

# 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 feel free to check if your therapist's door is open and if so to alert them that you are here.
- 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 speak on your cell phone.
- Please remember that parking spots under the building are reserved and not available.
- Please feel free to share any questions or special needs you may have with your therapist.

*Building deeper connections  
through the lifespan...*

<b>Client #1</b> Name: _____ Address: _____ _____ Birthdate: ____/____/____ Phone: (H) _____ (W) _____ (C) _____	<b>Client #2</b> 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: _____	

### 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 50 minutes. I am responsible for payment of fee at the time of service by cash or check or credit card. I understand that this practice does not participate as an in-network provider with insurance plans and that I am responsible in full for the payment of my fees.

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

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

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 seeking reimbursement from 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 and for me/us the missed fee is \_\_\_\_\_.**

**CLIENT 1**

Printed name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CLIENT 2**

Printed name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CLIENT 1**

I, \_\_\_\_\_, hereby give permission to The Relating Well Center, LLC, to disclose and/or obtain information from \_\_\_\_\_.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Type of information to be disclosed/obtained:

My entire record

The purpose for such disclosure is:

Continuity of care

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

Relevant to health status including but not limited to medical conditions, medication, diagnosis, treatment progress and outcome

Other: \_\_\_\_\_

The purpose for such disclosure is:

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

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling sad or blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Feeling hopeless about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling everything is an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Feeling no interest in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your heart pounding or racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Feeling fearful or afraid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Difficulty at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Difficulty socially	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Difficulty at work or school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

16. In the past week, approximately how many 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

**CLIENT 2**

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
25. Nervousness or shakiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Feeling sad or blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Feeling hopeless about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Feeling everything is an effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Feeling no interest in things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Your heart pounding or racing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Feeling fearful or afraid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Difficulty at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Difficulty socially	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Difficulty at work or school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How much do you agree with the following?	Strongly Agree	Agree	Disagree	Strongly Disagree
36. I feel good about myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. I can deal with my problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. I am able to accomplish the things I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. I have friends or family that I can count on for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. In the past week, approximately how many drinks of alcohol did you have?        drinks

41. In general, would you say your health is:  
 Excellent         Very Good         Good         Fair         Poor

42. Please indicate if you have a serious or chronic medical condition:  
 Asthma         Diabetes         Heart Disease         Back Pain/Other Chronic Pain         Other

43. In the past 6 months, how many times did you visit a medical doctor?  
 None         1         2-3         4-5         6+

44. In the past month, how many days were you unable to work because of your physical or mental health?        days  
 (answer only if employed)

45. 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)

46. In the past month, have you ever felt you ought to cut down on your drinking or drug use?     Yes     No

47. In the past month, have you ever felt annoyed by people criticizing your drinking or drug use?       Yes     No

48. In the past month, have you felt annoyed bad or guilty about your drinking or drug use?       Yes     No

***The Relating Well Center, LLC***  
**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)

\_\_\_\_\_  
\_\_\_\_\_