Sound Well

Creative Arts Therapy, PLLC

Katie Down LCAT, MT-BC
License# 001473-1
NPI# 1689952293
www.soundwellcenter.com
katie@soundwellcenter.com
917-426-4393

Name: _____

Address: _____

Phone: _____

Email: _____

Date of Birth: _____

Social Security Number: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ / Address: _____

Primary Care Physician: _____ Phone: _____

Insurance: _____ Policy#: _____ Group # _____

Phone: _____

Employer: _____ Employer Phone#: _____

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Thank you for I look forward to working together. Psychotherapy is a collaborative journey between the therapist and the client, and through the process of therapy and healing, deep feelings and emotions may arise. Participation in therapy and healing does not guarantee problem resolution. As with all medical, psychological, and hands on healing treatments, there are both benefits and risks. Please feel free to ask questions and address any concerns you may have about our process as we take this journey together.

Confidentiality

Sound Well Creative Arts Therapy is committed to following the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information for the purposes of treatment, payment, and health care operations. All information, discussions, and documents are confidential and privileged information for all patients. Under federal law, disclosure of information regarding services provided and information about a patient requires written consent of release to alternate or third parties.

The following are exceptions to the rules of confidentiality and will be understood by the patient involved.

1. When there is imminent danger to the patient or to another person.
2. Under circumstances of suspected child, elder, or dependent adult abuse or neglect.
3. When disclosure must be made to medical professionals in the case of a medical emergency.
4. When the mental health professional is compelled by law to disclose client records.

I may, at times, consult with colleagues and other mental health professionals for guidance, advice, and supervision. Your name and identity will not be disclosed. Consults will only be used for the betterment of our work together.

Because I am a performing artist and meditation teacher, there may be times in which you may see me in a more public forum. In this instance, feel free to say hello if you want and feel comfortable doing so. I will not make any attempt at contacting you in this context however. The manner in which we know each other will not be disclosed and your privacy will always be respected and maintained.

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Consent To Services

I voluntarily agree to receive the following services with Katie Down of Sound Well Creative Arts Therapy, PLLC (Please check any and all applicable services)

- Psychotherapy
- Sound and/or Music Therapy
- EMDR
- Reiki with light touch
- Private and small group sound bath meditations

I understand and agree that I, or I as a representative of my group, will participate in the planning and treatment process. I understand that I have the right to terminate such care and services that I receive from the undersigned therapist at any time. My signature affirms that I have read and understand the information presented and this enables me to make an educated, voluntary consent to treatment.

Printed Name of Patient or Personal Representative or Legal Guardian _____

Signature of Patient or Personal Representative or Legal Guardian _____

Date_____

CONSENT TO RELEASE INFORMATION

I give Katie Down of Sound Well Creative Arts Therapy, PLLC permission to release any necessary information obtained during treatment to support any insurance claims or to secure timely payments. I give Katie Down of Sound Well Creative Arts Therapy, PLLC consent to call my emergency contact if therapist deems it necessary and to contact 911 in case of emergency and what the therapist deems an emergency. I give Katie Down of Sound Well Creative Arts Therapy, PLLC consent to contact my primary care physician and to request medical records for the benefit of my continued therapeutic care and wellbeing.

I understand that I am personally responsible for all fees for services provided.

Printed Name of Patient or Personal Representative or Legal Guardian _____

Signature of Patient or Personal Representative or Legal Guardian _____

Date_____

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Patient Rights

Patients have the right to considerate, safe, and respectful care, in the absence of discrimination regarding race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy, therapist training, and therapist experience. You have the right to communicate your therapeutic needs if you feel dissatisfied or feel like any of the aforementioned rights have been violated in any manner.

Termination of Treatment

Sound Well Creative Arts Therapy maintains the right to terminate treatment at any time. A termination letter will be submitted when termination of treatment occurs.

Circumstances that may result in termination include but are not limited to: lack of payment, a development that occurs outside the scope of competence, personal and/or professional obligations that preclude continuation of treatment.

In the case of termination, Katie Down will support the transition to a service provider for continued care if desired by patient. Therapeutic counseling can result in changes in relationships, emotional states, patient's behavioral patterns, or there may be circumstances that result in a lack of improvement. Under the circumstances of extreme discomfort and emotional pain, the patient has the right to terminate or discontinue treatment at any time.

Professional Records

All records will be secured in a secure location following HIPAA standards. Records include, but are not limited to, documentation of attendance; purpose of treatment; any medical, social, and treatment history; evaluations and diagnoses; anecdotal notes of topics and discussions; copies of legal forms and consents; documents and copies of any forms or information shared with other professionals; and information provided by other professionals. Sound Well Creative Arts Therapy is committed to upholding privacy and security standards for the protection of electronic health information standardized by HIPAA, ensuring the confidentiality and integrity of all protected health information created, received, stored, or transmitted. This includes protecting client information from potential security threats, maintaining privacy disclosure statements, and using only authorized technical devices that have security systems.

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Please list all current medications and the doses.

Name of med:

Dose:

Please list all medications you have taken in the past and the doses

Name of med:

Dose:

Please briefly describe your daily diet including vitamins and supplements

What physical activities do you engage in on a regular basis?

Do you have a spiritual or religious practice? Y / N
If so, what is your practice and how does it figure in your life?

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Have you been in therapy before and if so what were some of the benefits?

Have you been hospitalized? Y / N

Dates of hospitalization if yes.

Name of hospital and attending psychiatrist if known.

Is there a history of family mental or physical illness? Y / N

If yes, please describe briefly.

What are some of the key issues on which you hope to focus?