SOUL WELLNESS NYC

Patient Information

Date_____ Referred by _____

Name of Patient _____ Age_____ Gender _____

Date of Birth_____/___/___

Name of responsible party (if patient is under 18 years of age)

Patient's Current Address

_____

_____

_____

City *State* *Zip Code*

Home Telephone_____ Cell Phone_____

Email Address_____

My primary reason for seeking therapy right now is:

_____

_____

_____

_____

SOUL WELLNESS NYC

Informed Consent

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long-term goals. Others may be more immediate goals. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

Appointments

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24-hour notice, you may be required to pay for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

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Confidentiality

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

If you are a client of Soul Wellness NYC, please note that your case information will be shared with Dr. Sara Gluck, who will assist in making sure that you or your child benefit from the best possible treatment plan. If you have any questions about this and would like to reach Dr. Gluck directly, please email: drsaragluck@gmail.com.

Confidentiality and Group Therapy

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your counselor cannot guarantee that other group members will maintain your confidentiality. However, your counselor will make ever effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your counselor also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal

information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur.

Record Keeping

Your counselor may keep records of your counseling sessions and a treatment plan, which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office.

Professional Fees

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, or credit card. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required.

Insurance

I am not a provider for any insurance companies. However, I would be glad to provide you with a receipt that you may submit to your insurance company for reimbursement. You are responsible for knowing your coverage and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance

company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Contacting Me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.

Email

Counselor may request client's email address. Client has the right to refuse to divulge email address. Counselor may use email addresses to periodically check in with clients. If you would like to opt out of email correspondence, please check here_____.

Consent to Counseling

Your signature below indicates that you have read this Agreement and agree to its terms.

Client Signature_____ Date_____

SOUL WELLNESS NYC

Credit Card Authorization Form

I authorize Soul Wellness NYC to process my credit card on a recurring basis for each session that myself or my child attends.

Name on Card_____

Credit Card Number _____

Expiration Date _____

Security Code_____

Billing Zip Code _____

Signature_____

Date_____