LAMPOST
WELLNESS CENTERS

AGREEMENT TO ENTER COUPLES COUNSELING

1. We understand that the clinicians at Lampost Wellness Centers are state licensed clinical professionals and are mandated to report child abuse, elderly abuse, and any intent to harm self or others.

2. We understand that by entering therapy we are choosing to potentially make changes to our thoughts, feelings, and behaviors. we are ultimately responsible for our lives and the changes we make.

3. We agree to provide a credit/debit card to pay for treatment and understand fees of $400/per 110 minute session (generally every two weeks) will be charged during the 48 hours preceding our appointment time. Interim sessions (50 minutes) will be charged at the rate of $215.

4. We agree to keep all our appointments unless we have given 48 hours' notice, either in person or on the phone. **We understand our obligation to pay fully for our therapist's time if we fail to provide this cancellation notice**. In rare and emergency situations, our therapist may make an exception to this obligation.

5. If at any time, we chose to terminate therapy, we agree to announce our intention during one session and then return for at least one more session, after which therapy may end. We agree to be charged for a final session. This charge is to encourage our attendance in order to provide adequate and safe closure to treatment.

6. We understand and agree that Lampost Wellness Centers will keep all our personal information confidential but, without personal identification, the organization may use our issues and solutions for clinical supervision.

7. This agreement will remain in effect until we provide notice and terminate therapy.

_____ _____

Name (Signature) Date

_____ _____

Name (Signature) Date

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PH 301-841-8930 FAX 240-235-3707
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COUPLES INTAKE FORM

Information you provide here is protected as confidential information.

Patient Name: _____

Patient Birth Date: _____ /_____ /_____

Gender: □ Male □ Female

Sexual Identification: _____ Orientation:_____

Address:
_____

_____
(City) (State) (Zip)

Cell: _____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.

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Patient Name: _____

Patient Birth Date: _____ /_____ /_____

Gender: □ Male □ Female

Sexual Identification: _____ Orientation:_____

Address:
_____

_____
(City) (State) (Zip)

Cell: _____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 (if any):

_____

How did you find us?
Referral
Psychology Today
Google Search
News article
Physician

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WHAT HAS PROMPTED YOU TO SEEK COUPLES COUNSELING?

_____

_____

_____

_____

_____

_____

_____

_____Date_____
Patient Signature

_____Date_____
Patient Signature

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MEDICAL HISTORY

Please complete: This is very important information. Please feel free to add any additional information that you feel is important.

Names_____

Address:_____City_____Zip_____

Phone:_____

Medications prescribed by this M.D. (Name and dosage)_____
_____
_____

Are either of you under the care of a psychiatrist? Yes_____ No_____

Name of Psychiatrist or Psychiatric Nurse
_____

Address:_____City:_____Zip_____

Medication and dosage prescribed by Psychiatrist:_____
_____

Have either of you been hospitalized for emotional problems?
Yes_____No_____

If so: When_____Where_____

Have either of you had previous individual therapy? Yes____No_____ Dates:_____

Name of Therapist:_____Address:_____

City:_____Zip_____Telephone_____

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Have either of you been treated for substance abuse? Yes _____Date: _____

Are you being treated now for substance abuse? Yes _____No_____

Please list any and all physical illnesses that are now being treated by M.D.

_____
_____
_____
_____

What would you want your therapist to know about your physical or emotional health:_____
_____
_____
_____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. And whose family.

Alcohol/Substance Abuse
Anxiety
Depression
Domestic Violence
Eating Disorders
Obesity
Obsessive Compulsive Behavior yes/no
Schizophrenia
Suicide Attempts

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I authorize Lampost Wellness Centers (LWC) to contact the following medical professionals for the purpose of consulting and coordinating care for our therapy and treatment. This authorization will remain in effect for the duration of our treatment, unless we notify LWC that we are revoking this release of information.

Doctor's
Name_____Address:_____

City:_____State_____Zip_____

Phone: ( )_____Fax: ( ) _____

_____Date_____
Authorization Signature

_____Date_____
Partner One Signature

_____Date_____
Partner Two Signature

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CLIENT RIGHTS AND PRIVACY PRACTICES

There may be times when we need to consult with a colleague or another professional about issues raised by clients in therapy. Client confidentiality is still protected during consultation by us and the professional consulted. Signing this disclosure statement gives us permission to consult as needed to provide professional services to you as a client.

CONFIDENTIALITY

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in the HIPPA Notice of Primacy Rights as well as other exceptions in Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. For example, some of the exceptions would include: suspected child abuse, molestation or incest, a client is in danger of hurting self or others, danger of violence, suspected abuse of the elderly or others unable to care for themselves, suspected threat to national security, subpoenaed testimony in criminal court cases, orders to violate privilege by judges in child custody and divorce cases.

CHILDREN AND ADOLESCENTS

A child fourteen or younger seen in this office must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or the court document presented giving sole custody

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 14, 2003 and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing another person to pick up health information.

We may use or disclose your health information when we are required to do so by law or when ordered to do so by a court having jurisdiction of an appropriate matter.

We must disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or health or safety of others.

Access: You have the right to inspect or obtain copies of your health information, except for therapist's notes and certain other limited exceptions. If you request copies, we will charge you $1.00 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will change a cost based fee for printing your health information in that format.

ACKNOWLEDGMENT OF RECEIPT OF
CLIENT RIGHTS AND PRIVACY PRACTICES

_____
Patient Signature

_____
Date

_____
Therapist signature

_____
Date

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INSURANCE INFORMATION

PATIENT: (Please Print Carefully)

_____

Home Address: _____

_____
City State ZIP

Phone #: _____-_____-_____

Date of Birth: _____/ _____/ _____
Month Day Year

Name of Employer / School: _____

INSURANCE:

Primary Insurance Company: _____

ID Policy #: _____

Group #: _____

Policy holder's Name: _____
Date of Birth: _____/____Month Day Year

Policy Holder's Employer: _____
Policy Holder's Phone #: _____- _____-_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

AUTHORIZATION TO SUBMIT TO INSURER:

Patient or Authorized person's signature: I authorize Lampost Wellness Centers to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims. **I realize that my insurer may or may not provide an out-of-network benefit.**

Signed _____ Date_____

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Credit Card Information Form

I understand fees of $400 will be charged 48 hours preceding my appointment times.

NAME ON CARD: _____

ADDRESS (IF DIFFERENT FROM PATIENT):

_____

_____

CARD NUMBER:

MC / VISA _____ - _____ - _____ - _____

AE _____ - _____ - _____

EXPIRATION DATE: _____/_____

SECURITY CODE _____

I authorize to have my card stored (under PCI compliance)

X _____

Patient

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