515-505-1903
6165 NW 86th St. Johnston, IA 50131
www.thewholeheartedway.net

Thank you for choosing The Wholehearted Way. I look forward to working with you. Please read the following information carefully to better understand the procedures and policies of The Wholehearted Way.

The Wholehearted Way Policies

Appointment Cancellations/Reschedules

I have reserved your appointment time expressly for you. Since I work off of a wait list, if you need to reschedule or cancel an appointment, a minimum of 24-hours notice is required so that others may have the opportunity to be seen. You may e-mail, text message, or leave a voice message to reschedule or cancel your appointment, as these will accurately record the date and time of your message. If you do not show up for your appointment or fail to give 24 hours notice, you are subject to a $60 late cancellation/no-show fee. Insurance does not cover the late cancellation/no-show fee.

If you consistently do not show for appointments, I have the right to cancel all future appointments. I will attempt to contact you regarding canceled appointments, but if I am unable to reach you, appointments can be canceled without notification.

Punctuality

I will do my best to be punctual for your appointment. I ask that you be punctual as well. If you are late for any reason, you will receive the remainder of your scheduled time. This is necessary so I can see subsequent clients at their scheduled time.

Phone calls and Other Communication

I am typically in the office 8:00/9:00am-4:00pm Monday through Thursday but am typically seeing clients during these times. If I am unavailable and you need me to contact you, please leave a message via voice message, text message, or e-mail. Please allow at least one *business day* for me to respond to any messages. In the event of an emergency, please contact your medical doctor, call 911, contact Foundation 2 Counseling Hotline (1-800-332-4224) or pursue 24-hour assistance from a local emergency room or police department.

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via e-mail or text messaging regarding scheduling or cancellations, I will do so. I request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. By sending personal information via these means of communication, you are acknowledging the risk of and will not hold The Wholehearted Way liable for any damage caused due to breach of privacy and confidentiality.

The Wholehearted Way has the right to use the contact information provided in the Demographics Form to send appointment reminders and information regarding health insurance, billing, and scheduling. Your signature below authorizes The Wholehearted Way to send health insurance and billing statements via e-mail or mail and to send appointment reminders via text message and/or e-mail.

Confidentiality

The information you share with your therapist is held in strictest confidence and may not be released to anyone without your written consent, as prescribed by law. There are a few exceptions to this, which are regulated by state law, in which your therapist is required to report this information to the proper authorities (i.e. in cases of suspected child, elder, or dependent abuse or if a person poses a serious and imminent danger to oneself or someone else). If you would like your therapist to contact or share your Protected Health Information with another person or agency, you will need to complete a Release of Information form that will be kept on file.

Certain limited information will be needed for billing services/health insurance, and other third-party payment arrangements. Only information pertaining to health insurance and billing will be released and will be held in utmost confidence. Your signature below authorizes the Release of Information necessary to process claims (Section 12 of the HFCA 1500 forms) and the payment of medical benefits and office fees for services rendered, for the purpose of insurance filing and client billing.

Health Insurance and Billing/Payment

Your health insurance company may cover all or part of the fees. It is your responsibility to confirm coverage and know your co-pay or deductible (amount not covered by health insurance). Please contact your health insurance company prior to your appointment to verify your outpatient behavioral health benefits and secure any preauthorization requirements. If a required authorization is not obtained, you will be responsible for payment of services. If services rendered are not covered by your health insurance company, you are fully responsible for all services rendered. *Full payment is expected at time of service.*

Please notify me immediately of any changes in your health insurance information or coverage. Cash, check, and most major credit cards are acceptable payment methods. Make checks payable to The Wholehearted Way. If your account shows a balance of $200 or more, services will be suspended until the balance is brought up to date. A $10.00 service charge will be charged for any checks returned for any reason for special handling. Disputed credit card charges are subject to a $15 credit card dispute fee and a $10 service charge for each fee. This also may be subject to a 1.5% interest fee if the disputed charges are over a month old. If you mistakenly dispute a charge you were in fact responsible for, it is your responsibility to contact your credit card company immediately to reverse the dispute. Services will not continue until the balance on your account is paid in full.

Termination

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of termination depends on the length and intensity of treatment. I may terminate treatment after appropriate discussion with you if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified therapists to treat you. You may also choose someone on your own or from another referral source.

If you have not been seen in 90 days, your treatment will automatically be terminated and your file will be closed. However, you can reach out at any time to resume therapy services and re-open your file.

Your signature below signifies your understanding and willingness to comply with ALL of the above information.

***X*_____**

(Print Client name)

X_____ _____

(Client or Parent/Guardian Signature) **(Date)**

DEMOGRAPHICS INFORMATION

Client Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____ Previously Married: Yes/No

If client is a child, marital status of parents: _____

Address:_____ City: _____ State: _____ Zip:_____

Home phone: (____)_____ Cell phone: (____)_____ Work phone: (____)_____

E-mail: _____

Emergency Contact Person/Relationship to Self: _____

Number: (____)_____

Employer/School (if applicable): _____

Occupation: _____ Full-time/Part-time (circle one)

Primary Insurance: _____

Insurance ID #: _____ Group #: _____

Policyholder Name: _____

Policyholder DOB: _____ Policyholder Employer: _____

Policyholder Address (if different from client's address): _____

Client's relationship to policyholder: _____

Secondary Insurance: _____

Insurance ID #: _____ Group #: _____

Policyholder Name: _____

Policyholder DOB: _____ Policyholder Employer: _____

Primary Care Physician: _____

List of Current Medications/Dosage/Reason for taking:_____

_____

_____

_____

Referred to The Wholehearted Way by: _____

BRIEF MEDICAL HISTORY—ADOLESCENTS

Please list any mental health services or hospitalizations received (dates and reasons):_____

_____

_____

Briefly describe your overall experience with these services:_____

_____

_____

Please describe any past/present health concerns/issues (i.e. pain, significant injuries, illnesses, hospitalizations, chronic health issues):_____

_____

_____

Briefly describe your eating habits and any issues related to eating past/present:_____

_____

Briefly describe your normal sleep patterns and any issues/sleep disturbances you may be experiencing:_____

_____

Briefly describe any alcohol or substance use/abuse, including smoking or vaping: _____

_____

_____

Briefly describe your typical caffeine intake: _____

_____

Briefly describe any physical exercise you participate in: _____

_____

Please check any area where you think you may have a problem:

___ anxiety or worry	___ body image	___ compulsive behavior	___ previous trauma
___ communication	___ eating	___ sexual issues	___ feeling hopeless
___ depression	___ weight	___mood swings	___ sleep
___ concentrating	___ identity	___low energy	___ physical health
___ anger, irritability	___ control	___ low motivation	___ drugs
___ stress	___ self-esteem	___ work/academic	___ alcohol
___ guilt or shame	___ grief/loss	___ finances	___ relationship problems
___ other: _____	___ other:_____		___ other:_____

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CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
3. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
4. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, technical difficulties, and/or limited ability to respond to emergencies. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
7. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others).
8. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
9. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
10. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact person's name, address, phone:

_____

_____

By signing below I am agreeing that I have read, understood and agree to the items contained in this document.

X_____

(Client Name)

X_____Date:_____

(Client or Parent/Guardian Signature)

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ASSUMPTION OF THE RISK AND WAIVER OF LIABILITY RELATING TO CORONAVIRUS/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

The Wholehearted Way LLC has put in place preventative measures to reduce the spread of COVID-19; however The Wholehearted Way LLC cannot guarantee that you will not become infected with COVID-19. Further, participation in any services at The Wholehearted Way LLC could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I or my child may be exposed to or infected by COVID-19 by attending in-person sessions or participating in any services or workshops at The Wholehearted Way LLC and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at The Wholehearted Way LLC may result from the actions, omissions, or negligence of myself and others, including, but not limited to employees, patients, staff, and other persons at the Regus office building.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself or my child (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child may experience or incur in connection with my or my child's attendance and participation in any services or workshops at The Wholehearted Way LLC and Regus office building. On my behalf, I hereby release, covenant not to sue, discharge, and hold harmless The Wholehearted Way LLC, its employees, agents, and representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of The Wholehearted Way LLC, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any services or workshops from The Wholehearted Way LLC.

_____

(Client name)

_____ _____

(Client or Parent/Guardian Signature) **(Date)**

NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in

group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on August 1, 2020.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

*X*_____

(Print Client name)

X_____ _____

(Client or Parent/Guardian Signature) (Date)