LIFE in BALANCE
COUNSELING & WELLNESS CENTER
Enriching Mind, Body & Spirit

NEW CLIENT PACKET CHECKLIST

Welcome to Life in Balance Counseling & Wellness Center!

Full completion of this packet will enable us to provide you with the best possible service. This packet will take approximately 45 to 60 minutes to complete.

To enable us to provide you with the best care possible, please be sure to complete each page and initial the bottom of each page, where indicated.

Please have the following with you at your first appointment. These documents are required for insurance and medical records compliance:

☐ Insurance Card

☐ Driver's License or Photo ID

☐ Any additional medical records or notes you may have from previous practitioners

☐ Co-pay or co-insurance or other payment required by your insurance company

☐ Required Credit Card on file

Please note the following:

- Client registration (next page) must be filled out completely. The date of birth and social security number of the Insurance Policy Holder is required to submit insurance claims. If you do not have this information, we cannot bill your insurance. You would then be held responsible for charges that your insurance my otherwise cover.
- Please complete this packet as completely and detailed as you can. This will help your practitioner understand more about your visit.
- The Authorization to release Protected Health Information (PHI), is on page 24. Please fill in your name, date of birth, the name of the practitioner that you will be working with at **Life in Balance Counseling & Wellness Center** on the line next to Clinician's Name, and the name and demographic information of the person or entity that you wish to share your information with. Please wait to sign this page until you check-in with the receptionist at the front office so they can witness your signature.
- **Please check and review that each page has been initialed and signed where indicated.**

Thank you for your cooperation and patience in filling out these forms to help us better understand your

ADULT

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CLIENT REGISTRATION

Today's Date: _____

CLIENT INFORMATION:

Full Name: _____ **Middle Initial:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Sex: ☐Male ☐Female

Gender Identity: ☐Transgender Male ☐Transgender Female ☐Transgender (as non-binary)

☐Non-Binary ☐Two-Spirit ☐Questioning/Not Sure ☐Other: _____

Marital Status: ☐Married ☐Single ☐Partnered ☐Separated ☐Divorced ☐Widowed

☐Annulled ☐Interlocutory ☐Polygamous ☐Polyamorous ☐Other: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Mailing Address (if different than above): _____

City: _____ **State:** _____ **Zip Code:** _____

Do we have authorization to send mail to the address listed above: ☐Yes ☐No

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:**

~~INSURANCE INFORMATION~~

Employment Status: ☐Employed ☐Retired ☐Unemployed ☐Disabled

Employer: _____ **Occupation:**

Initial Here: _____

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All items in this section must be completed to bill your insurance.

POLICY HOLDER'S INFORMATION:

Full Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Phone Number:** _____

Relationship to Client: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Employer: _____ **Phone:** _____

Employer's Address: _____

City: _____ **State:** _____ **Zip Code:** _____

WELCOME!

Thank you for choosing Life in Balance Counseling & Wellness Center. The initial appointment will take approximately 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of what to expect, our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you may need. All the Clinicians in our practice has earned a Graduate Degree (Masters or Doctorate) from an accredited University. All Life in Balance Clinicians is Licensed to practice in the State of Virginia or are Resident Clinicians who have completed a Graduate Degree and are pursuing licensure under direct supervision of a Licensed Clinician. The clinical supervisor's name and credentials may be obtained upon request. Our Clinician's only practice within their scope of training and experience. In the course of our training and previous employment, we have had experience in treating a wide variety of individuals, including children, adolescents, adults, individuals, couples, families and groups. Your counselor will have their own primary specialty areas of expertise. Treatment practices, philosophy, plan limitations and risks, will be discussed with you today.

OUR PRACTICE CONSISTS OF THE FOLLOWING CLINICIANS

Initial Here: _____

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Andrew Burns, LPC
Dr. Alan Forrest, LPC, LMFT
Angela Cardenas, LPC
Angela McGoldrick, LPC
Cynthia Blevins, LPC
Donna Wagner, LPC
Erin Sullivan, LCSW
Jennifer Merritt, LPC
Lisa Kirkner, LPC
Elizabeth Kates, LPC
Melissa Blau, LCSW
Sarah Trenis, LPC
Katie Anderson, LPC
Erin Justis, LCSW

RESIDENTS IN COUNSELING

Anda Ben Senior, MS	**Under the Supervision of Cynthia Blevins, LPC**	**(540) 381-6215 Ext. 307**
Chloe Muttart, MS	Under the Supervision of Angela Cardenas, LPC	(540) 381-6215 Ext. 308

Office Hours

Monday—Thursday:	9:00 a.m. — 6:00 p.m.
Friday:	9:00 a.m. — 5:00 p.m.
Saturday—Sunday:	CLOSED

You may reach our office by phone at (540) 381-6215 to schedule an appointment. If we are unavailable, you may leave a message on our confidential voicemail box, and someone will return your call as soon as possible during normal business hours. Most practitioners have confidential voicemail boxes.

DO NOT LEAVE A MESSAGE IF YOU HAVE A PSYCHIATRIC EMERGENCY. PLEASE CALL:

- **ACCESS: (540) 961-8300**
- **DIAL 911**
- **Proceed to the nearest Emergency Room**

COMMUNICATION

It is our standard practice to communicate with you about health matters, such as appointment reminders, using the home address and daytime phone number you provided when you scheduled your appointment. You have the right to request that our office communicate with you in a different way.

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FINANCIAL | INSURANCE

As a courtesy, we will bill your insurance company. **All payments, co-payments and/or co-insurance payments are due at the time of your appointment.** If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If the balance is not paid after 45 days, 1.5% interest/month (18% APR) will be applied. If the account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for collection fees charged to our office to collect the debt owed.

We accept the following forms of payment:

- Personal Checks
- Cash
- Discover
- Visa
- MasterCard

A returned check fee of $38.00 will be charged. If we receive a returned check from an individual, we may refuse future payments by check.

FEES FOR SERVICES

ADULT

Initial Assessment & Diagnosis	(45-55 Minutes)	$ 195.00
Individual Therapy Session	(55 Minutes)	$ 175.00
Individual Therapy Session	(45 Minutes)	$ 150.00
Individual Therapy Session	(30 Minutes)	$ 120.00
Family Therapy	(45-55 Minutes)	$ 175.00
Phone Consultation	(15 Minutes)	$ 65.00
Phone Consultation	(30 Minutes)	$ 120.00
Phone Consultation	(45 Minutes)	$ 150.00
Group Therapy Session	(50 Minutes)	$ 75.00
Deposition or Appearance in Court	---	$500.00 + $100.00/hr.
Records and Document Review	($30.00 Minimum Required)	$ 95.00/hr.
Written Correspondence	(Documentation Type Varies)	$50.00/pg.
Record Printing Fee	Charges as per Virginia Code §8.01-413 Section B2	$0.50 per page up to 50 pages; $0.25 per page thereafter
Search and Handling Fee	---	$ 20.00
No Show Appointment	---	$ 65.00
Late Cancellation Fee	---	$ 65.00
Returned Check Fee	---	$ 38.00

NO SHOW | LATE CANCELLATION POLICY

Please contact the office within 24 Hours if you are unable to make your appointment. If you do not show for a scheduled appointment, or cancel with less than 24 Hours' notice, a **NO SHOW and/or LATE CANCELLATION FEE of $65.00** will be charged to your credit card on file for the cost of the missed appointment, if permitted by your insurance company. This cost is **not covered by insurance** and is your responsibility. This fee must be paid in full before your next appointment. If a second appointment is missed without cancelling with a 24-Hour Notice, your counselor will speak with you about future appointments. If a third appointment is missed, your counselor may not be willing to reschedule with you depending on your situation.

Signature of Client (or person acting for client):

AUTHORIZATION

I authorize treatment deemed necessary by Life in Balance Counseling & Wellness Center Practitioners. I authorize Life in Balance Counseling & Wellness Center to release my health plan and all information which is deemed necessary regarding my care and treatment to ensure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Life in Balance Counseling & Wellness Center for any and all charges incurred in connection with services provided to me. I consent to a copy of this

Initial Here:

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UNDERSTANDING PSYCHOTHERAPY AND INFORMED CONSENT

It is important for you to understand what counseling is about and what you may expect during therapy. Please read this material carefully and ask the therapist to explain anything that is unclear to you.

What is Counseling and Psychotherapy?

"Counseling" and "Psychotherapy," or simply "therapy," are words used for the same process which is: using proven methods, to assist people in changing how they think, feel and behave. Legitimate therapy is practiced by professionals licensed (or license eligible under supervision) by the State in the areas of Clinical Social Work, Professional Counseling, Psychology, or Psychiatry.

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CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for situations covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communication(s) with practitioners or office staff. This includes e-mail, instant messages, social media and text messages. In addition, we will protect your privacy in public. We will not communicate with you in public unless you initiate contact, nor will we disclose that you are a client.

If any Emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to:

Initial Here: _____

- **Contact ACCESS: (540) 961-8400**

In the unlikely event that your clinician is unable to provide ongoing services, another clinician within the group practice can provide those services. Our office will maintain your records for a period of 7 years. Please contact the Executive Director, Angela McGoldrick, LPC, for any questions pertaining to this.

COORDINATION OF TREATMENT

Signature of Client (or person acting for client): _____

It is important that all Health Care Providers work together. As such, we would like your permission to communicate with your Primary Care Physician and/or Psychiatrist. Your consent is valid for one year. If you prefer to decline your consent, no information will be shared. However, we do need your Physicians name and demographic information for insurance billing.

Please check one:

☐ You may inform my physician(s) ☐ I decline to inform my physician

Physician's Name: _____ **Clinic:**

Initial Here: _____

Phone Number: _____

ADULT

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/WE have reviewed and received a copy of the Notice of Privacy Practices if so requested. The Notice of Privacy Practices is available on our website at www.lifeinbalancecenter.com or through request at the Front Office.

Signing the acknowledgement does not mean you have agreed to any uses or disclosures of your protected health information outside the purposes outlined in the Notice of Privacy Practices.

Signature of Client (or person acting for client): _____

CHILD SUPERVISION

Children's Name	Children's Age

Initial Here: _____

Life in Balance Counseling & Wellness Center strives to maintain a peaceful therapeutic environment to enhance well-being and healing. This includes keeping noise and activity levels to a minimum to avoid disrupting services. Many of our services such as meditation, message, yoga, and hypnosis are best

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CHIEF COMPLAINT: PRESENTING PROBLEM AND PAST TREATMENT

Please briefly describe why you are seeking counseling:

_____

_____

_____

HISTORY OF CURRENT PROBLEM:

How long have you had this problem:

_____

Did something happen before this problem started? ☐ Yes ☐ No

If you have been diagnosed with a mental health disorder, please list it here:

Initial ~~Here:~~ _____

_____

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HISTORY OF INPATIENT TREATMENT

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, please list when and where:

_____

If yes, please briefly describe the reason:

_____

SUICIAL | SELF-HARM HISTORY:

Have you ever had suicidal thoughts? ☐ Yes ☐ No **Have you ever attempted suicide?** ☐ Yes ☐ No

If yes, please list when and what was going on that led to these feelings and/or thoughts:

_____

Did you have a plan for suicide? ☐ Yes ☐ No

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ADULT SUMPTOMS SCREENER

Present	Past	Present	Past
☐	☐ Change in appetite (more or less)	☐	☐ Frequent daydreams
☐	☐ Feeling sad	☐	☐ Bored easily
☐	☐ Crying spells	☐	☐ Learning difficulties
☐	☐ Too little sleep (falling or staying asleep)	☐	☐ Often lose things
☐	☐ Sleep more than usual	☐	☐ Excessive dieting/exercise
☐	☐ Fatigue	☐	☐ Obsessed with losing weight
☐	☐ Loss of interest and/or pleasure	☐	☐ Use of laxatives
☐	☐ Avoiding friends or family	☐	☐ Engage in self-induced vomiting
☐	☐ Expect failure	☐	☐ Eating things that are not food
☐	☐ Decreased concentration	☐	☐ Vandalism
☐	☐ Thoughts of death	☐	☐ Fire-setting
☐	☐ Cutting or burning oneself	☐	☐ Lack of remorse for wrongdoing
☐	☐ Suicide plan or attempt	☐	☐ Selfish
☐	☐ Depression	☐	☐ Bullies/gets in fights
☐	☐ Often sick	☐	☐ Lying
☐	☐ Loneliness	☐	☐ Truancy
☐	☐ Slow moving	☐	☐ Theft
☐	☐ Hopelessness	☐	☐ Argumentative/sudden anger
☐	☐ Confusion	☐	☐ Defiant of authority

Initial Here: _____

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STRESSORS

FAMILY	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
FRIENDS	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
RELATIONSHIPS	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
EDUCATION	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
ECONOMIC	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
FINANCES	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
OCCUPATION	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
HOUSING	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
LEGAL	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE
HEALTH	☐	NONE	☐	MILD	☐	MODERATE ☐	SEVERE

Please explain what brings on stress:

_____

Please describe what helps with stressors:

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SUBSTANCE USE HISTORY

SUBSTANCE	HISTORY OF USE	DATE OF FIRST USE	DATE OF LAST USE
ALCOHOL	☐ Yes ☐ No		
MARIJUANA	☐ Yes ☐ No		
BARBITURATES	☐ Yes ☐ No		
KLONOPIN, ATIVAN, XANAX	☐ Yes ☐ No		
VALIUM	☐ Yes ☐ No		
COCAINE | CRACK	☐ Yes ☐ No		
HEROIN | OPIATES	☐ Yes ☐ No		
PCP, LSD, MESCALINE	☐ Yes ☐ No		
INHALANTS	☐ Yes ☐ No		
AMPHETAMINES, SPEED, UPPERS, CRYSTAL METH	☐ Yes ☐ No		
DESIGNER DRUGS, ECSTASY	☐ Yes ☐ No		
OVER THE COUNTER DRUGS	☐ Yes ☐ No		
CAFFEINE	☐ Yes ☐ No		
NICOTINE	☐ Yes ☐ No		

SUBSTANCE USE HISTORY (Continued)

If you are currently using any substances, please describe when and where you typically use:

_____

_____

Please describe how your use affects family and friends, including how they perceive your use:

_____

_____

_____

How do you perceive your use?

_____

Have you ever received substance use treatment? ☐ Yes ☐ No

Initial Here: _____

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CASE ASSESSMENT

If you currently or ever have used alcohol and/or recreational drugs or overused prescription drugs, please answer below:

Have you ever felt you should cut down your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

MEDICAL HISTORY

Physician's Name	Specialty	Reason for treatment	Date(s) of treatment

Date of last Physical Exam: _____ Date of last Dental Exam:

Prescriptions

Name of Medication	Prescribed By:	Dosage Frequency	Helpful	Side Effects and/or Comments	Taken as Prescribed
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N
			☐ Y ☐ N		☐ Y ☐ N

Initial Here: _____

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Please select if you have ever had any of these conditions:

☐	Hypertension	☐	PMS/Painful Mensuration	☐	Environmental Sensitivity
☐	Heart Disease	☐	Easy Bruising	☐	Numbness
☐	Arteriosclerosis	☐	Skin Rash	☐	Stabbing Pain
☐	Arthritis	☐	Allergies: _____	☐	Sensitive to touch/pressure
☐	Kidney Disease	☐	Asthma	☐	Abscess or open sore
☐	Varicose Veins	☐	Skin Sensitivity	☐	Thyroid ☐Hypo (High) ☐ Hyper (Low)
☐	Seizures	☐	Head Injury	☐	Headaches
☐	Back Pain	☐	Chronic Pain	☐	Fibromyalgia
☐	Chronic Fatigue	☐	Digestive Disorder	☐	Operations:

Medical

How do your medical conditions affect your life?

_____

_____

_____

Were you exposed to drugs or alcohol while your mother was pregnant? ☐ Yes ☐ No ☐ Unsure

Did you have any mental or physical problems growing up (birth defect, learning problems, etc.)? ☐ Yes ☐ No ☐ Unsure

Do you have any barriers to getting healthcare? ☐ Yes ☐ No

What types of foods do you usually eat?

_____

What is your activity level? ☐ Chores Only ☐ 30 Minutes Moderate Exercise

☐ 1—2 times per week ☐ 3—4 times per week ☐ 5—7 times per week

What is your current weight? _____ **What is your highest weight?** _____

What is your lowest weight? _____

How many hours do you sleep at night? _____

Initial Here: _____

Do you have trouble falling asleep? ☐ Yes ☐ No

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FAMILY HISTORY

Have any of your blood relatives (parent, sibling, grandparent, aunt, uncle, etc.) ever had issues or been diagnosed with any of the following: ☐ Mental Illness ☐ Suicide ☐ Alcoholism

☐ Drug Problems ☐ Seizure Disorder ☐ Mental Retardation ☐ Bipolar Disorder

☐ Chronic Illness ☐ ADD ☐ ADHD

Father's Name: _____ ☐ Living ☐ Deceased

If deceased, please list cause of death and age of death: _____

FAMILY HISTORY

List yourself and siblings (living and deceased) in birth order and include ages:

1.	2.
3.	4.
5.	6.
7.	8.

List your children in birth order (living and deceased) and include ages:

1.	2.
3.	4.
5.	6.
7.	8.

List all current members of your household (people who live with you):

1.	2.
3.	4.
5.	6.
7.	8.

Do you have pets? ☐ Yes ☐ No

If yes, please list what type and their names below:

RELATIONSHIP | COUPLES HISTORY

If you are involved in an intimate relationship (spouse, partner, fiancé, boyfriend/girlfriend, etc.) please describe if there are any struggles or problems in the relationship:

_____

_____

_____

_____

_____

_____

Have you ever been abused: ☐ Emotionally ☐ Mentally ☐ Sexually ☐ Physically ☐ Does not apply

Have you: ☐ Been in a War Zone ☐ Been in Civil Unrest ☐ Experienced a Natural Disaster

WORK, SOCIAL & LEISURE ACTIVITIES HISTORY

Are you currently: ☐ Employed ☐ Disabled

If employed, please list place of employment:

_____

Does your job involve: ☐ Hazardous Duties ☐ Irregular Shifts

☐ Other Stressors: _____ ☐ None of the above

Do you have any: ☐ Attendance Issues ☐ Job Performance Issues ☐ Threat of Job Loss

Initial Here: _____

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WORK, SOCIAL & LEISURE ACTIVITIES HISTORY (continued)

Highest level of education completed: ☐ K-8 ☐ 9-12 ☐ High School Graduate ☐ GED

☐ Some College ☐ Associate Degree ☐ Bachelor's Degree ☐ Graduate School ☐Master's or Doctorate

Did (or do) you struggle in school? ☐ Yes ☐ No

Did (or do) you get along with teachers and classmates? ☐ Yes ☐ No

In your daily life, can you adequately read? ☐ Yes ☐ No

In your daily life, can you adequately write? ☐ Yes ☐ No

In your daily life, can you adequately do math? ☐ Yes ☐ No

Who do you turn to for support?

_____

Do you struggle making friends? ☐ Yes ☐ No **Do you struggle keeping friends?** ☐ Yes ☐ No

What do you do for fun?

_____

_____

_____

What do you do for relaxation?

_____

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CULTURAL

What language(s) are spoken in your household? ☐ English ☐ Spanish ☐ Chinese ☐ Tagalog

☐ Vietnamese ☐ Arabic ☐ French ☐ Korean ☐ Russian ☐ German ☐ Other: _____

How would you describe yourself ethnically or culturally?

_____

_____

_____

Do you have any physical disabilities? ☐ Yes ☐ No

Do you have any limitations: ☐ Speech ☐ Hearing ☐ Vision

FINANCIAL HISTORY

What is your source of income?

_____

Do you receive any assistance (Select all that may apply): ☐ Food ☐ Housing

☐ Other: _____

Do you struggle with your bills? ☐ Yes ☐ No

Do you have your own transportation? ☐ Yes ☐ No

Initial Here: _____

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LEGAL HISTORY

Do you have a legal history? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Are you involved in a lawsuit? ☐ Current ☐ Past ☐ Never

Have you served a jail or prison sentence? ☐ Yes ☐ No

If yes, please describe for what crime:

_____

_____

_____

Do you have legal charges? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Do you have any involvement with Child or Adult Protective Services? ☐ Yes ☐ No

If yes, please describe:

_____

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FOR OFFICE USE ONLY

_____ _____
Therapist Signature **Date**

_____ _____
Supervisor Signature (if applicable) **Date**

CREDIT CARD AUTHORIZATION

I _____ agree to allow **Life in Balance Counseling and Wellness Center** to keep and charge my credit card on file. It is required by my insurance company for my co-pay to be paid prior to my appointment. Therefore, I agree and permit **Life in Balance Counseling and Wellness Center** to charge my credit card for mine or my minor child's co-pay in the event that prior to the appointment I am not able to be reached or should the front office be unavailable to take my payment. I understand that no one will contact me prior to making this charge as it is understood that if I owed a co-pay for an appointment that I have completed, the co-pay charge will be charged to my credit card. I also agree to allow my card to be charged for a no-show appointment or missed appointment without a 24-hour prior notice to the office. A credit card is required to be on file.

Signature of Patient:_____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Initial Here: _____

ADULT

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I (Patient Name): _____ **Date of Birth:** _____

Give permission to: **LIFE IN BALANCE COUNSELING & WELLNESS CENTER**

and to **(Clinician's Name):** _____

This permission grants the above to:

- Send and/or disclose confidential case records and/or test results;
- Send treatment summaries and diagnosis information to and receive confidential information from my PRIMARY CARE PHYSICIAN, PSYCHIATRIST, or OTHER PERSON/ENTITY listed below;

PLEASE LIST PRIMARY CARE PHYSICIAN, PSYCHIATRIST, or OTHER PERSON and/or ENTITY:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

I understand my service record is protected under Federal and State regulations and that information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse treatment and/or confidential HIV/AIDs related information.

This consent shall be in effect from: _____ **until:** _____ **(No longer than one year)**

Initial Here: _____

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TeleMentalHealth Consent Form

This form is to be completed I addition to **Life in Balance Counseling & Wellness Center** standard Consent and Services Agreement. It does not replace **Life in Balance Counseling & Wellness Center** standard Consent and Services Agreement.

I hereby consent to engaging in telehealth with a **Life in Balance** provider as part of my clinical treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/behavioral health information, both orally and visually, to health care practitioners located and licensed in the Commonwealth of Virginia.

I understand that I have the following rights with respect to telehealth:

- I have the right to withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive expectations to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my behavioral or emotional state an issue in a legal proceeding.
- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telehealth-based services and care may not be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.
- I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
- I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia Law.

Insurance Reimbursement:

I understand that my insurance may not cover telehealth with my **Life in Balance Provider.** I understand it is my responsibility to contact my insurance company to find out if my policy covers telehealth with my specific **Life in Balance Provider**. I also understand that **Life in Balance** will bill my insurance, but this does not guarantee that my insurance will pay for telehealth mental services with my **Life in Balance Provider**. If my insurance does not pay, I accept full responsibility for any payment due for services rendered by my Provider. If my insurance does not cover telehealth for my **Life in Balance Provider**, I understand that I can request face-to-face services or ask for a referral to a provider that my insurance covers.

Initial Here:
Signature of Patient:_____ **Date:**