THE CLINIC
FOR MENTAL HEALTH & WELLNESS

DEMOGRAPHIC INFORMATION

PERSONAL INFORMATION			
Date:	Referral Source:		
LAST NAME:	FIRST NAME:	MI:	NICKNAME:
D.O.B:	SOCIAL SECURITY NO:		
CELL PHONE #: Message: YES NO Text: YES NO	HOME PHONE #: Message: YES NO	WORK PHONE #: Message: YES NO	
Email: May we contact you by email: YES NO			
Email for telehealth services (leave blank if same as above):			
HOME ADDRESS:	CITY:	STATE:	ZIP:
BILLING ADDRESS:	CITY:	STATE:	ZIP:
BIRTH SEX: / RELATIONSHIP STATUS:	PREFERRED LANGUAGE:	RACE ETHNICITY:	
EMERGENCY CONTACT / NEXT OF KIN INFORMATION We would contact this person in case of an emergency			
FIRST NAME	LAST NAME	RELATIONSHIP:	PHONE:
RESPONSIBLE PARTY / GUARDIAN INFORMATION			
FIRST NAME	LAST NAME	RELATIONSHIP:	PHONE:

PLEASE COMPLETE PAGE 2 OF FORM

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

DEMOGRAPHIC INFORMATION

PAYMENT INFORMATION

PAYMENT SOURCE (select one):

- ☐ INSURANCE
- ☐ SELF PAY

INSURANCE INFORMATION: PRIMARY (PLEASE BRING OR COPY CARD)

Insured Name:	Relationship to Patient:	DOB of policy holder:
Insurance Company:		
Policy No.	Group No.	Employer:

INSURANCE INFORMATION: SECONDARY (PLEASE BRING OR COPY CARD)

Insured Name:	Relationship to Patient:	DOB of policy holder:
Insurance Company:		
Policy No.	Group No.	Employer:

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by The Clinic for Mental Health and Wellness. I assign and authorize payments to the Clinic for Mental Health and Wellness. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and coinsurance except where my liability is limited by contract or state or federal law.

Client / Responsible Party / Guardian Signature **Date**

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

INITIAL INTAKE

NAME:_____DOB:_____

Individual completing this form: Patient / Guardian / Grandparent / Case Worker / Other:_____

WHAT BRINGS YOU IN TODAY?_____

CURRENT SYMPTOMS:

- ☐ Sadness / depression
- ☐ Loss of pleasure / interest
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Loneliness
- ☐ Low self-worth
- ☐ Guilt / shame
- ☐ Fatigue
- ☐ Decreased appetite
- ☐ Increased appetite
- ☐ Lack of motivation
- ☐ Social withdrawal
- ☐ Difficulty concentrating
- ☐ Over sleeping
- ☐ Difficulty with sleep maintenance
- ☐ Difficulty with sleep onset
- ☐ Inability to sleep
- ☐ Seasonal mood changes
- ☐ Anxiety / Worry
- ☐ Panic attacks
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Recurring, disturbing memories
- ☐ Hypervigilance
- ☐ Aggressive physically
- ☐ Aggressive verbally
- ☐ Conduct Problems
- ☐ Disruptive Behavior
- ☐ Irritability / anger
- ☐ Fire setting
- ☐ Legal problem(s)
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Excessive money spending
- ☐ Hypersexual behaviors
- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity Boredom
- ☐ Poor Memory
- ☐ Hallucinations
- ☐ Delusions
- ☐ Suspicion/paranoia
- ☐ Eating problems
- ☐ Laxative / diet pill / diuretic misuse / abuse
- ☐ Body Image
- ☐ Gender Identity
- ☐ Financial problems
- ☐ Major loss
- ☐ Significant life changes
- ☐ Work / School problems
- ☐ Difficulties with religion / Spirituality
- ☐ Child-Parent relationship problems
- ☐ Peer relationship problems
- ☐ Marital problems
- ☐ Intimacy problems
- ☐ Chronic pain
- ☐ Health concerns
- ☐ Gambling addiction
- ☐ Computer addiction
- ☐ Pornography addiction
- ☐ Illicit substance use
- ☐ Prescription drug abuse
- ☐ Alcohol overuse

In your opinion, how severe is/are the problem(s)? Mild / Moderate / Severe

How long have you been experiencing symptoms? Days / Weeks / Months / 1 year / less than 5 years / more than 5 years

How often are your symptoms present throughout the day? Never Sometimes Frequent Constant

To what degree are these impacting your level of functioning? Mild / Moderate / Severe

Are you currently prescribed psychiatric medication? YES NO

Prescriber / Name of facility:

How long have you been seeing them?

Are you currently in counseling / therapy? YES NO

Therapist name:

How long have you been seeing them?

INITIAL INTAKE

Are you presently having any suicidal thoughts? NO YES

Do you have a plan? NO YES (details)_____

Do you own or have access to firearms? NO YES (are they locked up) yes no

Are you experiencing any homicidal thoughts? NO YES

Are you presently self-harming? NO YES

Have you recently been physically, emotionally, sexually hurt or threatened by someone? NO YES (details)

_____

PAST HISTORY:

Previous self-harm behaviors (cutting, burning, head banging): NO YES (details)

_____

Previous thoughts, made statements or attempted to hurt and/or kill yourself? NO YES (details)

_____

Previous thoughts, made statements or attempted to hurt and/or kill someone else? NO YES (details)

_____

History of abuse or trauma related events? NO YES (details)

_____

Previous diagnosis / treatment of any mental health problems or substance use? NO YES (list below)

Date Where treated Diagnosis Treatment

_____

_____

_____

_____

Previous Psychiatric testing performed? NO YES (Date(s), diagnosis)

_____

SOCIAL HISTORY:

Sexual Orientation: _____ Gender Expression:_____

Relationship status: married / single / divorced / widowed / partnered / other:_____

Duration & quality of relationship:_____

Previous marriage(s): NO YES Number: _____ Dates of marriage(s): _____

Children: NO YES Number of children: _____

Name & Ages (specify if biological, adopted, step, & previous or current relationship):

_____

_____

_____

_____

INITIAL INTAKE

EMPLOYMENT:

Current Employer:_____ Length of employment:_____

Current Position:_____ Do you like your job:_____

Previous Employment(s): _____

On Disability: NO YES (for what) _____

LIVING SITUATION: **House** **Apartment** **Other**:

	Current Members in the Household - NAME	Relationship to Patient	Age
1			
2			
3			
4			
5			

DEVELOPMENTAL HISTORY:

Place of Birth:_____

Raised by: _____

Siblings and ages (please indicate full, half, step, adopted):_____

Please note any speech, language, hearing, visual, learning disabilities, etc. Concerns or Problems:

Please explain any developmental concerns / delays: _____

CURRENT EDUCATION:

Are you presently attending school: NO (skip this section) YES (please fill out the following)

Current School & Grade:_____

IEP / 504: NO YES For what:_____

Academic performance below average average above average

Easiest subject: _____ Most difficult subject: _____

School / Parents' concerns:_____

EDUCATIONAL HISTORY:

Graduated High School: NOYES Year _____ GED: Year _____

Attended:

Trade (facility, focus, year): _____

Associates (college, degree, year):_____

Bachelors (college, degree, year):_____

Masters (college, degree, year):_____

PhD (college, degree, year):_____

INITIAL INTAKE

MILITARY:

Have you ever served in the military? NO YES

If YES, what branch and when? _____

LEGAL:

Current legal problems (arrests, charges, trial, probation)? NO YES (provide details)

_____

Previous legal proceedings (arrest, charges, trial, probation, jail or prison sentences): NO YES (provide details)

_____

ADDITIONAL INFORMATION:

Current support system (family, friends, community members, etc.)_____

_____

Personal strengths and abilities?_____

Interests and Hobbies?_____

Needs and preferences during treatment?_____

What role does spirituality or religion currently play in your life?_____

Do you have a need for assistive technology or accommodations with receiving services? _____

PATIENT'S FAMILY HISTORY:

Please list which blood relatives have been diagnosed with the following conditions:

ADHD / ADD		Seizures	
Alcohol abuse		Diabetes	
Anger		High blood pressure	
Anxiety		Thyroid	
Bipolar disorder		Cancer	
Depression		Osteoporosis	
Post Trauma Stress Disorder		Heart disease/arrhythmias	
Personality disorder		Strokes	
Schizophrenia			
Substance abuse		Other:	
Suicides			

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

INITIAL INTAKE

MEDICAL INFORMATION:

Primary Care Provider:_____ Last Seen:_____

Are your immunizations up to date? YES NO Do you have an advanced directive? YES NO

CURRENT Medical Problems / Health Concerns / Needs / Co-occurring Disabilities:_____

PAST Medical / Surgical History with dates:_____

History of Seizures: NO YES (details)_____

History of Head Injuries? NO Yes (how many, when, severity)_____

FEMALES:

Are you currently pregnant? NO YES – are you receiving prenatal care YES NO

Have you been pregnant before? NO YES – Health issues related to pregnancy? _____

Number of live births: _____ Miscarriages: _____ Abortions: _____

Do you use birth control? NO YES (what type) _____

MEDICATION:

ALL Current Medications: (prescription, supplement, over the counter) **Current Pharmacy:**

Medication	Dose	Frequency	Provider	Reason it's taken

Allergies to medications: NKDA YES (what & reaction)

Allergies to food: NKA YES (what & reaction)

Are you using any complementary health approaches (alternative medicine, natural products, mind and body practices, homeopathy, naturopathy)? _____

Additional Information you'd like your practitioner to know:_____

INITIAL INTAKE

SUBSTANCE USE:

CURRENT	YES	NO	HOW MUCH daily / weekly, often / amount
Caffeine			
Cigarettes			
Electronic cigarettes / Vape			
Chew			
Alcohol			
Marijuana (any form)			
Cocaine			
Methamphetamines			
Opioids / narcotics			
Mushrooms			
Ecstasy			
LSD			
PCP			
Inhalants			
Prescription pills			
(over use of own prescription)			
(not prescribed to you)			
OTHER			

Do you believe your substance use is a problem? YES NO

Do others believe your substance use is a problem? YES NO

PAST	YES	NO	HOW MUCH daily / weekly, often / amount
Caffeine			
Cigarettes			
Electronic cigarettes			
Chew			
Alcohol			
Marijuana (any form)			
Cocaine			
Methamphetamines			
Opioids / narcotics			
Mushrooms			
Ecstasy			
LSD			
PCP			
Inhalants			
Prescription pills			
(over use of own prescription)			
(not prescribed to you)			
OTHER			

In the past has your substance use been a problem? YES NO

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MEDICATION HISTORY

Name:

	DATE / RESPONSE		DATE / RESPONSE
Antidepressants		**Anxiolytics and hypnotics**	
Anafranil (Clomipramine)		Ambien (Zolpidem)	
Brintellix (Vortioxetine)		Ativan (Lorazepam)	
Celexa (Citalopram)		Belsomra (Suvorexant)	
Cymbalta (Duloxetine)		Buspar (Buspirone)	
Effexor (Venlafaxine)		Dayvigo (Lemborexant)	
Elavil (Amitriptyline)		Doral (Quazepam)	
Fetzima (Levomilnacipran)		Flurazepam	
Lexapro (Escitalopram)		Halcion (Triazolam)	
Luvox (Fluvoxamine)		Hydroxyzine	
Norpramin (Desipramine)		Klonopin (Clonazepam)	
Pamelor (Nortriptyline)		Librium (Chlordiazepoxide)	
Paroxetine (Paxil)		Lunesta (Eszopiclone)	
Pristiq (Desvenlafaxine)		Propranolol (Inderal)	
Prozac (Fluoxetine)		Quviq (Daridorexant)	
Remeron (Mirtazapine)		Restoril (Temazepam)	
Tofranil (Imipramine)		Rozerem (Ramelteon)	
Viibryd (Vilazodone)		Silenor (Doxepin)	
Wellbutrin (Bupropion)		Sonata (Zaleplon)	
Zoloft (Sertraline)		Trazodone	
		Valium (Diazepam)	
Antipsychotics		Xanax (Alprazolam)	
Abilify (Aripiprazole)			
Clozaril (Clozapine)		**Mood Stabilizers**	
Fanapt (Iloperidone)		Depakote (Valproate)	
Haldol (Haloperidol)		Keppra (Levetiracetam)	
Geodon (Ziprasidone)		Lamictal (Lamotrigine)	
Invega (Paliperidone)		Lithium / Lithobid	
Latuda (Lurasidone)		Tegretol (Carbamazepine)	
Loxitane (Loxapine)		Topamax (Topiramate)	
Mellaril (Thioridazine)		Trileptal (Oxcarbazepine)	
Nuplazid (Pimavanserin)			
Risperdal (Risperidone)		**Alcohol / Opioids**	
Saphris (Asenapine)		Antabuse (Disulfiram)	
Seroquel (Quetiapine)		Naltrexone / Vivitrol	
Stelazine (Trifluoperazine)		Suboxone (buprenorphine/ naloxone)	
Vraylar (Cariprazine)			

502 S. 4th Street, Laramie, WY 82070
Phone: (307) 755-1000 * Fax: (307) 742-9717 * counseling@tmentalhealth.com

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MEDICATION HISTORY

Zyprexa (Olanzapine)			
	DATE / RESPONSE		**DATE / RESPONSE**
Stimulants (Amphetamine)		**Other**	
Adderall (IR/XR)		Ketalar (Ketamine)	
Adzenys (ER/XR)		MAOI's	
Dexedrine (IR / ER)		Minipress (Prazosin)	
Dyanavel XR			
Mydayis		Gabapentin	
ProCentra		Lyrica (Pregabalin)	
Vyvanse			
Xelstryn (patch)		**Smoking Cessation**	
Zenzedi		Chantix (Varenicline)	
Stimulants (methylphenidate)			
Adhansia XR		**Narcolepsy**	
Aptensio XR		Nuvigil (Armodafinil)	
Azstarys		Provigil (Modafinil)	
Concerta		Xyrem (Sodium Oxybate)	
Cotempla XR			
Daytrana		**Obesity / weight loss**	
Evekeo		Belviq (Lorcaserin)	
Focalin (IR/ER)		Contrave	
Jornay PM		Qsymia	
Metadate (CD / ER)		Manjaro	
Methylin (IR / ER)			
Quillivant / Quillichew		**Parkinson**	
Ritalin		Aricept (Donepezil)	
		Artane (Trihexyphenidyl)	
Non Stimulant ADHD		Cogentin (Benztropine)	
Strattera (Atomoxetine)		Exelon (Rivastigmine)	
Clonidine		Namenda (Memantine)	
Guanfacine			
Qelbree			

Other:

THE CLINIC
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CONSENT AND DISCLOSURE FOR TREATMENT

This document, which is required by the Mental Health Professions Licensing Act, is intended to inform you about the professional backgrounds of those you may work with at The Clinic for Mental Health and Wellness (The Clinic), while providing you information about counseling and professional accountability. Please read this carefully and be sure to ask any questions you might have. When you sign this document, it will represent that you have been informed of your rights and responsibilities. We may refer back to this disclosure if related questions were to arise in our work in the future. I look forward to our work together.

Goals and Outcomes for Counseling: Counseling is used to assist individuals in exploring and resolving struggles impeding the person's quality of life, well-being, relationships, and happiness. Additionally, counseling can assist with individuals' self-awareness, acceptance, and development of effective problem-solving skills. The role of a counselor is to support you in the process of making changes.
Ultimately, however, you will decide the nature and amount of change you wish to make. Throughout the counseling process we will discuss your progress, and if at any time you are unhappy with the experience, please talk about this with me to assure you receive the support you need.
Typically, sessions occur weekly and last 50-60 minutes. The actual duration and frequency of counseling will depend upon your needs and your specific goals. As progress is made towards your goals and we closely evaluate your need for services, we can discuss meeting less frequently and working towards closing your file. If, at any time, you request to return to counseling, we can reinitiate services.

Benefits and Risks: Most people experience improvement or resolution to the concerns that brought them to counseling. However, the process of counseling can be difficult at times. Discussing psychological, emotional, and/or relationship issues occasionally causes some pain and anxiety, and making important changes will require effort on your part. I will support you during these difficult times and in addressing these issues.

Your Relationship with your Counselor: Although you may share personal information with your counselor during the course of counseling, your relationship must remain professional. The focus of counseling will be on *your* experiences, concerns and goals. Sexual intimacy between counselor and client is *never* appropriate.

Confidentiality and Limits to Confidentiality: Trust and honesty are critical to the development of counseling relationships.
Therefore, The Clinic places a high value on privacy and confidentiality of information you share in counseling. Wyoming Statute 33-38-113 provides privileged status for counselor-client communications. The confidentiality of client records maintained by The Clinic is protected by federal law and regulations (See 42 U.S.C. 290dd-2, 42 U.S.C. 290-cc, 42 CFR part 2 and 45 CFR part 160& 164). All records, which you are allowed access to, and verbal information are kept confidential and will not be disclosed without your express written consent, except in the following situations, as allowed by the law:

1. Where an immediate threat of self-inflicted harm exists;
2. Where an immediate threat of physical violence against a readily identifiable victim exists;
3. Where there is reasonable suspicion of abuse/neglect against a child, elder, disabled, or other dependent;
4. Where a judge has ordered the release of privileged information;
5. In the course of criminal or civil actions initiated by you against the counselor;
6. In the course of investigations and hearings conducted by the board initiated by you;
7. The disclosure is made to medical personnel in a medical emergency;
8. Where the client alleges mental or emotional damages in civil litigation or otherwise places his/her mental or emotional state in issue in any judicial proceeding concerning child custody or visitation.

Ethical Guidelines and Responsibilities: All licensed professionals are mandated and expected to follow the Rules and Regulations of the Wyoming Mental Health Licensing Board and the Codes of Ethics and Standards of Practice of the American Counseling Association and/or National Association for Social Work. This information can be obtained from me. If I am not able to help you resolve your concerns or you wish to obtain further information or report a complaint you may contact; the Mental Health Licensing Board, 2001 Capitol Avenue, room 104, Cheyenne, Wyoming, 82002, (307) 777-7788 or Wyoming State Board of Nursing, 130
Hobbs Ave, Ste B, Cheyenne, WY 82002, (307) 777-7601.

Emergency Contact Information: The Clinic does not provide emergency services or 24-hour care. If you were to need additional support services beyond what you are receiving with The Clinic or at a time when The Clinic is not open, please contact one of the following resources

- Emergency – 911
- National Suicide Prevention & Mental Health Hotline – 988
- National Suicide Prevention Lifeline –1 800 273 8255 (TALK)
- National Crisis Text Line — Text "GO' to 741741
- Ivinson Memorial Hospital ± Behavioral Health 255 N 30th Street, Laramie, WY — 307-742-0285 (Emergency Line)

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

CONSENT AND DISCLOSURE FOR TREATMENT

Consent for Treatment: I authorize The Clinic providers (therapists, social workers, students, interns nurse practitioners, nurses, physicians, and other qualified personnel), whether employed directly by them or brought in on a consulting basis, to provide any medical / psychiatric treatment, diagnostic tests and screenings as they deem appropriate. I understand that the results of any treatments, tests or care cannot be guaranteed. I also understand that I have the right to refuse any treatment, medication recommendations or procedures to the extent permitted by law. I understand that medical, nursing, and other health care personnel in training may be observing and participating actively in my care. I hereby give my consent to treatment.

Professionals: While receiving services at The Clinic, you may work with the following individuals:

Debbie Bastian, LPC # 900
M.S., Counselor Education, University of Wyoming

Jana K. Saltenberger, LCSW #218
B.A., Psychology, University of Montana
M.S.W. University of Cincinnati

Leah Rasmussen, APRN, PMHNP-BC
B.S.N. Nursing, University of Wyoming B.A., Psychology, University of Wyoming
B.S., Nursing, University of Wyoming
M.S., Nursing, University of Wyoming

CLIENT'S PRINTED NAME

CLIENT'S SIGNATURE / AUTHORIZED PERSON'S SIGNATURE **DATE**

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

PAYMENT POLICY

INSURANCE

- We participate in most insurance plans, including Medicare (depending on provider). If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any question you may have regarding your coverage
- Full payment is due at your first session unless other arrangements have been made prior to the session (exceptions include clients who are covered under *Medicaid, Tricare,* and the *Kid CHIP* program, among others. Please speak with The Clinic's biller or your provider upon arrival at your first appointment if you believe exceptions should apply to you.)
- If you are the parent of a minor child bringing your child in for services, you are responsible for payment for the services received by your child.

COPAYMENTS AND DEDUCTIBLES

- All copayments and deductibles must be paid at the time of service. This arraignment is part of your contract with your insurance company. Please help us in upholding the law by paying your co-payment at each visit.

PAYMENT

- Payment is accepted by cash, check or most major credit cards. Credit card payments are accepted via phone, patient portal or billing statement.
- Credit card information can be stored in our HIPPA compliant secure charting system and authorization may be given for regular payments from that card.
- Adjusted Rate accounts are due at the time of service unless other arrangements have been made.
- Adjusted Rate balances after insurance are due within 30 days from the first statement
- Statements are sent every 30 days in a 120-day running cycle.
- Patients have the opportunity to make payment in full or through financial arrangements which include:
    - Payment plan - can be established upon the patients' request. If payment is owed for two appointments, you will be asked to set up a payment plan as of the third session. If you are setting up a payment plan, a credit / debit card must be kept on file.
    - Providing additional information for billing another payer
- Failure to respond or to send payment will result in placement with the collection agency.

NONPAYMENT

- If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you/your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, the service provider will only be able to treat you on an emergency basis

PROOF OF INSURANCE

- All patients must complete our patient demographic form (paper or via patient portal) before seeing a provider. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of a claim.

COVERAGE CHANGES

- If your insurance changes, please notify us before your next appointment so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

SUBSTANCE ABUSE EVALUATIONS

- At the time of booking, the patient will pay for half the evaluation fee. If the patient reschedules within 24 hours, fee will be applied to the new appointment date. If the patient cancels within 24 hours, the fee will be refunded. If the patient does not reschedule or cancel within 24 hours of appointment, fees will not be refunded.

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

PAYMENT POLICY

NON-COVERED SERVICES

- Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

CLAIMS SUBMISSION

- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

LATE CANCELLATIONS OR NO-SHOW APPOINTMENTS

- If you are unable to attend your scheduled appointment, notification to The Clinic to cancel the appointment, needs to be done at least 24 hours prior to the appointment time. You can call the office, decline via text or email through the appointment reminder, or send notification through the patient portal to cancel the appointment. We reserve the right to charge at least $50, up to the full amount, for appointments not canceled 24-hours prior to the scheduled appointment time. These charges will be your responsibility and billed directly to you as insurance won't cover this charge. Please help us to serve you better by keeping your regularly scheduled appointment.
- If the appointment is missed without prior notification (no show), The Clinic reserves the right to assess a missed session fee of at least $50, up to the full amount. If there are 5 now show appointments within the course of a year The Clinic reserves the right to discharge you from the practice for a period of at least 1 year.
- Please be advised that being more than 15 minutes late may require you to reschedule.

CHARGES

- Fees are based on the length and type of evaluation or treatment, which are determined by the nature of the service.
- IEP, MDT, Treatment Team meetings, court appearances, and court testimony are billed at separate rates. Please speak with your provider for more information

PHONE AND EMAIL

- We will return phone messages at our earliest convenience, usually within one business day.
- In the case of an emergency, please call 911 or 988.
- We do not use email as primary communication.
- The patient portal is considered HIPPA compliant so direct communication about billing / payment can be communicated through there. As well as, payments can be made through the patient portal.
- Please contact The Clinic via phone for questions / concerns.

INDEPENDENT PRACTICE

- Please note that each provider within The Clinic is an independent practitioner. All practitioners work under policies and protocols consistent with licensing standards and ethical guidelines.
- Please make all payments directly to the practitioner who provided you the service.

The Clinic is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy.

CLIENT'S PRINTED NAME

CLIENT'S SIGNATURE / AUTHORIZED PERSON'S SIGNATURE **DATE**

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

HIPPA NOTICE

HIPPA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operation (§164.508(a)) I understand that as part of my healthcare, The Clinic for Mental Health and Wellness (The Clinic) originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among health professionals who may contribute to my health care;
- a source of information for applying my diagnoses and information to my bill;
- a means by which a third-party payer can verify that services billed were provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

A more detailed *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures is posted in the front office. A personal copy can be obtained by speaking with your current provider.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review The Clinic and Wellness's Notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))
I understand that:

- I have the right to review The Clinic's Notice of Information practices prior to signing this consent;
- The Clinic reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, The Clinic may decline to provide treatment to me.

I hereby give my consent for The Clinic to use and disclose my Protected Health Information (PHI) to perform treatment, payment and healthcare operations (TPO).

With this consent The Clinic for Mental Health and Wellness;

- May call, text, or email me at my home or other alternative locations
- May leave a message by voice, text, email or in person in reference to any items in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results. ● Mail to my home or alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care.

By signing this form, I am consenting for The Clinic to use and disclose my PHI to carry out TPO.

CLIENT'S PRINTED NAME

CLIENT'S SIGNATURE / AUTHORIZED PERSON'S SIGNATURE **DATE**

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

TELEHEALTH CONSENT FORM

At this time, The Clinic for Mental Health & Wellness offers sessions via telehealth service. I understand Telehealth service is the delivery of healthcare services when the provider and client are not in the same physical location/site. The provider accesses the service through a secure telehealth software program to connect electronically with clients. The clinic is using a HIPAA compliant telehealth site, for all telehealth appointments. I understand Telehealth psychotherapy may include mental health evaluations, assessments, consultations, treatment planning, medication management, and therapy, but may not be as complete as in-person services.

I understand there are additional risks to telehealth compared to traditional counseling. This includes, but not limited to, disruption or fault in internet services, technical difficulties, and chance of security breach of person and/or medical information. I understand I will be informed of the identities of all the people present during the teletherapy session and informed of their purpose for attending. I comprehend the Clinic for Mental Health and Wellness cannot guarantee the same level of privacy with telehealth, when physically present in the clinic.

I understand I am responsible for reducing risks to confidentiality of telehealth services by designating services to a private area and taking necessary precautions to limit the possibility of other people overhearing confidential information. I acknowledge the benefits of telehealth services include convenience and flexibility, but understand there may be conditions telehealth services may be inappropriate and the practitioner has the right to make this determination. I understand I still may need to see a specialist in-person.

I understand, acknowledge, and agree to the following statements:

A. I understand I have the right to withhold or withdraw your consent to the use of telehealth services at any time in the course of your care, without affecting my right to future care or treatment.
B. I authorize information about my medical and mental health care information to be transferred electronically through an interactive video connection between the Clinic for Mental Health and Wellness and telehealth complaint site.
C. I authorize the release of information pertaining to be determined by my mental health provider or by my insurance company for the purpose of processing insurance.
D. I understand my provider will not be physically present during my teletherapy sessions and we will see each other electronically. I comprehend video and audio recording is NOT permitted during telehealth sessions.
E. I understand that the information from my telehealth therapy sessions will be protected by HIPAA privacy laws. I may request a copy of my electronic record in writing.
F. I understand that, under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangers to myself and others.
G. I also comprehend emergency and crisis situations are inappropriate for audio/video/computer-based psychotherapy services. I understand that I should call 911 OR go to the nearest emergency room in case of an emergency. I am aware of local county crisis agencies and the National Suicide Hotline at 1-800-784-2433 in crisis situations.

By signing this form, I certify:

- That I have read or/and had this form explained to me.
- That I fully understand the contents of the form and accept the potential risks and benefits of telehealth services.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction relative to your telehealth encounter, security practices, technical specifications, and other related risks.

*****IN CASE OF EMERGENCY CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM******

CLIENT NAME (**PLEASE PRINT)** Date of Birth

Signature of Client/ Or Guardian Date

EMAIL Phone Number

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

GOOD FAITH ESTIMATE

The Clinic for Mental Health & Wellness recognizes that every client's therapy and medication journey is unique. Many factors influence how long you will need to engage and attend sessions. These factors will include:

- Your schedule and life circumstances
- Provider's availability
- Ongoing life challenges
- The nature of your specific needs and how they are addressed
- Medications
- Diagnoses
- Provider's recommendations

You and your provider will continually assess the appropriate frequency of treatments and will work together to determine when you have met your goals and are ready for discharge. This ongoing assessment may also change the diagnoses given.

Below, you will see rates and how much it would cost if you were to meet with your therapist for 52 sessions in one year as well as how much it will cost if you meet with your medication provider 9 times in one year.

This estimate DOES NOT INCLUDE services external than the initial intake and follow up sessions. If you require to be seen more or for add on services, you will be given a new Good Faith Estimate.

This is just an estimate, and your bill may be lower depending on treatment frequency and need.

The services provided by the Clinic for Mental Health & Wellness are:

- Professional Counseling
- Psychiatric Medication Management
- Substance Abuse Evaluations
- Group Therapy
- Co-parenting classes

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.
You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059

The current service codes and full rates are: *This is a list of the most common appointments. This is not a list of all possible codes and services at the Clinic.*
Locations of Service:

The Clinic for Mental Health and Wellness 502 S. 4th Street Laramie, WY 82070	Telehealth Laramie, WY 82070 Phone: (307) 755-1000

THE CLINIC
FOR MENTAL HEALTH & WELLNESS

GOOD FAITH ESTIMATE

Phone: (307) 755-1000	

Service	Code	Rate per session
Initial Therapy Intake	90791	$190
Follow-up Therapy - 60 min	90837	$170
Follow-up Therapy - 45 min	90834	$160
Follow-up Therapy - 30 min	90832	$90
Initial Medication Intake	90792	$300
Follow-up Medication - 30 min + complexity	99214	$190
Follow-up Medication - 20 min + complexity	99213	$150
Evaluation and Management - 30 min	90833	$90
Evaluation and Management - 45 min	90836	$130
Co-Parenting Class - 4 hours	N/A	$300
Substance Abuse Evaluation (SAE)	N/A	$230
DUI Class	N/A	$180

Example of Rates:

If you see your therapist 52x in one year:
$190 intake and then $170 x 51 weeks = $8,480
This total cost does not include the adjusted cost of an intake session if an intake session is necessary within the year.

If you see your psychiatric medication provider 12x in one year:
$300 intake and then $190 x 12 visits = $2,580
This total cost does include the adjusted cost of an intake session if an intake session is necessary within the year.

Providers:

Debbie Bastian, LPC # 900
NPI 1205802923

Jana Saltenberger, LCSW # 218
NPI 1992703094

Leah Rasmussen, APRN, PMHNP-BC 23260.1200
NPI 1417209362

CLIENT'S PRINTED NAME

CLIENT'S SIGNATURE / AUTHORIZED PERSON'S SIGNATURE **DATE**