Become YOUR Happy LLC

***Wendy Wahlquist, LMFT**: Individual, Couple, and Trauma Therapist*
71 Dutilh Rd Cranberry Twp, PA 16066 p) 412-368-2072
wendy@becomeyourhappy.com **www.becomeYourhappy.com**

Couple Therapy Intake Packet
Welcome. This document outlines important information about couple therapy services, confidentiality, policies, and your rights. Please read it carefully and discuss any questions before signing.

THERAPY CONSENT, POLICIES, & AGREEMENT

PART I: PROCESS AND POLICIES

About Couple Therapy
Couple therapy focuses on the relationship as the client. My role is to facilitate respectful communication, increase understanding, and help both partners work toward agreed-upon goals. At times, sessions may feel emotionally intense. Progress often requires openness, accountability, and willingness from both partners.
If at any point either partner believes couple therapy is not appropriate, referrals can be discussed.

Structure of Therapy
Sessions are typically 50–55 minutes unless otherwise agreed.
I may meet with partners together or individually as clinically appropriate.

No-Secrets Policy
Information shared with me individually may be brought into joint sessions if it is relevant to the therapeutic process. Couple therapy operates under a no-secrets policy, meaning I cannot agree to keep information from one partner that directly impacts the relationship.

Teletherapy
You have the option of conducting your therapy appointment virtually via a telephone or computer. I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. Under ethical guidelines, I can practice only in the state(s) where I am licensed. This means that I must be licensed in the state where you are receiving therapy services. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

If we lose the video or phone connection during our session, I will attempt to call you immediately. If you do not receive a phone call from me within one minute, please try to reach me at 412-368-2072. I will attempt to call you three times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me and there is time left in your session, we will continue with therapy or schedule an alternate time to complete the remaining minutes of our session. If the reason for the connection loss (*i.e.* technology issues, phone battery dying, bad reception, etc.) occurs on your part, you will still be charged for the entire session. If the loss of connection is a result of something on my end, I will call you from an alternate number. This number may show up as a restricted or blocked number, but please be sure to answer the call.

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Please note that recording (or screenshots) of any kind during a therapy session are **not permitted** and are grounds for termination of the client-therapist relationship.

Appointments & Cancellations
Your appointment time is reserved exclusively for you.

- Cancellations require at least **24 hours notice**.
- Late cancellations (less than 24 hours notice): **$50 fee**
- No-shows (no notice): **Full session fee ($150)**

Repeated cancellations may result in reassessment of treatment commitment. More than three missed sessions without proper notice may result in termination of services.

Fees & Payment

- 55-minute session (in person or virtually): $150

Payment is due at the time of service unless otherwise arranged. Accepted forms of payment include cash, check, credit/debit card, or Zelle (upon request). **I will not bill insurance for couple therapy**.

Services outside of session (phone calls over 10 minutes, documentation, letters, coordination of care, etc.) are billed at $150 per hour, prorated in 15-minute increments.

Outstanding balances may result in suspension of services.

Individual therapy is generally covered to some degree by insurance**, but couple therapy is not.**

Good Faith Estimate (Federal Requirement)
Under the No Surprises Act, you have the right to receive a Good Faith Estimate explaining the expected total cost of non-emergency healthcare services *if you are uninsured or not using insurance*.
• You may request a Good Faith Estimate at any time.
• If you receive a bill that is at least $400 more than your Good Faith Estimate, you may dispute the bill.
• Information on how to dispute a bill will be included with your estimate.

Trial, Cort Ordered Appearances, Litigation
Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest that you do not request my participation in your court case. If I do get called into court by you or your attorney, **you will be charged a fee of $300 an hour to include travel time, court time, preparing documents, working with legal and ethics board, etc.**

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Emergencies

I do not provide 24-hour crisis services.

In case of emergency:

- Call 911
- Call or text 988 (Suicide & Crisis Lifeline)
- Contact Resolve Crisis Services: 1-888-796-8226

If there is immediate danger, call 911.

Emergency Contact:

It is necessary that Wendy Wahlquist, LMFT of Become Your Happy LLC has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name	Relationship	Phone Number(s)

Please check here that you agree and sign below. Thank you.

☐ I agree to allow Become Your Happy LLC to contact my emergency contact on my behalf in the case of emergency

Signature	Date

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PART II: CONFIDENTIALITY

Your privacy is very important to me. What you share in therapy is confidential and will not be disclosed to others without your written permission, except as required or permitted by law. If you have questions about confidentiality at any time, please ask.

There are important exceptions to confidentiality, including situations involving suspected abuse or neglect of a child or vulnerable adult, risk of serious harm to yourself or others, certain court orders, or other legal requirements. When possible, I will make every effort to discuss these situations with you before taking action.

A more detailed explanation of how your information may be used or disclosed is provided in the **Health Insurance Portability and Accountability Act (HIPAA) – Client Rights & Therapist Duties** section of this document.

In addition to the disclosures required under HIPAA, confidential information may be disclosed without your authorization in the following circumstances:

Couple & Family Therapy

In couple or family therapy, information disclosed by either party may be part of the clinical record. The therapeutic relationship is with the couple, so records are maintained as a single clinical record unless otherwise required. I operate under a "no secrets" policy for conjoint therapy, meaning information shared individually that significantly impacts treatment may be brought into joint sessions. If secret-keeping interferes with treatment goals, a referral may be provided.

Electronic Communication & Social Media

Electronic communication is intended for scheduling or brief administrative matters. Clinical concerns should be addressed during sessions. Electronic communication carries privacy risks. By signing this document, you acknowledge understanding those risks. Electronic communications become part of the clinical record. Social media friend or connection requests from current or former clients will not be accepted in order to maintain professional boundaries and confidentiality.

Telehealth Confidentiality

Telehealth services are provided through HIPAA-compliant platforms when possible. However, electronic communication carries inherent risks, including technological failure or unauthorized access. For instance, phone conversations can be intercepted either accidentally or intentionally. I provide services from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. In other words, you are responsible for ensuring privacy on your end during sessions.

You must provide your physical location at each telehealth session in case emergency services are required.

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PART III: CONSENT

I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Wendy Wahlquist, LMFT. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services, either in-person or via teletherapy, and agree to abide by the agreement and policies listed in this consent. I authorize Wendy Wahlquist, LMFT to provide counseling services that are considered necessary and advisable.

Printed Name	Signature	Date

Witness –Wendy Wahlquist, LMFT **Date**

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APPOINTMENT CANCELLATION AND NO SHOW POLICY

There is a waiting list of clients for open time-slots, and when you schedule an appointment, that time-slot is reserved for you. If you need to cancel an appointment, please provide at least 24 hours notice to allow for sufficient time to offer your time-slot to another client.

Company policy requires that you have a current credit card on file. If you do not show up for your scheduled appointment, your credit card will be charged a $150 fee. If your appointment is cancelled less than 24 hours before the appointment (notice is given), your credit card will be charged a $50.00 fee. This fee may be waived for emergencies, or if you reschedule for the same week, provided there is an opening. Your signature bellows indicates your consent to this cancellation fee policy and authorization to charge your credit card the $150 or $50.00 fee when applicable. You may also choose to keep this card on file for any co-payments for sessions.

_____ _____
Credit Card Number expiration date

_____ _____
Name on Card CCV (3 digits on back)

_____
Signature

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HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal privacy law, including the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provides protection for your Protected Health Information (PHI) and gives you certain rights regarding how your information is used and disclosed.
Your Protected Health Information includes information about your mental health condition, treatment, payment for services, and any other information that could identify you.

HIPAA requires that Wendy Wahlquist LMFT of Become Your Happy LLC provides you with a Notice of Privacy Practices explaining how your PHI may be used and disclosed for purposes of treatment, payment, and health care operations. I am required to make this Notice available to you and to make a good faith effort to obtain your written acknowledgment that you have received it.

If you have any questions about your privacy rights or how your information is handled, please ask. You may revoke certain permissions in writing at any time, except to the extent that action has already been taken in reliance upon them.

Federal law provides additional privacy protections for certain Substance Use Disorder (SUD) treatment records under **42 Code of Federal Regulations Part 2 ("Part 2")**.

If you receive diagnosis, treatment, or referral for treatment related to a substance use disorder, records relating to that care may be subject to Part 2 protections.

Under this law:

- Your SUD treatment records may not be used or disclosed without your **explicit written consent**, except as permitted by law.
- Disclosures may be permitted in limited circumstances, including medical emergencies, mandatory reporting of child abuse or neglect, certain court orders, or other situations specifically authorized by federal law.
- If you provide written consent for disclosure, you may revoke that consent at any time, except to the extent that action has already been taken in reliance on it.

If Part 2-protected records are disclosed to us for purposes of treatment, payment, or healthcare operations, we will handle them in accordance with all applicable federal and state privacy laws.

The law requires that I make this Notice available to you and make a good faith effort to obtain your written acknowledgment that you have received it.

Uses and Disclosures of Your Information

In most situations, I may use or disclose your PHI for the following purposes without additional authorization:

- **Treatment** – Providing, coordinating, or managing your care.

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- **Payment** – Submitting claims to insurance and collecting payment for services.
- **Health Care Operations** – Administrative, legal, audit, or quality improvement activities necessary to operate the practice.

I may also disclose the minimum necessary information to business associates who perform services on my behalf (such as billing or electronic record services). All business associates are required to maintain the confidentiality of your information.

Limits on Confidentiality

The law protects the privacy of communications between a client and a therapist. However, there are circumstances in which I am legally permitted or required to disclose information without your authorization.

These include:

Court Proceedings and Legal Requests

If you are involved in a court proceeding and information about your treatment is requested, I will not release information without your written authorization, a valid court order, or a properly issued subpoena as required by law. If you are involved in litigation, you are encouraged to consult with an attorney regarding your rights.

Government Oversight

I may be required to disclose information to government agencies for health oversight activities within their legal authority.

Complaints or Legal Action Against the Practice

If you file a complaint or lawsuit against me, I may disclose relevant information to defend myself.

Worker's Compensation Claims

If you file a worker's compensation claim and I am providing treatment related to that claim, I may be required to provide relevant treatment information to appropriate parties.

Mandatory Reporting Requirements

I am legally obligated to take protective action in certain circumstances and may need to disclose information to comply with state or federal law.

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Child Abuse

If I know or have reasonable cause to suspect that a child under the age of 18 has been abused or neglected, I am required to file a report with ChildLine (1-800-932-0313). I may be required to provide additional information following such a report.

Vulnerable Adult Abuse

If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, I am required to report this to the Pennsylvania Abuse Hotline (1-800-490-8505).

Risk of Harm

If I believe there is a clear and immediate probability of serious physical harm to you or another person, I may disclose necessary information to protect your or others' safety, including contacting appropriate authorities or individuals.

Your Rights Under HIPAA
You have the right to:

- Request restrictions on certain uses and disclosures of your information (though I may not be able to agree to all requests).
- Request confidential communication (for example, at a different address).
- Inspect and request a copy of your record (subject to legal limitations).
- Request correction of inaccurate or incomplete information.
- Receive an accounting of certain disclosures of your information.
- Receive a copy of this Notice of Privacy Practices.

Requests must be made in writing.

Breach Notification

If a breach of unsecured Protected Health Information occurs, you will be notified in writing in accordance with federal law.

Complaints

If you believe your privacy rights have been violated, you may file a complaint:
• Directly with Wendy Wahlquist, LMFT
• With the U.S. Department of Health and Human Services, Office for Civil Rights

Complaints to HHS may be filed electronically through the Office for Civil Rights Complaint Portal or by mail.

You will not be retaliated against for filing a complaint.

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Acknowledgment
By signing this intake paperwork, you acknowledge that you have received and reviewed this Notice of Privacy Practices.

Your signature also acknowledges:
• Understanding of your rights under HIPAA
• Understanding of breach notification procedures
• Understanding that this Notice may be updated and how to obtain the most current version

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinician Typed Name & Credentials: Wendy Wahlquist, LMFT_____ Date: _____

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DEMOGRAPHIC INFORMATION FORM

1st Name: Date:

DOB: Age: Gender: Sexuality: Race:

Address:

Phone Number(s):
Is it ok to leave a voicemail? *YES* *NO*

Email:
Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

2nd Name: Date:

DOB: Age: Gender: Sexuality: Race:

Address:

Phone Number(s):
Is it ok to leave a voicemail? *YES* *NO*

Email:
Would you like to receive email communication? *YES* *NO*

Is it ok to send something in the mail? *YES* *NO*

Date Completed:

How were you introduced to us?