurance providers. However, if we are out of network with your insurance company, we will provide you with all of the necessary paperwork to file your own insurance reimbursement. Generally speaking, most insurance companies will pay a percentage of each session after you meet your deductible. The majority of insurance companies reimburse clinicians at a 60/40 or 70/30 percentage split. If you choose to utilize your insurance, please note that to meet the requirements for in-network reimbursement, the counselor must submit an official client diagnosis and an ongoing progress report, treatment plan, etc. Such information requires that the therapist divulge a good deal of personal information about the client, which then becomes part of his/her permanent medical record which can be accessed by others. If you are concerned about your confidentiality with insurance claims, please ask us regarding self-pay and sliding fee rates.

_____ *Initial*

TELEPHONE CALLS

Calls prompted by the client that require clinician to call back **will be charged**. Giving medical advice and treatment is a service we provide. Any co-payment or deductible will be the patient's responsibility. You may prefer to make an appointment vs. discussing your healthcare needs over the phone. At times, your clinician may initiate a phone or telehealth session. If this is the case, it will be treated similarly to a face-to-face session and all co-payments and deductibles will be the client's responsibility.

_____ *Initial*

***SCHEDULE OF FEES**

All clients begin with a 50-minute initial consultation with a counselor. Thereafter, clients schedule standard, weekly/biweekly sessions with their counselor. You are responsible for all fees at the time of service; cash, credit card, and personal checks are accepted. Any unpaid balance may be turned over to a collection agency if you refuse to remain responsible for your account. You will be expected to pay for late cancelled or forgotten appointments with a **$50 charge**, unless there has been an emergency or at least notice of cancellation given within 24 hours. The fee must be paid at your next appointment. There will be a $35 charge for any checks that are returned for insufficient funds.

SELF-PAY RATES

Fees vary according to the type and length of services. Sliding fees are granted for a limited amount of sessions no more than 10 sessions in a 12 month period. Clients must meet income requirements. Please contact us to apply.

I certify that the information provided on the Patient Profile is correct to the best of my knowledge. I have read and understand the above and duly authorize Lotus Wellness Center, PC and/or it's appointees to execute the above and its terms.

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship: _____

MEDICAL HISTORY

- Drug allergies: _____

- Last physical: _____
- Surgeries: _____
- Thyroid problems: _____
- Hormone problems: _____
- Medical illnesses (describe): _____
- Are you currently taking any prescription medication? Please include doses and frequency.

  □ Yes
  □ No
  Please list: _____

  _____

- Do you have a Primary Care Physician, Psychiatrist, Pediatrician and any other doctor that you see regularly?

  □ Yes
  □ No

  Please list ALL doctor(s) who you currently see:

  _____

  _____
  Would you like your clinician to coordinate care with your Primary Care Physician: □ Yes □ No

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

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

  □ Yes, previous therapist/practitioner: _____
  □ No

- How would you rate your current physical health? (Please circle)

  Poor Unsatisfactory Satisfactory Good Very Good

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

  _____

- How many times per week do you generally exercise? _____

  What types of exercise do you participate in? _____

- Are you currently experiencing overwhelming sadness, grief or depression? Yes ☐ No ☐
  If yes, for approximately how long? _____
- Are you currently experiencing anxiety, panic attacks or have any phobias? Yes ☐ No ☐
  If yes, when did you begin experiencing this? _____
- Are you currently experiencing any chronic pain? Yes ☐ No ☐
  If yes, please describe. _____
- Describe stressors (what upsets you): _____

  _____
- What significant life changes or stressful events have you experiences recently:

  _____

  _____

  _____

SOCIAL HISTORY

- Spouse/Children (names, ages): _____
  _____
- Are you currently in a romantic relationship? Yes ☐ No ☐
  If yes, for how long? _____
- On a scale of 1-10, how would you rate your relationship? _____
- Current support systems (family/friends): _____
  _____
- Leisure activities/hobbies: _____
- Alcohol: Yes ☐ No ☐ If yes, how many drinks per week: _____
- Smoker: Yes ☐ No ☐ If yes, what type of tobacco: _____
  How much and how often: _____
- Marijuana: Yes ☐ No ☐ If yes, how often: _____
- Drug use: Yes ☐ No ☐ Type of drug(s): _____

EMPLOYMENT INFORMATION

- Are you currently employed? Yes ☐ No ☐

  If yes, what is your current employment situation: _____
  _____

- Do you enjoy your work? Yes ☐ No ☐

- Is there anything stressful about your current work? _____

FAMILY 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 (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes/no	
Anxiety	Yes/no	
Depression	Yes/no	
Domestic Violence	Yes/no	
Eating Disorders	Yes/no	
Obesity	Yes/no	
Obsessive Compulsive Behavior	Yes/no	
Schizophrenia	Yes/no	
Suicide Attempts	Yes/no	

ADDITIONAL INFORMATION

- Do you consider yourself to be spiritual or religious? Yes ☐ No ☐

  If yes, describe your faith or belief: _____
  _____

- What do you consider to be some of your strengths?

  _____

_____

_____

- What do you consider to be some of your weaknesses?

_____

_____

_____

- What would you like to accomplish out of your time in therapy?

_____

_____

CURRENT SYMPTOMS (Check all that apply)

Sleep:

- ☐ No change
- ☐ Too much
- ☐ Cannot fall asleep
- ☐ Wake up too soon
- ☐ Panic at night
- ☐ Tired mornings
- ☐ Anxiety

Appetite:

- ☐ Increased
- ☐ Decreased
- ☐ Weight Change
- ☐ Binging
- ☐ Vomiting
- ☐ Sweet cravings

Concentration:

- ☐ OK
- ☐ Decreased memory
- ☐ Poor decision making
- ☐ Decreased attention

Energy:

- ☐ Low
- ☐ Normal
- ☐ High

Anxiety:

- ☐ Occasional
- ☐ Constant
- ☐ Panic
- ☐ Irritable
- ☐ Feel guilty

Interest:

- ☐ Social withdrawal
- ☐ Low sex drive
- ☐ Neglect of hobbies
- ☐ Loss of pleasure when active
- ☐ Loss of desire for usual activities

Mood:

- ☐ Stable
- ☐ Low
- ☐ Elevated
- ☐ Changes a lot

Suicide Thoughts:

- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Suicide Attempts:

- ☐ Yes

How? _____

- ☐ No

CHECKLIST OF CONCERNS

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- □ I have no problem or concern bringing me here.
- □ Abuse – physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- □ Aggression, violence
- □ Alcohol use
- □ Anger, hostility, arguing, irritability
- □ Anxiety, nervousness
- □ Attention, concentration, distractibility
- □ Career concerns, goals, and choices
- □ Childhood issues (your own childhood)
- □ Codependence
- □ Confusion
- □ Compulsions
- □ Custody of children
- □ Decision making, indecision, mixed feelings, putting off decisions
- □ Delusions (false ideas)
- □ Dependence
- □ Depression, low mood, sadness, crying
- □ Divorce, separation
- □ Drug use – prescription medications, over-the-counter medications, street drugs
- □ Eating problems – overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- □ Emptiness
- □ Failure
- □ Fatigue, tiredness, low energy
- □ Fears, Phobias
- □ Financial or money troubles, debt, impulsive spending, low income
- □ Friendships
- □ Gambling
- □ Grieving, mourning, deaths, losses, divorce
- □ Guilt
- □ Headaches, other kinds of pains
- □ Health, illness, medical concerns, physical problems
- □ Housework/chores – quality, schedules, sharing duties
- □ Inferiority feelings
- □ Interpersonal conflicts
- □ Impulsiveness, loss of control, outbursts
- □ Irresponsibility
- □ Judgement problems, risk taking
- □ Legal matters, charges, suits
- □ Loneliness
- □ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- □ Memory problems
- □ Menstrual problems, PMS, menopause

- □ Mood swings
- □ Motivation, laziness
- □ Nervousness, tension
- □ Obsessions, compulsions (thoughts or actions that repeat themselves)
- □ Oversensitivity to rejection
- □ Pain, chronic
- □ Panic or anxiety attacks
- □ Parenting, child management, single parenthood
- □ Perfectionism
- □ Pessimism
- □ Procrastination, work inhibitions, laziness
- □ Relationship problems (with friends, with relatives, or at work)
- □ School problems (see also "Career concerns…")
- □ Self -centeredness
- □ Self-esteem
- □ Self-neglect, poor self-care
- □ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- □ Shyness, oversensitivity to criticism
- □ Sleep problems – too much, too little, insomnia, nightmares
- □ Smoking and tobacco use
- □ Spiritual, religious, moral, ethical issues
- □ Stress, relaxation, stress management, stress disorders, tension
- □ Suspiciousness, distrust
- □ Suicidal thoughts
- □ Temper problems, self-control, low frustration tolerance
- □ Thought disorganization and confusion
- □ Threats, violence
- □ Weight and diet issues
- □ Withdrawal, isolating
- □ Work problems, employment, workaholic/overworking, can't keep a job, dissatisfaction, ambition
- □ Other concerns or issues:

_____

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

_____

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, 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 (Client's Parent/Guardian if under 18)

_____
Today's Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answer.

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

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

Not difficult at all Somewhat difficult Very difficult Extremely difficult

NOTICE OF PRIVACY PRACTCES ACKNOWLEDGEMENT.PHONE MESSAGE AND CONTACT AUTHORIZATION

Patient Name: _____ Date of Birth: _____

The **Notice of Privacy Practice (NPP)** tells you how we may use and share your health records. It also describes your rights with respect to your health records. Please read the entire NPP carefully. We will use and share your health records to: treat you and to bill you for the services we provide; to run our business and as required/allowed by law.

Under HIPPA, the law requires you to sign this page acknowledging that you had the opportunity to read and receive a copy of the NPP.

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____ Date: _____

Phone message and contact authorization:

Do the physicians and staff of Lotus Wellness Center, PC have your permission to leave messages containing medical and/or financial information on your voicemail? Please circle/fill in below.

At home Y N** **At work** Y N **On Cell** Y N**

** Even if you check N for no, the date, time and location of appointments will be left on your voicemail. **

The individual(s) mentioned below will be your additional contacts. **I give authorization to the doctors and staff of Lotus Wellness Center, PC to discuss my medical and/or financial information with the following people:**

	Name	Relationship	Phone #
1.			
2.			
3.			

I understand that it is my responsibility to inform Lotus Wellness Center, PC of any desired changes in the authorization.

Note: This authorization expires one year form the date of signature.

Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

The security of your personal information is extremely important. Lotus Wellness Center PC is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization, the" information regarding services" and/or "Notice of Privacy Policy Practices" forms provided for your review and agreement.

This form is requested for all clients and required to be on file. Please inform us when there are any changes made to this credit card so that we can have updated information on file.

Client Name/s: _____

Please read all below:

Acceptable forms of payment are: cash, check, debit card or credit card.

My initials below:

_____ Without my debit/credit card, I authorize Lotus Wellness Center PC to use my credit/debit card number provided below to process charges/fees assigned to any named individual listed above.

_____ I authorize Lotus Wellness Center PC to be compensated for missed appointments of which the client/s named above did not show up for session or cancel session less than 24 hours before the time of the appointment. Missed and late cancelled appointments are billed at a rate of $50 per session.

Please complete all the following information:

Type of card: _____

Exact name on card: _____

Relationship to client: _____

Card number: _____

Expiration date: _____ CUV: _____

Billing address: _____

Signature: _____ Date:_____

ADDITIONAL INFORMATION

- What do you consider to be some of your strengths?

  _____

  _____

  _____

- What do you consider to be some of your weaknesses?

  _____

  _____

  _____

- What would you like to accomplish out of your time in therapy?

  _____

  _____

- What have been your major crises of the last 1-5 years and how have you handled them?

  _____

  _____

- What are your goals for therapy?

  _____

  _____

- Do you consider yourself to be spiritual or religious? Yes ☐ No ☐

  If yes, describe your faith or belief: _____

- When are you happy? What are the positive factors in your life right now?

  _____

  _____

- What persons, ideas, or forces have been most influential or useful for you in the past?

  _____

  _____