

ALL THINGS POSSIBLE WELLNESS CENTER, PLLC

16645 15 Mile Rd Clinton Twp., 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.atpwc.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	
Cohabiting		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 Policyholder: _____

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 Policyholder: _____

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			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Father			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Step Mother			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Step Father			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Siblings			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Spouse			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Children			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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:

	<i>Current</i>	<i>Past</i>	<i>No</i>
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical/Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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Psychological/Psychiatric History:

Type of Treatment	Yes	No	Date (Month/Year)	Duration (# of weeks, months)	Where	Inpatient/ Outpatient
Counseling	<input type="checkbox"/>	<input type="checkbox"/>				
Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>				
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>				
Alcohol/Drug Treatment	<input type="checkbox"/>	<input type="checkbox"/>				
Self-Help Groups	<input type="checkbox"/>	<input type="checkbox"/>				
Other	<input type="checkbox"/>	<input type="checkbox"/>				

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	<input type="checkbox"/>	Irritability	<input type="checkbox"/>
Feeling hopeless/empty inside	<input type="checkbox"/>	Easily distracted/forgetful	<input type="checkbox"/>
Lack of interest/pleasure in activities	<input type="checkbox"/>	Difficulty following through	<input type="checkbox"/>
Fatigue/low energy	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>
Feelings of worthlessness	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>
Difficulty making decisions	<input type="checkbox"/>	Excessive risk-taking	<input type="checkbox"/>
Inability to sleep/sleep too much	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>
Chronic worry about events	<input type="checkbox"/>	Difficulties with/disrespect for authority	<input type="checkbox"/>
Racing thoughts	<input type="checkbox"/>	Difficulty maintaining relationships	<input type="checkbox"/>
Feelings of dread	<input type="checkbox"/>	Frequent temper flare ups/tantrums	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	Anger management problems	<input type="checkbox"/>
Restlessness	<input type="checkbox"/>	Bingeing/Purging	<input type="checkbox"/>
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, legal or employment 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		Bachelor's 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 you would like incorporated into 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: Fees for services are as follows: Intake session-\$250.00, 60 Min Individual/couple/family session- \$200.00, 45 min Individual/couple/family session- \$180.00, 30 min Individual/couple/family session-\$150.00, Testing/Assessments (per hour)- \$260.00, Court Appearances (per day 1-8 hours)-\$1000.00, Medical Records Fees (MCL 333.26269)- \$25.64 Initial fee (not payable by patient for own medical records). \$1.28 per page for pages 1-20, \$0.64 per pages for pages 21-50, \$0.26 per page for pages 51+.

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.

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 at entry points.

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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.
6. The patient commits a crime against agency or any person who works for the agency.

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. Additionally, information regarding clinician is found on their Professional Disclosure Statement that is offered at the time of the intake.

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.

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

Per Public Health Code (Excerpt) Act 368 of 1978 Part 181333 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 Name Printed _____ Date _____

Patient Signature (or Parent/Guardian Signature) _____

Clinician's Signature & Credentials _____

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

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:
Clinical Records Director @ All Things Possible Wellness Center 16645 15 Mile Rd Clinton Township, MI 48035 (586) 213-5505.

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 Name Printed _____ Date _____

Patient Signature (or Parent/Guardian Signature) _____

Clinician's Signature & Credentials _____

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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 HIPAA. 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

Social Media & Electronic Communication 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.

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 CARE RECORDS***

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 PAYMENT REQUEST***

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 PAYMENT AGREEMENT***

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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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

ALL THINGS POSSIBLE WELLNESS CENTER, PLLC

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Phone: 586.213.5505 Fax: 586.213.5504 www.atpwc.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ authorize the use or disclosure of my individually identifiable health information

PRINT NAME

as described below. I understand this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to All Things Possible Wellness Center (ATPWC). If I choose to revoke authorization, I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization or person authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Persons/Organization authorized to provide information is: ATPWC, located at _____.

Information to be provided ((including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment and information about mental health services):

- Psychological Testing/Assessment
- Summary Letter of Diagnosis, Dates of Service, and Treatment Plan
- Disclosure Log
- Specific Information Including Dates of Information Sought to Be Disclosed: _____

Person/Organization authorized to receive information is: _____ (Name of Person/Organization).

located at _____, _____
Address Phone Number Fax Number

Purpose For The Use/Disclosure:

- _____ (Specify Purpose), or
- At the Request of the Patient

This Authorization is valid for one year from date signed unless another date is provided here: _____

By signing below, I understand and acknowledge the following:

- That I have read and understand the Authorization; and
- If I have any questions about disclosure of my protected health information, I may contact Steven Latawiec, MA, LPC Clinical Records Director at ATPWC.

ATPWC will not condition treatment on whether this Authorization is signed on behalf of the Patient

Signature of Patient, Legal Representative, or Parent of Minor: _____
Signature Date

If you are signing as a Parent, Guardian, or Legal Representative of the Patient complete the following:

Relationship to Patient: _____ Print Name: _____

Witness: _____ 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 <u>last 4 weeks</u> , 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 <u>last 2 weeks</u> , 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 <u>last 2 weeks</u> , 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 some way				
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

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