WETHRIVE COUNSELING CENTER
WELCOME PACKET

Confidential Patient Intake Information

Patient Full Name _____ Date _____

Date of Birth _____ Who referred you? _____ May we thank them? _____

Address _____ City _____ Zip _____

Mobile Phone _____ Would you like text reminders? Y N

Email _____ Would you like email reminders? Y N

Marital Status _____ Preferred Pronoun (circle one) He She They

Who do you live with? _____

Medical issues that might interfere with therapy? _____

Do you have a physician/ psychiatrist you would like me to contact? Y N Name_____

Please list medications you are currently taking _____

_____

Describe why you are coming to see me now? _____

_____

_____

_____

What do you hope to gain by coming to see me? _____

_____

_____

Indicate your level of distress on a scale of 0 - 10 (0 = no distress) (10 = extremely distressed) _____

Are you currently experiencing any suicidal thoughts? Y N

Have any family member or friends attempted or committed suicide? Y N

If yes, who and when? _____

_____

Please check all of the symptoms you are currently experiencing:

Addiction		Fear of leaving home		Poor decisions	
Adoption		Frequent conflicts		Phobias	
Anger		Head injury		Physical abuse	
Anxiety / Stress/ Worry		Hearing/ seeing things		Recent Divorce/Separation	
Appetite problems		Headaches/ dizziness		Self-harm	
Argumentative		Hypertension		Sadness or crying	
Avoidance of responsibility		Intrusive thoughts		Secrets / hiding things	
Blaming others		Loss of energy		Sexual difficulties	
Concentration/Focus		Lack of Confidence		Sexual abuse	
Death in the family		Legal difficulties		Sex preoccupation/Porn	
Depression		Medication Issues		Social anxiety	
Disordered eating		Memory issues		Tiredness	
Domestic violence		Mood swings		Thoughts of death	
Drug or alcohol use		Nervousness		Sleeping problems	
Emotional abuse		Nightmares		Trauma (flashbacks)	
Excessive guilt		Obsessions		Veteran/Military Trauma	
Employment		Panic		Weight change	
Financial Concerns		Paranoia		Worthlessness	

If you had to rate these symptoms what is most concerning to you?

1. _____

2. _____

3. _____

So glad you took this courageous step. We look forward to helping you!

Understanding and Consent for Treatment

Therapy is not like a medical doctor visit; it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress.

Our policy for after-hours coverage is to leave a message and we will return your call as soon as possible. If you are in need of urgent or **emergency** services after hours, please **call COPES crisis line at (918) 744-4800 or 911**.

Please understand that information obtained from you is confidential. Information may not be shared with anyone without your permission except in the following circumstances:

1. When a court order is received.
2. When there is reasonable cause to believe that you will hurt yourself or someone else.
3. When there is reasonable suspicion to believe that abuse/ neglect of a child, elderly person or disabled person has occurred.
4. Information necessary for billing purposes to insurance companies.

WeThrive Counseling Center, its employees and contractors, utilizes various methods of communication to maintain contact with you including phone and email. We utilize text messaging in very limited circumstances and only for scheduling or basic informational purposes. No clinical information will be discussed via text message or email. If you attempt to discuss clinical matters you will be asked to call or wait until your next session to discuss.

Please be aware that electronic communication via telephone or email may not be secure for either party. Due to the nature of this type of communication, there is a potential for interception or misdirection of your information. Your use of phone or email to communicate protected health information indicates that you acknowledge and accept the possible risks associated with such communication. Please consider communicating any sensitive information in person to protect your privacy.

As a general rule, WeThrive Counseling Center, its employees and contractors, do not have contact with you outside of the office that is unrelated to mental health treatment. This rule applies to various Internet messaging sites, social networking sites and general emails unrelated to our professional relationship. Please understand that any contacts or requests for contacts will not be confirmed or acknowledged to protect your privacy as well as to eliminate a dual relationship.

Your ***INITIALS*** beside each of the following indicates your understanding and consent for treatment:

_____ I understand that I may withdraw consent for treatment at any time
_____ I have been offered a copy of HIPAA's Notice of Privacy Practices
_____ I understand the risk associated with utilizing and electronic methods of communication and do so at my own risk
_____ I understand I understand that email and texting will be utilized for scheduling And incidental purposes only, private communication will be made in person

I hereby consent for WeThrive Counseling Center to provide my treatment.

_____ _____
Signature Date

STATEMENT OF FINANCIAL RESPONSIBILITY AND MISSED APPOINTMENT POLICY

Fees: Counseling sessions are at least 53 minutes long. We provide services at $150 per session and the initial intake session $200. Participation in legal proceedings is billed at $200 per hour, including commute time, report writing, and other preparations. We ask that you put a credit card on file for billing.

Insurance: WeThrive will get an insurance quote from your insurance company before you start counseling. Please note, until we are paid by the insurance company the quote is sometimes incorrect and we will not know until the insurance company begins to pay us. Therefore, there may be some adjustments to your bill early on in treatment. We will also file your insurance for you. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Charges: Payment, copays, co insurance and deductibles are due in full by cash, check or debit/credit card. You are responsible for these bills including any portion not covered or reimbursed by your insurance company.

Cancellation Policy: Twelve hour notice is required for the cancellation of an appointment. Appointments canceled with less than 12 hours notice will be **charged a $100 fee** unless you are able to reschedule during the same week. Appointments missed because of inclement weather will not be charged. Your fee will be applied to your credit card on file. Understand it is your responsibility to maintain an **active and up to date credit card** on file to avoid any additional charges.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX. ☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____ Security Number _____

Expiration Date (mm/yyyy): _____ Cardholder ZIP Code _____

I authorize WeThrive Counseling to charge my credit card above for agreed upon services, as described above. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date

Release of Medical Information

I authorize payment of insurance benefits to WeThrive Counseling, PLLC. I understand that I am financially responsible for any charges not covered by insurance or third party payer.
I authorize the release of any medical information necessary to process this claim. Oklahoma State Law (O.S. 63 Sec. 1-5022) requires the following statement: The information may include records which may indicate the presence of a communicable or venerable disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immune Deficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS).

Signature of Responsible Party: _____ Date: _____

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Teletherapy Informed Consent Form

(1) "Teletherapy" includes consultation, treatment, emails, telephone conversations, and other medical information using interactive audio, video, or data communications. The platform WeThrive is utilizing is Clocktree and is HIPPA compliant.

(2) Teletherapy occurs in the state of Oklahoma (USA), and is governed by the laws of that state and the Board of Licensed Social Workers and the Board of Licensed Professional Counselors.

(3) The laws that protect the confidentiality of my (client) medical information also apply to teletherapy. Unless we (clinician and client) explicitly agree otherwise, our teletherapy exchange is confidential. Both parties will not include others in the session or have others in the room unless agreed upon.

(4) I (client) accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911, contact COPES with Family and Children's Services (918-744-4800) or proceed to the nearest hospital emergency room for help.

(5) In the event our teletherapy is not in my (client) best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

(6) I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understand, and agree to the information above. This consent is valid for one year from date signed.

Patient's Name: _____

Patient Signature: _____ Date: _____