Dr Malka Golden-Wolfe 360-770-3711

CONFIDENTIAL CLIENT INTAKE

Name ____

Street ____

City ______________________ Zip __________ DOB ______________

Phone ____________ Cell ____________ Occupation ________________

Emergency Name and Phone contact ______________________________

PRIMARY INSUREDS:

Name ______________________ Relationship ______________

DOB ____________ Employer ______________________ Phone ______________

Insurance ____

Policy ID# ______________________________ Group# ______________

Other Insurance ______________________ ID# ______________________

Responsible Party, Parent, Guardian ______________________________

OFFICE POLICY

I understand that I am financially responsible for: ALL appointment, co-pays, deductibles, non covered benefits, and missed appointment fees. I understand that to avoid a missed appointment fee of $120.00, I must give 24 hour prior notice. I am also responsible for verifying that my Insurance Company covers Mental Health Therapy. Insurance Companies will be billed directly, missed appointments can not be billed to the Insurance Company!

Signed ______________________________ Date ______________________

Keystone Wellness Center, LLC
Dr. Maika Golden-Wolfe PhD
616 Commercial Ave #18 Anacortes, WA.98221
360-770-3711

NOTICE OF PRIVACY PRACTICES: HIPPA

This notice describes how health information about you may be used or disclosed as a client of my office, as well as how you can get access to your health information. This information is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996

(HIPAA) LEGALLY DEFINED DUTY OF THIS OFFICE:

This office is required by legal statute to protect the privacy of your health information. This personal health information is defined as that health information that can be used to identify you, has been created by this office, or has been received from another office or entity. It applies to past, present and future health or conditions, your treatment, payment for services and other health practices which will be explained.

This office has the right to change the privacy practices as described in this notice at anytime,as permitted by law. The changes will apply to your health information held by this office. You will at that time received an updated copy of his notice and it will be posted in my office.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION:

This office is permitted to use and disclose your health information for the purpose of providing treatment, payment for service rendered, and healthcare operations. Some of these require your authorization and others do not.Some of the examples that do not require your authorization include:

1.Treatment: This office may use and disclose health information to physician, psychiatrist, or other mental health clinicians who provide treatment to you. The purpose of this disclosure is for coordination of you treatment. I may also call you by name in the waiting area

2.Payment: This office may use and disclose your health information to obtain payment for services provided to you. This disclosure may be to your health insurance company or health plan. If this office begins to use a third party billing service, we will make sure they comply with the safe management of your health information.

3.Emergency Situations: This office may use and disclose your health information to emergency personnel in case a situation warrants such treatment.

4.Federal, State, Local or Administrative Law: This office may use or disclose your health information when mandated by law. This includes reporting child and/or elder/dependent abuse, harm to self or others; when required by judicial or administrative actions, or when required by government agencies such as county coroner or workers' compensation laws.

5.National Security: This office may disclose your health information to military authorities of the Armed Forces under specific situations. For example, we may disclose to intelligence, counterintelligence and other national security agencies information required by them.

6.Authorization: This office may obtain your written authorization for use or disclosure of your health information for situations not listed above. You may give this office your written authorization for use of your health information or to disclose it to anyone for any purpose as defined by the written "Release of Information". You may revoke your authorization in writing at any time.

7.Family, Friends, or Others Involved in Your Healthcare: This office may provide your health information to a family member, friend or other individual designated by you as being involved in your healthcare or for the payment of your healthcare, unless you object.

8.Appointment Reminders and Other Communications: This office at times may use or disclose your health information to provide you with appointment reminders, appointment changes, and other office communications. These may include voicemail messages, letters, faxes or emails.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Access to Your Health Information: You have the right to examine or obtain copies of your health information, with some limited exceptions: This office will attempt to comply with the requested format, unless we are unable to do so. The request must be in writing, and we will comply within 30 days of receiving your written request. You will be charged price of $1.00 per page. We may also choose to provide you with a summary or synopsis of your health information. Should this office deny your request, you will be provided a reason in writing and an explanation of your rights to initiate a review of the denial. Requesting Limits on Uses and Disclosures of Your Health Information: You have the right to request limitations on the use and disclosure of your health information. Your request is to be submitted in writing, and if accepted, will be included in your records. The request may not interfere with the legally defined uses and disclosures of your health information. Receiving Health Information: You may request that health information be sent to you to a specific location and by specific means, such as mail, fax or email. This office will attempt to comply as long as it is feasible.Accounting Disclosures: You have the right to request and receive a list of disclosures made on your behalf by this office for reasons other than treatment, payment, or healthcare operations. You may make one such request a year and there will be a reasonable charge for additional request made in one 12 month period.

Your Right to Amend Your Health Information: You have the right to request an amendment or correction to your health information. The request much be made in writing and a reason for your request must also be included. The office must respond to your request within 60 days of the request. The request will be granted or denied. If your request is granted,the appropriate changes will be made, you will be informed of the changes made and third parties needing to know about the changes will be notified.

This office can deny your request if the information is complete or correct, if it was not created by this office, not part of the office records, or cannot be disclosed. You will receive a written statement stating the reason for the denial. You also have the right to request that your original request and my denial be attached to all future disclosures of your health information.

COMPLAINT PROCEDURES:

Should you believe this office has violated your privacy rights, should you disagree with a decision made about access to your health information, you may submit a written complaint to the U.S. Department of Health and Human Services, 200 Independence Ave., SW, Washington, DC, 20201. This office will not retaliate against you in any way should you choose to file a complaint.

Signed____ Date________________

NEW CLIENT INFORMATION/CONSENT FORM
Malka Golden-Wolfe,PhD, LMFT
License # 00002365

Welcome to my practice. Please take a few minutes to fill out the following form. This Information will enable me to get to know you and better meet your needs. Thank you for your time.

Client Name: ______________________________

Today's Date ______________

(To be completed by the Parent/Guardian if patient is younger than 18 years)

Date of Birth ______________ Age ____________

Address______________________________

Street address City State Zip

Email Address______________________________ I do not wish to receive emails

Phone Number(s): Home ______________ Work ______________ Cell

May we call you ...at home? Yes, no ...at work? Yes, no

Current Relational Status: ☐ Single ☐ Married - Date __________

Separated - Date __________ Widowed-Date______________

Prior Marriages: Please list all prior marriages, including the date of marriage and date of divorce:______________________________

____

Please list all of your children:

Name ______________________ Age_______ In home? ___Y ___N
Name ______________________ Age_______ In home? ___Y ___N
Name ______________________ Age_______ In home? ___Y ___N
Name ______________________ Age_______ In home? ___Y ___N

Employer/ School______________________________

Occupation______________________________

Referred by: ______________________________

Person to be contacted in case of an emergency

Name ______________________________

Relationship ______________________________

Home phone:______________________________

Work phone: ______________________________

Presenting Problem(s):

Please describe your reasons for seeking counseling (include date and month the problem started):

Please list any serious medical conditions that you are or have been treated for:

When did you last have a physical examination?

Name, Phone Number

Please List all Medications, **dosage, frequency and reason for taking medication.**

PLEASE INDICATE ANY AREAS OF CONCERN TO YOU AT THIS TIME:

Marriage/Relationship ____
Family _____
Job/School performance _____
Friendships ______
Hobbies ______
Financial Situation ______
Physical Health ______
Anxiety level/Nerves ______
Depression ______
Suicidal Ideation ______
Mood ______
Eating Patterns ______
Sleeping Patterns ______
Sexual functioning ______
Ability to concentrate ______
Ability to control your temper______

Please describe any current or past problems with substance abuse:

Please give a brief description of any previous therapy experiences you have had including substance abuse
treatment.

Please add any information that you would like me to know that is relevant to your treatment.

Confidentiality

All information between counselor and patient is held strictly confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a physical danger to others.
4. Child/elder abuse or neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

Clients whose costs are covered by insurance should be aware that coverage always requires a diagnosis. Some insurance companies require even greater information in order to complete treatment reports. Any treatment reports will be discussed with you.It is assumed that by requesting the completion of an insurance form you are granting permission to fill out the necessary information concerning diagnosis and treatment. Questions regarding your insurance company's policies on confidentiality should be taken up with the company directly.

Financial Terms

The hourly therapy fee is $150. Unless other arrangements have been made. Full payment is due at each session. While some insurances may cover a portion of the fee, payment is the responsibility of the client. Assistance with the billing of insurance carriers will be provided at no fee by the therapist.

Canceled/Missed Appointments

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the client will be billed according to the scheduled fee. Missed appointments are not covered by insurance and are the responsibility of the client.

Sessions are 50 minutes in length unless otherwise scheduled.

Consent for Treatment

I authorize and request that Malka Golden-Wolfe PhD, LMFT provide treatments, and/or diagnostic procedures which now or, during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

______________________________ ____________

Signature of Client (or parent/guardian) Date

______________________________ ____________

Signature of Therapist Date