ALL THINGS POSSIBLE WELLNESS CENTER, PLLC

16645 15 Mile Rd, Ste B Clinton Township, MI 48035 43393 Schoenherr Sterling Heights, MI 48313 21619 E 9 Mile Rd St. Clair Shores, MI 48080
Phone: 586.213.5505 Fax: 586.213.5504 www.allthingspossiblewc.com

Patient Information and History

Please take your time and complete this entire form to the best of your ability. The information you provide will help your therapist understand you and your counseling needs better. If you need more space please feel free to use the back of each page as necessary. Thank you!

Patient Name: _____ **Date of Birth**: _____

Address: _____

City:_____**State**: _____ **Zip:** _____ **Sex:** _____

Phone : _____ □ Home □ Cell □ Work **Email:** _____

Current Marital Status	Months/Years		Months/Years
Single		Separated	
Cohabitating		Divorced	
Married		Widowed	

Referral Source:
□ Self □ Family/Friend □ Doctor/Hospital □ Psychology Today □ Website □ Insurance
□ School □ Church □ Other: _____

Whom should we contact in case of an emergency? Name: _____
Do you give consent to release information in case of an emergency to the named person? Y____N____

Phone #:_____Address: _____

City:_____State:_____Zip:_____Relationship: _____

Primary Insurance:
Name of Insurance Company:_____Contract #: _____

Name of Policy Holder:_____Date of Birth of Policy Holder: _____

Policy Holder's Employer:_____ Group #: _____

Relation to policy holder: □ Self □ Spouse □ Dependent

Secondary Insurance:
Name of Insurance Company:_____Contract #: _____

Name of Policy Holder:_____Date of Birth of Policy Holder: _____

Policy Holder's Employer:_____ Group #: _____

Relation to policy holder: □ Self □ Spouse □ Dependent

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Family History:

Family Information	Name	Current Age	Deceased		Your age then	Living with you	
			Yes	No		Yes	No
Mother			☐	☐		☐	☐
Father			☐	☐		☐	☐
Step Mother			☐	☐		☐	☐
Step Father			☐	☐		☐	☐
Siblings			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐
Spouse			☐	☐		☐	☐
Children			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐
			☐	☐		☐	☐

Parent's current marital status: ☐ Married ☐ Separated ☐ Divorced
If divorced/separated, how old were you? _____

Relationship with parents during childhood: ☐ Good ☐ Fair ☐ Poor

Relationship with siblings during childhood: ☐ Good ☐ Fair ☐ Poor

How would you describe your current relationship with family: ☐ Good ☐ Fair ☐ Poor Please list/describe any other family information that your therapist may find helpful in treating you. For example, were you raised outside the home by grandparents, other family members, or foster homes, etc.?

_____

_____

As a child, did you meet all developmental milestones at appropriate times? ☐ Yes ☐ No

Is there anything else that we need to know about your birth/childhood development?

_____

_____

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Have you experienced any of the following:

	Current	*Past*	*No*
Physical Abuse	☐	☐	☐
Sexual Abuse	☐	☐	☐
Emotional Abuse	☐	☐	☐
Neglect	☐	☐	☐
Physical/Domestic Violence	☐	☐	☐
Head Injury	☐	☐	☐

If you answered current/past to any of the above please describe: _____

Medical History:

Please list any current or past medical conditions:

Type of illness or condition	Are you currently being treated?	
	Yes	No
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Please list your current medications, including over the counter medications:

Medication Name	Dosage	RX Date	Prescribing physician's name	Reason

Do you have any physical concerns/complaints that are not currently being treated? ☐ Yes ☐ No

If yes, please explain/describe: _____

_____

Do you have a family history of medical illness? ☐ Yes ☐ No

If yes, please explain/describe: _____

_____

Psychological/Psychiatric History:

Type of Treatment	Yes	No	Date (Month/Year)	Duration (# of weeks, months)	Where	Inpatient/ Outpatient
Counseling	☐	☐				
Psychiatric Treatment	☐	☐				
Hospitalization	☐	☐				
Alcohol/Drug Treatment	☐	☐				
Self-Help Groups	☐	☐				
Other	☐	☐				

Have you ever been diagnosed with a mental illness or taken medication for psychiatric reasons: □ Yes □ No

If yes, please explain/describe: _____

_____

Do you have a family history of mental illness? □ Yes □ No

If yes, please explain/describe: _____

_____

Symptom Checklist – Please place a check mark next to each symptom you are currently experiencing:			
Depressed mood most of the day	☐	Irritability	☐
Feeling hopeless/empty inside	☐	Easily distracted/forgetful	☐
Lack of interest/pleasure in activities	☐	Difficulty following through	☐
Fatigue/low energy	☐	Hyperactivity	☐
Feelings of worthlessness	☐	Impulsivity	☐
Difficulty making decisions	☐	Excessive risk-taking	☐
Inability to sleep/sleep too much	☐	Mood swings	☐
Chronic worry about events	☐	Difficulties with/disrespect for authority	☐
Racing thoughts	☐	Difficulty maintaining relationships	☐
Feelings of dread	☐	Frequent temper flare ups/tantrums	☐
Panic attacks	☐	Anger management problems	☐
Restlessness	☐	Bingeing/Purging	☐
Other (Please describe):			

Are you currently having suicidal thoughts? ☐Yes ☐No
Are you currently having homicidal thoughts? ☐Yes ☐No
Have you had suicidal thoughts in the past? ☐Yes ☐No
Have you self-harmed in the past? ☐Yes ☐No
Are you currently self-harming? ☐Yes ☐No

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Substance Use/Abuse History:

Please fill this chart out as completely as possible by checking all substances used past and present

Type of Drug	Age of first use	Age of last use	Method of use				Amount	How Often?	Used in last 48 hours		Used in last 30 days	
			Oral	Injection	Smoke	Inhale			Yes	No	Yes	No
Caffeine			☐	☐	☐	☐			☐	☐	☐	☐
Nicotine			☐	☐	☐	☐			☐	☐	☐	☐
Alcohol			☐	☐	☐	☐			☐	☐	☐	☐
Barbiturates			☐	☐	☐	☐			☐	☐	☐	☐
Valium/Librium			☐	☐	☐	☐			☐	☐	☐	☐
Cocaine/Crack			☐	☐	☐	☐			☐	☐	☐	☐
Heroin/Opiates			☐	☐	☐	☐			☐	☐	☐	☐
Marijuana			☐	☐	☐	☐			☐	☐	☐	☐
PCP			☐	☐	☐	☐			☐	☐	☐	☐
LSD			☐	☐	☐	☐			☐	☐	☐	☐
Mescaline			☐	☐	☐	☐			☐	☐	☐	☐
Inhalants			☐	☐	☐	☐			☐	☐	☐	☐
Ecstasy			☐	☐	☐	☐			☐	☐	☐	☐
Other:			☐	☐	☐	☐			☐	☐	☐	☐

Have you suffered any consequences as a result of your substance use/abuse (i.e., physical symptoms such as hangovers or withdrawal, relationship or employment issues, or legal issues): ☐ Yes ☐ No

If yes, please explain/describe: _____

_____

Do you have a family history of substance abuse? ☐ Yes ☐ No

If yes, please explain/describe: _____

_____

Educational History:

Highest level of schooling completed:

Grade School K-12 (which grade):				Other:	☐
High School		GED	☐	Vocational/Trade School	☐
Associates Degree	☐	Bachelors Degree	☐	Graduate Degree	☐

Major or field of study: _____

Are you currently enrolled in a school or educational program? If yes, where?

_____

Were/are you receiving special accommodations for your education? 504? IEP? Special education services?

_____

Employment:

Please check all that apply:

Employed full-time	☐	Laid off (How long?)		Medical Disability (Type)	☐
Employed part-time	☐	Retired (How long?)		Suspended	☐
Unemployed	☐	Homemaker ☐		Student	☐
Are you a Veteran? ☐ Active Duty? ☐ and/or Military connected? ☐					

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Are you satisfied with your current job? ☐ Yes ☐ No
If no, please explain: _____

_____

Are you experiencing financial problems that are impacting your mental health? ☐ Yes ☐ No
If yes, please explain: _____

_____

Legal History:

Have you ever been or are you currently involved in any legal or court proceedings? ☐ Yes ☐ No
If yes, please complete the following:

Type of case, charge, arrest, etc.	Date	Location	Result

Spiritual and Religious Information:

Do you have any spiritual/religious preferences that may affect/impact your treatment? ☐ Yes ☐ No
If yes, please explain: _____

_____

Do you currently engage in spiritual/religious activities? ☐ Yes ☐ No
If yes, please explain: _____

_____

Cultural/Ethnic Information:

What is your cultural or ethnic background? _____
Is your cultural/ethnic background a significant part of your life? ☐ Yes ☐ No
If yes, please explain: _____

_____

Do you have any cultural/ethnic preferences that may affect your treatment? ☐ Yes ☐ No
If yes, please explain: _____

_____

Additional Information:

Is there anything else that you feel is important for your therapist to know about you or your reasons for seeking counseling at this time? If yes, please comment in the space provided. Thank you.

_____

_____

_____

_____

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INFORMED CONSENT

Patient Services

All Things Possible Wellness Center (ATPWC) provides:

- Therapeutic counseling services for individual adults and children/adolescents
- Therapeutic counseling services for couples and families
- Therapeutic counseling services for substance abuse
- Therapeutic group counseling services

Counseling/Psychotherapy involves the sharing of personal problems, concerns, and stories with a professional who is skilled at helping others come to a resolution or solution about their particular situation(s). Counseling is a relatively short-term, interpersonal, and theory based professional activity. Counseling is guided by ethical and legal standards that focus on helping persons resolve developmental issues, situational problems, and more complex personal and psychological diagnosis.

The general goals in counseling/psychotherapy are to identify current presenting issues, develop a plan of action, and then implement a plan of action to bring about healing and change. Counseling/psychotherapy also helps in identifying triggers to psychological symptoms and helps one to find positive coping skills to alleviate or reduce the severity of said symptoms. This is a very personal process. Counseling/psychotherapy is educational and developmental by nature. All clinicians with ATPWC are licensed with the state of Michigan to provide your services unless otherwise notified (interns are identified prior to start of treatment). Our clinicians utilize a treatment team to ensure that you are receiving the best care possible. This treatment team maintains strict confidentiality and is utilized only on an as needed basis for help with treatment planning, diagnoses, and/or case conceptualization.

Office Hours

- Monday - Friday 9:00 AM to 9:00 PM by Appointment
- Saturday-Sunday By Appointment

Clinic Policies

Fees: Our fees are based on a 45 to 55-minute session for individuals, couples, or families and a 90-minute to 120-minute session for group therapy.

- Fees for services are as follows:
  - Intake session: $200.00
  - Individual/couple/family session (per 45 min session): $150.00
  - Individual/couple/family session (per 60 min session): $180.00
  - Testing/Assessments (per hour): $240.00
  - Court appearances (per day 1-8 hours): $1,000.00
  - Medical Records: $0.45 per page. Administrative charges: 0-15 minutes-$2.50, each additional 15 minutes-$2.50
- If your insurance is not accepted, our clinicians will work with you individually on a cash pay rate.
- All session fees are collected prior to the start of each session.
- We accept cash, personal checks, Visa, Discover, American Express, and MasterCard. We will bill your account $25.00 if your check is returned from the bank and your personal checks will no longer be accepted.

Cancellation:

- If you do not cancel your appointment at least **24 hours** in advance, you will be charged a No-Show /Late Cancel Fee of $50.00 per appointment. Arrival of 15 minutes or later is considered a No-Show. Fees are charged at your counselors' discretion.
- These fees cannot be billed to your insurance and must be paid at your next scheduled appointment.

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Compliance

- Failure to show for two (2) consecutive appointments will result in termination of treatment with no notification, unless there are extenuating circumstances.
- Additionally, frequent cancellations without proper notice, no-shows, or no face-to-face contact with your therapist within thirty (30) days may lead to termination of treatment for noncompliance.

*Recipient Rights – Consent to Treatment – **Patient** Confidentiality*

I understand that I have rights as a recipient of services, including confidentiality of my records, and that I can get more information about my rights if I inquire.

I consent to mental health treatment or substance abuse treatment as recommended by the therapist. I understand that I will participate in the development of my treatment plan and that I am free to withdraw my consent and discontinue treatment at any time. I consent to security camera recording of my presence in the waiting area.

Federal law and regulations protect the confidentiality of Protected Health Information, and/or alcohol and substance abuse patient records maintained by this agency. The agency may not say to a person outside the program that a patient attends the program, or disclose any information identifying an individual as a patient, or as an alcohol or substance abuser, UNLESS:

1. The patient consents in writing.
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.
4. The patient presents with homicidal ideation or suicidal ideation.
5. The patient reports suspected or actual abuse or neglect.

Violation of Federal law and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the agency or against any person who works for the agency, or about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Code of Conduct: The State of Michigan requires counselors to adhere to a specific Code of Conduct that is determined by the Board of Counseling. Should you wish to file a complaint you may contact them at: Michigan Department of Licensing and Regulatory Affairs Bureau of Professional Licensing Investigations & Inspections Division P.O. Box 30670 Lansing, MI 48909 (517) 241-0205

Emergencies

Emergencies arise in people's lives. You can handle most emergencies. You are welcome to call ATPWC at 586.213.5505 if you need an appointment. However, ATPWC is not a walk-in crisis center. In case of an emergency (suicidal ideation, homicidal ideation, anxiety attacks, etc.) please immediately go to your local hospital, call 911, and/or call the National Suicide Prevention Line at 1.800.273.8255.

Potential Counseling Risk

As a result of counseling/psychotherapy you may realize that there are additional issues that did not surface prior to the onset of counseling/psychotherapy. This is an inherent risk in any counseling relationship. Also, couples, marriage, and family counseling may involve certain risks. As one-person changes in any relationship, stresses and strains are created. This is part of the counseling/psychotherapy process and is dealt with within the counseling relationship.

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Social Media Policy

Separate Accounts

ATPWC Clinicians/Admin hold separate and isolated accounts to be used for the sole purpose of professional matters regarding ATPWC. These accounts are separate from any personal accounts held by our clinicians individually.

Email

Please use our allthingspossiblewc.com email addresses to contact us for administrative reasons only (modifying appointments, billing information, etc.). Please do not email content related to our counseling sessions or assessments unless otherwise discussed. Email communication is not completely secure or confidential even though we have a BAA on our server for HIPAA as we do not use HIPAA compliant email systems (such as Hush mail).
Any emails I receive from you and any responses I send to you become a part of your legal record.

Text Messages

Please do not send text messages, unless otherwise agreed upon for administrative reasons only. I will not respond to other texting. Please do not text content related to our counseling sessions or assessments unless otherwise discussed. Text communication is not completely secure or confidential. Any text message I receive from you become a part of your legal record.

Friending

I do not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship.

Following

It is the policy of ATPWC that we will not follow any patient on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

Search Engines

It is the policy of ATPWC that it is not a regular part of our practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If we have reason to suspect you are a danger to yourself or others and we have exhausted all other reasonable means to contact you and/or your emergency contact, then I may use a search engine for information to ensure your welfare. If this ever occurs, we will fully document the search and discuss it with you at your next session.

Location-Based Services

Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending sessions at ATPWC. This office is not a check-in location on various sites such as Foursquare, however it can be found as a Google Earth location, on our Facebook business page, and on Yelp. Enabled GPS tracking makes it possible for others to surmise you are a counseling patient due to regular check-ins at our office location.

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I have read the ATPWC Informed Consent Agreement. I had the opportunity to ask questions which have been answered to my satisfaction. I understand and agree to the conditions specified herein on the ATPWC Informed Consent.

□ I HAVE RECEIVED a copy of the Informed Consent □ I WOULD NOT like a copy of the Informed Consent

Patient's Name Printed _____ Date _____

Patient's Signature (or Parent/Guardian Signature) _____

Clinician's Signature & Credentials _____

Per Public Health Code (Excerpt) Act 368 of 1978 Part 181 Counseling I am to be provided with a copy of my clinicians Professional Disclosure Statement upon request.

□ I HAVE RECEIVED a copy of the Prof Disclosure Stmt □ I WOULD NOT like a copy of the Prof Disclosure Stmt

Patient's Name Printed _____ Date _____

Patient's Signature (or Parent/Guardian Signature) _____

Clinician's Signature & Credentials _____

Per the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, I am to be provided with a copy of the HIPAA privacy and security rules upon request.

□ I HAVE RECEIVED a copy of HIPAA Privacy & Security Rules □ I WOULD NOT like a copy of the HIPAA Disclosure Stmt

Patient's Name Printed _____ Date _____

Patient's Signature (or Parent/Guardian Signature) _____

Clinician's Signature & Credentials _____

It is generally suggested that we coordinate care with your primary care physician. If you would like us to do this please fill out an auth.

□ I HAVE filled out an auth for coordination of care □ I WOULD NOT like you to communicate with my primary MD/DO.

Patient's Name Printed _____ Date _____

Patient Signature (or Parent/Guardian Signature) _____

Clinician's Signature & Credentials _____

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INSURANCE CONSENTS AND ACKNOWLEDGEMENTS

- *FINANCIAL AGREEMENT*
  I hereby assume full responsibility for all charges incurred for professional services rendered by All Things Possible Wellness Center, unless the services are deemed "paid in full" as a result of a contractual agreement between All Things Possible Wellness Center and my insurer.

- *CONSENT TO AUDIT PATIENT CARERECORDS*
  Your insurance carrier reserves the right to audit your case records on a regular basis to verify that services for which it is billed are performed, that documentation of such services is maintained, and that appropriate quality care is provided. The insurance carrier also reserves the right to refuse payment for treatment if a patient does not consent to an audit by the insurance company. If you do not consent to auditing of your case records, you are agreeing to assume responsibility for full payment of professional fees.

  I hereby give consent to an audit of my patient records by representatives of my insurance carrier. I also hereby release All Things Possible Wellness Center from any and all liability stemming from agency compliance with my consent to allow auditing of my records by my insurance company.

- *GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS*
  I authorize my health insurance benefit plan to pay directly to All Things Possible Wellness Center medical benefits, if any otherwise payable to me for their services as described on the attached claim but not to exceed the charges for those services. I understand I am financially responsible to All Things Possible Wellness Center for charges not covered by this assignment.

- *MEDICARE CLAIM AUTHORIZATION AND PAYMENTREQUEST*
  I authorize any holder or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

- *INSURANCE BENEFITS AND PAYMENTAGREEMENT*
  I understand that my insurance policy is a contract between myself and my insurance carrier, and that it is my responsibility to know my benefits including my co-pays and deductibles. I also understand that any benefit information provided to All Things Possible Wellness Center by my insurance carrier is NOT a guarantee of payment and that payment of my claims will be determined by my insurance carrier when my claim is received by them. I agree to pay my copays and/or deductibles in full as determined by my insurance carrier after my claim is processed.

Patient(s) Name: _____

Signature: _____ Date: _____

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HIPAA 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 READ IT CAREFULLY.

This notice is effective as of June 22, 2015.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy upon request.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.
We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. We may use or disclose information from your record to obtain payment for the services you receive. For example, we may submit your diagnosis with a health insurance in order to demonstrate to the insurer that the service should be covered. We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with other providers.

Your rights
You have a right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us. You have a right to inspect the information from your record, and may obtain a copy of it. If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing. You have the right to request an accounting of certain disclosures made by us.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation.

Use or disclosure of your protected health information that we are required or permitted to make without your permission.
There are certain situations where we are required or allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims. We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court. We may disclose information from your record to a law enforcement official if certain criteria are met. If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities you may direct your complaint to:
Review Committee @ All Things Possible Wellness Center
16645 15 Mile Rd, Ste B
Clinton Township, MI 48035
(586) 213-5505

This notice, and any alterations made hereto will expire seven years after the date upon which the record was created.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I_____for_____ authorize ATPWC to:

□ physically/verbally RELEASE □ physically/verbally RECEIVE

(as indicated below) my/my child's protected health information (PHI) to/from:

Company Name:	
Contact Person:	
Company Address:	
Company Phone No:	
Company Fax No:	

Identifying Information on Patient(s) that PHI will be released on:

DOB: _____

Full Name: _____

For the purpose of review/examination, I authorize you to provide the following information:

☐COMPLETE COPY OF MEDICAL RECORD
☐PSYCHOLOGICAL TESTING/ASSESSMENT
☐LETTER SUMMARIZING DX(S), DOS, AND TREATMENT PLAN
☐DISCLOSURE LOG
☐SPECIFIC INFORMATION:_____

I give specific permission to release any information related to:

☐SUBSTANCE ABUSE
☐PSYCHIATRIC/MENTAL HEALTH INFORMATION
☐HIV/AIDS INFORMATION

This authorization does not expire. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPAA, this information is no longer protected by HIPAA.

_____ _____
Patient's or Legal Guardian's Signature Date

_____ _____
Patient's or Legal Guardian's Printed Name Witness

ALL THINGS POSSIBLE WELLNESS CENTER, PLLC

16645 15 Mile Rd, Ste B Clinton Township, MI 48035 43393 Schoenherr Sterling Heights, MI 48313 21619 E 9 Mile Rd St. Clair Shores, MI 48080
Phone: 586.213.5505 Fax: 586.213.5504 www.allthingspossiblewc.com

Credit/Debit Card Authorization Form

I_____ authorize All Things Possible Wellness Center, PLLC to keep the credit card below on file to use for payments on my account for copayments, coinsurance payments, deductible payments and late cancellation or no-show fees.

Patient Name: _____

Credit Card Number: _____

Name on Card: _____

Exp Date: _____

CV Code: _____

Credit Card Billing Address:

_____

_____

_____ _____

Patient Printed Name Date

_____

Patient (or Parent/Guardian Signature if minor) Authorizing Charges

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VERIFICATION OF RECEIPT OF HIPAA PRIVACY NOTICE AND AUTHORIZATION FOR CONTACT

Patient Contact Information for Messages and Written Correspondence

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made to alternative means, such as sending correspondence to the individual's office instead of the individual's home. All Things Possible Wellness Center has permission to contact me at the following:

(Check all that apply)

☐Home telephone # _____
- ☐OK to leave a message with detailed information
- ☐OK to leave a message with other family members

☐Cell Phone # _____
- ☐OK to leave a message with detailed information
- ☐OK to leave a message with person answering
- ☐OK to communicate via text message

☐Work Telephone # _____
- ☐OK to leave a voicemail message with detailed information
- ☐OK to leave a message with _____

☐Written Communication
- ☐OK to mail to my home address
- ☐OK to Email me at: _____
- ☐OK to fax to this number: _____

☐Other:

By signing below, I authorize the above as means and ways to disclose my PHI. By signing below, I also verify again that I have been given a copy of the Notice of Privacy Practices (HIPAA) upon request. This agency recognizes that a great deal of communication is conducted through the use of cell phones, text messages/messaging programs, email, and other electronic means. In an effort to make communication convenient your therapist may agree to communicate with you via any of these options AT YOUR OWN RISK and with certain limitations. Your therapist will make reasonable attempts to protect your confidentiality. Please be aware, however, that confidentiality cannot be protected with the same level of privacy as communicating with your therapist face-to-face. By signing this policy, you understand and are in agreement that this agency will not be held responsible for the confidentiality and privacy of any communication conducted outside of the physical office and those limitations specified by HIPPA. In addition, you acknowledge and understand that your therapist has no obligation to engage in any communication outside of the office in face-to-face sessions, but will strive to address all communication in a timely manner when possible.

_____
Patient Printed Name

_____ _____
Patient or Legal Guardian's Signature Date

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Patient Name: _____ Date: _____

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

During the last 4 weeks, how much have you been bothered by any of the following problems	Not Bothered (0)	Bothered a little (1)	Bothered a lot (2)
1. Stomach pain	◯	◯	◯
2. Back pain	◯	◯	◯
3. Pain in your arms, legs, or joints (knees, hips, etc.)	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯
5. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯
6. Menstrual cramps or other problems with your periods	◯	◯	◯
7. Pain or problems during sexual intercourse	◯	◯	◯
8. Headaches	◯	◯	◯
9. Chest pain	◯	◯	◯
10. Dizziness	◯	◯	◯
11. Fainting spells	◯	◯	◯
12. Feeling your heart pound or race	◯	◯	◯
13. Shortness of breath	◯	◯	◯
14. Constipation, loose bowels, or diarrhea	◯	◯	◯
15. Nausea, gas or indigestion	◯	◯	◯
PHQ-15 Score: _____	=	_____+	_____

Over the last 2 weeks, how often have you been bothered by any of the following problems	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous anxiety or on edge	◯	◯	◯	◯
2. Not being able to stop or control worrying	◯	◯	◯	◯
3. Worrying too much about different things	◯	◯	◯	◯
4. Trouble relaxing	◯	◯	◯	◯
5. Being so restless that it is hard to sit still	◯	◯	◯	◯
6. Becoming easily annoyed or irritable	◯	◯	◯	◯
7. Feeling afraid as if something awful might happen	◯	◯	◯	◯
GAD-7 Score: _	=	_____+	_____+	_____

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Patient Name: _____ Date:

	YES	NO
1. In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic?	◯	◯
If you checked "NO", go to next section		
2. Has this ever happened before?	◯	◯
3. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	◯	◯
4. Do these attacks bother you a lot or are you worried about having another attack?	◯	◯
5. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, or your heart racing, pounding or skipping?	◯	◯

Over the last 2 weeks, how often have you been bothered by any of the following problems	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	◯	◯	◯	◯
2. Feeling down, depressed, or hopeless	◯	◯	◯	◯
3. Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4. Feeling tired or having little energy	◯	◯	◯	◯
5. Poor appetite or overeating	◯	◯	◯	◯
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	◯	◯	◯	◯
7. Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
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	◯	◯	◯	◯
9. Thoughts that you would be better off dead or hurting yourself in someway	◯	◯	◯	◯
PHQ-9 Score: _____	=	_____ +	_____ +	_____

	YES	NO
1. Has there ever been a period of time when you were not your usual self and…	◯	◯
…you felt so good or so hyper that other people thought you were not your normal self or were so hyper that you got into trouble?	◯	◯
…you were so irritable that you shouted at people or started fights or arguments?	◯	◯
…you felt much more self-confident than usual?	◯	◯
…you got much less sleep than usual and found that you didn't really miss it?	◯	◯
…you were much more talkative or spoke much faster than usual?	◯	◯

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Patient Name: _____ Date: _____

	YES	NO
…thoughts raced through your head or you couldn't slow your mind down?	○	○
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
…you had much more energy than usual?	○	○
…you were much more active or did more things than usual?	○	○
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
…you were much more interested in sex than usual?	○	○
…you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	○	○
…spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period?	○	○
3. How much of a problem did any of these causes you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? ☐ ☐ ☐ ☐ Please circle one response only: No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive or bipolar disorder?	○	○

If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not at all difficult
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

_____ _____

Clinician Signature & Credentials Date