**EACH PERSON ATTENDING COMPLETES A SEPARATE INTAKE PACKET; PLEASE BRING WITH YOU TO INITIAL APPOINTMENT**

809 N. Lafayette St., Suite A
Shelby, NC 28150
Phone: (704) 284-0554
Email: info@shelbytherapy.com

## CONFIDENTIAL CLIENT INFORMATION

**Date**: _____ **Social Security Number**: _____ - _____ - _____

**Name**: _____ _____ _____
First Middle Last

**Date of Birth**: _____/_____/_____ **Age**: _____ **Highest Grade Completed**: _____

**Address**: _____
Number and Street City State Zip

**How do you prefer we contact you (☒ all that apply)?** ☐ Mail ☐ Email ☐ Telephone ☐ Text Message

**Phone Number(s)**: (h) _____ (c) _____ (w) _____

Please ☒ the number that you **DO NOT** want to receive a message (voice/text)? Home ☐ Cell ☐ Work ☐

**Primary Email Address**: _____ @_____

**Secondary Email Address**: _____ @_____

**Gender:** ☐ Woman ☐ Man ☐ Transgender ☐ Other (Please Describe):_____
**Race:** ☐ Black ☐ White ☐ Asian ☐ Hispanic ☐ Indian ☐ Other:_____
**Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partners
**Employment Status:** ☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Other: _____
**Active Duty Military Status:** ☐ Yes ☐ No ☐ Veteran
**Primary Language:** ☐ English ☐ Sign Language ☐ French ☐ Spanish ☐ Other: _____

**Occupation**: _____ **Religious Preference**: _____

**Living Arrangement:** ☐ Private Residence ☐ Homeless ☐ Foster Home ☐ Group Home ☐ Nursing Home

**Legally Responsible Person** (For Minor Clients)
*[SWTC must have a copy of official custody documents on file prior to servicing a minor]*

_____
Name Relationship

**Emergency Contact Name, Relationship, Date of Birth**: _____
**Emergency Contact Telephone #:** ( ) _____

Please check any/all that apply in your **current** family (only yourself, spouse, and/or kids). History of:
☐ Suicide ☐ Alcoholism ☐ Substance Abuse ☐ Mental Illness ☐ Domestic Violence
☐ Sexual Abuse ☐ None ☐ Other: _____

Please check any/all that apply **anywhere** in your family tree (your parents, relatives, spouse's family, etc.). History of:
☐ Suicide ☐ Alcoholism ☐ Substance Abuse ☐ Mental Illness ☐ Domestic Violence
☐ Sexual Abuse ☐ None ☐ Other: _____

**Current Medications (attach an additional sheet if necessary)**:

| Medication | First Prescribed | Reason | Dosage | Prescribing Doctor |
|---|---|---|---|---|
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**Please list previous counseling**:

| Name of Therapist | Dates Attended | Reason | Diagnoses |
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**Please briefly describe what you hope to accomplish as a result of working with your therapist**:

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**Please briefly describe why you chose SWTC over another therapy practice**:

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How did you come to hear about Shelby Wellness and Therapy Center?
☐ Referrals ☐ Ads ☐ Flyers ☐ Family ☐ Friend ☐ Other: _____

Please list below any internet search engines or websites you visited in your therapist search:
☐Google ☐ Psychology Today Website ☐ www.shelbytherapy.com ☐ Other: _____

**Please check any/all issues which are a concern for you today**:

| | | | | |
|---|---|---|---|---|
| ☐ Abortion | ☐ Adoption | ☐ Alcohol Use | ☐ Ambition | ☐ Anger |
| ☐ Anxiety | ☐ Appetite | ☐ Attention Probs. | ☐ Children | ☐ Codependency |
| ☐ Chronic Pain | ☐ Communication | ☐ Concentration | ☐ Constant Conflicts | ☐ Crying |
| ☐ Death of Loved One | ☐ Decision Making | ☐ Depression | ☐ Divorce | ☐ Domestic Violence |
| ☐ Drug Abuse | ☐ Eating Habits | ☐ Education | ☐ Emotional Abuse | ☐ Energy Level |
| ☐ Exhaustion | ☐ Family Problems | ☐ Fears | ☐ Finances | ☐ Focusing Probs. |
| ☐ Friends | ☐ Gender Identity | ☐ Headaches | ☐ Health | ☐ Hyperactivity |
| ☐ Incest | ☐ Inferiority | ☐ Infertility | ☐ Infidelity | ☐ Insomnia |
| ☐ Legal Problems | ☐ Loneliness | ☐ Marital Problems | ☐ Marital Separation | ☐ Memories |
| ☐ Motivation | ☐ My Thoughts | ☐ Nail-biting | ☐ Nervousness | ☐ Nightmares |
| ☐ Obsessive Thoughts/Behaviors | | ☐ Overweight | ☐ Parenting | ☐ Perfectionism |
| ☐ Pornography Use | ☐ Procrastination | ☐ Sexual Abuse | ☐ Self-Control | ☐ Self-Esteem |
| ☐ Sexual Addiction | ☐ Sexuality | ☐ Sexual Orientation | ☐ STIs | ☐ Shyness |
| ☐ Smoking | ☐ Spirituality | ☐ Stress | ☐ Suicidal Thoughts | ☐ Temper |
| ☐ Underweight | ☐ Unhappiness | ☐ Work | ☐ Other: _____ | |

| | |
|---|---|
| **What do you consider your strengths?** | |
| **What do you consider your areas of improvement?** | |

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## BILLING AND INSURANCE INFORMATION

*Please give your insurance card and picture I.D. to the receptionist.*

Person responsible for bill (This is your information as the client - unless client is under 18 years of age)

Name: _____ Social Security Number: _____-_____-_____

Is this person a client here? ☐ Yes ☐ No Is the client covered by insurance? ☐ Yes ☐ No

Client's relationship to subscriber: _____ Birth Date: _____/_____/_____

Address: _____
Number and Street City State Zip

Phone Number(s): (h) _____ (c) _____ (w) _____

Employer: _____ Occupation: _____ Phone : _____

Address: _____
Number and Street City State Zip

Please indicate primary insurance:

☐ Aetna ☐ Carolina Behavioral Health Alliance ☐ Magellan Health Services ☐ MedCost
☐ Tri Care ☐ Cigna ☐ United Healthcare (UMR) ☐ Blue Cross Blue Shield ☐ Ceridian Lifeworks
☐ Medicaid/Medicare ☐ Other: _____

Subscriber's Name as on card: _____ Subscriber's Social Security Number: _____-_____-_____

Subscriber's Birth Date: _____/_____/_____ Group No.: _____

Policy No.: _____ Co-Payment: $_____

Name of Secondary Insurance (if applicable): _____

Subscriber's Name: _____ Client's Relationship to Subscriber: _____

Group No.: _____ Policy No.: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Shelby Wellness and Therapy Center. I understand that I am financially responsible for any balance on my account. I also authorize Shelby Wellness and Therapy Center or insurance company to release any information required to process my claims.

_____ _____
Client/Guardian Signature Date

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## ACKNOWLEDGMENT OF CLIENT'S RIGHTS AND RESPONSIBILITIES:

**Please ☒ if you acknowledge and agree:**

| | |
|---|---|
| ☐ | I have read and/or have had explained to me and understand all of the following Shelby Wellness and Therapy Center, PLLC (SWTC) documents: Agency Policies/Procedures, Informed Consent, Insurance Information and Release Form, Audio/Video Recording Preferences, and Couples/Family/Child and Group Therapy Privacy Policy. I understand these are posted on the company's website and I may either print these from the internet or request and receive written copies of them by SWTC at any time. By signing and dating below I accept full responsibility to comply with all policies of SWTC. |
| ☐ | I understand that any balance over 60 days past due will incur a 1.5% interest fee, *retroactive to the date of service*, and that it is my responsibility to pay this balance regardless of any expectation on my part of third-party reimbursement. I realize that any money received by Shelby Wellness and Therapy Center, PLLC, from third parties, over and above my indebtedness will be refunded to me after my account is paid in full, including any interest charges, at the end of treatment, or of the fiscal year, whichever comes last. |
| ☐ | I acknowledge that there is no guarantee of results. I am responsible to pay in full, any balance for services rendered regardless of the outcome of therapy. I also realize SWTC may utilize all legal means to collect unpaid balances, and that I may incur further costs associated with the collection of this debt, including but not limited to legal fees and reimbursement for administrative time spent in the collections or court process. |
| ☐ | I will be responsible for arriving on time, and for making and keeping all appointments. I realize that if I opt out of reminder text messages/emails/phone calls, I will *not* receive reminders and that SWTC is not responsible to remind me of my appointments. I understand that insurance companies do not reimburse for missed appointments. Any non-emergency missed appointments or cancellations without a minimum of 24 business-hours' notice will incur the entire session fee (not a co-pay or discounted rate). Business hours are Monday and Wednesday 9am to 5pm, Tuesday and Thursday 9am to 9pm, and two Saturdays per month 9am to 4pm. |
| ☐ | I read in the Informed Consent document, or have had explained to me, the potential risks of therapy and by signing below have agreed to all conditions. I understand the limits of confidentiality described in the Informed Consent document. Alternative treatment options have been or will be explained to me in my first appointment to my satisfaction, and I take responsibility to ask any questions I may have regarding this or anything else regarding my treatment. I also realize SWTC is not a crisis service, and I realize I will need to call 911 if I am in a life-threatening emergency. |

_____ _____

Client/Legal Guardian Signature Date

_____ _____

Clinician Signature Date

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## AUDIO/VIDEO RECORDING PREFERENCES

As a standard practice in the psychotherapeutic context, therapists and therapists-in-training occasionally audiotape or videotape counseling sessions for purposes of case review with peers and/or supervisors, or for use in training, research or professional publication.

Therapists and therapists-in-training at Shelby Wellness and Therapy Center, PLLC (SWTC) may occasionally choose to tape sessions for the above purposes, with the express understanding that confidentiality will be protected to the highest professional standard, and that no identifying client information would be used in any publications or research without specific consent to this effect. Recordings of all counseling sessions will be destroyed immediately after its use as stated above, and will not become a part of the clients' permanent record.

Clients of SWTC have the right to decline audio and/or video taping of counseling sessions; this is not a condition of treatment. Please sign below indicating your understanding of this policy, and your preference regarding the occasional use of audio/video tapes for the above stated purposes.

PICK ONE ONLY

| | |
|---|---|
| ☐ | Please ☒ this box if you **prefer not** to have any appointments taped at this time. |
| ☐ | Please ☒ this box if you understand the audio/video taping policy and **give your consent** to have your counselor occasionally record your sessions. |

_____ _____
Client Signature Date

_____ _____
Legal Guardian (if minor) Signature Date

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# INSURANCE, 3RD PARTY REIMBURSEMENT INFORMATION AND RELEASE FORM

PLEASE COMPLETE ONE PER INSURED PERSON IF PLANNING TO FILE IN- OR OUT-OF-NETWORK CLAIMS

| | |
|---|---|
| **IN NETWORK:** | Shelby Wellness and Therapy Center, PLLC (SWTC) is in-network with Aetna, Carolina Behavioral Health Alliance, Magellan, and MedCost. SWTC will file insurance claims on behalf of clients who hold policies with these networks, **with the express understanding that if reimbursement is not received within 60 days of the date of service, balance will be due in full, or may begin to incur a 1.5% interest charge, retroactive to the date of service.**<br><br>By signing below, you are requesting that SWTC file claims with Aetna, Carolina Behavioral Health Alliance, Magellan, or MedCost on your behalf and hereby assign payment directly to SWTC for benefits, if any, otherwise payable to you for services rendered, but not to exceed the reasonable and customary charges for those services.<br><br>You further authorize SWTC to release to your insurance company any protected health information acquired in the course of your examination or treatment for insurance purposes. In the case that you are not covered by Aetna, Carolina Behavioral Health Alliance, Magellan, or MedCost, you will be responsible to file any claims related to potential reimbursement, and SWTC will not be filing on your behalf. |
| **OUT OF NETWORK:** | With the exception of Blue Cross Blue Shield (who will send a reimbursement check directly to the client, who is still responsible for any unsatisfied balances at SWTC), SWTC encourages clients who have third party health coverage besides that listed above, to file claims themselves and to insist on reasonable coverage for out-of-network benefits (if applicable). In this case, clients may pay the full fee out of pocket, and any reimbursement paid from the insurance company is paid directly to the client. On occasion, SWTC may assist clients with out of network insurance claims, but we are under no obligation to do so. In this case, any moneys paid to SWTC by out of network insurance companies over and above clients' indebtedness including any interest charges, will be credited or refunded at the end of treatment, or of the fiscal year, whichever comes last.<br>**By signing below, you are acknowledging your understanding that out of network claims will not be filed by SWTC and that there is no implied or expressed guarantee being made, regarding reimbursement by a third party.**<br><br>I, the undersigned, understand that any third-party reimbursement coverage I may have is a contract between me and my insurance company and that there is no guarantee that SWTC or I will receive any reimbursement. I understand that I am responsible in full for the entire SWTC account balance regardless of what I believe to be my insurance "benefits," "co-pay," "coinsurance," "coverage," or "my portion," and regardless of any expectation I have of possible reimbursement by my insurance company or another third party.<br><br>I further realize that insurance companies do not reimburse for missed appointments, and that I will be charged the entire out of pocket (non-discounted) session fee if I do not provide at least 24-business hours' notice to cancel or change appointments. These fees are listed on the "Policies and Procedures" form of Intake Paperwork, which was provided prior to all initial appointments, and is available at any time on the company website or in the office |

_____ _____

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## COUPLES/FAMILY/CHILD/GROUP THERAPY POLICY

| | |
|---|---|
| **COUPLES/FAMILY/CHILD /GROUP THERAPY IS DIFFERENT** | This statement of policy is intended to inform all participants in couples, family, child, or group therapy how therapists at Shelby Wellness and Therapy Center choose to handle privacy/confidentiality, as well as the treatment records, which is fundamentally different than in the case of individual therapy. |
| **TREATMENT UNIT** | When SWTC therapists agree to treat a couple, family, child, or group, we consider everyone attending (also known as the "treatment unit") to be the client. If, for example, clinical records of the treatment unit were ever requested by anyone, inside or outside the treatment unit, your therapist would be required to seek the authorization of all members of the treatment unit before releasing any confidential information, and would not release any information without this authorization (see exceptions to this on SWTC's "Informed Consent" document which all new clients receive at the onset of therapy). If clinical records were ever *subpoenaed in a legal situation*, your therapist would assert the psychotherapist-client privilege on behalf of the entire treatment unit |
| **CONFIDENTIALITY IN COUPLES/FAMILY/CHILD /GROUP THERAPY** | During the course of couples, family, child, or group therapy, your therapist may find it clinically appropriate to consult with a smaller set of the larger treatment unit (e.g. an individual or two siblings) for one or more sessions. Unless occurring for specific, individual issues that are unrelated to the couples/family/child/group work, these sessions would be seen by all participants of the treatment unit as a part of the larger whole: the work that the entire treatment unit is doing, unless otherwise indicated. If you are involved in one or more of such sessions with your therapist, please understand that generally these sessions are still considered confidential in the sense that your therapist would not release any confidential information to a third party unless required to do so by law, or prior written authorization was provided. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, we would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party. |

| | |
|---|---|
| **"NO SECRETS"** | However, your therapist may find it clinically necessary to discuss information learned in a session with only a portion of the treatment unit being present, with the entire treatment unit – that is, the family, couple, or group – to effectively serve the goals of the unit being treated. Your therapist will use professional judgment as to whether, when, and what extent they may make disclosures to the treatment unit, and will also, if appropriate, first inform and give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if any individual within the treatment plan feels it necessary to talk about matters that they absolutely do not want shared with anyone else in the larger treatment unit, a consultation with an individual therapist who can help treat you individually may be necessary. SWTC can make a referral to an individual therapist in this case.<br><br>This "no secrets" policy is intended to allow your therapist to continue to treat the couple, family, child, or group, by preventing, to the greatest extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the treatment unit. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple of the family. If your therapist is not free to exercise clinical judgment regarding the need to bring this information to the couple, family, or group during their therapy, your therapist might be placed in a situation where termination of treatment is necessary. This policy is intended to prevent the need for such a termination.<br><br>If choosing to engage in couples, family, child, or group therapy, please sign at the bottom of this document. A signature on this agreement indicates that <u>each member</u> of the treatment plan has read or had read to them, this policy, has had an opportunity to discuss its contents with the therapist, and chooses to undertake couple/family/group therapy in agreement with and with an understanding of how this policy may impact confidentiality and the handling of any records. |

_____ _____

Signature of Client/Legal Guardian Date

**PLEASE READ AND KEEP THE "NOTICE OF AGENCY POLICIES AND PROCEDURES" BROCHURE**

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I have read and agree to the "Notice of Agency Policies and Procedures" brochure of Shelby Wellness and Therapy Center, PLLC that has been provided for me; if it has not been provided to me I have had opportunity to request and receive one.

**I have read and agree to the terms of the following sections of the agency policies and procedures area of the brochure (please initial beside each section):**

_____ Responsibility for Appointments and the Cancellation Policy

_____ Business Hours

_____ A Note Regarding Children/Minors

_____ Time of Appointments

_____ Check-in/Payments

_____ Fees

_____ Payment and Billing

_____ Insurance/Third Party Reimbursement

_____ Electronic Communication

**I have read and agree to the terms of the following sections of the informed consent areas of the brochure (please initial beside each section):**

_____ Potential Risk/Alternative Treatments

_____ Consent to Treatment

_____ Results/Outcomes and Termination

_____ Confidentiality

_____ Client's Request for Information

**By signing, you acknowledge that you have read and agree to the above terms found in the Agency Policies and Procedures brochure.**

_____ _____

Signature of Client/Legal Guardian Date