

WELLNESS ASSOCIATES, P.C.
1001 Hickory Rd. , Suite 8A, South Bend, IN 46615
574-210-0771 (Phone) 574-287-1667 (Fax)
Katie L. Steele, Ph.D., CGP - Crystal Whitlow, LCSW - Denise Sellers, MS

Identifying Information:

Date: _____ SS # _____ - _____ - _____

Name: _____ Date of Birth: _____
First Middle Initial Last

Address: _____ Phone # _____
 _____ Cell # _____
City State Zip

E-mail address: _____

Age: ____ Sex: M F Relationship Status: Single/Married/Divorced/Widow/Significant Other

May we call you at home? Yes No May we leave messages at home? Yes No

Were you referred to this office? Yes No If yes, by whom? _____

Employment Information:

Employer: _____ Job Title: _____

May we contact you at work? Yes No Work Phone #: _____ - _____ - _____

Family and important relationship information:

Spouse/

Significant Other: _____ SS #: _____ - _____ - _____

Address: _____ Date of Birth: _____
If Different

Employer: _____ Job Title: _____

Please list individuals who are important to, or who live with, you. (Children, parents, friends)

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Someone (other than spouse) to contact in case of emergency:

Name Relationship Phone #

Present Situation:

Please circle any of the following problems that pertain to you:

- | | | | |
|-----------------------------|------------------|--------------------------|------------------------------|
| Nervousness | Depression | Fears | Motivation |
| Shyness | Interest in sex | Suicidal thoughts | Aggressiveness |
| Separation from partner | Divorce | Finances | Sexual or physical abuse |
| Drug use | Alcohol use | Intimate relationships | Family relationships |
| Anger | Self-control | Unhappiness | Difficulty paying attention |
| Tension | Stress | Tiredness | Sleep problems |
| Legal matters | Headaches | Anxiousness | Urge to repeat actions |
| Too much energy | Panic attacks | Concentration | Mood swings |
| Loneliness | Feeling inferior | Isolation or withdrawal | Impulsivity |
| Education | Work or Career | Physical health problems | Troublesome thoughts |
| Temper | Nightmares | Marriage | Being a parent |
| Relationships w/ child(ren) | Eating problems | Stomach trouble | Self-harm (cutting, burning) |

In your own words, please describe your present difficulties:

Health Information:

Family Physician: _____ Psychiatrist: _____

Are you on any medications? Yes No

If yes, list the type of medication and reason for taking it.

_____	_____
_____	_____
_____	_____

Other significant health problems: _____

Psychotherapy is very personal and by ethical standards a confidential process. However, we often find it helpful to discuss treatment procedures with your personal physician especially when there are physical symptoms. Please sign your name below giving our professional staff permission to contact your personal physician regarding your care and any medications you may be taking.

Signature: _____ Date: _____

Have you had any previous therapy/counseling? Yes No

If yes, please give Therapist/Agency and when: _____

Have you ever been diagnosed with any mental illness? Yes No

If yes, please describe: _____

Psychiatric Hospitalization? Yes No If yes, when/where: _____

Have you ever been addicted or a member of any 12 Step program (AA, NA, SAA, OA, EA, Al-Anon, etc)? Yes No

If yes, please describe: _____

Permission to Treat:

I, _____ give my permission for
(Client's Name)
Crystal Whitlow, LCSW to provide me with mental
(Therapist's Name)

health services that are within the scope of his/her license, certification, and training.

If you do not have insurance, please skip the following section and go to the next page.

Regarding Your Insurance:

If you would like us to file your insurance for you, it is necessary that you complete all of the following information. Please be sure to sign where indicated as this gives us permission to file for you and also to receive payment from your insurance company.

If you have any questions regarding the following, please ask your therapist.

Policyholder's Name: _____

Policyholder's Date of Birth: _____

Policyholder's Employer: _____

Client's Relationship to Policyholder: _____

Identification #: _____ Group #: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Phone # to verify coverage: _____

Phone # for mental health benefit pre-certification: _____

I acknowledge Wellness Associates, P.C. Services privacy notice, as required by HIPAA, has been made available to me. One facet of this notice outlines the information which can be released to insurance companies in order to process claims.

Signed: _____

I authorize payment of medical benefits to the provider for mental health services delivered:

Signed: _____

Insurance co-payment is due at the time of each visit.

Wellness Associates, P.C. Services Policies

Payment Policy And Confidentiality Disclaimer

Initial evaluation	120.00	Group Psychotherapy	60.00
Individual psychotherapy	100.00	Family Psychotherapy	125.00

Payment in full is expected at the conclusion of each session unless other arrangements have been made in advance. If we can verify your insurance benefits at the time of service and your deductible has been met, we will accept the amount (your co-pay) your insurance will not cover and bill them for the remaining amount. This also applies to all HMO's with a specific co-pay. In the event that your insurance company would deny payment at any time, payment for services provided then become your responsibility. For those whose insurance coverage or financial status does not allow payment in full, alternate payment schedules need to be discussed with the clinician and a specific payment plan arranged with the office manager.

I have read and understand these policies and agree to accept them.

Client signature

Confidentiality Disclaimer:

Understand that you are financially responsible for any remaining balance on your account once reasonable efforts to collect from your insurance company have been made. However, failure to respond in a reasonable manner to any accumulated debt on your account may result in involving our attorney. Should this occur we will follow all HIPAA requirements to protect your confidentiality. Your name, address, account balance, and other identifying information necessary to the collection procedures may be legally released to collect payment of debt. Your signature below indicates that you understand this possibility.

I have read and understand these policies and agree to accept them.

Client signature

Missed Appointments:

A specific time has been reserved exclusively for you when a therapy appointment is made. Therefore, notice is required 24 hours in advance of the scheduled appointment should you find you would be unable to keep your appointment. Appointments canceled with less than 24-hour notice will result in an assessment at a rate of a half the fee charged for a full session. Should you fail to keep a scheduled appointment without advance notice; a fee will be assessed at the full session rate. It should be understood that insurance policies will not cover costs incurred due to missed appointments. Your signature below indicates your understanding of this process.

I have read and understand these policies and agree to accept them.

Client signature