Mindful Living Counseling
904 Washington Road, Suite D, Westminster, MD 21157
443-536-3239

CLIENT INFORMATION FORM

Name _____ Date of Birth _____/_____/_____
Age _____Relationship Status _____Soc. Sec. Number_____
Gender: ☐Male ☐Female ☐ Transgender/Gender Non-Conforming
Home address (city, state, zip code):
_____
_____

Please list your phone numbers and check next to the number(s) where you prefer to be contacted:
☐Home phone (____) _____Message may be left at this number: Yes ☐No ☐
☐ Cell phone (____) _____Message may be left at this number: Yes ☐ No ☐

Email Address_____
Emergency Contact/Relationship _____ Phone Number: _____

Insurance information

Primary Insurance: _____ Co-pay amount $_____
ID No.: _____ Group No: _____
Policy Holder's Name and address: _____
Policy Holder's Date of Birth: _____Policy Holder's Employer: _____

Secondary Insurance: _____Co-pay amount $_____
ID No.: _____ Group No: _____
Policy Holder's Name and address:
_____
Policy Holder's Date of Birth: _____Policy Holder's Employer: _____

Have you previously been seen for mental health treatment? Yes ☐ No ☐
If yes, please list the provider(s), treatment(s), duration(s):
_____
_____

How were you referred to my practice?
_____

Patient Name (please print):
_____
Signature of Client or authorized representative

_____

Date: _____Relationship to client_____

Office Policy and Procedures

MEETINGS

A regular therapy session lasts for 45-50 minutes. During our initial consultation meeting(s) we will jointly decide if I am the best clinician to provide the services you need. If either you or I decide for any reason that you would be better helped by another professional or method of intervention, I will offer referrals for alternative services or providers. If we decide to continue with ongoing therapy, we will schedule sessions during a mutually agreed upon time.

CANCELLATIONS & MISSED APPOINTMENTS

Because the success of therapy depends on the regularity and continuity of our meetings, the expectation is that we will meet regularly at the time that we decide upon together. Once we agree on scheduling, I will reserve those hours for you. It is understandable that on occasion you will need to cancel or reschedule a session due to unforeseen circumstances. If you need to reschedule or cancel outside of unforeseen circumstances, I require that you provide me with at least 48 hours advance notice in order to avoid being charged $60.00 for the session. If I receive notice less than 48 hours in advance or you miss a session with no advance notice, you may be charged for the missed session. Additionally, if any two consecutive appointments or a total of three appointments are missed, you may be discharged at my discretion.

FEES FOR SERVICE (No Insurance)

During our initial consultation meeting we will jointly determine a fee and payment schedule. Payment by check, cash or credit card is due the day of each session. I charge the same fee for other professional services you may need. Other services might include, but are not limited to, telephone consultations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries. I will prorate the cost if I work for periods of less than one hour. I periodically raise my fees with reasonable advance notice.

CONTACTING ME

By Phone or Email: You may contact me by calling the main office phone number at 443-536-3239 or email at info@mindfullivingcounselingcc.com. Although I am often not immediately available, you may leave a message or email which will be checked frequently during business hours. I will attempt to return your call or email within 48 hours. I will give you verbal advance notice of any vacations or other planned absences.

By Text: Because the security of text cannot be guaranteed, it is recommended that such contact be limited to general requests such as phone contact, appointment arrangements, or requests for information. Any communication that requires a timely response should be made by phone or email.

SOCIAL MEDIA

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc.). In adding patients as friends or contacts on these sites, it can compromise confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. Please consider follow the practice, Mindful Living Counseling on Facebook or Instagram.

EMERGENCIES

Although you can leave me a message at any time, I am often not available to call you back immediately. In the event of a psychiatric emergency, please call me and leave a message as well as, call 911 or go to your nearest emergency room.

ENDING TREATMENT

Your treatment is voluntary and you have the right to end or take a break from therapy at any time. However, if you do decide to exercise this option, I encourage you to talk with me about the reason for your decision in a therapy session so that we can bring sufficient closure to our work together. We can also discuss any referrals you may need at that time. Social Workers are ethically required to continue therapeutic relationships only so long as it is reasonably clear that clients are benefiting from the relationship. Therefore, if I believe that you need additional treatment, or if I believe that I can no longer be of help to you, I will discuss this with you and make appropriate referrals.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist, and all written treatment records, are protected by law, and I may only release information about our work to others with your written permission. There are a few exceptions, under Maryland law, when disclosure is required. They are as follows:

- when there is a reasonable suspicion of child, dependent or elder abuse or neglect;
- when a patient presents as a danger to self or to others
- when a patient's family member/support person communicates to the patient's therapist that they present as a danger to self or others.

Please acknowledge that you:

1. Have carefully reviewed all the information in this document.
2. Received a printed copy of this document if so requested.
3. Received a Notice of Privacy Practices explaining HIPAA.
4. Understand that this is an agreement with Mindful Living Counseling, a corporation that is unrelated to other physicians.
5. Understand that your therapist is an individual business responsible for providing mental healthcare services.

Signature: _____Date: _____
Print name_____

Financial Responsibility

I authorize my provider and/or Mindful Living Counseling representative(s) to release information to the insurance carrier(s) listed and be paid directly by the insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance carrier(s) including: copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancellation fees. In providing credit card information, I authorize my therapist/Mindful Living Counseling representative(s) to charge outstanding balances for any of the above reasons.

Signature: _____Date: _____
Print name_____

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CONSENT FOR TREATMENT OF THERAPY

I _____ hereby authorize my therapist at Mindful Living Counseling to provide therapy as explained to me. I understand that while this therapy may be beneficial, as with any treatment, there are inherent risks. During therapy, I will discuss personal issues which may bring up uncomfortable feelings such as anxiety, anger, guilt, and sadness. The benefits of therapy can far outweigh this discomfort and can lead to benefits such as improved personal relationships and reduced feelings of emotional distress. I acknowledge however, that no guarantee can be made as to the results of therapy. At any time, I may initiate a discussion of possible negative or positive effects of entering, not entering, continuing or discontinuing therapy. I understand that therapy is a personal exploration and may lead to major changes in my life, perspectives and decisions. These changes can affect my significant relationships, school, job and/or understanding of myself. Some of these changes could be temporarily distressing. The exact nature of these changes cannot be predicted.

CONFIDENTIALITY: I understand that discussions between myself and my therapist as well as, any records are confidential with the exceptions noted below:

- when there is a reasonable suspicion of child, dependent or elder abuse or neglect;
- when a client presents a danger to self, and/or to others
- when a client's family members communicate to the client's therapist that the patient presents a danger to others.

No information will be released without my written consent unless mandated by law. If I have any questions regarding confidentiality I will bring them to the attention of my therapist. By signing this Consent Form, I am giving consent to my therapist to share confidential information with all persons mandated by law as well as the insurance carrier responsible for providing my mental health care services and payment for those services. I am also releasing and holding harmless Mindful Living Counseling from any departure from my right of confidentiality that may result.

DUTY TO WARN AND PROTECT: If my therapist believes that I am in physical or emotional danger or I am a danger to another human being, I understand that my therapist is required by law to contact medical or law enforcement personnel to prevent harm to me or another person and may also contact the person in danger.

CONSENT TO TREATMENT: By signing the Informed Consent and Privacy Practices Receipt, I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services at any time. By signing the Informed Consent, I acknowledge that I have both read and understood all the terms and information.

PATIENT NOTIFICATIONS: I understand that I will be notified by my therapist if the therapist anticipates the termination or interruption of services to me, and that I will be provided with alternative resources/therapists.

Authorization:
Patient Name (please print):

_____
Signature of client or authorized representative

_____

Date: _____Relationship to client_____

Clinician Signature_____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

I, _____ authorize my therapist at Mindful Living Counseling to: ☐Request Health Information from, ☐ Discuss Health Information with, and/or ☐ Send Health Information to the identified people on this form. I authorize information to be requested or released by representatives of:

Name of Person, Provider or Facility:
_____
Address: _____
City: _____ State: _____ Zip Code: _____
Fax: _____ Phone: _____

Name of Person, Provider or Facility:
_____
Address: _____
City: _____ State: _____ Zip Code: _____
Fax: _____ Phone: _____

Name of Person, Provider or Facility:
_____
Address: _____
City: _____ State: _____ Zip Code: _____
Fax: _____ Phone: _____

Specific Health Information Authorized to Release:

☐ I authorize disclosure of all of my health information including medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or
☐ I authorize only the disclosure of the following information:
_____

Specific Health Information Requested: ☐Entire Record / OR ☐ Other: Please specify if other:
_____

I understand and agree that:

● This authorization is voluntary;
● My health information may contain information created by other persons or entities, including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
● I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
● My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.
● This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Authorization:

Patient Name (please print):
_____

Signature of Client or authorized representative:
_____

Date: _____Relationship to patient_____