Empowered Harmony Counseling, Psychiatry & Wellness Center

"REAL SOLUTIONS FOR REAL LIFE."

CLIENT INTAKE PACKET

CONFIDENTIAL CLIENT DOCUMENTS

"REAL SOLUTIONS FOR REAL LIFE."

CONFIDENTIAL

Empowered Harmony Counseling, Psychiatry & Wellness Center®

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ACKNOWLEDGMENT OF RECEIPT OF CLIENT INTAKE PACKET

ACKNOWLEDGMENT

I acknowledge that I have received a complete copy of the Empowered Harmony Counseling, Psychiatry & Wellness Center® Client Intake Packet.

I understand that the intake packet contains important information regarding my rights and responsibilities as a client, informed consent, privacy practices, financial policies, office policies, and other documents related to my care.

I understand that it is my responsibility to retain this copy for my personal records and future reference.

If I request an additional paper or electronic copy of the intake packet after today's appointment, I understand that applicable copying, administrative, shipping, or mailing fees may apply, as permitted by applicable federal and state law and the policies of Empowered Harmony Counseling, Psychiatry & Wellness Center®.

I acknowledge that I have had the opportunity to review the intake packet, ask questions, and receive clarification regarding its contents before signing below.

CLIENT ACKNOWLEDGMENT

Client Name: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian (if applicable): _____ Date: _____

Witness/Staff Signature: _____ Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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Patient Registration Form

Patient Information

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ Date of Birth: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Best Contact Number: _____ Email: _____

Primary Care Physician: _____ Psychiatrist: _____

Insurance Information

Primary Insurance: _____

Member/Enrollee ID Number: _____ Group Number: _____

Insured Party Name (if different from patient): _____

Relationship to Patient: _____ Date of Birth: _____ Sex: _____

Insured Party Street Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance (if applicable): _____

Member/Enrollee ID Number: _____ Group Number: _____

Responsible Party for Billing

(The person responsible for any out-of-pocket costs including copays, late cancellation fees, etc.)
The responsible party will receive phone calls, email, and mail if there is a balance on the account.

*If the patient is 18 or older and someone else is responsible for billing, the patient must sign a release.

Patient is the responsible party for billing: Yes [ ] No [ ]

Responsible Party Name: _____ Sex: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Employer: _____

Street Address (if different from patient): _____

City: _____ State: _____ Zip: _____

Best Contact Number: _____ Email: _____

Emergency Contact

Contact Name: _____ Best Contact Number: _____ Relationship: _____

How did you hear about us? _____

Signature: _____ Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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CLIENT INFORMATION ADDENDUM

CLIENT INFORMATION

Legal Name:

Preferred Name:

Date of Birth:

Pronouns:

Occupation:

Employer (Optional):

EMERGENCY CONTACT

Name:

Relationship to Client:

Phone Number:

Alternate Phone:

MEDICAL PROVIDERS

Primary Care Provider:

Primary Care Provider Phone Number:

Last Therapist:

Last Therapist Phone Number:

Psychiatrist / Provider:

Psychiatrist Phone Number:

Voicemail permission with signed ROI: ☐ Yes ☐ No

Empowered Harmony Counseling, Psychiatry & Wellness Center

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Nondiscrimination and Language Access Policy

Policy Statement

Empowered Harmony Counseling, Psychiatry & Wellness Center® is committed to providing equitable, respectful, and accessible care to all patients. We comply with applicable federal and state civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, religion, gender identity, sexual orientation, or any other characteristic protected by law. Patients will not be denied services, treated differently, or receive a lower quality of care because of a protected characteristic.

Communication Assistance for Individuals with Disabilities

In accordance with the Americans with Disabilities Act and other applicable laws, Empowered Harmony Counseling, Psychiatry & Wellness Center® provides appropriate auxiliary aids and services to support effective communication for qualified individuals with disabilities. Services may include qualified sign-language or oral interpreters, accessible electronic materials, large-print documents, and other reasonable communication accommodations. When required by law, these services are provided at no cost to the patient.

Language Assistance Services

Patients whose primary language is not English may request language assistance to support meaningful access to care. When required by applicable law, Empowered Harmony Counseling, Psychiatry & Wellness Center® will provide a qualified healthcare interpreter at no cost to the patient. Services may include telephone interpretation, video remote interpretation when clinically appropriate, qualified spoken-language interpreters, translated essential documents when required, and interpretation during clinical discussions and informed-consent activities.

Minor children should not be used as interpreters except during an emergency involving an imminent threat when no qualified interpreter is immediately available. Family members or friends should not be used when a qualified interpreter is needed for accurate, confidential, and clinically appropriate communication, except as permitted by law and after the patient has been informed of available language-assistance options.

Requesting an Accommodation or Interpreter

Patients should notify the practice as early as possible when an interpreter, auxiliary aid, translated document, or other communication accommodation is needed. Requests may be made during scheduling, before an appointment, or when services begin. The practice will assess each request based on the patient's communication needs, the clinical setting, available technology, and applicable legal requirements.

Questions or Grievances

Patients who believe they were denied appropriate communication assistance or experienced discrimination may contact the Civil Rights Coordinator at hr@empoweredharmony.com. Empowered Harmony Counseling, Psychiatry & Wellness Center® will review concerns promptly and will make reasonable efforts to resolve complaints involving accessibility, language access, or discrimination in accordance with applicable law. Retaliation against a person who requests an accommodation or files a grievance is prohibited.

Empowered Harmony Counseling, Psychiatry & Wellness Center®

INFORMED CONSENT FOR COUNSELING AND PSYCHOTHERAPY MENTAL HEALTH SERVICES

Purpose of This Consent

At Empowered Harmony Counseling, Psychiatry & Wellness Center®, we recognize that seeking help from a mental health professional may not be easy. We hope that treatment will help you better understand your circumstances, strengthen coping skills, and move toward growth in challenging areas of life. Our clinicians work within the context of each patient's beliefs, values, culture, and preferences. No clinician will attempt to impose a personal theology or belief system.

Therapist and Scope of Services

Your therapist is a licensed or otherwise appropriately credentialed mental health professional who provides behavioral health services within the limits of professional training, licensure, and applicable law. Your therapist will discuss the evaluation process, diagnostic formulation when applicable, recommended treatment methods, potential benefits and risks, possible side effects, and reasonable alternatives. You may ask questions at any time. You may withdraw from treatment at any time, although you are encouraged to discuss that decision with your therapist so that appropriate referrals or transition planning may be considered.

Number and Length of Sessions

The number, frequency, and length of sessions depend on clinical need, treatment goals, availability, insurance or program requirements, and mutual agreement between you and your therapist. No specific result or length of treatment can be guaranteed.

Professional and Therapeutic Relationship

Your relationship with your therapist is professional and therapeutic. To preserve clinical objectivity and protect treatment, your therapist will avoid relationships that could impair professional judgment or create a conflict of interest. Personal, social, romantic, financial, or business relationships with your therapist are not appropriate. Gifts, bartering, trading services, and social-media relationships may be declined or limited in accordance with ethical and practice policies.

Goals, Purposes, and Techniques of Therapy

There may be several appropriate interventions for the concerns you are experiencing. You are encouraged to discuss questions about treatment recommendations and to participate in setting goals. Treatment goals and methods may change as therapy progresses. Services may include assessment, psychotherapy, care coordination, psychoeducation, referrals, safety planning, and other clinically appropriate interventions.

Confidentiality and Its Limits

Information shared in treatment is confidential and will not be released without your written authorization unless disclosure is permitted or required by law. Exceptions may include suspected abuse or neglect of a child, older adult, dependent adult, or person with a disability; a serious and imminent threat of harm; medical emergencies; court orders or other lawful legal process; health oversight activities; insurance, payment, and health-care operations; professional consultation; audits; licensing-board matters; or other disclosures authorized or required by federal or state law. Additional information appears in the Notice of Privacy Practices.

Duty to Protect and Emergency Intervention

When your therapist reasonably believes that you present a serious risk of harm to yourself or another person, the therapist may take steps permitted or required by law. These steps may include contacting emergency services, law enforcement, a hospital, an identified person at risk, a parent or legal representative, or another person who may help reduce the danger. Only information reasonably necessary for safety may be disclosed.

Authorization, Revocation, and Re-disclosure

When you sign a separate authorization for the release of protected health information, you may revoke that authorization in writing at any time, except to the extent that action has already been taken in reliance on it or when another legal exception applies. Information disclosed to certain recipients may no longer be protected by the federal HIPAA Privacy Rule and may be subject to re-disclosure, although other federal or state protections may still apply. Treatment generally will not be conditioned on signing an authorization unless the authorization is necessary for the requested service or otherwise permitted by law.

Risks and Benefits of Therapy

Therapy may provide increased insight, improved coping, stronger relationships, symptom relief, and better daily functioning. Therapy may also involve discussing painful experiences and may temporarily increase sadness, anxiety, anger, grief, fatigue, relationship tension, or other distress. Progress is not always immediate or linear, and results cannot be guaranteed. Please tell your therapist if treatment feels unsafe, unhelpful, or overwhelming so the plan can be reviewed.

Records and Documentation

Your therapist will maintain clinical records as required by law, payer contracts, and professional standards. Records may include assessments, diagnoses, treatment plans, progress notes, communications, billing information, and other documentation. Requests for access, copies, amendments, restrictions, or accounting of disclosures will be handled under applicable law and the Notice of Privacy Practices.

Empowered Harmony Counseling, Psychiatry & Wellness Center®

INFORMED CONSENT FOR COUNSELING AND PSYCHOTHERAPY MENTAL HEALTH SERVICES

Payment for Services

Payment is due at the time services are rendered unless a different written payment arrangement applies. Certain appointments, evaluations, intensives, self-pay services, or other designated services require payment at least 24 hours before the scheduled service. If required advance payment is not received by the applicable deadline, the appointment may be canceled, released to another patient, and treated under the applicable late-cancellation, no-show, or administrative-fee policy. You remain responsible for charges not paid by insurance and for fees permitted under the financial agreement and applicable law.

Court, Legal, and Record-Request Fees

When records, reports, consultation, testimony, deposition, mediation, court attendance, or other legal involvement is requested or required, these services are not considered routine psychotherapy and may not be covered by insurance. **Copies of records are charged at $5.00 per page, plus applicable shipping and handling costs, where permitted by law. Report writing, record review for legal matters, deposition, mediation, consultation, testimony, and court attendance are billed at $350.00 per hour.** Additional charges may include preparation time, travel time, mileage, transportation, lodging, meals, parking, waiting time, and other reasonable expenses. A retainer or advance payment may be required before legal services are provided. Payment responsibility remains with the requesting or responsible party unless otherwise required by law or court order.

After-Hours Urgent Needs and Emergencies

Empowered Harmony Counseling, Psychiatry & Wellness Center® is not a 24-hour crisis service. Routine messages may be answered during normal business hours. If you are experiencing a life-threatening medical or mental health emergency, call 911 or go to the nearest emergency department. You may also call or text 988 for the Suicide & Crisis Lifeline. Do not rely on voicemail, email, text, a patient portal, or social media for emergency assistance.

Therapist's Incapacity, Death, or Practice Closure

If your therapist becomes incapacitated, dies, leaves the practice, or is otherwise unable to continue services, a licensed or otherwise legally authorized mental health professional or records custodian may obtain access to your records for continuity of care, record maintenance, required notices, transfer, or lawful release. Reasonable efforts will be made to protect confidentiality and provide information about available options.

Electronic Communication and Telehealth

You understand that telephone, voicemail, email, text messaging, portals, electronic forms, and telehealth involve privacy and technology risks. The practice will use reasonable safeguards, but absolute security cannot be guaranteed. You agree to provide accurate contact information, promptly report changes, and tell the practice about communication restrictions or preferences. Telehealth may be limited by your physical location, technology, clinical needs, emergencies, or licensing rules.

Coordination of Care

With your written authorization, your therapist may coordinate with physicians, psychiatrists, schools, attorneys, family members, or other providers. Certain coordination may occur without authorization when permitted or required for treatment, payment, health-care operations, safety, or legal compliance. You may decline optional coordination, although doing so may limit the effectiveness of care in some situations.

Consent to Treatment

By signing this form, you voluntarily agree to receive mental health assessment, counseling, psychotherapy, and related behavioral health services. You authorize the treating clinician to provide care considered clinically appropriate within the clinician's professional scope. You understand that you may participate in treatment planning, ask questions, request alternatives, decline a recommendation, or stop treatment at any time, subject to legal, safety, program, or court-related requirements that may apply.

Acknowledgment

Your signature confirms that you have had an opportunity to read this document, ask questions, and receive clarification. Your signature also confirms receipt of, or access to, the practice policies and Notice of Privacy Practices. This consent remains in effect during your episode of care unless revoked or replaced in writing, except where continued action is permitted or required by law.

Patient Name	**Date of Birth**
Patient Signature	**Date**
Parent or Legal Representative	**Relationship**
Representative Signature	**Date**
Therapist or Witness Signature	**Date**

Empowered Harmony Counseling, Psychiatry & Wellness Center

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NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Commitment to Your Privacy

Our practice is committed to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and privacy practices concerning your PHI. By federal and state law, we must follow the terms of the notice that we have in effect at the time.

II. Uses and Disclosures

Treatment. Your PHI may be used by staff members or disclosed to other health-care professionals for the purpose of evaluating your health, diagnosing clinical conditions, and providing treatment. An example of treatment would be when we consult with another health-care provider, such as your family physician or another professional counselor.

Payment. Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit-card companies that you may use to pay for services. For example, your health plan may request and receive information about dates of service, the services provided, and the clinical condition being treated.

Health-care operations. Your PHI may be used as necessary to support the day-to-day activities and management of Empowered Harmony Counseling, Psychiatry & Wellness Center®. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your PHI may be disclosed to federal, state, or local law-enforcement agencies, without your permission, to support government audits and inspections, facilitate law-enforcement investigations, and comply with government-mandated reporting.

Public-health reporting. Your PHI may be disclosed to public-health agencies as required by law. For example, we may be required to report certain communicable diseases to the state's public-health department.

Appointments. Your PHI will be used by our staff to contact you to schedule an appointment, remind you of an appointment, reschedule an appointment, or notify you of other pertinent information. Contact may be made by telephone, U.S. mail, email, or text message.

Informative information. Your PHI may be used to send you information about the treatment and management of your psychological or medical condition that you may find helpful. We may also send information describing health-related goods and services that we believe may interest you.

Breach notification. If there is ever a breach of your health-care information and it comes to our attention, we will inform you as soon as possible as required by applicable law.

NOTICE OF PRIVACY PRACTICES, CONTINUED

III. Personal Rights

You have certain rights under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your PHI. However, we are not required to agree to every restriction you request.
- The right to receive confidential communications concerning your psychological or medical condition and treatment.
- The right to amend or submit corrections to your protected health information.
- The right to receive a printed copy of this notice.
- The right to file a complaint.
- The right to inspect and/or copy PHI that may be used to make decisions about you, including psychological or medical records and billing records, but not including psychotherapy notes. The provider may provide a summary of the patient's PHI when, in the provider's professional judgment, unlimited access could cause emotional or mental distress or endanger the life or physical safety of the patient or another person. A patient does not have the right to access psychotherapy notes except to the extent the treating professional approves access in writing or a court order authorizes access. The practice will respond within the time required by applicable law.

IV. Requests to Inspect PHI

As permitted by federal regulation, requests to inspect or copy protected health information must be submitted in writing. You may obtain a form to request access to your records by contacting the office staff at Empowered Harmony Counseling, Psychiatry & Wellness Center®. We may deny access to PHI under certain circumstances, but in many cases you may have the decision reviewed. Upon request, we will discuss the request and denial process with you.

V. Revisions to Privacy Practices

As permitted by law, we reserve the right to amend or modify this Notice of Privacy Practices. Any revision or amendment will apply to all records that the practice has created or maintained in the past and to records that may be created or maintained in the future. We will post a copy of the current notice in a visible location and you may request a copy of the most current notice at any time.

VI. Complaints

If you believe your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you may do so in writing. Please send your concerns to:

Civil Rights and Privacy Coordinator
Empowered Harmony Counseling, Psychiatry & Wellness Center®
Email: hr@empoweredharmony.com

You may also contact the Secretary of the U.S. Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Empowered Harmony Counseling, Psychiatry & Wellness Center

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received or have been offered a copy of the Empowered Harmony Counseling, Psychiatry & Wellness Center® Notice of Privacy Practices. I understand that this notice explains how my protected health information may be used and disclosed, how I may obtain access to this information, and how I may exercise my privacy rights.

Patient Name

_____

Date of Birth **Date Signed**

_____

Parent or Legal Guardian, if applicable

_____

Patient or Legal Guardian Signature

_____

Patient Acknowledgement

- ☐ I received or was offered a copy of the Notice of Privacy Practices.
- ☐ I had the opportunity to ask questions regarding the notice.
- ☐ I understand that I may request another copy at any time.

Staff Witness

Staff Name

_____

Staff Signature **Date**

_____

Office Use Only

If the patient or legal representative declined to sign, document the reason and the date the notice was provided or offered.

Reason

Staff Initials _____ **Date** _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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ELECTRONIC COMMUNICATION CONSENT FORM

PURPOSE AND AUTHORIZED USE

Empowered Harmony Counseling, Psychiatry & Wellness Center® may use email, text messaging, voicemail, patient portals, and other electronic methods for appointment scheduling, reminders, billing, forms, care coordination, general follow-up, and limited treatment-related communication. Electronic communication is not a substitute for a scheduled clinical appointment and may not be appropriate for detailed or highly sensitive information.

RISKS AND LIMITATIONS

I understand that electronic communication may be intercepted, misdirected, delayed, lost, forwarded, copied, stored, printed, accessed by unauthorized persons, or delivered to a shared device or account. Messages may contain metadata, remain on servers or devices, or be exposed through malware, weak passwords, network failures, or other security events. Confidentiality cannot be guaranteed when communication occurs through unencrypted email, standard text messaging, personal devices, or third-party services. I will not include unnecessary identifying details, diagnoses, treatment records, or other sensitive information unless specifically requested through an approved secure method.

COMMUNICATION EXPECTATIONS

- Messages may not be reviewed immediately.
- Response times vary and are not guaranteed.
- Electronic communication must not be used for emergencies, urgent safety concerns, or time-sensitive clinical needs.
- For an emergency, call 911, go to the nearest emergency department, or contact 988.
- The practice may redirect detailed clinical matters to a scheduled session or secure platform.
- I am responsible for keeping my email address, telephone number, and communication preferences current.

PATIENT ACKNOWLEDGMENTS

- I have had an opportunity to ask questions.
- I understand the benefits and risks of electronic communication.
- I understand that participation is voluntary and that I may request another reasonable communication method.
- I authorize communication using the selections below.
- I understand that this consent remains effective until I revoke it in writing, except for actions already taken in reliance on it.
- I understand that the practice may suspeed electronic communication when privacy, safety, identity, or clinical concerns arise.

COMMUNICATION AUTHORIZATION

☐ Email ☐ Text messages ☐ Voicemail ☐ Patient portal

Preferred email: _____ Preferred phone: _____

May detailed messages be left by voicemail? ☐ Yes ☐ No May appointment details be sent by text? ☐ Yes ☐ No

CONSENT AND SIGNATURE

By signing below, I voluntarily consent to the electronic communication methods selected above. I acknowledge that reasonable safeguards will be used, but no electronic method can be guaranteed to be completely private or secure. I accept the risks described in this form and agree to notify the practice promptly if my contact information or communication preferences change.

Patient Name: _____ Date of Birth: _____

Patient/Parent/Legal Guardian Signature: _____ Date: _____

Printed Name of Parent/Legal Guardian, if applicable: _____

Relationship to Patient: _____ Staff/Witness: _____

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PROVIDER LEVELS, PAYMENT, AND ACCEPTANCE

ADVANCED-LEVEL CLINICIANS

Advanced-level clinicians generally hold a master's or doctoral degree and an independent professional license. They practice within the scope of their license and may participate with selected insurance plans.

ASSOCIATE OR PROVISIONALLY LICENSED CLINICIANS

Associate-level or provisionally licensed clinicians have completed graduate education and hold an associate, temporary, limited, or provisional license. They receive clinical supervision as required by the applicable licensing board and may participate with selected insurance plans when permitted.

INTERNS

Interns are therapists-in-training who are completing the supervised clinical portion of an approved degree program. Interns are directly supervised by a qualified clinician. Intern services may be self-pay and generally are not billed to insurance unless expressly permitted by the payer and applicable law.

INSURANCE AND SELF-PAY RESPONSIBILITY

When the practice participates with a patient's insurance plan, contracted rates and payer rules apply. Insurance verification is not a guarantee of payment. The patient remains responsible for deductibles, copayments, coinsurance, non-covered services, services rendered when coverage is inactive, and charges denied for reasons that are the patient's responsibility. Self-pay patients are responsible for the agreed-upon fee. Payment is due according to the applicable financial policy or service agreement.

ACCEPTED PAYMENTS AND OUTSTANDING BALANCES

Accepted payment methods may include credit card, debit card, HSA or FSA card, Zelle, Cash App, Venmo, PayPal, or other approved electronic methods. Cash may not be accepted. A service charge of $50.00 per month may be added to unpaid balances that remain outstanding for more than 15 days, when permitted by law, payer contract, and the patient's financial agreement.

QUESTIONS AND ACKNOWLEDGMENT

We welcome questions about these policies. By signing below, the patient confirms that they have reviewed this consent, had an opportunity to ask questions, and agree to follow the practice policies and financial responsibilities described here and in any related forms, fee schedules, platform agreements, or notices.

Patient Printed Name _____ Date of Birth _____

Patient or Legal Representative Signature _____ Date _____

Clinician or Authorized Staff Signature _____ Date _____

This document should be used together with the Notice of Privacy Practices, financial policy, cancellation policy, telehealth consent, and any service-specific agreement.

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INDEPENDENT CONTRACTOR ACKNOWLEDGMENT AND PATIENT FEES AGREEMENT

NOTICE OF PROVIDER INDEPENDENT CONTRACTOR STATUS

All providers rendering services through Empowered Harmony Counseling, Psychiatry & Wellness Center® are independent contractors and are not employees of the company. Each provider is solely responsible for their own clinical services, treatment decisions, documentation, and professional conduct. By signing below, you acknowledge that concerns, disputes, or issues arising during your care should be addressed directly with your treating provider. The practice is not liable for the independent clinical acts or omissions of individual providers.

PATIENT FEES AND ADMINISTRATIVE SERVICES

Patients must complete a minimum of six sessions before FMLA, medical leave, workplace accommodation, disability, or similar forms will be considered for completion. Completion is based on the provider's clinical judgment and the information available in the patient's record.

ADMINISTRATIVE SERVICE	PATIENT FEE
Completion of FMLA, Long-Term Medical Leave, or other similar forms	**$150+**
Completion of Short-Term Medical Leave forms, or other similar forms requiring completion in fewer than 7 days	**$250+**
Late Cancellation or No-Show Fee, without at least 24+ hours' notice	**$185**
Medication Refill Requests without a Scheduled Appointment	**$35**
ESA, Emotional Support Animal, Letter	**$99**
Medical Record Copying	**$5 per page, plus mailing costs**

INSURANCE AND PAYMENT DISCLAIMER

None of the fees listed in this agreement are covered by insurance. Payment is due in full before any document, form, letter, record copy, or related administrative service is created, completed, or sent to the patient or any third party.

PATIENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and understand the independent contractor notice, minimum session requirement, administrative service fees, and insurance and payment terms stated in this agreement.

Patient Name, Printed: _____

Patient Signature: _____ Date: _____

Empowered Harmony Counseling, Psychiatry & Wellness Center

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INFORMED CONSENT FOR TELEHEALTH SERVICES

PURPOSE AND NATURE OF TELEHEALTH

Telehealth uses secure video, audio, messaging, or other electronic communication to provide behavioral health assessment, diagnosis, consultation, treatment, care coordination, and psychoeducation when the patient and clinician are in different locations.

POTENTIAL BENEFITS

- Improved access to care, including for rural and underserved communities.
- Convenience, reduced travel, and greater continuity of treatment.
- Access to specialized clinicians when clinically appropriate.

POTENTIAL RISKS AND LIMITS

- Technology failures may interrupt, delay, or end a session.
- Privacy or security breaches may occur despite reasonable safeguards.
- Some assessments or interventions may require in-person care.
- Telehealth outcomes cannot be guaranteed.

PATIENT ACKNOWLEDGMENTS AND RESPONSIBILITIES

- I will provide my current physical location and a reliable call-back number at the beginning of each session.
- I will identify an emergency contact and authorize the clinician to contact emergency services or my emergency contact when clinically necessary to address an imminent safety concern.
- I will participate from a private, reasonably secure location and understand that the clinician cannot control other people, devices, or recording equipment in my environment.
- I will not record, photograph, livestream, or permit another person to observe a session without the clinician's prior written consent.
- I understand that services generally may be provided only when I am physically located in a jurisdiction where the clinician is authorized to practice.
- If technology fails, the clinician may attempt to reconnect, call me, reschedule, or recommend in-person or emergency services based on clinical need.
- I understand that in-person care may be available as an alternative and may be recommended when telehealth is not clinically appropriate.

PRIVACY, CONSENT, AND RIGHT TO WITHDRAW

Federal and state privacy laws apply to telehealth. I understand that electronic communication carries some risk. I may ask questions, decline telehealth, or withdraw this consent at any time without affecting my right to request other available services. Withdrawal does not change services already provided or actions already taken in reliance on this consent.

PATIENT CONSENT

I have read and understand this form. I had the opportunity to ask questions, and my questions were answered to my satisfaction. I voluntarily consent to receive telehealth services from Empowered Harmony Counseling, Psychiatry & Wellness Center® and its authorized clinicians. I understand that this consent remains effective until I withdraw it in writing or applicable law requires renewal.

Patient Printed Name: _____ DOB: _____

Patient/Legal Representative Signature: _____ Date: _____

Clinician/Witness Signature: _____ Date: _____

Emergency Contact Name and Phone: _____

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PSYCHIATRY AND MEDICATION MANAGEMENT ACKNOWLEDGMENT

INTEGRATED BEHAVIORAL HEALTH MODEL

I understand that psychiatric evaluation and medication management services are offered as part of an integrated behavioral health treatment model. Medication management is intended to complement psychotherapy and other clinically appropriate interventions. It is not designed to replace ongoing therapeutic care when therapy is recommended by my treatment team.

I ACKNOWLEDGE AND UNDERSTAND

1. My prescriber will determine whether psychiatric medication is clinically appropriate based on my symptoms, medical history, diagnosis, treatment response, and professional judgment.
2. Treatment recommendations may include psychotherapy, medication management, both services, or referral to another provider when clinically appropriate.
3. I agree to attend scheduled psychiatric appointments and actively participate in treatment.
4. If ongoing psychotherapy is recommended as part of my treatment plan, failure to participate may require reassessment of my treatment plan, including medication management services.
5. Prescriptions may be delayed, modified, or discontinued when clinically indicated, including concerns regarding safety, missed appointments, noncompliance with treatment recommendations, misuse of medication, or failure to complete requested laboratory testing or medical follow-up.
6. Psychiatric medications may have risks, side effects, interactions, and limitations, which will be discussed by my prescriber.
7. No medication or treatment outcome can be guaranteed.
8. I agree to notify my prescriber of changes in my medical condition, pregnancy status, medications, allergies, hospitalizations, or adverse medication effects.
9. I have had the opportunity to ask questions and understand the information provided.

CLIENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have read, understand, and agree to the terms of this Psychiatry and Medication Management Acknowledgment.

Client Name: _____

Client Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____

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Counseling, Psychiatry & Wellness Center®

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WELLNESS AND COACHING CONSENT FORM

PURPOSE

This consent explains the nature of wellness and coaching services. Coaching supports personal growth, goal achievement, behavior change, stress management, and wellness. Coaching is not psychotherapy, counseling, psychiatry, medical treatment, crisis care, or a substitute for licensed mental health services.

SCOPE OF SERVICES

Services may include accountability, education, motivation, goal planning, lifestyle improvement, mindfulness, and personal development. Coaches do not diagnose mental health conditions, prescribe medication, or provide psychotherapy.

CONFIDENTIALITY

Information is handled respectfully and privately. Confidentiality may be limited when disclosure is required by law or when there is a risk of serious harm to yourself or others.

COMMUNICATION

Email, text, and phone communication are intended for scheduling and brief administrative matters only. These communication methods are not continuously monitored and must not be used for emergencies.

VOLUNTARY PARTICIPATION

You may discontinue coaching at any time. If your needs exceed the scope of coaching, you may be referred to a licensed mental health or medical provider.

ACKNOWLEDGMENT

By signing this form, you acknowledge that you have received and agreed to the Wellness and Coaching Financial Payment Policy and Rates. You also understand that wellness coaching is separate from psychotherapy and mental health treatment. You have had the opportunity to ask questions and voluntarily consent to receive wellness and coaching services.

Patient Name: _____

Patient Signature: _____ Date: _____

Coach Signature: _____ Date: _____

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SPECIALTY SERVICES CONSENT FORM

Empowered Harmony Counseling (EHC)

Empowered Harmony Counseling (EHC) offers a range of specialty services that support holistic wellness and complement traditional therapy. These services may include, but are not limited to:

- **Reiki Energy Healing**
- **Hypnotherapy**
- **Wellness Coaching**
- **Nutritional Psychiatry Support**
- **Virtual Spiritual Therapy & Meditation Practices**

These services are offered by trained and qualified practitioners. Participation in these services is entirely voluntary and **NOT** required to receive psychotherapy, medication management, or other clinical services at EHC.

PAYMENT & INSURANCE

Most specialty services offered by Empowered Harmony Counseling, Psychiatry & Wellness Center® are not covered by health insurance and are provided on a self-pay basis. Clients are responsible for all applicable fees. Payment is due according to the practice's financial policies. Insurance coverage or reimbursement is not guaranteed. Clients should verify any available benefits directly with their insurance carrier.

BENEFITS & LIMITATIONS

Specialty services are not a substitute for medical or mental health treatment. They may serve as supportive interventions and are intended to enhance personal growth, relaxation, healing, and overall well-being.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT:

- You understand these services are optional and not medically necessary.
- You have the right to decline or discontinue participation at any time.
- You understand that outcomes vary and are not guaranteed.
- You may discuss any concerns or questions about these services with your provider at any time.

Client Name: _____

Client Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

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IMPORTANT INSURANCE NOTICE

YOUR INSURANCE COVERAGE

It is your responsibility to understand your individual insurance policy. Many policies contain exclusions. Most policies include deductibles, co-payments, and co-insurance. Some insurance policies may not cover our services. Most services at Empowered Harmony Counseling should be covered by your insurance.

NETWORK STATUS AND INSURANCE VERIFICATION

You are responsible for contacting your insurance carrier to confirm whether the provider you are seeing is listed as an "in-network" provider. If the provider is not in network, you may have a higher deductible, co-payment, co-insurance amount, or other out-of-pocket expense.

IMPORTANT FINANCIAL RESPONSIBILITY NOTICE

Regardless of insurance coverage, YOU ARE RESPONSIBLE for all charges not covered by your insurance policy.

INDEPENDENT PRACTITIONERS AND PROFESSIONAL RESPONSIBILITY

The practitioners at Empowered Harmony Counseling are independent of one another in the delivery of their professional services. Any claim, concern, or dispute, whether implied or expressed, regarding professional care will be addressed between the patient and the treating psychotherapist, provider, MHNP, PA-C, or psychiatrist.

PAYMENT, MISSED APPOINTMENTS, AND COLLECTIONS

- I accept full responsibility for payment of services and agree to pay all amounts due at the time of service unless other arrangements have been approved by my insurance carrier or provider.
- I accept full responsibility for a missed-appointment charge of $185 or more when at least 24 hours' advance notice of cancellation is not provided. This policy includes new-patient appointments.
- I accept responsibility for a $100 collection fee if collection action is required to recover an unpaid account balance. I authorize the minimum necessary release of information required for collection purposes.

CLIENT ACKNOWLEDGMENT

By signing below, I acknowledge that I have read, understand, and agree to this insurance and financial responsibility notice.

Client Name: _____

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

This form explains how your protected health information (PHI) may be used and disclosed and how you can access this information. Please read it carefully and sign below to acknowledge your understanding.

PURPOSE OF THIS CONSENT

This consent authorizes Empowered Harmony Counseling, Psychiatry & Wellness Center® to use and disclose your protected health information for treatment, payment, healthcare operations, and as otherwise permitted or required by law.

AUTHORIZATION

1. **TREATMENT:** We may use and share your PHI with healthcare providers and professionals who are involved in your care to coordinate and provide appropriate treatment.
2. **PAYMENT:** We may use and disclose your PHI to obtain payment for services, including communicating with your insurance company or other payers.
3. **HEALTHCARE OPERATIONS:** We may use and disclose your PHI for business activities that support high-quality care, such as quality improvement, training, compliance, and administrative functions.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received (or have been offered a copy of) the Notice of Privacy Practices, which describes how my health information may be used and disclosed and my rights regarding that information.

PATIENT RIGHTS SUMMARY

You have the right to:

- Get a copy of your health information
- Request corrections to your health information
- Request restrictions on how your information is used or disclosed
- Request confidential communications
- Revoke this consent at any time
- Receive an accounting of disclosures
- File a complaint if you believe your privacy rights have been violated

We will not retaliate against you for exercising your rights.

CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about your health information in a specific way or at a specific location. We will accommodate reasonable requests.

REVOCATION OF CONSENT

You may revoke this consent in writing at any time, except to the extent that we have already taken action in reliance on this consent. Revocation will not affect uses or disclosures that occurred before we received your written request.

COMPLAINTS & PRIVACY OFFICER

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services.

Privacy Officer:
You may contact our Privacy Officer in writing for any questions, concerns, or to file a complaint regarding your privacy rights.
No retaliation will occur for filing a complaint.

PATIENT AUTHORIZATION

By signing below, I acknowledge that I have read and understand this consent. I voluntarily authorize Empowered Harmony Counseling, Psychiatry & Wellness Center® to use and disclose my protected health information as described above.

Patient Printed Name _____

Date of Birth _____ Today's Date _____

Patient Signature _____

PARENT / LEGAL REPRESENTATIVE (If applicable)

Printed Name _____

Relationship to Patient _____

Signature _____

Date _____

Documentation of legal authority may be requested.

WITNESS / INTERPRETER (If applicable)

Printed Name _____

Signature _____

Role (Witness / Interpreter) _____

Date _____

A signed copy of this consent will be maintained in your clinical record.

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NO SURPRISES ACT
FEE DISCLOSURE, RIGHTS, AND RESPONSIBILITIES

IMPORTANT FEDERAL FEE NOTICE

Under federal law, patients who are uninsured or not using insurance may request a Good Faith Estimate of expected charges before receiving services.

PATIENT RIGHTS

- You have the right to receive a Good Faith Estimate before scheduling non-emergency services.
- If your bill is at least $400 more than your Good Faith Estimate, you may dispute the bill.
- You are not required to receive services and may decline or withdraw at any time.
- For additional information, visit www.cms.gov/nosurprises or call 1-800-985-3059.

FEES

Current service fees are available on our website. Please visit www.empoweredharmony.com for the most current pricing information before scheduling services.

PATIENT RESPONSIBILITIES

- Arrive on time and participate actively in services.
- Provide at least 24 hours' notice for cancellations.
- A no-show fee and late-cancellation policy apply to all scheduled sessions.
- Maintain updated payment information on file.

PROVIDER RESPONSIBILITIES

- Deliver high-quality, ethical, and culturally competent care.
- Provide transparent communication regarding fees.
- Offer a Good Faith Estimate upon request.

ACKNOWLEDGMENT

By signing below, I acknowledge that I received and reviewed this fee disclosure and understand my rights and responsibilities.

Patient Name: _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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TELEHEALTH SESSION SAFETY, PRIVACY, AND NO-RECORDING POLICY

PURPOSE

This policy protects client safety, confidentiality, and the integrity of telehealth services. It applies to all virtual therapy, counseling, psychiatry, coaching, consultation, and wellness sessions provided by Empowered Harmony Counseling, Psychiatry & Wellness Center®.

1. NO DRIVING OR OPERATING A VEHICLE

Clients may not drive, sit in active traffic, or operate any moving vehicle, machinery, or equipment during a session. Clients must be safely parked before the session begins. If the provider determines that a client is driving or otherwise participating from an unsafe setting, the provider may immediately pause or end the session. The appointment may be treated as a late cancellation or missed session under the applicable payment policy.

2. PRIVATE AND CONFIDENTIAL SPACE REQUIRED

Clients must participate from a private, secure space where other people cannot hear, observe, interrupt, or participate in the session unless the provider has approved their presence in advance. This includes family members, children, friends, coworkers, partners, and other third parties. Headphones are strongly encouraged when complete sound privacy cannot otherwise be maintained.

3. NO RECORDING, SCREENSHOTS, OR LIVE TRANSMISSION

Clients may not audio-record, video-record, photograph, screen-record, take screenshots, livestream, copy, distribute, or allow another person or device to capture any part of a session without the provider's prior written consent. The practice will not record a session without the client's prior written consent, except when specifically permitted or required by law.

SESSION LOCATION AND EMERGENCY INFORMATION

At the beginning of each telehealth session, the client may be asked to confirm their physical location and a reliable emergency contact. The client agrees to provide accurate information so the provider can respond appropriately if a medical, psychiatric, or safety emergency occurs.

POLICY VIOLATIONS

A violation may result in the session being paused or ended, application of the applicable late-cancellation or no-show fee, review of whether telehealth remains clinically appropriate, or termination of services when necessary. The provider may consider emergencies, accessibility needs, age, clinical circumstances, and other relevant factors before taking action.

CLIENT ACKNOWLEDGMENT AND AGREEMENT

By signing below, I confirm that I have read, understand, and agree to follow this policy. I understand that these requirements are intended to protect my safety, privacy, confidentiality, and quality of care.

Client Name: _____

Client Signature: _____ Date: _____

Legal Guardian, if applicable: _____ Date: _____

Provider Signature: _____ Date: _____

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SLIDING-SCALE FEE AGREEMENT AND PAYMENT POLICY

IMPORTANT NOTICE

Sliding-scale services are limited, income-based, and available only after financial eligibility is verified. Approval is not automatic and may be reviewed or discontinued when eligibility changes.

1. SLIDING-SCALE ELIGIBILITY AND VERIFICATION

Sliding-scale fees are offered based on demonstrated financial need. Clients must provide accurate and current income verification and any additional supporting documentation requested by the practice. Acceptable documentation may include recent pay stubs, benefit statements, unemployment documentation, tax records, or other proof of household income. Eligibility may be reviewed periodically, and updated documentation may be required to continue receiving the reduced rate.

2. PAYMENT AND APPOINTMENT REQUIREMENTS

2.1. Payment is due in full at least 24 hours before each scheduled appointment.

2.2. If payment is not received at least 24 hours in advance, the appointment may be canceled and the full scheduled session fee will be charged as the missed-appointment or no-show fee.

2.3. The no-show fee equals 100% of the client's approved sliding-scale session rate.

3. MISSED APPOINTMENTS, DISCONTINUATION, AND REACTIVATION

After two missed appointments or no-shows, services may be discontinued at the practice's discretion. A client who requests to resume services may be required to complete the reactivation process and pay a non-refundable $50 administrative reactivation fee before a new appointment is scheduled. Payment of the reactivation fee does not guarantee reinstatement, provider availability, or acceptance back into care.

4. ACCURACY OF FINANCIAL INFORMATION

Providing false, incomplete, or misleading financial information may result in immediate loss of sliding-scale eligibility, adjustment to the standard self-pay rate, responsibility for unpaid fee differences, termination of this agreement, or possible discharge from services.

5. APPROVAL, REVIEW, AND EXCEPTIONS

Sliding-scale approval applies only to the client and rate listed below. The practice may review eligibility when household income, employment, insurance coverage, or financial circumstances change. Exceptions to advance-payment or missed-appointment requirements may be considered for documented emergencies at the practice's sole discretion. Consistent attendance and timely payment are conditions of continued sliding-scale participation.

6. CLIENT ACKNOWLEDGMENT

By signing below, I confirm that I have read, understand, and agree to this Sliding-Scale Fee Agreement and Payment Policy. I understand that sliding-scale approval is based on verified financial need, payments are due 24 hours in advance, and missed appointments may result in the full session fee, discontinuation of care, or a $50 reactivation fee.

Client Name: _____

Household Size: _____ Verified Monthly Income: $ _____

Approved Session Rate: $ _____ Effective Date: _____

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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COURT-ORDERED THERAPY AND CHILD-WELFARE DISCLOSURE POLICY

NOTICE REGARDING RECORDS, COMMUNICATIONS, TESTIMONY, SUBPOENAS, AND COURT APPEARANCES

Client Name: _____	**Date of Birth:** _____
Case Number, if applicable: _____	**Court or Agency:** _____

1. PURPOSE AND SCOPE

Empowered Harmony Counseling, Psychiatry & Wellness Center® provides behavioral-health services that may be court-ordered or connected to child-welfare, custody, dependency, probation, guardian ad litem, or other legal matters. This policy explains the limits of the provider's role and the conditions under which information may be released.

2. PRIVACY AND AUTHORIZATION REQUIREMENTS

Information may be disclosed only when permitted by applicable law and supported by one of the following:

1. A valid, specific written authorization or Release of Information signed by the client or legally authorized representative.

2. A valid court order, or another legally sufficient directive, that clearly identifies the information requested and the persons authorized to receive it.

3. A legal exception that permits or requires disclosure, including an immediate safety concern, suspected abuse or neglect, or another mandatory-reporting duty.

3. LIMITS OF THE THERAPIST'S ROLE

- The provider does not act as an investigator, custody evaluator, parenting coordinator, mediator, expert witness, or legal advocate unless a separate written agreement specifically states otherwise.
- Treatment is designed to support clinical goals. It is not intended to determine custody, parental fitness, criminal responsibility, credibility, or the legal merits of a case.
- The provider will not communicate with attorneys, courts, child-welfare workers, probation officers, or other third parties without proper authorization or a legally recognized exception.

4. RECORDS, SUBPOENAS, AND COURT TESTIMONY

A subpoena alone may not automatically authorize disclosure of protected health information. The provider will review each request and may seek legal or professional consultation before responding. When disclosure is legally required, the provider will release only the information required or permitted. Psychotherapy notes, if maintained separately, receive additional protection under federal law.

Court appearances, depositions, affidavits, record preparation, legal consultation, travel, waiting time, and testimony are not included in routine therapy fees. These services require advance payment under the practice's current legal-service fee schedule. Fees may apply even when an appearance is cancelled with limited notice.

5. CLIENT ACKNOWLEDGMENT

By signing below, I confirm that I have read and understand this policy. I understand that treatment records and communications are protected, that disclosure requires proper legal authority, that the provider's role is clinical rather than forensic, and that additional fees may apply to legal requests or court involvement.

Client or Legal Representative Signature _____	**Date** _____
Printed Name and Relationship, if applicable _____	**Case Number** _____
Provider Signature _____	**Date** _____

Administrative Notice: This policy does not provide legal advice and does not replace any order issued by a court with proper jurisdiction. The practice may revise this policy to remain consistent with changes in law, regulation, professional standards, or court requirements.

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INTERN INTAKE & THERAPY CONSENT FORM

Self-Pay Behavioral Health Services | Complete all sections. Write N/A when a question does not apply.

1. PATIENT INFORMATION

Legal name: _____ Preferred name: _____

Date of birth: _____ Pronouns: _____ Gender identity: _____

Street address: _____ City: _____ State/ZIP: _____

Phone: _____ Email: _____ Best contact method: _____

☐ Phone ☐ Text ☐ Email ☐ Voicemail permitted ☐ Portal message Other: _____

Parent/legal guardian, if applicable: _____ Relationship: _____ Phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

2. CLINICAL INTAKE

Primary reason for seeking services: _____

Current concerns, symptoms, or stressors: _____

When did these concerns begin? _____ What would you like to improve through therapy? _____

Prior mental health treatment: ☐ No ☐ Yes Provider/type and dates: _____

Current psychiatric medications: ☐ None Medication, dose, and prescriber: _____

Medical conditions, allergies, or accessibility needs: _____ Primary care provider: _____

Substance use that may affect treatment: ☐ None Describe: _____

Current safety concerns: ☐ None ☐ Thoughts of self-harm ☐ Thoughts of harming others ☐ Recent violence/abuse

If checked, explain current risk, plan, intent, access to means, protective factors, and actions already taken: _____

3. INTERN SERVICES, FEES, AND PAYMENT

You will receive counseling from a student intern who has completed the education and training required to begin supervised clinical practice. The intern may provide assessment, psychotherapy, psychoeducation, supportive counseling, care coordination, and referrals within the intern's approved scope. The intern is not independently licensed and practices under a qualified, fully licensed clinical supervisor. The practice may reassign or transfer care when clinically necessary.

☐ $80 intake session ☐ $50 ongoing therapy session ☐ Self-pay only ☐ Insurance will not be billed

Payment is due at the time of service. Appointments canceled with less than 24 hours' notice and no-shows are charged the full appointment rate. The patient is responsible for keeping payment information current and for all balances due.

4. CONFIDENTIALITY, SUPERVISION, AND RECORDS

Sessions and records are confidential as permitted by law. The intern must review clinical notes, treatment planning, risk concerns, and relevant case details with the licensed supervisor and, when applicable, the training program. Supervision supports ethical, lawful, and high-quality care. Information may be disclosed without authorization when required or permitted by law, including suspected abuse or neglect of a child, elder, or dependent adult; serious threats of harm to self or others; court orders; medical emergencies; or other legal requirements. Electronic communication has privacy limits. This practice is not an emergency service. For an immediate emergency, call 911 or go to the nearest emergency department.

5. RIGHTS, RESPONSIBILITIES, AND INFORMED CONSENT

You may ask questions, receive respectful and culturally responsive care, participate in treatment planning, refuse a recommendation, stop services, request a different provider, or request referral to a licensed clinician. You agree to attend appointments, provide accurate information, communicate respectfully, complete agreed-upon tasks, follow safety recommendations, and notify the practice of changes in contact, payment, health, medication, or risk status. Therapy may involve discussing difficult experiences and may temporarily increase emotional discomfort. Benefits may include improved coping, insight, relationships, and functioning, but outcomes cannot be guaranteed. By signing, you confirm that you understand the intern's status, supervision, fees, payment policy, confidentiality limits, risks and benefits, and your right to withdraw consent. You voluntarily consent to assessment and therapy with the intern.

6. ACKNOWLEDGMENT AND SIGNATURES

Patient name, printed: _____ Patient/parent/legal guardian signature: _____

Date: _____ Relationship to patient, if applicable: _____ Time: _____

Intern name and credentials: _____ Intern signature: _____

Date: _____ Clinical supervisor name and credentials: _____ Supervisor signature/date: _____

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Spiritual History & Psychotherapy Integration

Would you like spirituality to be integrated into therapy? ☐ Yes ☐ No Initials: ___

Religious affiliation, if any: _____

Do you currently attend a place of worship? ☐ Yes ☐ No

List three words that describe your personal faith: _____ _____ _____

Do you have any sleep problems? ☐ Yes ☐ No

If yes, please describe: _____

Have you experienced spiritual trauma or religious abuse? ☐ Yes ☐ No

If yes, please explain: _____

_____

How does your faith or spiritual practice support your mental health?

_____

_____

Are there any spiritual beliefs or practices you would like to explore or strengthen through therapy?

_____

_____

Are there any spiritual or religious topics you prefer not to discuss in therapy?

_____

_____

Do you use prayer, meditation, or rituals for emotional support? ☐ Yes ☐ No

If yes, please describe: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

PRIVACY NOTICE

To protect your privacy, we cannot share information or confirm that you are receiving services without your written consent. This authorization must be completed before information about treatment, scheduling, billing, or other services may be shared with a spouse, co-parent, physician, provider, agency, or other third party.

PATIENT INFORMATION

Name of Patient: _____ Date of Birth: _____

PURPOSE AND AUTHORIZATION

I understand that the purpose of this release is to assist with my or this patient's treatment by improving communication between professional service providers or agencies and important individuals in my or the patient's life. I authorize Empowered Harmony Counseling, Psychiatry & Wellness Center® to use, disclose, and/or request the protected health information selected below.

INFORMATION AUTHORIZED FOR USE, DISCLOSURE, OR REQUEST

- ☐ Name of therapist or doctor
- ☐ Scheduled appointments
- ☐ Treatment plan or summary
- ☐ Psychological evaluation or test results
- ☐ Treatment plan
- ☐ Discharge or termination plans
- ☐ Diagnosis
- ☐ Progress notes
- ☐ Compliance with treatment
- ☐ Medications
- ☐ Billing or account-related information
- ☐ Other: _____

PERSON, PROVIDER, FACILITY, OR THIRD PARTY

Name: _____ Relationship to Patient: _____

Phone: _____ Email: _____

Facility: _____ Fax: _____

Method of Communication: ☐ Phone ☐ Fax ☐ Email ☐ Secure Portal

AUTHORIZATION RIGHTS AND LIMITS

I have the right to request a copy of this form after signing it and to inspect or copy information used or disclosed under this authorization when permitted by state and federal law, including 45 CFR §164.524. I may revoke this authorization at any time by notifying Empowered Harmony Counseling, Psychiatry & Wellness Center® in writing as described in the Notice of Privacy Practices. Revocation will not affect actions taken before the revocation was received or actions taken in reliance on this authorization. The practice will maintain the confidentiality of my protected health information; however, information disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA.

ACKNOWLEDGMENT AND SIGNATURES

Client Name: _____ Date: _____

Client Signature: _____ Date: _____

Parent or Guardian Name: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Witness Name: _____ Date: _____

Witness Signature: _____ Date: _____

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MENTAL HEALTH SAFETY PLAN

Patient Name: _____ Date: _____

Date of Birth: _____ Clinician: _____

1. MY PERSONAL WARNING SIGNS

_____

_____

2. HEALTHY COPING STRATEGIES I CAN USE ON MY OWN

_____

_____

3. PEOPLE AND PLACES THAT HELP ME FEEL SAFE

_____

_____

_____

4. PEOPLE I CAN CONTACT FOR SUPPORT

Name: _____

Phone: _____

Name: _____

Phone: _____

5. PROFESSIONAL SUPPORTS

Psychiatrist/Provider: _____ Phone: _____

Other Professional Support: _____ Phone: _____

988 Suicide & Crisis Lifeline: Call or Text 988 **Emergency: 911 or nearest emergency department.**

6. MAKING MY ENVIRONMENT SAFER

_____

_____

7. MY REASONS FOR LIVING AND STAYING SAFE

_____

_____

ACKNOWLEDGMENT AND SIGNATURES

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

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Provider Credential Reference

The credentials below may appear beside the names of clinicians and wellness professionals.

BCBA: Board Certified Behavior Analyst.

CADC: Certified Alcohol and Drug Counselor.

CMH: Clinical Mental Health Counselor.

DO: Doctor of Osteopathy, Psychiatrist.

Health Coach: A professional who helps clients make lifestyle changes to improve physical and mental health.

LCADC: Licensed Clinical Alcohol and Drug Counselor.

LCP: Licensed Clinical Psychologist.

LCPC: Licensed Clinical Professional Counselor.

LCSW: Licensed Clinical Social Worker.

LICSW: Licensed Independent Clinical Social Worker.

LMFT: Licensed Marriage and Family Therapist.

LMHC: Licensed Mental Health Counselor.

LMSW: Licensed Master Social Worker.

LPC: Licensed Professional Counselor.

LPCC: Licensed Professional Clinical Counselor.

Life Coach: A professional who helps individuals achieve personal or professional goals.

MD: Doctor of Medicine, Psychiatrist.

PA-C: Physician Assistant, Certified, who may specialize in psychiatry.

PMHNP: Psychiatric Mental Health Nurse Practitioner.

PhD: Doctor of Philosophy in psychology or a related field.

PsyD: Doctor of Psychology.

RDN: Registered Dietitian Nutritionist, who may provide mental health-related support.

Wellness Coach: A professional who supports clients in improving overall well-being, including mental and physical health.

PREVIOUS COUNSELING

Outpatient, place and year: _____

Inpatient, place and year: _____

Intensive outpatient program or partial hospitalization, place and year: _____

FAMILY & SUPPORTIVE RELATIONSHIPS

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Committed partnership

Name	Age	Relationship (spouse, child, friend, etc.)	Quality	Lives with you?
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No
			☐ Good ☐ Fair ☐ Poor	☐ Yes ☐ No

EDUCATION

Highest level completed: ☐ High school ☐ Attended college or technical school ☐ College degree ☐ Graduate degree ☐ Other: _____

EMPLOYMENT / CAREER

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Stay-at-home parent

FINANCES

Overall financial stress level: ☐ High ☐ Medium ☐ Low

SPIRITUALITY / RELIGIOUS BACKGROUND & PRACTICE

Religious upbringing: ☐ None ☐ Attended religious services ☐ Belief in God ☐ Other: _____

Present practice: ☐ Inactive ☐ Active ☐ Searching ☐ Other: _____

TRAUMA HISTORY

Have you experienced trauma, abuse, or neglect? ☐ Yes ☐ No

If yes, check all that apply: ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect ☐ Verbal ☐ Other: _____

Please provide any details you would like your clinician to know:

_____

_____

_____

MEDICATIONS & SUPPLEMENTS

List all current medications and supplements. Attach another page or bring a complete list to your appointment if needed.

Name of medication or supplement	Dosage / amount	Frequency

Have you had an allergic reaction to medication? ☐ Yes ☐ No

Medication: _____ **Reaction:** _____

Medication: _____ **Reaction:** _____

MEDICAL INFORMATION (Optional)

Check all medical issues for which you have received treatment:

☐ **Allergies**
(allergic reactions, seasonal allergies, etc.)

☐ **Blood disease**
(anemia, bleeding disorders, etc.)

☐ **Bone disease**
(osteoporosis, arthritis, broken bones, etc.)

☐ **Digestive system disease**
(ulcers, heartburn, celiac disease, IBS, etc.)

☐ **Endocrine disease**
(diabetes, thyroid conditions, low testosterone, etc.)

☐ **Genetic disease**
(sickle cell disease, fetal alcohol syndrome, other syndromes, etc.)

☐ **Head or brain illness / injury**
(fainting, concussion, seizures, dementia, etc.)

☐ **Heart / cardiovascular disease**
(arrhythmia, heart attack, high blood pressure, etc.)

☐ **Immune disease**
(serious infections, rheumatoid arthritis, etc.)

☐ **Lung or breathing disease**
(asthma, COPD, emphysema, etc.)

☐ **Mouth or dental disease**
(gum disease, cold sores, canker sores, etc.)

☐ **Muscle or movement disease**
(tremors, tics, restless legs, Parkinson's disease, etc.)

☐ **Poisoning or chemical exposure**
(overdose, lead exposure, workplace fumes, etc.)

☐ **Serious injuries or wounds**
(burns, cuts, stabbing injuries, crushed limbs, etc.)

☐ Other: _____

Check all areas in which you have had surgery:

☐ Cancer procedures

☐ Cardiac / vascular

☐ Ear, nose, or throat

☐ Gastroenterology / digestive system

☐ Obstetrics and gynecology

☐ Orthopedic

☐ Plastic surgery

☐ Neurosurgery

☐ Urology

☐ Vision

☐ Weight-loss surgery

☐ Other: _____

Do you have any current or ongoing medical concerns?

_____

_____

PAIN & FUNCTIONING

Do you have problems with pain? ☐ Yes ☐ No
Severity of pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Location of pain: _____

Have your medical concerns interfered with your ability to work, relate to others, or participate in activities outside your home? ☐ Yes ☐ No
If yes, please explain:

SUBSTANCE USE

Do you use alcohol? ☐ Yes ☐ No. If yes, number of drinks and frequency:

Do you use recreational or illicit drugs? ☐ Yes ☐ No. If yes, substance and frequency:

Have others viewed your substance use as a problem? ☐ Yes ☐ No
Have you ever tried to reduce or stop your alcohol or drug use? ☐ Yes ☐ No

Has alcohol or drug use interfered with family, work, or interpersonal relationships? ☐ Yes ☐ No

Have you had prior substance-use treatment? ☐ Yes ☐ No

When? **Where?**

LEGAL HISTORY

Are you currently involved with the legal system, Friend of the Court, or Child Protective Services? ☐ Yes ☐ No
If yes, please explain:

Do you currently have a probation or parole officer? ☐ Yes ☐ No
If yes, provide the officer's name and contact information:

Have you been involved with the legal system in the past? ☐ Yes ☐ No
If yes, please explain:

Patient signature: _____ **Date:** _____

Holmes-Rahe Life Stress Inventory
Social Readjustment Rating Scale

Instructions: Mark each life event that occurred during the past year. Add the corresponding point values to determine your total score.

✓	Life Event	Value
	Death of spouse	100
	Divorce	73
	Marital separation	65
	Detention in jail or institution	63
	Death of close family member	63
	Major personal injury or illness	53
	Marriage	50
	Being fired from work	47
	Marital reconciliation	45
	Retirement	45
	Major change in health/behavior of family member	44
	Pregnancy	40
	Sexual difficulties	39
	Gain of new family member	39
	Major business readjustment	39
	Major change in financial state	38
	Death of close friend	37
	Change to different line of work	36
	Major change in arguments with spouse	35
	Mortgage over $10,000	31
	Foreclosure of mortgage/loan	30
	Change in responsibilities at work	29
	Child leaving home	29
	Trouble with in-laws	29
	Outstanding personal achievement	28
	Spouse begins/stops work	26
	Begin/end school	26
	Major change in living conditions	25
	Revision of personal habits	24
	Trouble with boss	23
	Change in work hours/conditions	20
	Change in residence	20
	Change in school	20
	Change in recreation	19
	Change in church activities	19
	Change in social activities	18
	Small loan	17

	Change in sleeping habits	16
	Change in family get-togethers	15
	Change in eating habits	15
	Vacation	13
	Major holidays	12
	Minor violations of law	11
	TOTAL SCORE	_____

Interpretation
0-149: Low level of life change.
150-299: Moderate level of life change.
300 or higher: High level of accumulated life change associated with increased health risk.

This assessment is for screening purposes and should be interpreted in clinical context.

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		Not at all	A little	Moderately	Mostly	Completely
10	The following questions ask about how completely you experience or were able to do certain things in the last two weeks. Do you have enough energy for everyday life?	1	2	3	4	5
11	Are you able to accept your bodily appearance?	1	2	3	4	5
12	Have you enough money to meet your needs?	1	2	3	4	5
13	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
		Very poor	Poor	Neither poor nor good	Good	Very good
15	How well are you able to get around?	1	2	3	4	5
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16	The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks. How satisfied are you with your sleep?	1	2	3	4	5
17	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18	How satisfied are you with your capacity for work?	1	2	3	4	5
19	How satisfied are you with yourself?	1	2	3	4	5
20	How satisfied are you with your personal relationships?	1	2	3	4	5
21	How satisfied are you with your sex life?	1	2	3	4	5
22	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24	How satisfied are you with your access to health services?	1	2	3	4	5
25	How satisfied are you with your transport?	1	2	3	4	5
		Never	Seldom	Quite often	Very often	Always
26	The following question refers to how often you have felt or experienced certain things in the last two weeks. How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highes Domai Score** (clinicia
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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WHO - Quality of Life - Brief (WHOQOL-BREF)

Instructions:

This assessment asks how you feel about your quality of life, health, or other areas of your life. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last two weeks.

		Very poor	Poor	Neither poor nor good	Good	Very good
1	How would you rate your quality of life?	1	2	3	4	5
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2	How satisfied are you with your health?	1	2	3	4	5
		Not al all	A little	A moderate amount	Very much	An extreme amount
3	The following questions ask about how much you have experienced certain things in the last two weeks. To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
		Not at all	A little	A moderate amount	Very much	An extreme amount
4	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5	How much do you enjoy life?	1	2	3	4	5
6	To what extent do you feel your life to be meaningful?	1	2	3	4	5
		Not at all	A little	A moderate amount	Very much	Extremely
7	How well are you able to concentrate?	1	2	3	4	5
8	How safe do you feel in your daily life?	1	2	3	4	5
9	How healthy is your physical environment?	1	2	3	4	5

Do I Have Anxiety?

Taking self-assessments like the Generalized Anxiety Disorder-7 (GAD-7) for generalized anxiety can help you understand yourself better. They can also help you:

- Quickly check for common symptoms of anxiety and depression
- Notice patterns and how they relate to your feelings
- Be a starting point for talking with a doctor or therapist

These assessments are being used worldwide in routine clinical practice, every day to help people understand their mental health. To get the most accurate results, complete the questionnaire in a quiet, private space and use the same version each time to track changes consistently.

Over the last two weeks, how often have you been bothered by the following problems?	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

Add the scores for each question (0–3) for a Total Score: 0–21

0–4: Minimal anxiety **5–9: Mild anxiety** **10–14: Moderate anxiety** **15–21: Severe anxiety**

If your score is elevated or your symptoms are persistent or concerning, consider sharing your results with a medical or mental health professional. A healthcare provider can help determine whether further evaluation or treatment may be appropriate.

Important: Self-assessments do not provide a diagnosis. Only a qualified health professional can diagnose a mental health condition and recommend treatment.

ADAA and Other Mental Health Resources:

ADAA GAD and other Anxiety Resources
ADAA Find Your Therapis:
ADAA Peer-to-Peer Communities

National Alliance on Mental Illness (NAMI)
Crisis Support (U.S.): Dial or text 988

The GAD-7 screening tool was developed and validated by leading experts in psychiatry and clinical psychology to provide a brief, reliable measure of anxiety symptoms. Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). The GAD-7. Archives of Internal Medicine, 166(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐