sound well

Creative Arts Therapy, PLLC

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Thank you for taking the time to fill out this form which will provide me the information needed for us to begin our work together. Therapy is a collaborative journey and through the process of healing, deep feelings and emotions may arise. Participation in therapy and healing does not guarantee problem resolution. As with all medical, psychological, and energy 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. I look forward to working with you.

POLICIES:

Time frame of therapy sessions:	55 minutes
Fee:	$225 per session due at least 1-hour prior to meeting
Sliding Scale:	Some sliding scale clients are accepted on a case-by-case basis
Insurance:	In network with Cigna. Out of network benefits may apply. Inquire with your provider. Some co-pays may be required at time of service so be advised that you may be responsible for a co-pay for each session.
Payment Methods:	Zelle
	Cash and Checks are also accepted if in person. I do not accept credit cards.
Cancellation:	24-hours-notice required. Remittance of full fee is required if session is cancelled less than 24-hours in advance.

CLIENT INFORMATION:

Name_____

Preferred Pronouns _____

Address: Street _____

City _____ Zip Code _____

Phone ( ) _____

Email_____

Date of Birth___Month_____Day_____Year_____

Social Security Number _____/_____/_____

Creative Arts Therapy, PLLC

Insurance Provider_____

Phone (_____) _____

Policy#_____ Group #_____

Co-Pay_____

Employer:_____

Employer Phone# (_____) _____

Emergency Contact_____Relationship_____

Emergency Contact Phone_____

Emergency Contact Address_____

Primary Care Physician:_____Phone:_____

Confidentiality

Sound Well Creative Arts Therapy, PLLC 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

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Consent To Services

I voluntarily agree to receive the following services of Sound Well Creative Arts Therapy, PLLC (Please check next to services that you are interested in.)

- Psychotherapy
- Sound Healing
- EMDR
- Reiki
- 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 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 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 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_____

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, your clinician at Sound Well Creative Arts Therapy will offer referrals for the transition to another 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.

Please list all current medications and the dose.

Name of medication:

Dose:

Please list all medications you have taken in the past and the dose.

Name of medication:

Dose:

Please briefly describe your daily diet including vitamins and supplements

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

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?