Welcome to Mental Health & Wellness Center, LLC –

Thank you for allowing our practice to work with you and/or your family. We want Mental Health & Wellness Center, LLC to be a place of encouragement and effective change. We realize that this investment of your time, energy, and resources is valuable, and we are grateful you have chosen our practice as the place to begin the process of counseling and healing.

Please take a moment to read the enclosed paperwork and complete the requested information. It's important this is completed and turned in at your first appointment. Our Clinical Therapists will be happy to assist you and answer any questions you may have at the initial therapy session.

Please have your payment and insurance card ready upon arrival. (Including co-pay, Deductible, etc.) We cannot bill you for appointments, all payments/copays are due at time of service.

Please try to arrive 15 minutes before your scheduled appointment time to allow for any additional paperwork that may be required. If you need to CANCEL your appointment, we do ask that you call at least 24 HOURS prior to the appointment.

Again, thank you for selecting our practice and allowing us to help. We look forward to working with you.

Sincerely,

Mental Health & Wellness Center, LLC

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Client Registration Form – Adult

DEMOGRAPHIC INFORMATION

Client's Full Name_____ D.O.B._____ Age_____

SSN _____ Male _____ Female_____

Address _____ City _____ State _____ Zip code _____

Home Phone _____ Cell Phone _____ Other Phone _____

OK to leave messages? (Check all that apply) Home ____ Cell ____ Text _____ Email _____

Email Address: _____

Place of Employment _____ Occupation: _____

Marital Status (circle one) Single Married Separated Divorced Widowed

INSURANCE INFORMATION

Primary Insurance:
Name on Card (exactly as written): _____ Date of Birth: _____

Primary Insurance Company_____ Phone #_____

Member ID# _____ Group ID# _____

Secondary Insurance:
Name on Card (exactly as written): _____ Date of Birth: _____

Secondary Insurance Company_____ Phone #_____

Member ID# _____ Group ID# _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone #:_____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Clinical Assessment – Part I

Demographic Information

Client Name: _____ Person Completing This Form (if not client): _____

How did you hear about Mental Health & Wellness Center, LLC? □ Insurance □ Physician □ Employer □ Friend □ Online:_____ □ Other: _____

Is the client required to attend therapy by an outside source (i.e. court ordered): □ yes □ No If yes, by whom: _____

Name of Household Members	Age	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Information

Please describe any medical/physical health problems:

_____

_____

Currently prescribed medication? □ Yes □ No If yes, please list:

_____

_____

Previously prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

_____

_____

Clinical Assessment – Part I

History of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No If yes, please list client's previous therapist/practitioner: _____

Do any family members or extended family members have a history of any type of mental illness? □ Yes □ No If yes, please list and include the type of problems, hospitalizations, with dates and the providers: _____

_____

Presenting Problem

Describe your reason for visiting Mental Health & Wellness, LLC:

_____

_____

Circle current problems and indicate how long each problem has been present.

Problem	*How Long?*	*Problem*	*How long?*	*Problem*	*How long?*
Abuse/Violence		Adoption / Foster Care		Anger Management	
Anxiety/Worry		Attachment Issues		Chronic Pain/Illness	
Depression		Eating Disorder		Family Concerns	
Financial Stressors		Grief & Loss		Homicidal Thoughts	
Hyperactive		Inattentiveness/Distracted Easily		Low Self Esteem /Self Worth	
Mood Swings		Poor Social Skills		Recent Weight Loss/Weight Gain	
Relationship/Marital Concerns		School-Related Issues		Sexual Concerns/Behaviors	
Sibling Rivalry		Sleeping Problems		Suicidal Thoughts	
Substance Abuse		Trauma		Work-Related Issues	

Additional information: _____

_____

Clinical Assessment – Part I

Substance Use/Abuse

Substance Used	*Amount?*	*How Often?* (*Please check the correct response.*)				*Date of Last Use?*
Nicotine (Any form)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Alcohol (Beer, Wine, Liquor)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Marijuana or Hashish (Weed, Pot, Grass)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Barbiturates (Downers, Quaaludes, Ludes, Blues)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Amphetamines (Uppers, Speed, Ritalin, Ecstasy, Molly, Meth, Crystal)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
LSD, MDA, Mushrooms, Peyote, Other Hallucinogens (Acid, Shrooms)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
PCP (Angel Dust)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Cocaine (Coke, Powder)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Crack Cocaine (Crack, Rock, Freebase)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Inhalants (Glue, Gasoline, Spray Cans, Whiteout, Rush, etc.)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Opioids (Heroin, Methadone, Suboxone, Smack, Horse, Opium, Morphine)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Synthetic Drugs (Synthetic Marijuana, Bath Salts, Dilaudid, Fentanyl)		*Experimented*	*Monthly*	*Weekly*	*Daily*	
Other: _____		*Experimented*	*Monthly*	*Weekly*	*Daily*	

Do any family members or extended family members have a history of any type of substance abuse? □ Yes □ No If yes, please list and include the type of problems, treatments, with dates and the providers: _____

_____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Clinical Assessment – Part I

Therapeutic Goals

Please list three client strengths:

_____ _____ _____

Please list three client limitations or weaknesses:

_____ _____ _____

What goals do you have for therapy?

_____

_____

Staff Use Only:

Notes:

Therapist Signature: _____ *Date:* _____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Release of Information

Communication between behavioral health care providers and your primary care physician (PCP), the specialist/medical professional prescribing and overseeing your psychotropic mediations, other behavioral health providers and/or medical/psychiatric facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) your other provider(s). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress and medication, if necessary.

Patient Authorization

☐ I hereby refuse to give authorization for any release/exchange of information.

☐ I agree to give Mental Health & Wellness Center, LLC, authorization for the exchange of information with: (COMPLETE SECTIONS BELOW)

Provider Name _____Provider Phone/Fax _____

Provider Address _____ _____ _____ _____
Street City State Zip Code

Disclosure may include the following verbal and/or written information: (check all that apply)

☐ Psychological eval/testing results ☐ Medication records ☐ Substance abuse treatment records

☐ Laboratory/diagnostic testing results ☐ Psychological consult ☐ Psychosocial assessment

☐ Mental/Behavioral health consult ☐ Psychiatric evaluation ☐ Summary of treatment records

☐ Intake/Discharge summary ☐ Educational/Social Evaluations or assessments

☐ Behavioral reports in school/daycare ☐ Other: _____

☐ Treatment Attendance

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Release of Information

Redisclosure Notice: I understand that if a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be redisclosed by the recipient and no longer be protected by such laws.

I have the right to inspect or copy the health information to be used or disclosed for this release. I have the right to receive a copy of this release. I understand that this release is voluntary and that I may refuse to sign this release. Unless allowed by law, my refusal to sign this release will not affect my/client's ability to obtain treatment, receive payment or eligibility for benefits. I have the right to revoke release with written notification to Mental Health & Wellness Center, LLC to cancel this release. This release of information is active for one year or until (insert date) _____.

I have had an opportunity to review and understand the consent for release of information. By signing this release, I am confirming that it accurately reflects my wishes.

_____ _____ _____
(Client Name) (Client SS#) (DOB)

Client Signature _____ Date_____

Parent/Guardian Signature (if applicable) _____ Date_____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Informed Consent & Permission for Treatment

Please review the information provided below. Your signature will indicate that you understand and accept the information contained in the Informed Consent Information and Permission for Treatment.

Therapeutic Services:

At Mental Health & Wellness Center, LLC, we believe that the therapeutic process requires your active involvement. Change can be easy and quick, but often it is slow and deliberate; mutual hard work between a therapist and a client is important for success. We also recognize that there are both benefits and risks associated with therapy. Therapy can lead to an improved ability to identify important things about yourself, acquire helpful life management skills, and integrate past and present learning to live a happier and healthier life. Risks of the process might include experiencing uncomfortable levels of sorrow, guilt, anxiety, anger, frustration, or difficulties with other people. Some changes may lead to what seems to be worsening circumstances or even losses. (For example, therapy will not necessarily keep a marriage intact.) While we expect that therapy will be helpful, there is no guarantee of any specific outcome; therefore, it is vital that you discuss any questions or concerns about the process with your therapist at any point during therapy.

Confidentiality:

Mental Health & Wellness Center, LLC respects your legal right to confidentiality. We will work to protect your information and all records will be maintained in a confidential manner. Consent forms will be required for the release of any information except in specific situations. The following are legal and policy exceptions to your right to confidentiality.

- In the case of medical or mental health emergencies
- If we have good reason to believe that you are in imminent danger of harming yourself (for example, suicidal thoughts/behaviors/attempts, severe depression, etc.)
- If we have good reason to believe that you will harm another person (for example, homicidal thoughts/behaviors/attempts, etc.) *Please note that the person threatened, and the police will be notified.*
- If we have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you provide information about someone else who is doing so
- We receive a court order or subpoena directing the release of information or testimony in a court proceeding
- Any litigation is initiated by you/your family related to treatment or complaints
- Inappropriate behavior concerning another named health/mental health care provider is reported (for example, that this person has either a. engaged in sexual contact with a patient, including yourself or b. is impaired with providing treatment in some manner by cognitive, emotional, behavioral, or health problems) *Please note that the law requires that we report this to their licensing board. Also note that if you are a client and a health care provider, however, your confidentiality remains protected under the law from this kind of reporting.*
- If a third party, such as an insurance company or an EAP provider, is paying for part of your bill (We may be required to provide information, including a diagnosis to that third party to receive payment.)
- If your therapy is being paid for in full or in part by a managed care firm (There are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the approved amount of time within which you must complete your therapy, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network, if we are not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy on a regular basis, and on occasion, copies of your case file.)
- Appointment reminders, if you choose to receive those, could be intercepted and may not be private.
- In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Informed Consent & Permission for Treatment

- Legal guardians have the right to request records. *Please note that this is not advisable during treatment.*
- If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered part of the couples therapy, and can/probably will be discussed in joint sessions.

Contact After Hours:
In cases of emergency please go to the nearest emergency room or call 911. If you need to make an appointment call the office phone number and leave a message. If you need to reach your therapist between sessions by phone for a phone therapy session, you will be charged at a rate of 25.00 per 15 minutes, which may not be reimbursable by insurance.

Termination of Treatment:
You normally will be the one who decides therapy will end, with three exceptions. 1). If we have contracted for a specific short-term piece of work, 2.) It is our judgment that we are unable to meet your mental health needs, specifically due to the kind of treatment needs you have or because we feel our training and skills are not beneficial in your treatment, 3.) If you are violent, threatening, or harassing toward the staff, customers, and/or family member of this practice *(In this case we reserve the right to terminate you unilaterally and immediately from treatment.)*

Other Services:
- FMLA and/or disability documentation will not be provided unless otherwise pre-authorized by Mental Health & Wellness Center, LLC
- Mental Health & Wellness Center, LLC, does not perform custody evaluations

Court/Deposition Appearance:
Mental Health & Wellness Center, LLC, services will not be used for court hearings, litigation, and/or child custody hearings. Be aware that it is not our policy to serve as a witness or advocate for you in court proceedings; however, if we need to prepare documents for any court proceedings, reasonable fees will be assessed. If required to testify in any case, the requesting parties will be charged for preparation of the testimony, written or verbal correspondence with parties (attorney, or other professionals), travel time to and from the destination, and waiting time to be called to testify. Court appearance fee includes a $500 initial fee and $125 per hour. Deposition fee includes a $250 initial fee and $125 per hour. The requesting parties will be charged for copies of documents needed for court at $0.45/page and any parking fees as well. Please note that these services are NOT covered by your insurance coverage.

By signing this form, I hereby authorize all contracted therapists of Mental Health & Wellness Center, LLC, to assess, diagnose and treat mental health and/or substance abuse problems for myself and/or my family members. By signing this form, I understand and agree to the limits of confidentiality as indicated above. I agree to hold any therapist working under contract and Mental Health & Wellness Center, LLC, harmless for any loss, cost and or damages sustained by my family, my child, or me.

_____ _____
Client Name-Printed Date

_____ _____
Client Signature **Parent/Guardian Signature (if applicable)**

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Credit / Debit Card Payment Authorization Form

NO SERVICES WILL BE RENDERED WITHOUT A COPY OF THIS FORM ON FILE.

Your information is confidential and protected by federal and state privacy laws. Payment is expected at the time of service. This form is not intended for primary method of payment, but a copy will be on file for the following circumstances:

- To bill any unpaid charges that may accrue due to having a deductible, co-payment, or coinsurance, and/or any other fees agreed upon that were not paid at the time of service delivery
- To collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, an EAP program, or managed care company
- To collect fees due to late cancellation or failure to show for an appointment
- To collect fees associated with unpaid or returned check fees and NSF (this includes the check amount, any returned check fees from the bank, and an extra $50.00 charge)

By providing the information below you agree to allow our offices to bill unpaid fees listed in the Fee Agreement and any other agreed upon fees located in the Informed Consent not paid by you at the time of service delivery, in person, or by regular billing. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card. Please note refunds may take 3-4 days to process. Your signature also verifies that your credit card information, provided above, is accurate to the best of your knowledge. If this information is incorrect or fraudulent or if your payment is declined, you understand that you are responsible for the entire amount owed and any interest or additional costs incurred if denied. You also understand by signing this form that if no payment has been made by you, your balance will go to collections if another alternative payment is not made within ninety days.

Print Client Name: _____ Client/Guardian Signature:_____

Name exactly as it appears on card: _____

Type of Card: Visa Master Card American Express

Card Number: _____

Expiration Date: Month_____ Year_____ CCV/Security Number (3 digits on back of card) __ __ __

Billing address and phone number for card:

Street Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Cardholder Signature: _____ Date: _____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Agreement & Explanation of Service Fees

Counseling is a fee-for service. Payment for services is due at the time of service delivery. Cash, check or credit cards and Health Savings/Spending Accounts (HAS's) are accepted forms of payment. We do NOT regularly send out statements for payments owed.

Insurance Billing: We will try to bill your insurance when authorized to do so. Any payments not made by your insurance provider will be your responsibility, including (but not limited to): deductibles, co-pays, co-insurance and any fee not covered by your insurance provider. It is your responsibility to know your plan's deductibles/limits/copays. Please acquire this information prior to your appointment. We require payment at the time of service. If you have a deductible or co-pay, this payment is expected at the time of service.

If your insurance company requires a deductible, Mental Health & Wellness Center, LLC, must accept the contracted and discounted rate for the session. If you have insurance, please understand that this is an agreement between you and your insurance company. If your insurance company requires an authorization for your visits, please make sure that you have obtained this authorization prior to your first appointment. If your insurance company denies your visits for any reason, you will be responsible for the full cash fee rate of each of these visits at the rate listed in this document.

I consent to release any personal or clinical information required to process my claim to my insurance provider listed on the back of this form. I also authorize any payments made by my insurance company to be paid directly to Mental Health & Wellness Center, LLC. This form will be considered a signature on file for all future insurance claims. This release will expire 1 year from the date of my last appointment.

The billing department will assist you in submitting your insurance forms and resolving any problems with payments. However, if, your insurance company does not pay the anticipated amount, you are still responsible for the total amount of the bill. Please be aware that insurance benefits quoted by your insurance company are not a guarantee of payment. Ultimately, it is your responsibility to know the benefits of your policy and any changes that may arise are your responsibility.

Non-payment for services: In the event your account is not paid within 90 days, regardless of whether you receive a bill from us, we will try to collect from you. If your balance exceeds $500, collection proceedings will be instituted at your expense. You understand this office will release my information to a third-party Credit agency to attempt to collect a debt. The information provided to the Credit agency will only be demographic information to collect this debt. If your account is sent to collections, you will be responsible for all costs of collections including reasonable collection agency fees, attorney fees, and court costs.

I have read and understand the above statements and agree to be bound by the terms in this policy. I have had the opportunity to ask questions about anything in this policy and have had my questions answered to my satisfaction. By signing this form, I agree to the financial responsibility of payment for the services I receive at the costs indicated above.

Client Signature _____ Date_____

Parent/Guardian Signature (if applicable) _____ Date_____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Agreement & Explanation of Service Fees

Service	Time/ Minutes	Cost
Initial Intake/Assessment	53 - 60	$150
Individual Therapy Session	53 - 60	$125
Marriage/Couple Counseling	53 - 60	$150
Family Therapy Session	53 - 60	$150
Group Session per Individual	60 - 90	$50
Telephone/Email Communication (other than appointment scheduling/changes)	15	$25/every15 min.
"No Show" Fee	- - - - - - - -	$125
"Late Cancel" Fee (24 hours or less)	- - - - - - - -	$55
Return Check Fee	- - - - - - - -	$50 minimum
Copies of Records (first copy is free)	- - - - - - - -	$0.45/page
Letter Writing	- - - - - - - -	$35/page
Court Preparation and Court Reports	- - - - - - - -	$125/hour
Court Appearance (initial fee due prior to court appearance)	- - - - - - - -	$500(initial fee) + $125/hour
Deposition (initial fee due prior to deposition)	- - - - - - - -	$250 (initial fee) + $125/hour
Any matter in which we must hire an attorney to assist or protect our office involving your case, the case of a minor or a related case and any action brought upon our office by any attorney for any reason related to your case.	- - - - - - - -	All attorneys' fees billed to us by our attorney, plus any regular fees that we charge.

All work our office does on your part will be discussed prior to performing the service. By signing this form, I agree that all fees not paid by my insurance will be my responsibility. All bills not paid within 90 days will be turned over to a collection agency. I also agree to allow any fees not paid in full at the time of service to be billed to my debit/credit card on file. By signing this form, I agree to the financial responsibility of payment for the services I receive at the costs indicated above.
ALL APPOINTMENT CHANGES MADE WITHOUT 24 HOURS PRIOR NOTICE WILL INCUR A CHARGE.

Client Signature _____ Date_____

Parent/Guardian Signature (if applicable) _____ Date_____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

No Show, Late Cancellation, and Co-payment Policy

1. I understand that I will be charged a NO SHOW fee of $125 if I fail to show for an appointment without cancelling. I understand that I will be charged a LATE CANCELLATION fee of $55 if I fail to give at least 24-hour notice prior to cancelling my appointment.

2. I understand that it is my responsibility to determine session frequency and time that I can commit to my therapy goals. I also understand that when I schedule an appointment that the appointment time is exclusively reserved for my treatment goals. In order to better serve all our clients with available appointments, please understand that if THREE appointments are missed without notice MHWC must terminate your care due to non-compliance with treatment. If your schedule requires you to cancel with notice more than one appointment per month, your therapist will explore with you adjusting your appointment time and/or appointment frequency to better meet your needs.

3. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is _____; my deductible amount per year is _____. I have met my deductible for this year? □ N/A □YES □ NO (I still owe $_____ towards my deductible.)

4. I understand that these charges are an out of pocket expense and that my insurance carrier will NOT cover these charges as they CANNOT be billed for a missed appointment. I understand that this means that I will pay the entire cost of the session at $125, not the co-pay.

5. I understand that the therapy session will last 53-60 minutes, and I understand that if I am late to the appointment, I will still have to end the session at the allotted time.

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from Mental Health & Wellness Center, LLC.

_____ _____
Print Client Name Date

_____ _____
Client Signature **Parent/Guardian Signature (if applicable)**

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

Client Rights & Responsibilities

In the course of care, a Client has both rights and responsibilities.

Clients have the right to:

- Be treated with respect and recognition of their dignity and right to privacy
- Receive care that is considerate and respects their personal values and belief system
- Personal privacy and confidentiality of information
- Receive information about their managed care company's services, practitioners, clinical guidelines, quality improvement program and patient rights and responsibilities
- Reasonable access to care, regardless of their race, religion, gender, sexual orientation, ethnicity, age or disability
- Participate in an informed way in the decision making process regarding their treatment planning
- Discuss with their mental health professional appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage
- Have family members participate in treatment planning and, if over the age of 12, to participate in such planning.
- Individualized treatment, including: adequate and humane services regardless of the source(s) of financial support, provision of services within the least restrictive environment possible, an individualized treatment or program plan, and the periodic review of the treatment or program plan
- An adequate number of competent, qualified and experienced professional clinical staff or referrals to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that arise in the provision of care and services, including: Resolving conflict.
- Designate a surrogate decision maker if they are incapable of understanding a proposed treatment or procedure or are unable to communicate their wishes regarding care
- Be informed, along with my family, of my rights in a language I/we understand
- Voice complaints or appeals about their managed care company, provider of care or privacy practices
- Make recommendations regarding their managed care company's rights and responsibilities policies
- Be informed of rules and regulations concerning their own conduct
- Be informed of the reason for any utilization management adverse determination including the specific utilization review criteria or benefits provision used in the determination
- Have utilization management decisions based on appropriateness of care.
- Request access to their Protected Health Information (PHI) or other records that are in the possession of their managed care company
- Request to inspect and obtain a copy of their PHI, to amend their PHI or to restrict the use of their PHI, and to receive an accounting of disclosures of PHI

Client Rights & Responsibilities

Clients are responsible for:

- Providing (to the extent possible) their treating clinician and managed care company with information needed in order to receive appropriate care
- Following plans and instructions for care that they have agreed on with their treating clinician
- Understanding their health problems and participating, to the degree possible, in developing, with their treating clinician, mutually agreed upon treatment goals

Client Signature _____ Date_____

Parent/Guardian Signature (if applicable) _____ Date_____

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.
Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

_____ _____
Print Patient's Name Date

I,_____, acknowledge that I
(Signature of Patient or Parent or Legal Guardian)

Have either received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

My personal health information by your office for Treatment, Billing / Payment and Health care Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

Mental Health & Wellness Center, LLC
125 Orchard Dr.
Nicholasville, KY 40356

Phone: 859-241-3081
Fax: 859-241-1045
http://www.mhwcenterky.com

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	