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). 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 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.

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.

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—ADULTS

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	___ chronic pain
___ depression	___ weight	___ marriage	___ sleep
___ concentrating	___ identity	___ parenting	___ physical health
___ anger	___ control	___ in-laws	___ drugs
___ stress	___ self-esteem	___ work/academic	___ alcohol
___ guilt or shame	___ grief/loss	___ finances	___ other:_____