The Relating Well Center
413 Johnson Street, Suite 210 • Jenkintown, PA 19046

Welcome to
The Relating Well Center, LLC

Thank you for choosing our practice. We appreciate your trust and look forward to helping you to meet your goals. Please review the guidelines on this page, and then fill out the attached paperwork. If you are here as part of a couple, there is an additional packet for partners to complete. We will be happy to answer any questions you may have.

- At the time of your appointment, your therapist will greet you in the waiting area.
- If you arrive after your appointment time, please go to the third office and knock.
- To reach the restrooms, go out the door of the suite, turn left, and at the end of the hall turn right. Please return the key.
- Please step outside to use your cell phone if others are waiting.
- Please remember that parking spots under the building are reserved for building employees until after 5 p.m.
- Please feel free to share any questions or special needs you may have with your therapist.

Building deeper connections
through the lifespan…

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CONTACT INFORMATION

Client #1
Name: _____

Address: _____

_____

Birthdate: ____/_____/_____

Phone: (H) _____

(W) _____

(C) _____

Client #2
Name: _____

Address:_____

_____

Birthdate: ____/_____/_____

Phone: (H) _____

(W) _____

(C) _____

*What number should be tried first?
* Indicate whether it is okay to leave a message regarding therapy at each of these phone numbers.

Emergency contact and phone number:
_____

Email address: _____
I would like to be informed of upcoming events:
Yes No

Emergency contact and phone number:
_____

Email address: _____
I would like to be informed of upcoming events:
Yes No

I/We heard about this practice through: Friend Doctor Insurance/EAP Website Other: _____

FOR THIRD PARTY PAYMENT:

Name of policyholder: _____ Birthday: ____/_____/_____

Address/Phone: _____

Name of insurance company: _____

Type of plan: (circle) EAP HMO PPO Other: _____

ID#: _____ Group Number: _____

Referral needed? Yes No Referral Obtained? Yes No Authorization #: _____

Number of sessions approved: _____ Expiration date: ___/___/___

Co-pay amount for behavioral healthcare: _____ Deductible amount: _____

Phone number on card or referral for behavioral healthcare: _____

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CONSENT FOR TREATMENT

I agree and consent to participate in behavioral health care services offered and provided by The Relating Well Center, LLC, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that this provider is qualified to provide within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or am legally authorized to initiate and consent to treatment on behalf of this individual.

I understand that developing a plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. Together we will evaluate my goals and progress. I understand that while the goals of therapy are to feel better, there may be times in the course of working together that I feel worse. While positive results are often the outcome of individual and couples therapy, these results are not guaranteed. I understand that I am responsible for the consequences of what I choose to disclose or not disclose during therapy. I also understand that engaging in open communication with my therapist about how I am responding to therapy will increase the therapist's ability to help.

I am aware that I may stop my treatment with my therapist at any time, though I also understand that prior communication with the therapist regarding ending treatment is highly recommended. Sessions will typically last 45 minutes. I am responsible for payment of fee and/or applicable copays at the time of service by cash or check. Any bills denied by my insurance company are my responsibility to pay directly to my therapist.

In the event of an emergency, I can call the Center and/or my therapist's cell phone. I understand that if I am in emergent need of care and/or unable to make contact, I will proceed to the nearest emergency room or call 911. I also understand that while my therapist may discuss health and lifestyle with me, this should not be construed as medical advice and I should consult my physician regarding medication, exercise, diet, or other related matters.

In order to maintain a professional relationship and safeguard my privacy, I understand that my therapist will not engage with me through social media such as Facebook, LinkedIn, Twitter, etc. While cell phones, email, and text may be mutually agreed upon between therapist and myself for appointment scheduling, I understand that these are not secure electronic media and that significant issues are best addressed in session.

All information disclosed in therapy is considered confidential according to the laws of the State of Pennsylvania. In Pennsylvania, Clinical Social Workers are mandated to breach confidentiality in situations where the therapist suspects serious suicidal intent, serious intent to harm others, or suspects abuse or neglect of a minor or an elder. The mandate also includes breaching confidentiality if subpoenaed by a court of law for records or to appear for a deposition. The Center will make every effort to inform you prior to any mandated breach of confidentiality. For those clients using third party payers such as insurance companies, please be aware that those companies have the right to review clinical records.

I understand that **if I need to cancel an appointment, I must give at least 24 hours notice**, except in the case of illness or emergency. **Failure to give 24 hour notice will result in a missed session fee equal to the full cost of the session, including any amount typically paid by a third party such as a health insurance plan, and for me/us the missed fee is _____.**

CLIENT 1
Printed name: _____

Signature: _____ Date: _____

CLIENT 2
Printed name: _____

Signature: _____ Date: _____

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CLIENT 1

I, _____, hereby give permission to The Relating Well Center, LLC, to disclose and/or obtain information from **insurance provider**:

_____
_____
_____

Type of information to be disclosed/obtained:
__x__ My entire record
The purpose for such disclosure is:
__x___ Continuity of care
__x___ Payment purposes such as authorization of care and claims processing
_____ Other: _____

I, _____, hereby give permission to The Relating Well Center, LLC, to disclose and/or obtain information from the **doctor/ medical practice** named below:

Name of doctor and/or practice: _____

_____

Phone: _____ Address: _____

_____

Type of information to be disclosed/obtained:
____ My entire record
_x___ Relevant to health status including but not limited to medical conditions, medication, diagnosis, treatment progress and outcome
____ Other: _____

The purpose for such disclosure is:
__x___ Continuity of care
_____ Payment purposes such as authorization of care and claims processing
_____ Other: _____

I may revoke these consents at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire one year after I have terminated treatment at The Relating Well Center, LLC. I understand that I am under no obligation to authorize release of information.

_____
Signature of client Date

_____
Signature of parent, guardian, or authorized representative (when required) Date

_____
Signature of therapist Date

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CLIENT 1

Name: _____ Date: _____

Visit ❑ 1 - 2 ❑ 3 – 5 ❑ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	**Not at All**	**A Little**	**Somewhat**	**A Lot**
1. Nervousness or shakiness	❑	❑	❑	❑
2. Feeling sad or blue	❑	❑	❑	❑
3. Feeling hopeless about the future	❑	❑	❑	❑
4. Feeling everything is an effort	❑	❑	❑	❑
5. Feeling no interest in things	❑	❑	❑	❑
6. Your heart pounding or racing	❑	❑	❑	❑
7. Trouble sleeping	❑	❑	❑	❑
8. Feeling fearful or afraid	❑	❑	❑	❑
9. Difficulty at home	❑	❑	❑	❑
10. Difficulty socially	❑	❑	❑	❑
11. Difficulty at work or school	❑	❑	❑	❑

How much do you agree with the following?	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
12. I feel good about myself	❑	❑	❑	❑
13. I can deal with my problems	❑	❑	❑	❑
14. I am able to accomplish the things I want	❑	❑	❑	❑
15. I have friends or family that I can count on for help	❑	❑	❑	❑

16. In the past week, approximately how any drinks of alcohol did you have? ☐☐ drinks

17. In general, would you say your health is:
❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
18. Please indicate if you have a serious or chronic medical condition:
❑ Asthma ❑ Diabetes ❑ Heart Disease ❑ Back Pain/Other Chronic Pain ❑ Other
19. In the past 6 months, how many times did you visit a medical doctor?
❑ None ❑ 1 ❑ 2-3 ❑ 4-5 ❑ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? ☐☐ days (answer only if employed)
21. In the past month, how many days were you able to work, but had to cut back on how much you got done because of your physical or mental health? ☐☐ days (answer only if employed)
22. In the past month, have you ever felt you ought to cut down on your drinking or drug use? ❑ Yes ❑ No
23. In the past month, have you ever felt annoyed by people criticizing your drinking or drug use? ❑ Yes ❑ No
24. In the past month, have you felt annoyed bad or guilty about your drinking or drug use? ❑ Yes ❑ No

MAGELLAN BEHAVIORAL HEALTH
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services. If asked, Magellan will act on the member's behalf as an advocate.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I have received a copy of the **Notice of Privacy Practices** the Relating Well Center, LLC.

CLIENT 1

_____ _____

Printed name of client Date

_____

Signature of client

_____ _____

Signature of LCSW Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____