FOR OFFICE TO COMPLETE
Intake Date:_____
Practitioner:_____
Fee:$_____

CHILD/ADOLESCENT CLIENT INFORMATION

Date Completed: _____ Completed By (name & relationship to child):_____

Client Name: _____ Age: _____ Date of Birth: _____

If Teen, phone #:_____ May we send text reminders? __No __Yes- Wireless provider:_____

Gender:_____ Place of Birth: _____ Ethnicity/Race:_____

School: _____ Grade: _____ Primary Language:_____

Primarily lives with: _____

Parent/Guardian Name: _____ Relationship to child:_____

Address: _____

Phone Numbers: Cell_____ Home_____ Work_____

May we leave a message? ___Yes ___No ___Yes ___No ___Yes ___No

May we send text reminders to cell phone? __No __Yes- Wireless provider:_____

Email (I consent to being added to email list): _____

Other Parent/Guardian Name: _____ Relationship to child:_____

Address: _____

Phone Numbers: Cell_____ Home_____ Work_____

May we leave a message? ___Yes ___No ___Yes ___No ___Yes ___No

May we send text reminders to cell phone? __No __Yes- Wireless provider:_____

Email (I consent to being added to email list): _____

Other Address (If seasonal or not listed above): _____

Text reminders are sent automatically through our software system & we do not have access to replies. CALL our office directly to cancel or change your appointment and leave voicemail if needed (48 hr notice). Inform us of any changes to your wireless provider, or if you are not receiving text reminders.

Other Emergency Contact or Adults authorized to transport client to/from sessions & their relationship to child & phone #/s: _____

How did you hear about our practice? _____

For internet, please indicate Search Engine or Referring Website if known: _____

If applicable- may I have your permission to thank this person/site for the referral? ____Yes ____No ___N/A

Please indicate any agencies involved (eg. DCF, CCSO, CAC, etc.):_____

POLICIES AND INFORMED CONSENT FOR PSYCHOTHERAPY

Welcome to Monarch Wellness®. We appreciate you giving us the opportunity to be of help to you. This document contains important information about our professional services and business policies and answers questions that clients often ask about therapy. Please read it carefully and feel free to ask any questions before signing. When signed, it will represent an agreement between us.

Mental Health Treatment

Psychotherapy is not easily described in general statements. It varies depending on the practitioner and client and the particular issues brought forward. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the treatment to be successful, you will have to work on things we talk about both during our sessions and at home and remain open and honest throughout the process. Psychotherapy can have benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. It often leads to improved relationships, solutions to specific issues, and significant reduction in feelings of distress. Be aware that there are no guarantees of what you will experience, and issues can appear to worsen before improving as they unfold. Treatment involves a large commitment of time, money, and energy, so it is important to be aware of the full process. If you have questions about our procedure, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another professional for a second opinion.

Confidentiality

In general, the law protects the privacy of all communications between a client and psychotherapist, and we can release information about our work to others only with your written permission. However, there are a few exceptions, as outlined further in the Notice of Privacy Policy. This includes mandatory reporting of suspected abuse or neglect of a child, elderly, or disabled person, protective actions for persons at risk of harm to self or others, and valid court orders requiring disclosure. Please see Monarch Wellness®' Notice of Privacy Policy for further information.

We also consult with colleagues and specialists at times. This pursuit of quality assurance never involves your name or any specifics through which you might be identified without your consent, and these professionals are also required to keep your information private. Minimally necessary information may also be disclosed to the Monarch Wellness® treatment team with the same purpose to provide the most effective care. If I am away from the office for an extended period of time, I may ask a colleague or Monarch Wellness® representative to be my back-up to be available to my clients in case of emergencies. Therefore, he or she needs to know about you and is bound by the same laws and rules as I am to protect your confidentiality. Further, if I must discontinue our relationship because of illness, disability, or other unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

Meetings

Our first few sessions will involve an evaluation/assessment of your needs. During this time, we can both decide whether I am the best person to provide the services you need in order to meet your treatment goals. By the end of the evaluation, I will be able to offer you some first impressions of what our work may include, and we will develop a treatment plan together including realistic goals, how often we will meet, and a target date for completion of treatment.

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

(239) 231-3208 ~ MonarchWellness.net

If psychotherapy is begun, we will usually schedule one session per week or biweekly at a time we agree on; some sessions may be longer or more frequent depending on your needs. Some clients see us more frequently in the beginning stages and sessions taper off later as progress is made. From time to time, we will review our progress towards the goals we have set. Once an appointment is scheduled, you will be expected to pay for it unless you provide at least 48 hours' advance notice of cancellation (unless we both agree that you were unable to attend due to illness or emergency that is not a repeated occurrence). If possible, we will try to find another time to reschedule the appointment. If at any time you wish to stop therapy, we ask that you communicate your feelings openly and agree now to meet then for at least one more session to review our work together.

Minors

Our policy is to have both parents' consent prior to treatment. The only exception to this policy (at the discretion of the assigned therapist) is if you have a legal document granting one adult with 100% parental decision-making rights. If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to encourage parents to respect confidentiality of their child. However, we will provide information as necessary, particularly if there appears to be a risk of harm to yourself or someone else. I will discuss my concerns with you if possible before giving them any information, and I will do my best to handle any objections you may have about what I am prepared to discuss.

Your Rights

As a client, you have the right to terminate treatment at any time and request appropriate referrals. If at any time you want another professional's opinion or wish to consult with another therapist, we can assist you in finding an appropriate and qualified mental health professional of your choice. If needed in such a case, we can provide him or her with any essential information if you provide written consent. You also have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when we assess that releasing such information may be harmful in any way. Because they are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, we recommend that you schedule an appointment to review them in our presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

You also have a right to be treated fairly and professionally. If you feel that you have not been treated accordingly and are unable to resolve the issue with me directly, you may present your concerns in writing to the attention of me and Monarch Wellness®. While therapists other than the owner are independent contractors, Monarch Wellness® may be able to assist with resolving any concerns. If you have continued concerns or the matter is unresolved, you may file a complaint with the Florida Department of Health, further explained in the Monarch Wellness®' Notice of Privacy Policy.

Legal Proceedings

If you become involved in a legal divorce dispute, or other legal case, we want you to understand and agree that you and anyone representing you will not request us to testify in court, or disclosure of psychotherapy records. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on the following reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship, (2) The testimony might affect my therapy relationship with you (and/or your child), and I must put this relationship first, thereby protecting the safety and confidentiality of therapy, and (3) There are other mental health professionals who specialize in court related cases and are more experienced and qualified than our practice.

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

(239) 231-3208 ~ MonarchWellness.net

Professional Relationship

As professionals, we will use our best knowledge and skills to help you. This includes following the ethical standards of the National Association of Social Workers (NASW), Association for Play Therapy (APT), American Counseling Association (ACA), American Association for Marriage and Family Therapy (AAMFT), and American Psychological Association (APA). In your best interests, they put limits on the relationship between a practitioner and a client, and we will abide by these; they are not personal responses to you. We are trained in the mental health field—not law, medicine, finance, or any other profession. We are not able to give you advice from these other professional viewpoints. State laws and rules of our profession require us to keep what you tell us confidential (that is, just between us), except in certain limited situations, as described further in the "Confidentiality" section of this packet and the Notice of Privacy Policy. If we meet on the street or socially, I may not say hello or talk to you very much in order to protect your privacy. Also, in your best interests and following professional standards, I can only be your therapist. I cannot have any other role in your life that may impair my objectivity, clinical judgment, therapeutic effectiveness, or can be exploitive in nature. I cannot, now or ever, be a close friend to or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship.

Contacting Us

Therapists are often unavailable in between sessions, so if you need to talk to me directly before our next appointment, it is recommended to schedule an earlier session. You may also give the front office staff a specific message if you want to deliver to me before our next appointment. We are not always available to answer our office telephone (239) 231-3208. If no one is able to answer, our telephone is answered by a confidential voicemail that we monitor frequently. Our front desk will make every effort to return your call on the same day you make it, or at least within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform us of times when you will be available. If you are unable to reach us and feel that you are in crisis and can't wait for us to return your call or for your next appointment, contact your family physician, 911, or the nearest emergency room and ask for the clinician/psychologist/psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. By signing this document, you authorize a colleague or representative of Monarch Wellness® to contact you regarding any appointment changes, including if there were any emergency related to me. To ensure confidentiality, our office does not typically communicate with clients individually via email, social media, or text messages (with the exception of courtesy text reminders with your consent, which are automatically sent by our software system).

Supervision

If your practitioner is a Life Coach, Registered Clinical Social Work, Marriage and Family Therapy, or Mental Health Counseling Intern working towards licensure, it has been disclosed and you are fully aware of this status. If your practitioner is a registered intern during this time, he or she will be supervised by a licensed supervisor on or off site, which will be disclosed to you. Confidentiality pertaining to your information will be maintained to ensure that you are receiving the highest quality of services.

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

Monarch Wellness®

Therapists and other individual practitioners (with the exception of the owner) are independent contractors, and thus operate independently of Monarch Therapy LLC dba Monarch Wellness®. Monarch Wellness® does not control the manner or methods by which therapists and other practitioners provide services to clients. To that end, Monarch Wellness® and its owner are not legally responsible for your treatment. By signing this document, you knowingly, voluntarily, and expressly waive, and covenant not to sue for, any claim that you may have against Monarch Therapy LLC

dba Monarch Wellness®, its owner/s of operation and staff, regardless of whether that claim may exist now or arise only in the future, whether it is based on past or future acts or omissions, whether it is foreseen or unforeseen, known or unknown, and whether it is based on anyone's negligence, including but not limited to the negligence of Monarch Therapy LLC dba Monarch Wellness®, its owner/s, or staff. You further agree to indemnify, defend and hold harmless Monarch Therapy, LLC dba Monarch Wellness®, its owner/s and staff from and against all claims arising out of or resulting from your participation in therapy. Although the individual practitioners are independent contractors, Monarch Wellness® works hard to refer you to, and/or otherwise facilitate your, high quality care with trained and experienced professionals with specific specializations. However, Monarch Wellness® makes no guarantee or warranty with respect to any practitioner or the services he or she will provide.

I have read the above Contract carefully and understand that I have the right to not sign this form. I had the opportunity to ask questions or gain clarification on anything I did not understand and know that I can also ask questions throughout treatment. I understand the policies and procedures, including my rights & responsibilities as a client, and the limitations of liability of the Monarch Wellness® practice. I consent to treatment with this practitioner, and agree to cooperate fully to the best of my abilities. I understand that I can discontinue services at any time and can also request a copy of these policies and procedures.

_____	_____	_____
PRINTED NAME OF CLIENT	**CLIENT SIGNATURE**	**DATE**
_____	_____	_____
PRINTED NAME OF PARENT/GUARDIAN	**PARENT/GUARDIAN SIGNATURE**	**DATE**
_____	_____	_____
PRINTED NAME OF OTHER PARENT/GUARDIAN	**OTHER PARENT/GUARDIAN SIGNATURE**	**DATE**

I, the provider, have met with this client (and/or his or her parent/guardian) for a suitable period of time, and have informed him or her of policies in this brochure. I have responded to all of his or her questions. I believe this person fully understands the guidelines, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

_____	_____	_____
PRINTED NAME OF PRACTITIONER	**PRACTITIONER SIGNATURE**	**DATE**

Notice of HIPAA Privacy Policy *(CLIENT COPY)*

Tel: (239) 231-3208 ~ www.MonarchWellness.net

Confidentiality

Monarch Therapy LLC dba Monarch Wellness is committed to protecting medical information about you. No information is released without your knowledge and written consent except for those rare instance where therapists are required by law or by court to reveal particular information. In an emergency situation where clients demonstrate a high probability of harming themselves or others, the staff may be required to release information to ensure safety. We are also mandated reporters of suspected abuse or neglect of minors, disabled, and elderly individuals, as described further below. This notice describes how medical information about you or your child may be used and disclosed by Monarch Wellness and how you can get access to this information. Please review this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of you/your child's issues, assessment, recommendations, treatment plan, and other mental health or medical information. Your record is the physical property of Monarch Wellness; the information which is within, belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosure to others. In using and disclosing your protected health information (PHI), it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirements of Florida law.

Your mental health and/or medical records serve as:

- A basis for planning your counseling
- A legal document describing the counseling care you receive
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of Monarch Wellness

We are required to:

- Maintain the privacy of your protected health information (PHI) as required by law and provide you with notice of our legal duties and privacy practices with respect to the protected health information that we collect and maintain about you. This also applies to you and any other member of your family that participates in the counseling process aimed to help you/your child.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the office, on the website, and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests to communicate with you about protected health information by alternative means. For example, you may not want a family member to know that you are participating in counseling. Upon your request, we will communicate with you, if needed, at a different time or via other means of communication.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of information practices upon request and of your health information, except that you are not entitled to access, or to obtain a copy of your medical records upon written request.
- Request and provide written authorization and permission to release information for purposes of outside treatment and health care operations. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except to the extent that action has already been taken.
- Request a restriction on certain uses and disclosures of protected health information, but we are not required to agree to the restriction request. You should address your restriction request in writing to your therapist at Monarch Wellness. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with the reasons supporting the request to your therapist. We are not required to agree to the requested amendment.
- Request confidential communications of your health information by alternative means, such as only at home or only by mail.

Disclosures for Treatment and Health Operations

I. Monarch Wellness will use your PHI, *with your consent*, in the following circumstances:

- **Counseling:** Information obtained by your therapist will be recorded in your record and used to determine the management and coordination of services that will be provided for you.
- **Disclosure to others outside Monarch Wellness:** If you give us a written authorization, you may revoke it in writing at any time, but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except (as described below) to report serious threat to health or safety or child and adult abuse or neglect.
- **To you or legal guardian:** Upon your request, we will disclose your health information to you. If you authorize us to do so, we may use your or your health information or disclose it to the person or entity you name on your signed authorization. Once you provide us with an authorization, you may

revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. In certain situations, when disclosure of your or your child's information could be harmful for you or another person, we may limit the information available to you, or use an alternative means of meeting your request.

- **Your family and friends:** If you are unable to consent to the disclosure of your or your child's health information, such as in a medical emergency, we may disclose your or your child's personal information to a family member or friend to the extent necessary to help with your or your child's health care. We will only do so if we determine that the disclosure is in you/your child's best interest.
- **For health care operations:** Your therapist may use information in your health record to assess the performance of operations of our services (e.g. sending a satisfaction follow up survey). This information will then be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.
- **Provision of care and Supervision:** If your provider is a Registered Clinical Social Work, Marriage and Family Therapy, or Mental Health Counseling Intern, or Board Certified Assistant Behavior Analyst, your information may be discussed during supervision for the purpose of providing the most effective treatment, with every effort to maintain confidentiality of identifying information. Minimally necessary information may also be disclosed to the Monarch Wellness treatment team with the same purpose to provide the most effective care.
- **Research:** We may disclose health information to researchers when necessary for purposes of evaluating our programs or learning more about the problems our clients face. Established protocols will be followed to ensure the privacy of your health information.

II. Monarch Wellness. will use your PHI, *without your consent or authorization,* in the following circumstances:

- **Child Abuse or Neglect:** If we have reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected, or have reason to believe that a child seen in the course of professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, we must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If we believe that an elder or disabled person is the victim of abuse, neglect, or domestic violence or the possible victim of other crimes, we may report such information to the relevant county department or state official.
- **Serious Threat to Health or Safety:** If we have reason to believe, exercising best judgment and our professional care and skill, that you may cause harm to yourself or another person, we may take steps, without your consent to notify the relevant police or sheriff's department to ensure safety.
- **To your parents, if you are a minor:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of Florida and will make disclosures consistent with such laws.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your counseling treatment and the records thereof, such information is privileged under state law and we will not release the information without written authorization from you or your personal or legally-appointed representative, or a subpoena/court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered.
- **As required by law for national security and law enforcement:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information required for lawful intelligence, counterintelligence, and other national security activities to authorized federal officials. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or crime investigation.
- **Law/Health Oversight:** As required by law, we may disclose your health information to governmental and/or licensing agencies. For example, if the Florida Department of Regulation and Licensing requests that we release records to them in order for the Examining Board to investigate a complaint against a provider, we must comply with such a request.
- **Marketing:** We may contact you to provide appointment reminders or information about counseling alternatives or other health-related benefits and services that may be of interest to you. We may also contact you to provide information about Monarch Wellness sponsored activities and events. We would only use contact information, such as your name, address, and phone number.
- **Worker's Compensation:** We may disclose health information to the extent authorized by you and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law; we may be required to testify.
- **As required by law for purposes of public health:** We may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, disability, as required by law.

For more information or to report a problem

- If you would like to make a request to amend or restrict the use or disclosure of your health information, or if you have questions or would like additional information, contact your therapist.
- If you are concerned that your privacy rights have been violated or if you disagree with a decision we have made about access to your health information, present your concerns in writing to the attention of your therapist and/or the owner and a meeting will be arranged to resolve the matter. If you have continued concerns or the matter is unresolved, you may file a complaint with the Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, through the Department of Health, or the Behavior Analyst Certification Board. Monarch Wellness respects your right to the privacy of your health information. You will not be penalized for filing a complaint.

Revised 09/21/2020

HIPAA PRIVACY NOTICE CONSENT

I, _____ certify that I have received and reviewed the
(Client or Legal Guardian)
Monarch Therapy LLC (dba Monarch Wellness®) Notice of Privacy Policy and I understand that my Protected Health Information (PHI) may be used for counseling services and other health operations as described in the Privacy Statement. I also understand the circumstances that would warrant using my health information and that I have the right to withhold consent in writing if I do not want information released for any purpose other than the legal requirements specified in the Monarch Wellness® Privacy Policy. I further understand that I may obtain additional copies by requesting them from my therapist.

I wish to be contacted in the following ways:

(Please check all that apply)	May we leave a message? (Please check)	
___Home Phone:_____	Yes_____	No_____
___Cell Phone:_____	Yes_____	No_____
___Work Phone:_____	Yes_____	No_____

___By mail at my home address:_____

_____ _____ _____
Printed Name of Client **Client Signature** **Date**

For Parent/Guardian of Minor: I am the legal parent/guardian of _____ and I may legally receive information regarding my child's counseling care within the limitations of confidentiality.

_____ _____ _____
Printed Name of Parent/Guardian **Parent/Guardian Signature** **Date**

_____ _____ _____
Printed Name of Other Parent/Guardian **Other Parent/Guardian Signature** **Date**

FINANCIAL RESPONSIBILITY POLICY

It is a pleasure to provide you with the best possible services to help you achieve your therapeutic goals. Included in that effort, we clearly specify each client's financial responsibility to avoid any billing confusion. In order to set realistic treatment goals, it is important to evaluate how your treatment is prioritized and what resources you have available to pay for your treatment.

FEES

When your appointment is scheduled, our front desk staff will inform you of your therapist's self-pay fee at this time. **Please write in here before your first appointment so that you are fully aware**: $_____.
Please note that in addition to weekly sessions, missed appointments, or cancellations within 48 hours, we charge this amount if sessions extend beyond a therapy hour (including EMDR sessions) and for other professional services you may need, at a prorated cost if we work for periods of less than one hour. Other services include telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation/writing of records or treatment summaries, and the time spent performing any other service you may request of me as your practitioner. We realize that our fees involve a substantial amount of money, although they are well in line with similar professionals' charges. For you to get the best value for your money, we must work hard and well together.

CANCELLATION AND NO SHOW POLICY

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 48 hours' advance notice of cancellation or reschedule request (unless we both agree that you were unable to attend due to illness or an emergency that is not a repeated occurrence). We are a busy practice with frequent wait lists, so please provide as much notice as possible if you need to cancel or reschedule, to allow for the space to be offered to someone else in need. We will provide the same courtesy to give you as much notice as possible if your therapist is unable to make the appointment for any reason. If you have 3 no shows or cancellations, it is at the practitioner's discretion to discontinue treatment. Please call the office to let us know if you are running late for an appointment. If you are 15 minutes late or more, the appointment may be cancelled, and you may be responsible for the cancellation/no show fee (unless you have called to let us know you are running late due to circumstances we both agree are outside of your control).

APPOINTMENT REMINDERS

Although we offer text reminders for appointments as a courtesy, it is ultimately your responsibility for maintaining your appointments. We cannot be held responsible if a courtesy text reminder is not received or if our system does not accommodate your wireless provider. If you change wireless providers, it is your responsibility to let the office know so that our system can be updated; otherwise, text reminders will not be received. Text reminders are automatically sent by our software system, and we do not have access to any responses or text messages. Please call the office to communicate with our front office or to cancel or reschedule an appointment.

INITIALS OF CLIENT (OR GUARDIANS IF A MINOR) _____ _____

INSURANCE

If you have a health insurance policy, it may provide some coverage for mental health treatment. Our therapists are not contracted with insurance companies at this time. If you are interested in insurance coverage, we recommend you contact your insurance company and ask about your out of network benefits. We can provide a billing receipt upon request which you can submit to your insurance companies if you have out of network benefits.

As an ethically guided practice, we inform our clients that any insurance involvement (in or out of network) requires us to assign a mental health diagnosis code which becomes part of your permanent medical record. This may or may not impact you in the future if an insurance company chooses to charge a higher premium for previous medical care, including mental health services. In addition, your diagnosis may be taken into consideration and records requested if you (or your child if they are the client) choose to pursue a career in certain government related jobs. Further, insurance companies may request additional clinical information such as treatment plans, summaries, or your entire mental health record for payment purposes, and they also often limit the number of sessions that will be covered, or require pre-authorization for more visits.

PAYMENT METHOD

Unless we have reached an agreement regarding payment or you have paid in advance, payment is expected at the beginning of each session at the time it is held. Payment may be made in the form of cash or major credit card (Visa, MasterCard, Discover, American Express). Our policy is to obtain your credit card information for your convenience and to prevent interruption of your session with the payment process. Your information is maintained with the highest level of confidentiality, is not shared with any other source, and is securely protected separately from your therapy file. If you would like to change your method of payment at any time, please let our front office staff know before your appointment. If you have a balance due to missing an appointment or not cancelling at least 48 hours in advance, you can call the office to use a different form of payment than your card on file. The payment must be received before another appointment will be scheduled. If your account has not been paid for more than 60 days and arrangements have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

I have read the above Policy carefully and understand and agree to my Financial Responsibilities.

_____	_____	_____
PRINTED NAME OF CLIENT	**CLIENT SIGNATURE**	**DATE**
_____	_____	_____
PRINTED NAME OF PARENT/GUARDIAN	**PARENT/GUARDIAN SIGNATURE**	**DATE**
_____	_____	_____
PRINTED NAME OF OTHER PARENT/GUARDIAN	**OTHER PARENT/GUARDIAN SIGNATURE**	**DATE**

FOR OFFICE TO COMPLETE
CLIENT:_____
PRACTITIONER:_____
□ SELF-PAY □ INS:_____
STAFF DATE/INITIALS_____

PRE-AUTHORIZED CREDIT CARD PAYMENT FORM

Like many offices, our policy is to keep a credit card on file for the convenience of virtual payment for sessions, to prevent interruption of your session time with the payment process, and to cover any unpaid balance. If you would like to use a different form of payment (cash or another credit or debit card) for your sessions, please let the front office staff know before your appointment time. If you have a balance due to missing an appointment or cancelling within a 48-hour timeframe not due to emergency or illness, please call our office if you prefer to provide another form of payment. We assure you that your information is respected with the highest level of confidentiality, is not shared with or sold to any other source and is securely protected separately from your therapy file.

I, _____ authorize Monarch Wellness® (Monarch Therapy, LLC) to keep my signature on file and charge my credit card account as indicated below for payment security.

- **Initial and ongoing therapy appointments**.
- **Missed appointments** (no shows or cancelling within 48 hours) at your therapist's full self-pay fee.

I agree to inform staff of any changes with my credit card (expiration date, number, or different card if this account reaches its limit). Monarch Staff agree to give me a courtesy call regarding any unpaid balance prior to charging my card, to only charge for the circumstances listed above, and to keep my credit card information confidential in a separate locked file.

Please present card at initial session for verification.

CLIENT NAME:_____

CARDHOLDER NAME:_____

CARDHOLDER BILLING ADDRESS:_____

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

CC # that is active and below its limit:_____

EXPIRATION DATE:_____ **SECURITY CODE:**_____

CARDHOLDER SIGNATURE:_____**DATE:**_____

CHILD/ADOLESCENT QUESTIONNAIRE FOR PARENTS

Thank you for allowing us to travel with you and your child on your healing journey. As the expert regarding your child, your responses to the following questions will help guide our path together. We realize the questions are quite thorough, as we see the value in considering the complete picture to adequately address your child's concerns. We are shaped by our environment, biological and psychological make-up, as well as past experiences. All is inter-connected, and we believe that full integration and healing occurs once the impact of all factors is acknowledged and understood. As with all counseling related information, you and your child's privacy will be protected in accordance with HIPAA standards of confidentiality, with exceptions outline the Monarch Wellness® Notice of Privacy Policy.

What are your child/teen's strengths or what are some positive things about your child?

_____

_____

_____

Please describe the reason/s for which you are seeking counseling for your child/adolescent.

_____

_____

_____

_____

What do you hope to accomplish by working together? How do you hope your child and family's lives will be different?_____

_____

_____

_____

How long have the concerns existed or when did they start?_____

_____

How often do the concerns occur? _____

Has anything in the past helped your child/adolescent with the concerns?_____

_____

What makes it worse? _____

_____

HEALTH HISTORY

How is your child's physical health? ___Excellent ___Good ___Fair ___Poor ___Very Poor

Please explain any physical health challenges/injuries/hospitalization affecting your child currently or in the past. _____

_____

Does your child currently have a pediatrician? ___No ___Yes- Please list:

Physician's Name:_____ Telephone number: _____

Has your child seen a psychiatrist? ___No ___Yes- ___Currently or ___In the past Please list:

Psychiatrist's Name:_____ Telephone number: _____

Has your child seen another therapist? ___No ___Yes- ___Currently or ___In the past Please list:

Therapist's Name:_____ Telephone number: _____

Please explain reason or issue/s addressed and when?_____

Is your child currently taking any prescription medication? ___No ___Yes- Please complete:

Medication	Taken for	Started when	Dosage & frequency	Take as Prescribed?	Prescribing Physician

Has your child ever been prescribed psychiatric medication in the past? ___No

___Yes-Please list prior psychiatric medications, reason, and approximate dates. _____

_____

_____

Have any immediate family members seen a therapist? ___No ___Yes-Please indicate relationship to child, when, reason & if helpful. _____

_____

Please explain any physical or mental health challenges affecting any immediate family members currently or in the past. _____

_____

_____

HEALTH, WELLNESS, AND SOCIAL PATTERNS

How would you rate your child's sleeping habits? __Excellent __Good __Fair __Poor __Very Poor

Please explain any sleep issues they are currently experiencing. _____

_____

How are your child's eating habits & appetite? ___Excellent ___Good ___Fair ___Poor __Very Poor

Please explain any eating issues they are currently experiencing. _____

_____

Does your child experience any weight or body image concerns? ___No ___Yes-Please explain.

_____

How often does your child usually exercise? _____

What type of exercise do they usually participate in? _____

Please list any after-school activities in which your child participates and how often. _____

_____

How would you describe your child's social skills/friendships? _____

_____

What activities does your child enjoy- Alone: _____

With family/friends :_____

For adolescents, do you have any concerns about substance use? ___No ___Yes- Please explain.

_____

Any concerns about sexual activity? ___No ___Yes- Please explain. _____

_____

Do you consider your child and family to be spiritual or religious? ___No ___Yes- Please describe your faith or beliefs. _____

FAMILY ENVIRONMENT AND RELATIONSHIPS

Who primarily raised your child? _____

Who primarily raised your child in their first three years of life? _____

Does your child have other birth parents? ___No ___Yes- Please explain and provide age of adoption if applicable. _____

Were there any physical, mental, or environmental issues during pregnancy or your child's birth?

_____

_____

Has your child experienced any developmental concerns (walking, talking, socialization, etc.)?

___No ___Yes- Please explain. _____

_____

Did you (or your child's birth parents if different) separate/divorce? ___No ___Yes- How old was your child? _____

If your child has more than one home, please explain visitation or shared parenting arrangements.

_____

Please indicate who lives in the home with your child (including yourself if applicable). If your child has more than one home, please specify different homes.

Home #1- Adults: _____

Children (names, ages, & relationship to child): _____

_____

Pets: _____

Home #2 (if applicable- Adults: _____

Children (names, ages, & relationship to child): _____

_____

Pets: _____

Does your child have any siblings (including step and half siblings) living outside the home/s?

___No ___Yes- _____

What is your child's order of birth? ___Only Child ___Oldest ___Middle ___Youngest

Please explain any moves your child has experienced. _____

_____

How would you describe your child's home environment? _____

_____

_____

How would you describe your child's relationships with their family members? _____

_____

_____

How would you describe each parent/caretaker's disciplinary style and effectiveness? _____

_____

Are there any other significant adults or caretakers in your child's life (babysitter, significant other of parent, grandparent, etc.)? ___No ___Yes- Who & how would you describe your child's relationship with them?_____

_____

How would you describe the relationships between the adults in your child's life? _____

_____

_____

Did you or your child's other parent/guardian struggle with similar or other challenges as a child or adolescent growing up? ___No ___Yes- Please explain. _____

_____

_____

Have any family members experienced issues with their physical or mental health, or struggle with substance use or other difficulties? _____

_____

_____

SCHOOL AND WORK

How is your child doing in school? _____

_____

Is your child in any special classes (gifted, ESE, speech, etc.) or have they participated in the past?

___No ___Yes_____

Has your child ever repeated a grade? ___No ___Yes- Grade/s:_____ Reason:_____

_____

Do you, the other parent/guardian, or teachers have any concerns for your child academically, socially, or behaviorally? ___No ___Yes-Please explain. _____

_____

Did you or the child's other parent/guardian experience any school related challenges? ___No ___Yes-Please explain. _____

If an adolescent, does your teen work? ___No ___Yes_____

If an adolescent, does your teen have, or have they had in the past, any significant issues at work? ___No ___Yes-_____

Does your child or teen have career or education goals? ___No ___Yes-_____

What is your family's income source? ___Both parents work ___One parent works ___Child support ___Relatives support us ___Government assistance ___Disability ___Other:_____

What kind of work do you as parents/guardians do, or did you do?_____

_____

Do you as parents/guardians (or did you) enjoy your work? ___Does not apply ___Love it ___It's enjoyable with some challenges ___It's a job ___I don't enjoy it

Do you as parents/guardians currently have, or have you had in the past, any significant issues at work or school? ___No ___Yes-_____

STRESS AND TRAUMA

What were the biggest stressful events in your child's and family's lives?_____

_____

_____

_____

How did your child and family cope and who helped? _____

_____

_____

_____

Has your child experienced any abuse, neglect, or witnessed domestic violence? ___Unsure ___No ___Yes-_____

SAFETY

Has your child expressed any thoughts or ideas of harming or killing themselves, or tried to hurt themselves? ___No ___Yes-Please explain. _____

_____

Has your child expressed any thoughts or ideas about, or recently harmed or tried to hurt anyone else? __No __Yes-Please explain. _____

_____

Have any other close family members struggled with suicidal or homicidal thoughts or ideas or attempted harm to self or others? ___No ___Yes-Please explain. _____

_____

LEGAL

Has your child or their close family members experienced any legal issues? ___No

If yes, Please explain. _____

Are there any current, pending, or potential court cases or lawsuits? ___No

___Yes-Please explain. _____

Is your reason for seeing me related to any accident, injury, arrest, or court involvement? ___No

___Yes-Please explain. _____

Is your child or are any immediate family members required to participate in therapy? ___No

___ Yes-Please explain. _____

_____

Is there any other information not included above that you would like me to know about?

_____

_____

_____

_____

_____

_____

Thank you for taking the time to answer these questions. We hope to help you find peaceful resolution and achievement of your goals along your wellness journey.

(239) 231-3208 ~ MonarchWellness.net