Love & Kindness
WELLNESS SERVICES

Child InTake Form

Date: _____

Child's Last name: _____

First Name_____

Date of Birth: _____ **Age:** _____

Place of Birth:_____

Birth Gender:_____Current Gender:_____ Pronouns:_____

Social Security Number: _____ Weight:_____ Height_____

Guardian's Last name: _____ First name: _____

Relationship to Child:_____Relationship status:_____

Significant other's age and sex:_____How long together?_____

_____

Names and ages of any children in the home:

_____

Employment Status:_____ Professional Title:_____ For how long?_____

Employer: _____ Education:_____

Race_____ Ethnicity_____ Religion_____

Preferred language:_____Address:_____

City, State: _____Zip: _____

Phone numbers with area code Home: ( )_____ Work: ( )_____

Cell: ( )_____ Email:_____

How did you hear about me?_____

Who shall we contact in case of emergency? Name: _____

Phone ( )_____ I hereby consent for _____ to provide evaluation and treatment to the client listed above.

Signature: _____ Date: _____

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HEALTH INSURANCE INFORMATION

If you are using or may use in the future, health insurance, the following information is necessary in order to bill the insurance company.

Insured's Information (the "insured" is the person who owns the policy or is the employee to whom a group policy is applicable)

1. Name of Insured _____

2. STREET ADDRESS OF INSURED _____

3. CITY _____

4. STATE & ZIP CODE _____

5. INSURED'S DATE OF BIRTH _____

6. SOCIAL SECURITY # _____

7. TELEPHONE _____

8. INSURED'S PLACE OF EMPLOYMENT: _____

9. INSURANCE PLAN NAME OR PROGRAM NAME. _____

10. INSURED'S INSURANCE ID NUMBER_____

POLICY GROUP NUMBER _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to Love & Kindness Wellness Services, LLC and authorize Love & Kindness Wellness Services, LLC to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

Signature of Insured_____ Date _____

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Medical and Health History

Name:_____

Date:_____

List any allergies you have: _____None_____

Primary Care Physician: _____Address:_____

City:_____ State:_____ ZIP:_____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination:_____

Do you allow communication with your PCP? Yes_____ No_____

Please list all current medications and dosages:

Please include over the counter medications, vitamins, & herbs

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

108 Kenilworth Place Suite 2, Brooklyn, NY 11210 Office: 347-627-8400 Mobile: 917-741-0810
Email: info@lk-wellness.com | Website: www.LK-wellness.com

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DEVELOPMENTAL CLIENT HISTORY

Mother's course of pregnancy: _____Normal; _____Abnormal

Describe: _____

_____

Mother's course of pregnancy: _____Normal; _____Abnormal

Describe: _____

_____

SCHOOL AND VOCATIONAL HISTORY

Current grade_____

School Problems: _____None or:_____ Academic Performance:

_____Grade level

_____Below grade level. Describe:

Behavior:
_____Appropriate _____Inappropriate.

Describe: _____

Please indicate any school needs or concerns that you would like addressed: _____

_____

Does client have friends at school or at home: ___Y ___N? If No, please describe:_____

_____Is client in any vocational school? ___Y____N

List all therapists your child have seen, and dates you saw them:_____

_____

_____

List any substance abuse treatment or inpatient psychiatric treatment your child have had, and the dates:

_____

_____

_____

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Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event:_____

_____

_____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not Applicable
Marriage/Relationship	1	*2*	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	*2*	3	4	5	N/A
Financial situation	1	*2*	3	4	*5*	N/A
Physical health	1	*2*	3	4	*5*	N/A
Anxiety level/Nerves	1	*2*	3	4	*5*	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	*2*	3	4	5	N/A
Sexual functioning	1	*2*	3	4	5	N/A
Alcohol/Drug usage	1	*2*	3	4	*5*	N/A
Ability to concentrate	1	*2*	3	4	5	N/A
Ability to control your temper	1	*2*	3	4	5	N/A

What result(s) do you expect from treatment?_____

_____

_____

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Psychotherapist-Client Services Agreement

Welcome to Love & Kindness Wellness Services, LLC. This document (Agreement) contains important information about our 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 with regard to the use and disclosures of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which will be provided to you on your first visit, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of our first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during and outside of our sessions.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and frustration. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Our practice is multiculturally centered with an emphasis on mindfulness and wellness. In addition, We participate in continuing education activities including conferences, workshops, and seminars. Our area of expertise includes working with people coping with complex trauma, depression, anxiety, identity/self-esteem issues related to, but not limited to, gender, sexual orientation, & race/ethnicity. Coaching and teaching effective skills for success for personal and professional development, immigration issues and acculturation, relational problems, LGBTQI related issues and people dealing with a recent medical diagnosis. Building and fostering a strong therapeutic alliance is an exceptional gift. We work with individuals, couples, families and groups, within an integrative framework of various therapeutic techniques, including Psychodynamic, Interpersonal/Relational, Cognitive Behavioral, Dialectical Behavioral Informed, Family Systems, Body Centered and Person Centered Psychotherapy.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy involves a commitment of time, money, and energy, so you should be careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

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Notice of HIPAA Privacy Practices

APPOINTMENTS

Appointments can be scheduled by calling Love & Kindness Wellness Services, LLC (917) 741-0810 or (347) 627-8400. We normally conduct an evaluation that will last from one to two sessions. During this time, we can both decide if we are the best person to provide the services you need in order to meet your treatment goals.

If we begin psychotherapy, we usually schedule one 55-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. When an appointment is scheduled, that time is specifically reserved for you. This will be your time every week unless one of us cancels or reschedules.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide advance notice of cancellation. A minimum of 48 hours' notice is required to cancel appointments for reasons that you could not anticipate in advance.

Insurance companies generally do not reimburse failed appointments or lateness.
If you are more than 15 minutes late for your appointment you will be responsible for paying for part of the session.

TELEPHONE CALLS AND EMERGENCIES

Due to our work schedule, we often are not immediately available by telephone. We do not answer the telephone when we are with a patient. We do not have regular call-in hours. When we are unavailable, our telephone is answered by voicemail which we monitor frequently. We will make every effort to return your call on the same day you make it, with the exception of weekends or holidays, or when we are away on vacation. If you are difficult to reach, please inform me of some times when you will be available.

In emergencies please call 911 or go to a hospital emergency room. As this practice does not have an answering service we may not receive emergency calls in a timely manner. After calling for emergency services leave a message for us or provide our phone number to the hospital staff working with you. We can work with the hospital at that point to ensure appropriate care. *If we will be unavailable for an extended period of time, we will provide you with the name of a colleague to contact, if necessary.*

To cancel appointments and for other non-emergency communication or to get in touch with us directly – we are not available 24hrs a day, however, if you leave a message we will return your call as soon as possible, usually within 24hrs Mon. – Fri. and by the next business day on weekends and holidays.	Office: 347-627–8400 Or: 917-741-0810
For emergencies	9111-800-LIFE-NET (543-3638)

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There are some situations where we are required to disclose information without your consent or authorization:

• If a client is clearly likely to seriously harm him/herself, we may be obligated to take action to prevent self-destruction.

• If there is a clear risk that a client plans to seriously harm another person, we may be required to take protective actions. These actions may include a duty to warn the potential victim; or disclose the risk to appropriate public authorities.

• If we suspect that abuse of a child or senior citizen may have taken place, I am obligated to report the suspected abuse to the Department of Social and Health Services.

• If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the doctor-patient privilege law. We cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders or subpoenas us to disclose information, we are required by law to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

• If a client files a complaint or lawsuit against me, we may disclose relevant information regarding that client in order to defend myself.

• We may present disguised case material in seminars, classes, or scientific writings. In this situation, all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.

_____

Client or responsible party

Date

_____

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Billing, Payments, and Financial Agreement

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed upon as they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan.

Your therapist will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

1. FEE INCREASES

Occasionally, we may increase our standard fee. If you are in therapy when an increase is to occur, you will be notified in advance. At that time, your fee will be adjusted to the new fee, this fee agreement will be terminated, and you will be asked to sign a new agreement which reflects the new fee.

2. PAYMENT ARRANGEMENT:

All fees are payable in full at the time of service. Established clients may be offered an account arrangement at the discretion of the therapist. Payment may be made in cash or by check.

_____STANDARD PAYMENT ARRANGEMENT: Payment in full at the time of service.

_____ ALTERNATIVE PAYMENT ARRANGEMENT: _____

INSURANCE:_____

I request that payment of authorized Medicare benefits or my health insurance benefit as indicated above be made either to me or on my behalf to Love & Kindness Wellness Services, LLC for service furnished by the healthcare provider. I authorize any holder of health/treatment information about me to release to the Health Care Financing Administration and it s agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Client or Responsible Party Date

3. COLLECTIONS PROCEDURES:

Love & Kindness Wellness Services, LLC reserves the right to collect any unpaid balance due to us. If a client is not making regular monthly payments on the account balance, Love & Kindness Wellness Services, LLC may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before we take action to collect.

4. LIMIT ON UNPAID BALANCE:

Love & Kindness Wellness Services, LLC may terminate treatment and refer the client elsewhere for continued care if any unpaid balance exceeds $350.00.

I have read and understood the above fee agreement, and I agree to abide by its terms.

_____ _____

Client or Responsible Party Date