AGREEMENT TO ENTER PSYCHOTHERAPY

While in therapy at Lampost Wellness Centers, I will abide by the following:

1. I understand that the clinicians at Lampost Wellness Centers are state licensed clinical professionals and are mandated to report child abuse, elderly abuse, and any intent to harm self or others.

2. I understand that by entering therapy I am choosing to potentially make changes to my thoughts, feelings, and behaviors. I am ultimately responsible for my life and the changes I make.

3. I agree to provide a credit/debit card to pay for treatment, and understand fees of $215/per 50 minute session will be charged during the 48 hours preceding my appointment time.

4. I agree to keep all my appointments **unless I have given 48 hours notice,** either in person or on the phone. I understand my obligation to pay fully for my therapist's time if I fail to provide this cancellation notice. In rare emergency situations, my therapist may make an exception to this obligation.

5. If at any time I chose to terminate therapy, I agree to announce my intention during one session and then return for at least one more session, after which therapy may end. I agree to be charged for this final session. This charge is to encourage my attendance in order to provide adequate and safe closure to treatment.

6. I understand and agree that Lampost Wellness Centers will keep all my personal information confidential but, without personal identification, the organization may use my issues and solutions for clinical supervision purposes.

7. This agreement will remain in effect until I provide notice and terminate therapy.

______________________________ ______________________

Name (Patient Signature) Date

______________________________ ______________________

Witness (Therapist Signature) Date

INTAKE FORM

Information you provide here is protected as confidential information.

Patient Name: ____

Patient Birth Date: ______ /______ /______

Gender: □ Male □ Female

Sexual Identification: _______________ Orientation:________________

Address:
____

____
(City) (State) (Zip)

Cell: __________________________________May we leave a message? □Yes □No

E-mail: ____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):

____

How did you find us?
Referral
Psychology Today
Google Search
News article
Physician

WHAT HAS PROMPTED YOU TO SEEK TREATMENT?

____

____

____

____

____

____

____

____Date_____________
Authorization Signature
Parent or Guardian

____Date_____________
Patient Signature

5410 McKinley Street Bethesda MD 20817
PH 301-841-8930 FAX 240-235-3707
www.lampostwellness.com

MEDICAL HISTORY

Please complete: This is very important information. Please feel free to add any additional information that you feel is needed.

Current Physician and/or Primary Care Physician___________________________________

Address:____________________________City_______________Zip____________________

Phone:______________________________

Have you been hospitalized for emotional problems? Yes_________-No__________________

If so: When____________________Where____

Have you had previous individual therapy? Yes____No_____ Dates:_______

Name of Therapist:__________________________Address:___________________________

City:_______________Zip___________Telephone___________________________________

Please list any and all physical illnesses that are now being treated by M.D.

____
____
____
____

What would you want your therapist to know about your physical or emotional health:____

Please list ALL medications (and dosage) you're currently taking or have recently stopped:

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following.

Alcohol/Substance Abuse
Anxiety
Bipolar Disorder
Depression
Domestic Violence
Eating Disorders
Obsessive Compulsive Behavior
Schizophrenia
Sexual trauma
Suicide Attempts

I authorize Lampost Wellness Centers (LWC) to exchange information with the following medical professional for the purpose of consulting and coordinating care for my therapy and treatment. This authorization will remain in effect for the duration of my treatment, unless I notify LWC that I am revoking this release of information.

Doctor_______________________________

Address:_____________________________

City:_________________State______________Zip______________________________

Phone: (   )___________________________

Fax: (   ) ______________________

_______________________________________Date_____________
Patient Signature

_______________________________________Date______________
Patient Signature

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CLIENT RIGHTS AND PRIVACY PRACTICES

There may be times when we need to consult with a colleague or another professional about issues raised by clients in therapy. Client confidentiality is still protected during consultation by us and the professional consulted. Signing this disclosure statement gives us permission to consult as needed to provide professional services to you as a client.

CONFIDENTIALITY

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in the HIPPA Notice of Primacy Rights as well as other exceptions in Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. For example, some of the exceptions would include: suspected child abuse, molestation or incest, a client is in danger of hurting self or others, danger of violence, suspected abuse of the elderly or others unable to care for themselves, suspected threat to national security, subpoenaed testimony in criminal court cases, orders to violate privilege by judges in child custody and divorce cases.

CHILDREN AND ADOLESCENTS

A child fourteen or younger seen in this office must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or the court document presented giving sole custody

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices that are described in this Notice while it is in effect. The Notice takes effect April 14, 2003 and will remain in effect until we replace it.

USES AND DISCLOSURES OF HEALTH INFORMATION

In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences in your best interest in allowing another person to pick up health information.

We may use or disclose your health information when we are required to do so by law or when ordered to do so by a court having jurisdiction of an appropriate matter.

We must disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or health or safety of others.

Access: You have the right to inspect or obtain copies of your health information, except for therapist's notes and certain other limited exceptions. If you request copies, we will charge you $1.00 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will change a cost based fee for printing your health information in that format.

ACKNOWLEDGMENT OF RECEIPT OF
CLIENT RIGHTS AND PRIVACY PRACTICES

____
Patient Signature

____
Date

____
Therapist signature

____
Date

INSURANCE INFORMATION

PATIENT: (Please Print Carefully)

____

Home Address: ____

____
City State ZIP

Phone #: _____-_____-_____

Date of Birth: _____/ _____/ _____
Month Day Year

Name of Employer / School: _______________________________

INSURANCE:

Primary Insurance Company: ____________________________________

ID Policy #: ______________________

Group #: ___________

Policy holder's Name: ____
Date of Birth: _____/_____Month Day Year

Policy Holder's Employer: _______________________________________
Policy Holder's Phone #: _____- _____-_________

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

AUTHORIZATION TO SUBMIT TO INSURER:

Patient or Authorized person's signature: I authorize Lampost Wellness Centers to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims. **I realize that my insurer may or may not provide an out-of-network benefit.**

Signed ____ Date______________

Credit Card Information Form

I understand fees of $215 will be charged 48 hours preceding my appointment times.

NAME ON CARD: ____

ADDRESS (IF DIFFERENT FROM PATIENT):

____

____

CARD NUMBER:

MC / VISA __________ - __________ - _________ - __________

AE ________ - _________________ - __________

EXPIRATION DATE: _______/_______

SECURITY CODE ______________

I authorize to have my card stored (under PCI compliance)

X ____

Patient

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