Become YOUR Happy LLC

***Wendy Wahlquist, LMFT**: Individual, Couple, and Family Therapist*
11565 Perry Hwy Ste 8 Wexford, PA 15090 p) 412-368-2072 f)412-430-0268
becomeYourhappy@gmail.com **www.becomeYourhappy.com**

INTRODUCTION TO BECOME YOUR HAPPY LLC

I am thrilled you have chosen Become Your Happy LLC to begin or continue your personal and/or relational growth. It can be a daunting process (not to mention what it already took you to get to this spot now). Seeing all these forms and policies can also be overwhelming, which I totally get. You can always have a copy (whether you do this electronically or hard copy) to refer to if needed. I also keep the intake packet up on my website for people to download, so in case you lose yours, you can still see what you signed.

The following pages review informed consent (the first one is a general one for everyone to sign), there is a consent form for couple's work if you are here with someone else (no need to sign this one if you are here alone). There are also policies and financial agreements spelled out, along with your HIPPA/privacy policy form, and lastly a demographic/client information form. Please complete them to the best of your ability, and feel free to ask questions. If you are coming in as a couple, please put both of your information down in the client information form, even though there is only space for one of you. Also, please both of you sign in every signature spot designated.

Thanks, and take a big breath before going to the first page of documents!

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INFORMED CONSENT FOR TREATMENT

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

I, Wendy Wahlquist, am a Licensed Marriage and Family Therapist (LMFT) in the state of Pennsylvania. I am also a clinical member of the American Association for Marriage and Family Therapists (AAMFT). I have taken advanced trainings in Somatic Experiencing (SE). I believe that people tend to know what is best for them deep down, and it is my job to assist them in discovering what they feel is the best solution. I am systemically oriented in my therapeutic work, seeing a problem as imbedded in relationships either within the family, or even the larger societal system.

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ACKNOWLEDGEMENT: I agree and consent to participate in therapy treatment provided through Become YOUR Happy LLC, by Wendy Wahlquist LMFT, a licensed marriage and family therapist. I understand that I am consenting and agreeing only to those services that the above named provider is qualified within the scope of the provider's license, certification, or training.

If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I agree to pay for all services provided by Become Your Happy LLC, including any charges not fully reimbursed by the insurance company. I understand that no insurance company will pay for missed sessions, and we agree to Become Your Happy LLC's policy of charging if we fail to cancel appointments in advance.

Signature(s) indicates that client(s) and/or guardian has read, understood, and agrees to all the above terms and conditions for receiving therapy services from Become YOUR Happy LLC.

_____ _____

Signature Date

_____ _____

Signature Date

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COUPLE And/Or FAMILY INFORMED CONSENT FORM

This document deals with privacy issues specific to couples and families and supplements the following Become Your Happy LLC forms: Practice Policies, Financial Policies, Privacy Practices, and Client Information Forms.

We understand that couple/family therapy begins with an evaluation of our relationship, past and present. While Wendy Wahlquist, LMFT at Become Your Happy LLC is deciding whether she is the appropriate therapist for us, we will decide whether we wish to begin couple/family therapy with her. We understand that because of the commitment of time and money, plus the potential impact on us and others (see below), it is important to make an informed choice for a couple/family therapist.

We have read and understand the potential limits of confidentiality, including those imposed by Become Your Happy LLC's policies and by state law, and we have received a copy to keep. If we have dependent children, we have read and understood the potential limits of confidentiality regarding access to records in child custody cases.

We understand that information discussed in couple/family therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners or children. We agree not to subpoena Wendy Wahlquist LMFT at Become YOUR Happy LLC to testify for or against either party or to provide records in a court action.

We understand all policies as described in Become Your Happy LLC's policy forms (as listed above) and accept them as conditions for entering into couples/family therapy with Wendy Wahlquist, LMFT at Become Your Happy LLC. We understand the limits and benefits of using insurance to pay for couples/family therapy. If we use insurance, we agree to provide all information needed to comply with insurance regulations. We understand that if we use insurance, Become Your Happy LLC will not retain control over information provided to the insurance company.

We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Wendy Wahlquist, LMFT. We understand that while working as a couple/family, anything either (any) of us tells Wendy Wahlquist, LMFT individually, whether by phone or in an individual session, may not be held as confidential, and at Wendy Wahlquist LMFT's discretion may be shared with the spouse/partner during a subsequent couple/family session.

We agree to share responsibility with Wendy Wahlquist, LMFT for the therapy process, including goal setting and termination. By entering into couple/family therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them. This is especially true if we have dependent children.

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Wendy Wahlquist, LMFT has explained that her therapeutic focus in couples therapy is on preserving and enhancing the relationship rather than a focus on individual happiness. In instances where if remaining together is harmful to one or both partners, the focus will be on facilitating an amicable separation and in cases with children how to separate in a way that is best for the children.

We agree to pay for all services provided by Become Your Happy LLC, including any charges not fully reimbursed by the insurance company. We understand that no insurance company will pay for missed sessions, and we agree to Become Your Happy LLC's policy of charging if we fail to cancel appointments in advance.

By signing below, we agree to accept mental health services from Become Your Happy LLC and accept full responsibility for payment for such services.

Partner #1_____ Date_____

Partner #2_____ Date_____

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PRACTICE AND FINANCIAL POLICIES

PRACTICE POLICIES

Welcome to my therapy practice. It is my hope and intent that our therapeutic relationship will be productive and helpful to you in achieving your desired goals. This document outlines most of my policies and practices. There are additional forms to supplement these policies, but are separated for ease of reference. Please read these carefully and feel free ask any questions you may have.

INITIAL ASSESSMENT: The first one to three sessions are considered intake sessions. I will be getting to know you, compiling a thorough biopsychosocial assessment, and learning what you hope to accomplish through therapy. This will determine the course of your future treatment. Together we will agree on what you want to accomplish, and we will develop an appropriate course of action. Periodically, we will review these objectives to determine if the therapy is productive. If necessary, you may be referred to other professionals, programs, and/or community resources.

APPOINTMENTS AND CANCELLATIONS

The standard meeting time for psychotherapy is 45-50 minutes. I have reserved a time slot just for you. Please let me know at least 24 hours in advance if you are not able to make it to your appointment so that I may open up that slot for someone else. You will be responsible for up to the entire fee if cancellation is less than 24 hours. If there is some type of notice given with a reasonable need to reschedule or cancel that is less than 24 hours, then the late cancellation fee is reduced to $50, otherwise the fee is $100. This charge will not be covered by insurance. I reserve the right to waive that fee for agreed upon emergencies, or if you are able to reschedule for another slot that week, provided there is an opening.

Cancellations and re-scheduled session will be subject to a full charge if notice is not received at least 24 hours in advanced. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY AND AVAILABILITY

If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours during the work week. If you call during the weekend, I will attempt to return calls on Monday and Tuesday. Please note that Face- to-face sessions are highly preferable to phone ore telehealth sessions. However, in the event that you are out of town, sick or need additional support, phone consultations or telehealth sessions are available (see next two paragraphs). Become YOUR Happy LLC does not provide emergency counseling services. If you are in crisis or critical distress and/or have thoughts of hurting yourself or others, please seek the support of friends and family, utilize community resources such as the crisis hotline, call 911, and/or go to the nearest hospital emergency room.

TELEPHONE CONSULTATIONS: Brief telephone contacts lasting less than five minutes and calls or emails relating to scheduling issues will not be billed. "Phone therapy" or Telephone consultations are available, though they need to be scheduled in advance. The fee for telephone consultations is $100 per hour, as the entire hour was blocked out for your use. This is not covered under insurance, so it is an out of pocket expense.

TELEHEALTH SESSIONS: Breakthrough is a platform that is like "skyping" yet is HIPPA compliant. When the need arises, we can agree to use Breakthrough and do a video session. These are the same fee as regular sessions, and some insurance companies reimburse for these. If your insurance doesn't cover, then you can pay out of pocket. Using that website will have a special consent form for using it.

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ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. It is a great way to communicate with me for said purposes, and you will likely get a quicker response to email than phone in between sessions. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Occasionally people will send clinical information through email. Please be advised that email is not a secure medium, and confidentiality is at risk. Email communication is also considered part of your chart/record. Additionally, clinical issues are best addressed during our therapy sessions so the general policy is to keep clinical issues out of email. If you do send a lengthy email that would require significant time to read and/or respond to, I may confirm with you whether you would like me to wait until our scheduled session to read and address the topics, or I will charge you for the time it takes to read and respond via email, which is pro-rated at $125 an hour.

SOCIAL MEDIA

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn,Google+ etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. I do however, have a business page on Facebook as well as Google + which I welcome your "likes" and participation. You can find both of these as Become Your Happy LLC.

CONFIDENTIALITY: All communications between us are confidential with some significant exceptions, which are outlined in both the *Notice of Privacy Practices* form, and respective *Informed Consent* forms. In addition, there are instances when there is more than one person in the therapy room (*i.e.* couples or families). In these instances, the need for confidentiality needs to be clear between all parties. This can be discussed at the beginning of treatment or as situations arise.

MINORS

If you are a minor (under 18), your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential. Generally speaking, when there is a minor in therapy, there is a certain degree of confidentiality to allow that person to feel secure sharing information that won't go back to the minor's parents, but only with the understanding that if anything is considered dangerous or a risk to the minor's health or to others, that it will be shared with parents/caregivers.

COUPLES AND FAMILIES

There are instances when there is more than one person in the therapy room (i.e. couples or families). In these instances, the need for confidentiality needs to be clear between all parties. This can be discussed at the beginning of treatment or as situations arise. For situations where there is a couple in treatment, and communication from one party occurs without the other present or aware (phone calls, emails, or individual sessions) there is a general understanding that the information can be shared with the other party as the goal is to help the couple, unless circumstances require confidentiality.

INCLEMENT WEATHER POLICY

I will honor the Seneca Vally School District closing and delay schedule. I may or may not be able to get to the office myself during these times, so please look for an email by 8am that day whether I will be in the office or not. If it is unsafe for you to make your appointment, please do not come in. Please call and leave me a voice mail, or send me an email. There will be no missed appointment or late cancellation fee for inclement weather issues dealt with in this way. We also have the option of doing a phone consultation or a telehealth session.

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LEGAL

Your work with me is not intended for use in any legal proceedings that you may be involved in with others, or with your spouse or partner. You agree through this consent to not subpoena Wendy Wahlquist LMFT/Become Your Happy LLC to testify (against either party) or to provide records in court actions (these include divorce and child custody proceedings).

TERMINATION OF TREATMENT

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

If you wish to terminate, please bring this up for us to discuss. If you cancel or miss a scheduled appointment and do not contact me within 30 days of the missed appointment date, it will be understood that you have terminated treatment. Legal obligations require me to inform you that once treatment is terminated, I am no longer your therapist and our therapeutic agreement ceases. If you decide at a future date to re-enter therapy with me, I will be happy to make every effort to see you. You will be expected to take care of any balance you owe. If I am unable to fit you in my schedule, I will provide appropriate referrals. If two sessions are missed or no contact made after 30 days, your file will be closed. Usually, no follow up attempts will be made to contact you once your file is closed.

FINE PRINT LEGAL STUFF

Become YOUR Happy LLC is not responsible or liable for any property loss, property damage, physical injury, or psychological stress that clients may sustain which is not a result of gross negligence by Become YOUR Happy LLC. Clients are completely responsible for their actions and well-being.

ACKNOWLEDGEMENT:

Signature(s) indicates that client(s) and/or guardian has read, understood, and agrees to all the above terms and conditions for receiving therapy services from Become YOUR Happy LLC.

_____ _____
Signature Date

_____ _____
Signature Date

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FINANCIAL POLICIES

SERVICE FEES

I charge $100 for a 45 minute session, and $125 for a 53-60 minute session. This includes making the payment and rescheduling. The Initial Diagnostic Interview or intake process for the first session is charged at $150. The fee structure may be reassessed periodically, and if you are a "self pay" client, feel free to talk to me about fees.

For your convenience, I accept cash, check, and credit card; a $4 convenience fee may be added for payments made by credit card. If you pay by check, please ensure that you have sufficient funds in your account as there will be a $35 fee for a bounced check, plus whatever balance was due and any additional fees charged by the bank due to the bounced check. Insurance will not cover this fee.

PAYMENT AND THIRD PARTY REIMBURSEMENT

Payment is due at the time of service. I accept select insurance assignments, currently Highmark Blue Cross Blue Shield. You will then be responsible and billed for any allowable balance which was not paid by your insurance. If you have a co-pay, it will be due at the time of your session. Please also remember to bring your insurance card with you to the first visit. By signing this form, you agree that I (or any contracted billing company I hire) may submit claims to your insurance company for payment.

For insurance companies that I am out of network with, I can provide a receipt for services that contains the information that most insurance companies require. It will be your responsibility to submit your bills for reimbursement. If you have no insurance coverage, you will be responsible to make payment for all charges on the date of service. If you wish for me to submit claims for out of network benefits, please discuss this with me on our first session.

For your convenience, I accept cash, check, and credit card. If you pay by check, please ensure that you have sufficient funds in your account as there will be a $35 fee for a bounced check, plus whatever balance was due and any additional fees charged by the bank due to the bounced check. Insurance will not cover this fee.

SPECIAL FEES

Please be aware that I may charge special fees for services that are done outside of our sessions, such as copying records, phone consultations, completion of certain forms, letters, security clearance checks, long emails or phone calls, etc. The rate for these services is based on the amount of time required, prorated from my hourly fee. Please note that this is not covered by insurance, and completely your responsibility.

LEGAL FEES

Your work with me is not intended for use in any legal proceedings that you may be involved in with others, or with your spouse or partner. You agree through this consent to not subpoena Wendy Wahlquist LMFT/Become Your Happy LLC to testify against either party or to provide records in court actions (these include divorce and child custody proceedings).

In my role as a marriage and family therapist, I find that being pulled into legal matters alters the therapeutic relationship and ability to help all parties involved. I do not voluntarily take on legally charged cases where I may be required to attend court or legal proceedings for this reason. If I am subpoenaed or requested to participate in legal proceedings despite my stance, and your agreement here to not have me/forms subpoenaed, my fees for anything related to court/legal issues are $250 an hour. This includes travel time, document preparation, consultation with legal and ethics board, being at court, and anything else that may be required in this process. Please consider our work together as something to help you grow, and not something that will be involved in court.

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COLLECTION FEES

If your account goes into collections, you will be responsible for any fees which may be associated with such collection efforts. Please let me know in advance if you are having difficulty with your payments so that I can help you work out a payment plan before your account goes into collections. I do my best to avoid sending anything to collections, trying to work with you first.

ACKNOWLEDGEMENT:

Signature(s) indicates that client(s) and/or guardian has read, understood, and agrees to all the above terms and conditions for receiving therapy services from Become YOUR Happy LLC.

_____ _____

Signature Date

_____ _____

Signature Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. MY PLEDGE REGARDING HEALTH INFORMATION:
I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.
• Give you this notice of my legal duties and privacy practices with respect to health information.
• Follow the terms of the notice that is currently in effect.
• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

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III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. If I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
   a. For my use in treating you.
   b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
   c. For my use in defending myself in legal proceedings instituted by you.
   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
   e. Required by law and the use or disclosure is limited to the requirements of such law.
   f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
   g. Required by a coroner who is performing duties authorized by law.
   h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

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VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on September 20, 2013

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

_____ _____

Signature of Client / Custodial Parent / Guardian Date

_____

Printed Name of Client

Become YOUR Happy LLC

***Wendy Wahlquist, LMFT**: Individual, Couple, and Family Therapist*
11565 Perry Hwy Ste 8 Wexford, PA 15090 p) 412-368-2072 f)412-430-0268
becomeYourhappy@gmail.com **www.becomeYourhappy.com**

CLIENT INFORMATION FORM

Date Completed: _____

Basic Demographic info:

Name of person completing form :_____Relationship: _____

Identified Client name: _____ Date of Birth: _____

Address:_____

Telephone Nos.: (H) _____ (W) _____ (C) _____

Other Telephone No: (H)_____ (W)_____ (C) _____ emails:

_____

Insurance info: *Information needed to obtain **outpatient mental health benefits**:*

Policy Holder Name: _____ Policy holder Date of Birth: _____

Insurance Carrier: _____ Insurance ID: _____

Group #: _____ Provider Service # from back of card: _____ (Look for a different number for mental health benefits and/or possibly a different insurance company listed on the card specifically for mental health benefits)

- *Please complete the following information when you place the call to verify outpatient mental health benefits.*

Effective Date: _____

Benefit Year (calendar, fiscal, monthly) : _____ to _____

Co-Pay: _____ Co-Ins: _____ Deductible: _____

Out of Pocket Max per Year: Individual: _____ Family: _____

Number of Office Visits Allowed Per Benefit Year: _____

Number of Visits Remaining: _____

Authorization Required: (Y/N)_____ Authorization#:_____

Effective/Expiration Date: _____

Number of sessions: _____

Verify Where Mental Health Claims get sent - Electronic Payer ID: _____

Address: _____

_____

Date Verified: _____ Person Verified With: _____

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Emergency Information:

Name of Emergency Contact and relationship:_____

Phone(s): _____

Other contact info:_____

Identified Client Information:

Check as many as apply:	Committed Relationship _____	Single _____
	Divorced _____	Separated _____
	Widowed_____	Other _____

Highest level of education attained: _____

Employer: _____Occupation: _____

School (for children, and adults when applicable): _____

Guardianship (for children and adults when applicable): _____

Name of partner, child/children:	Age:	Date of birth:	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental Health History:

Have you ever been involved in therapy or any other type of counseling program? □Yes □No

If yes, when? _____ Where? _____

Reasons: _____

Reasons for considering therapy at this time: _____

_____

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

Are you in treatment with another counselor presently? □Yes □No

If yes, with whom? Name: _____How long? _____

Have you ever taken medications for mental health reasons? □Yes □No

If so, please list, with any side effects: _____

_____

Are you currently prescribed **any** medications? □Yes □No Please list: _____

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_____

Name of prescribing physician: _____ Phone: _____

Have you ever been hospitalized for any mental health reason? □Yes □No

If yes, when? _____ Where? _____

Reason: _____

Substance Abuse History:

Have you ever, or are you now being treated by any type of chemical dependency abuse? □Yes □No

If yes, when? _____ Where? _____

By whom? _____ Length of treatment: _____

Are you using any type of chemical substance at this time? □Yes □No

Medical History:

Are you presently under a physicians care for physical problems? □Yes □No

Height:_____ Weight:_____ Date of last physical exam:_____

Physician:_____ Phone:_____

Please circle any of the following illnesses or conditions that you have experienced:

□ BLADDER/BOWEL	□ CANCER/TUMORS	□ DIABETES	□ EATING DISORDER
□ EYE/EARS/THROAT	□ HEADACHES	□ FAINTING	□ HEART
□ HIGH BLOOD PRESSURE	□ HIV INFECTION	□ LUNG/BREATHING	□ THYROID
□ MENSTRUAL PROBLEMS	□ SEIZURES/CONVULSIONS	□ SKIN DISEASE	
□ SLEEP PROBLEMS	□ STOMACH/LIVER		

Please list major surgeries/serious diseases/serious injuries that you have had and when these occurred:

_____
_____
_____
_____

List any prescription or over the counter medication or supplement that you currently use:

MEDICATION	AMOUNT	FREQUENCY	DATE BEGAN TAKING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any medication therapy which proved ineffective? YES □ NO
If yes, Please describe:_____
Have you had any allergies or adverse reactions to any medications? □ YES □ NO

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If yes, please describe:_____

_____

_____

Have you used any of the following substances in the last six months? If yes, please describe amount and frequency of use:

□ YES □ NO ALCOHOL_____

□ YES □ NO CAFFEINE_____

□ YES □ NO TOBACCO_____

□ YES □ NO ILLEGAL DRUGS_____

Please list any serious medical/psychiatric illness or condition found in your parents or siblings:

_____

_____

_____

_____

Please check any of the following that you currently experience:

□	DIFFICULTY FALLING ASLEEP	DATE BEGAN_____
□	EARLY MORNING AWAKENING	DATE BEGAN_____
□	WAKING UP TIRED	DATE BEGAN_____
□	SLEEPING TOO MUCH	DATE BEGAN_____
□	DIFFICULTY CONCENTRATING	DATE BEGAN_____
□	FREQUENT TEARFULNESS	DATE BEGAN_____
□	FATIGUE	DATE BEGAN_____
□	SIGNIFICANT WEIGHT CHANGE	DATE BEGAN_____
□	FEELINGS OF WORTHLESSNESS	DATE BEGAN_____
□	FEELINGS OF GUILT	DATE BEGAN_____
□	FEELINGS OF SADNESS	DATE BEGAN_____
□	FEELINGS OF HELPLESSNESS	DATE BEGAN_____
□	SENSE OF FEELING SLOWED DOWN	DATE BEGAN_____
□	DIFFICULTY EXPERIENCING PLEASURE	DATE BEGAN_____
□	INDECISIVENESS	DATE BEGAN_____
□	RESTLESSNESS	DATE BEGAN_____
□	THOUGHTS OF DEATH	DATE BEGAN_____
□	SUICIDAL THOUGHTS	DATE BEGAN_____

Current Reasons for seeking therapy:

What problems are you experiencing at this time?

_____

_____

_____

_____

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What do you expect from therapy?

_____

_____

_____

Please list everyone with whom you presently live:

_____

_____

_____

What resources do you have (internal and external) that help you feel a bit better when you think about them?_____

_____

_____

_____ Date:_____

(Signature)

_____

(Signature)