Personal Information – General Background Information

IDENTIFIYING INFORMATION

Date:____ /____ /_____

Name:_____ Date of Birth:____ /____ /_____

Address: _____

Phone (Home): _____ (Work):_____ (Cell): _____

The best number to reach you: _____

Your Preferred Email: _____

Do we have your permission to leave a message and identify ourselves?

YES: ❑ Voicemail home ❑ Voicemail Cell ❑ Text ❑ E-mail **NO:** _____

Occupation: _____ ❑ Full- time ❑ Part-time ❑ Not Employed

Employer: _____ Job Title: _____

FINANCIAL

❑ Cash pay ❑ Out of Network Insurance

**For inquiries regarding insurance coverage: *We do take out of network insurance and we are willing to help you with completing forms for authorization and reimbursement. Please contact your insurance company regarding the necessary steps to take for out of network authorization and billing.*

Person responsible for payment: ❑ client ❑ parent/guardian

Insurance Company:_____

OTHER

How did you hear of us: ❑ Website ❑ Family Member ❑Friend ❑ Online Search ❑Physician
❑Other_____

May we thank someone in particular? _____

Sex: ❑M ❑F Height: _____ Weight _____

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed _____Number of Children

Race/Culture(*Check all that apply):*
❑ African ❑ Hispanic ❑ African American ❑ Native American ❑ Asian Pacific Islander
❑ Asian American ❑ Caucasian ❑ Other: _____
Religion/Spiritual Orientation: _____
Highest Completed Educational Grade: _____

The Wellness Connection services you are currently engaging in: (please check)
❑ Mental Health Therapy ❑ Psychological Testing ❑ Psychiatry ❑ Occupational Therapy
❑ Speech Therapy ❑ Chiropractic ❑ Acupuncture ❑ Massage Therapy
❑ Dietitian/Nutrition Counseling ❑ Wellness Coach ❑ Professional Organizer
❑ Workshop/Support Group (specify name of class): _____
❑ Yoga ❑ Kid's Yoga ❑ Pilates

Previous Services? ❑Yes ❑No
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____
Dates: _____-_____ With Whom? _____

IN CASE OF EMERGENCY THE WELLNESS CONNECTION MAY CONTACT:
NAME: _____
RELATIONSHIP: _____
ADDRESS: _____
PHONE: Home: _____ Work: _____ Cell:_____

HIPAA PRIVACY NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of this practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Virginia Department of Child and Family Services.

- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- **Health Oversight:** If a complaint is filed against me with the Virginia Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and The Wellness Connection's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

The Wellness Connection's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide a revised notice in person or through the mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the office administrator to discuss this further.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2013.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that on (date) ___ / ___ / _____, I received the Notice of Privacy Practices from The Wellness Connection, which sets forth the ways in which my personal health information may be used or disclosed by The Wellness Connection, and outlines my rights with respect to such information.

_____ Patient's signature/Date

24600 MILLSTREAM DRIVE, SUITE 340, STONE RIDGE, VA 20105
703. 864.5824 ***www.WellnessConnectionLLC.com***

Adult Information Form

Thank you for your interest in our clinical services. To help us better serve you, please provide us with the information requested below. Please be assured that this information will be held confidential, and is necessary for the Center staff to determine appropriate evaluation and therapy services

Client Name: _____ Date: _____

Date of Birth: ___/____/____ Age: _____ Sex: ☐ M ☐ F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: _____ Cell: _____

Work: _____

E-mail: _____

Present Occupation: _____

Highest Level of Education Completed: _____

School Presently Attending, if applicable: _____

Place of Birth: _____

Native Language: _____ Other Languages Spoken: _____

How did you find out about this Center? _____

Name of person filling out questionnaire: _____

Relationship to client, if other than client: _____

Services Requested:
☐ Speech-Language Evaluation (*this includes Voice, Fluency)*
☐ Speech-Language Therapy
☐ Other _____

GENERAL INFORMATION

What symptoms/problems led you to request this evaluation? _____

_____

_____

What do you think may have caused the problem?

_____

_____

Date of onset (*month, day, year* problem was first noticed):

_____

Has the problem changed since it was first noticed (e.g. improved or worsened)?

_____

_____

Have you ever been treated for this problem before? ☐ Yes ☐ No

If yes, where and when?

_____

If yes, what were the recommendations?

_____

Have you had previous therapy for this condition? ☐ Yes ☐ No

Is yes, where and when?

_____

Was the treatment/therapy successful? ☐ Yes ☐ No

Have you seen any other specialists (physicians, audiologists, psychologists, neurologists, surgeons, etc)? ☐ Yes ☐ No

If yes, indicate the type of specialist, when you were seen, and the specialist's results or recommendations.

_____

_____

_____

MEDICAL HISTORY

Do you have or have you had any eating or swallowing difficulties?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you have or have you had any problems with your breathing?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Do you have or have you had any problems with vocal quality?

☐ Yes ☐ No

If yes, please describe:

_____

_____

Please list any serious injuries, high fevers, seizures, hospitalizations, surgeries, neurological events or diseases, physical handicaps, or other medical information that you think may be relevant. Please give dates or approximate ages for each event.

_____

_____

_____

_____

Are you presently under the care of a specialist (e.g. neurologist, an ear- nose- and throat

specialist (ENT), physiatrist (rehab M.D.), physical therapist, psychologist, or other? ☐Yes ☐ No

If yes, please list each specialist's name, address, and type of specialty:

_____

_____

_____

_____

_____

_____

Please complete this chart regarding any medication that you are currently taking.

Medication	Dosage	Frequency of Administration	Reason for Meds

Please describe any side effects you may be experiencing as a result of taking medications listed above:

_____

_____

_____

Please describe any problems with your teeth, tongue, mouth, ears, nose, or throat:

_____

_____

_____ _____

Are you right- handed or left- handed?

_____

Describe any vision or hearing problems you may have:

_____

_____

_____

FAMILY, SOCIAL AND EDUCATION INFORMATION

Do you have, or have you ever had, any school or learning problems?

☐Yes ☐ No

If so, please describe:

_____

_____

Do you have, or have you ever had, problems with memory or thinking?

☐Yes ☐ No

If yes, please describe:

_____

_____

Is there a family history of the problem that has brought you to our Center?

☐Yes ☐ No

If yes, please describe:

_____

_____

Do you use tobacco? ☐Yes ☐ No

If YES, amount: _____

Drink alcoholic beverages? ☐Yes ☐ No

If YES, amount: _____

Drink caffeinated beverages? ☐Yes ☐ No

If YES, amount: _____

Is there anything else you would like us to know?

_____

_____

_____

_____

_____

At the time of your evaluation, please bring all pertinent medical reports/information to the Center.

We thank you for your time, and the care with which you filled out this form. We look forward to serving you at our Center.

The Wellness Connection Team