Mind Body Wellness Center Intake Form

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 first session.

Name: _____

Name of parent/guardian (if under 18 years):

_____

Birth Date: _____ /_____ /_____ Age: _____ Gender: Male Female

Marital Status:

Never Married Domestic Partnership Married

Separated Divorced Widowed

Please list any children/age: _____

_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ --- _____ May we leave a message? Yes No

Cell/Other Phone: (_____) _____ --- _____ May we leave a message? Yes No

Cell Phone Carrier/Provider: _____

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

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
No

Yes, previous therapist/practitioner: _____

ADDITIONAL INFORMATION:

1. Are you currently employed: No Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

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

If yes, describe your faith or belief:

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

6. Are you currently experiencing anxiety, panic 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. Do you drink alcohol more than once a week? No Yes

9. How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? No Yes

If yes, for how long? _____
On a scale of 1---10, how would you rate your relationship? _____

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

_____

_____

_____

FAMILY MENTAL 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 (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 Disorder	YES / NO	
Schizophrenia	YES / NO	
Suicide Attempts	YES / NO	

Are you currently taking any prescription medication?

Yes
No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

Yes
No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. 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:

_____

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

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 patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

No
Yes

If yes, for approximately how long? _____

AGREEMENT FOR PSYCHOTHERAPY/EVALUATION SERVICES
Mind Body Wellness Center

Consent To Treatment Or Evaluation: By signing below, you hereby give full consent for your child or yourself/yourselves to receive and treatment services of Mind Body Wellness Center until we determine that services are no longer appropriate or will no longer be provided. You also certify that you have the legal authority to authorize and consent to this evaluation and/or treatment as parent(s), managing conservator, or guardian(s) of this child. You further certify that you have the legal authority to authorize and consent to this evaluation and/or treatment as parent(s), managing conservator, or guardian(s) of this child.

In case of a divorced or divorcing family, please indicate whether the child is subject to a court order (e.g., divorce decree):

_____ Child is subject to a court order

_____ Child is NOT subject to a court order

If the child is subject to a court order, I will need to see a full, true, and correct copy of that court order before meeting and working with the child.

_____ _____
Client's Parent/Guardian Signature Date

_____
Client's Parent/Guardian Printed Name

E---MAIL CONSENT FORM

Email communication offers an efficient way to communicate with the staff at Mind Body Wellness Center. From appointment reminders to providing brief updates and information, email allows the Therapist and the Client to avoid some of the frustrations of "phone tag," finding appropriate times to make phone calls and voice mail communication that may not convey all of the necessary data. However, this medium is not without its risks.

1. RISKS OF USING EMAIL. Transmitting client information by email has a number or risks that clients should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Backup copies of email may exist even after they are sent or the recipient has deleted his or her copy.
- Employers and on---line services have a right to inspect email transmitted through their systems.
- Email can be used to introduce viruses into computer systems.
- Emails may not be secure, and therefore, it is possible that the confidentiality of such communications may be breeched by a third party. Email can be intercepted, altered, forwarded, or used without authorization or detection.

2. GUIDELINES FOR USE OF EMAIL COMMUNICATION. We cannot guarantee, but will use reasonable means, to maintain security and confidentiality of email information sent and received. We will not be liable for improper disclosure of confidential information that is not caused by intentional misconduct.
Clients must acknowledge and consent to the following conditions:

- Email is not appropriate for urgent matters or an emergency situation. Instead, please call the office. We cannot guarantee that any particular email will be read and responded to within any particular period of time.
- Email should be concise. The client should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- We will check email on a regular basis, however, there may be exceptions to this. In addition, there can be server problems or line/connection problems. Therapist will not check email when out of the office, on vacation or in training.
- Most email messages will be filed electronically in the client record.
- Therapist will not forward client identifiable emails to others outside the practice without the client's prior written consent, except as authorized or required by law. Our Therapist will never distribute a client's email address to a third party.
- We are not liable for breach of confidentiality caused by the client or any third party.
- Use caution when using your employer's computer.
- Inform provider of changes in your email address.
- Ordinarily there will be no charge for use of periodic, brief emails. Should a message require a lengthy response, a regular correspondence rate will apply. The patient can then choose to discuss the matter during the scheduled session rather than paying a correspondence fee.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email communication with staff at Mind Body Wellness Center and consent to the conditions and instructions outlined.

_____ _____

Client's Signature/Authorized Individual Email Address to be Used Date

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than 24---hour notice unless it is due to illness or emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

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

_____

Today's Date

Mind Body Wellness Center Credit Card Authorization

(All clients must have credit card on file to receive services at this office.)

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, a $150 fee will be charged. An additional $50.00 fee will be assessed for inaccurately disputed claims/chargebacks.

I, _____, hereby authorize Mind Body Wellness Center to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone and email consultations
- Appointments that I have cancelled with less than 24 hours notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

____ Visa ____ MasterCard ____ Discover ____ American Express

Card # _____ Exp. Date: _____

Name as Printed on Card: _____

Verification/Security Code (3 or 4 digit code on back of card): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

By signing below I am authorizing Mind Body Wellness Center to bill my credit card at the usual fee for professional services. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Signature: _____ Date: _____

Print Name: _____

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement of activities, auditing functions, cost---management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de---identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health---related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice on our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Dr. Riaz Rahman
Mind Body Wellness Center
6902 South Peek Rd.
Richmond TX 77407
(713) – 984 -- 4546

For more information about HIPAA

US Dept. of Health & Human Services

Washington, DC 20202

Toll Free: 1---877---696---6775

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow---up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third---party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: _____

Relationship to Client: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

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

Intake Information

The following page contains vital information for your counseling process. Please read its contents carefully. Thank you.

From time to time, for your convenience we may contact you via email about appointment times with your permission. This is one of the ways we may confirm appointments or contact clients. We will always be discreet; the name of the office will not be used in our correspondence. For example, we would say, "Reminding you of your appointment with (therapist's name) on Tuesday, March 17th at 2:00 pm. Please call 713---365---0700 to confirm." To assure absolute confidentiality, we will correspond via e---mail ONLY about appointment dates and times. We will NEVER disclose other information in e---mails even if you solicit a reply pertaining to another matter or issue.

I give my permission to contact via email. ____ Yes ____ No

I give my permission to receive text reminder message for appointments ____ Yes ____ No *if

yes, please list telephone number: _____

Do you want to receive the newsletters when it is available? ____ Yes ____ No

Would you like to receive emails concerning upcoming events or information related to counseling?
____ Yes ____ No

My home e---mail address is _____

Second e---mail is _____

I do voluntarily agree to participate in the assessment and counseling as offered by Mind Body Wellness Center. I am aware that treatment often involves individual, family and/or group therapy of which the therapist may recommend if the therapist deems it important to the healing process. I understand that my rights and responsibilities as stated in this document. I also understand that therapy varies according to each individual and that the therapist cannot guarantee desired treatment results.

I consent to the use of my personal health information for routine practices for treatment, payment and health care operations according to the laws of the State of Texas and the Federal government as outlined in the Confidentiality Section of this document and discussed in detail in the Confidentiality Policy and Privacy Practices.

Court or Legal Proceedings: It is in your best interest to know that conducting expert witness/testimonial services is not my area of interest or expertise. As a result, I do not agree to serve as an expert witness or to provide expert testimony on your behalf, and you agree not to cause my services to be used in any way related to any legal proceeding or as expert witness testimony. If you are seeking counseling for court or court---related purposes or motivations, I will provide you with alternative and appropriate referral sources. In the even that you, your attorney, or any attorney related to any litigation that you may be involved in, subpoena me or your client file as a factual or expert witness, or involve me in any way to court---related proceedings, you agree to pay $300.00 per hour for any involvement of my time related in any to the litigation proceeding, including but not limited to, review of medical records, generation for any expert reports, deposition testimony, trial testimony, or any other case preparation, travel expenses and travel time, and any other time commitments related in any way to such litigation.

Signature: _____ Date: _____

Coordination of Benefits

Claimant Name:		
Subscriber Information		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
DOB:	ID: Number:	
Employer:		
Does claimant have any other health insurance coverage including Medicare? No Complete item 8 below Yes Complete all items 1---8 below		
1. Is the other health insurance coverage offered through the claimant's employer? Yes No		
2. Name of Insurance Company:		
3. Name of Subscriber:		
4. Relationship of subscriber to the claimant:		
5. Effective coverage dates: START: / / END: / /		
6. Type of Coverage: Individual Family		
7. In the case of divorce, is health coverage for this claimant court ordered? Yes No		
If yes, who is required to provide?		
With whom does the client live?		
Who are the natural parents?		
Father:	DOB: / /	
Mother:	DOB: / /	
8. Signature:	Date:	