VIP Mental Health and Life Coaching Intake Packet

This packet of information is your INTAKE PACKET, which needs to be completed prior to initiating services.
It contains required disclosures called INFORMED CONSENTS.
Please read carefully and complete all blanks, including initials and signatures. Instructions to you are provided in RED ITALICS.
If you have any questions, please ask them before you sign and submit this paperwork.

Email completed paperwork to ktg@vipmhlc.com OR
Mail completed paperwork to VIPMHLC, 4300 W Lake Mary Blvd, #1010-407, Lake Mary, FL 32746 OR
Fax completed paperwork to 407 915 6722

PLEASE COMPLETE THE 1st THREE PAGES AND RETURN THEM TO US

CLIENT BASIC INFORMATION

Please complete this section and provide a photocopy of current photo identification such as a driver's licensee

Today's Date: ______________________ Your Date of Birth: ______________________

Your Name: ______________________

Your Address: ______________________

Address cont'd: ______________________

Phone Number(s): Home/Cell ______________________

E-Mail Address: ______________________

Skype User Name: ______________________

How did you hear of us? ______________________

Emergency Contact (how related): ______________________

That person's Phone Number(s): ______________________

COORDINATION OF CARE

We will coordinate care with the professionals whose names and phone numbers you provide here:

Primary Care Physician/Phone: ______________________

Psychiatric Prescriber/phone: ______________________

Other (such as PO, CM, etc.) ______________________

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DBT ☒Pre ☐Post Test

*Name:*____ *Date*__________________

1=All of the time 2=Most of the time 3=Some of the time 4=Rarely or never

_____ 1. I am able to relax or achieve a peaceful feeling.

_____ 2. I am able to prevent hurts and problems in relationships from building up.

_____ 3. I am able to ask other people for help when I need it.

_____ 4. I am able to set and reinforce boundaries with other people.

_____ 5. People take my opinions seriously.

_____ 6. I interact with other people in a way that makes me feel confident and competent.

_____ 7. Relationships go smoothly for me.

_____ 8. I know what my values are, and what is important to me.

_____ 9. My mood is stable.

_____ 10. When my emotions are unpleasant, I am able to effectively manage my behaviors.

_____ 11. I am able to effectively influence my own mood, and create pleasant emotions.

_____ 12. I am able to reduce how strongly I feel my emotions.

_____ 13. I am able to function effectively when I am afraid or anxious, and I can deal with what I fear.

_____ 14. I am able to function effectively when I feel guilty or ashamed.

_____ 15. When I am angry or frustrated, I am able to function effectively, and I can deal with what triggers my anger.

_____ 16. When I am depressed, I take good care of myself, and I carry on with normal routines.

_____ 17. When I get overwhelmed, I am able to focus my attention and prioritize skillfully.

_____ 18. When I go into crisis, I am able to get though it with at least one effective strategy that I have.

_____ 19. I am able to accept whatever life hands me

_____ 20. I am able to be open-minded when I look at myself.

- In the last six months, I have intentionally tried to hurt myself _____ times.
- In the last six months, I have tried to kill myself _____ times
- In the last six months, I have been hospitalized for psych reasons _____ times
- I am ☐working ☐part time ☐full time; or ☐going to school ☐part time ☐full time
- In the last six months, the accomplishment I am most proud of is____
  ____
- In the next six months, what I'd like to most accomplish is____
  ____

Developed by Karen Torry Greene, MSW, LCSW c2003, 1st revision 2008, 2nd revision 2010

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ACKNOWLEDGEMENTS AND SIGNATURES

Initial each blank, sign where indicated, and return pages 1-3 prior to initiating services.

1. _____ I certify that I have read all the information herein, that I have been given the opportunity to ask questions.
2. _____ I certify that the information I have provided herein is accurate and true.
3. _____ I have attached a copy of a photo ID.
4. _____ I authorize Coordination of Care with the professionals I have named herein

____

Signature and date

5. _____ Informed Consent Part I: Licensure - I understand VIPMHLC is licensed to practice psychotherapy in AZ and FL
6. _____ Informed Consent Part II: Insurance - I understand that VIPMHLC does not work with insurance companies.
7. _____ Informed Consent Part III: HIPPA - I understand privacy, confidentiality, and TPO as it pertains to my record.
8. _____ Informed Consent Part VI: Rights - I understand there are generally understood rights in Behavioral Healthcare
9. _____ Informed Consent Part V: The following Macro-Community(s) has(have) been identified as potential Boundary-Crossing situations, and a plan has been discussed and put in place. ____________________________________
10. _____ Informed Consent Part VI: Consent to Treat - I authorize VIPMHLC to treat me

____

Signature and date

11. _____ I have attached a copy of my debit or credit card, front and back
    Number____Exp Date__________CVC Code_______
12. _____ Informed Consent Part VII: Fees - I understand what my fees are and how payment is handled. My signature herein serves as authorization for VIPMHLC to charge these fees to my credit card prior to each session

____

Signature and date

13. _____ DBT Skills Class Guidelines – I agree to follow these guidelines if I participate in any group setting or psychoeducational class.
14. _____ I have completed the attached Pre-Test and I am attaching it.

My signature below indicates that I have read and am in agreement with this document as outlined in #1-14 immediately above.

____

Signature and date

PLEASE READ THE FOLLOWING PAGES AND RETAIN THEM FOR YOUR RECORDS

INFORMED CONSENT PART I: LICENSURE

VIP Mental Health and Life Coaching, PLLC is licensed to practice psychotherapy in Arizona, and VIP Mental Health and Life Coaching – Florida, LLC is licensed to practice psychotherapy in Florida. We do not provide psychotherapy in any other state. Since services provided in other states cannot be provided under licensure, your rights and the extent of services we can provide are limited.

INFORMED CONSENT PART II: INSURANCE

VIP Mental Health and Life Coaching, PLLC (AZ) and VIP Mental Health and Life Coaching –Florida LLC (VIPMHLC) do not work with insurance companies. If you would like to submit to your insurance company for reimbursement, please let us know so that we can provide you with the paperwork you will need (called "Superbills"). Please note that some insurance companies do not reimburse for E-Therapy. Some HSAs and FSAs can be used for E-Therapy; it depends on your benefits package. We encourage you to check with your insurance company before you use your HAS/FSA card.

INFORMED CONSENT PART III: NOTICE OF PRIVACY PRACTICES and TPO

This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. If you have any questions, please ask.

VIP Mental Health and Life Coaching, PLLC, and VIP Mental Health and Life Coaching –Florida, LLC ("VIPMHLC") provide health care to our clients in partnership with other professionals and health care organizations. The information privacy practices in this notice are followed by our workforce and Business Associates.

Our pledge to you: We understand that information about you is personal, and we are committed to protecting it. We create a record of the services you receive to provide quality care and to comply with legal requirements. This notice applies to all of your records generated by any of our workforce and cooperating facilities. We are required by law to keep information about you private; give you this notice of our legal duties and privacy practices with respect to information about you; and follow the terms of the notice that is currently in effect.

How we may use and disclose information about you: We may share your information for coordination of care, treatment, payment, and healthcare operations purposes. We may use and disclose information about you without your prior authorization for treatment (such as sending medical information about you to a specialist as part of a referral) (this includes psychiatric or HIV information if needed for purpose of your diagnosis and treatment): to obtain payment for treatment; and to support our operations (such as comparing patient data to improve treatment methods or for professional education purposes) (Note: only limited psychiatric or HIV information may be disclosed for billing purposes **without your authorization**.) If you are treated for substance abuse, your special authorization will be needed for most disclosures other than emergencies.

Other examples of such uses and disclosures include contacting you for **appointment reminders** and telling you about or recommending **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you. We may also contact you to support our **fundraising efforts.**

We may use or disclose medical information about you without your prior authorization **for several other reasons**. Subject to certain requirements, we may give our information about you, without prior authorization for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, medical examiners, funeral arrangements and organ donation, workers' compensation purposes, emergencies, national security and other specialized government functions, and for members of the Armed Forces as required by Military Command authorities.** We also disclose information when **required by law**, such as in response to a request from **law enforcement in special circumstances**, or in response to valid judicial or administrative orders or other **legal purposes. We may also disclose information about you when you are considered to be dangerous to yourself or other persons.**

Under certain circumstances, we may use and disclose information about you for **research purposes,** subject to a special approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the information they review does not leave our facility, and so long as they agree to specific privacy protections. We may disclose information about you to a friend or family member whom you designate or in appropriate circumstances, unless you request a restriction, and we may disclose information to them if you die. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

We encrypt our computer equipment and email delivery systems. We do not encrypt cell phone data, and we may transmit and/or receive information with you via our cell phones. **We are not responsible for the encryption of the computer equipment you will be using.**

Other uses of Information: In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Right to Access and/or Amend your Records: In most cases, you have the right to look at or get a copy of information that we use to make decisions about your care, when you submit a written request. If you request copies, we will charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting: You have the right to request a list accounting for any disclosures of your information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions. To request this list of disclosures, indicate the relevant period, which must be after April 14, 2003, but in no event for more than the last six years. You must submit your request in writing to us.

Right to Request Restrictions: You may request, in writing, that we not use or disclose information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it when possible, but we are not legally required to accept it. We will inform you of our decision on your request.

Requests for Confidential Communications: You have the right to request that information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you. If we do not get such a request from you, we may contact you and leave messages for you though any channel you have provided.

Right to request a paper copy of this Notice: You may receive a paper copy of this Notice from us upon request, even if you have agreed to receive this notice electronically.

Changes to this Notice: We may change our policies at any time. Changes will apply to information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice on our Website at www.VIPMHLC.COM . You can receive a copy of the current notice at any time. The effective date is listed in the footer of this Notice. Copies of current notices will be available any time you ask. You may be asked to acknowledge in writing your receipt of this notice.

Complaints: If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, let us know in writing. If you are not satisfied with our response, you may send a written complaint to the US Department of Health and Human Services Office of Civil Rights. We can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

This health care facility may use your information for the following reasons:

TREATMENT: We will use your information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your information with another professional whom we need to consult with respect to your care. These are only examples of uses and disclosures of information for treatment purposes that may or may not be necessary in your case. (Note: If you were referred to us, we will share information with that Professional.)

PAYMENT: We may need to use or disclose information in our record to obtain reimbursement from you, from your health insurance carrier, or from another payer for the services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purposes of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

OPERATIONS: Your records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions

INFORMED CONSENT PART IV: MENTAL HEALTH RIGHTS GUIDELINE

This is a summary of some of the rights and resources generally agreed upon regarding persons who receive behavioral health care. Your legal rights may differ from these ethics-based guidelines that we follow.

- The right to appropriate mental health services based on your individual needs
- The right to ask questions and participate in all phases of your mental health treatment
- The right to consent to or refuse treatment (except in an emergency or by court order)
- The right to treatment in the least restrictive setting
- The right not to be abused
- The right to file a complaint when you disagree with the services you receive or your rights are violated
- The right to choose a designated representative(s) to assist you
- The right to a written treatment plan that sets forth the services you will receive
- The right to confidentiality of your records
- The right to obtain copies of your own records (unless having them wouldn't be in your best interests)

Note: If you are dissatisfied for any reason, please let us know. We are committed to the people we serve, and your feedback will help us and the people who we help. Our email is ktg@vipmhlc.com.

INFORMED CONSENT PART V: MICRO COMMUNITY

Psychotherapy is a collaborative relationship that works in part, because of clearly defined rights and responsibilities held by both client and therapist. It is important to know, before commencing with psychotherapy, what your rights and responsibilities are, as well as what the rights and responsibilities of the provider are. It is also important to know what kind of situations may limit these rights and responsibilities. The following is designed to educate you about micro-community boundary issues.

VIPMHLC personnel operate from a point of reference of informed consent. Therefore we are informing you that you may share micro-community interests with VIPMHLC personnel. It is our goal to help you understand policy and ethical considerations within micro-communities. Non-Professional relationships are inherent to Social Work within micro-community settings. Social Work within these settings creates challenges to maintaining client confidentiality.

"BOUNDARY-CROSSING" refers to the unavoidable mix of professional and personal relationships in which the anonymity of clients and workers is compromised. "BOUNDARY VIOLATION" refers to the avoidable and/or intentional manipulation, exploitation, coerciveness and deception.

Micro-communities include ties with ample opportunity for chance encounters and boundary-crossings with clients. Essentially, micro-community Social Workers are never off duty within these communities, which causes professional and personal relationships to overlap. Expectations for membership in a micro-community include the existence of close-knit bonds, the engagement of cultural mores and community events, consistent participation in the community, and support of relationship-building activities.

The micro-community Professional is responsible for maintaining appropriate boundaries regarding confidentiality and the protection of client-related information. Although the National Association of Social Workers (NASW) and state licensing boards set standards and parameters with regard to confidentiality and privacy matters, no established guidelines and practice tools are available to address these issues within micro-communities.

In the event that we believe our respective micro-communities will potentially and significantly overlap (see chart below), we will disclose, discuss, and develop a plan with you to avoid discomfort and ethics violations.

Type	Definition	Examples
Business Transactions	client-owned or client-employed businesses	grocery store, gas station, bank, farm implement store, telephone and electrical companies
Community committees or clubs	worker-client joint affiliation and memberships	Parent Teacher Association (PTA), Gardening and Quilting Clubs, 4-H, Rotary Club, Special Interest Groups, and Non-Profit Organizations
Community events	community-wide participatory activities	fund raisers, parades, celebrations, dances, and dinners
Social events	activity attendance that supports community members	athletic events, weddings, anniversaries, funerals, sporting events, hunting and fishing activities
Residence location	geographical proximity between client and worker	same neighborhood
Organizational location	attendance at the same organizations	schools, hospitals, and places of worship
Social and friendship networks	mutual worker-client social networks	spouses/partners, children, relatives, and friends
Incidental occurrences	addressing each other in public places	greetings on the sidewalk

INFORMED CONSENT PART VI: CONSENT TO TREAT

VIPMHLC provides psychotherapeutic/clinical services to persons who present voluntarily for intervention. VIPMHLC specializes in working with Personality Disordered Individuals, and clinical interventions will frequently focus on cognitive and behavioral change. VIPMHLC only works with adults. Many of the individuals who present for treatment at VIPMHLC have unusual issues, and a non-judgmental stance is promoted

There are few studies regarding the efficacy of E-Therapy, despite its popularity and apparent success. Official E-Therapy protocol has not been fully developed at the time of this writing, though professional organizations have been established for the purpose of analyzing clinical studies and developing standardized procedures.

With the exception of E-Therapy, the therapist will only use methods that are empirically proven and in which she is sufficiently trained. The methods that will be used include, *but are not limited to* Cognitive Behavioral Therapy, Schema Therapy, Dialectical Behavioral Therapy, Behaviorism and Shaping, Brief Therapy, Strategic Therapy, Rogerian Techniques, Freudian Analysis Techniques, Gestalt Techniques, Motivational Interviewing, Mindfulness, Relaxation Techniques, Use of Metaphors, Transactional Analysis, and Neuroscientific Education.

If you have self-harm/suicidal tendencies, you must agree to actively and collaboratively work on discontinuing ALL thoughts, urges, and behaviors that are associated with them.

You have the right and obligation to participate in the treatment planning so that the therapy goes in a direction so as to resolve the issues you present with. You have the right to change this direction at any time. You have the right to ask questions, investigate and/or refuse any treatment. You will have an opportunity to be informed of and discuss your diagnosis, if one applies. If you want to tape or film your sessions, you will have to sign a Release of Information. Psychotherapeutic interventions can cause anxiety and pain, and in some cases, people you know might not support the changes you make.

Services are based on availability, and while every effort will be made to accommodate your needs, ultimately, appointment availability may be limited. Your therapist meets with other therapists for professional consultation on a regular basis, and cases may be discussed to enhance the likelihood of clinical success.

VIPMHLC limits work with several issues, including but not limited to: Psychotic Symptoms, Drug and Alcohol Abuse and Addictions, Narcissistic Personality Disorders and Traits, Antisocial Personality Disorders and Traits, Eating Disorders, and Sociopathy. If it is determined that symptoms of these disorders are driving your behaviors, services may be unilaterally discontinued in good faith that another provider would be more effective. The therapist may unilaterally discontinue my services at any time if there is reason to believe that the interventions that are being offered are not effective. ANY threatening or bullying behaviors directed at any VIPMHLC employee or clinical participant will be grounds for immediate termination of clinical services. Suicidal and self-harm threats for the purpose of influencing the therapist fall into this category.

This authorization may be revoked in writing by either party at any time.

A**LTHOUGH THE THERAPIST MIGHT BE FRIENDLY, SHE IS NOT A "FRIEND". SHE IS BOUND BY A CODE OF ETHICS TO NEITHER SOCIALIZE OUTSIDE THE SESSIONS, NOR EXCHANGE GIFTS. THE CLINICAL RELATIONSHIP IS A PROFESSIONAL RELATIONSHIP, THIS MAY BE DISCUSSED THIS AT ANY TIME.**

INFORMED CONSENT PART VII: FEES AND PAYMENTS

You must agree to adhere to the fees and payment terms outlined herein. We do not work with insurance companies. Insurance coverage VARIES and CHANGES depending on your policy and coverage, and we strongly urge you to contact them to find out what your insurance company will cover. *Verification and authorizations by insurance companies do NOT guarantee payment or coverage.* VIPMHLC reserves the right to adjust any fees or payment terms at their sole discretion. Fee/Payment Terms Policy changes will be communicated to you; written notice will be provided whenever possible; notification may be posted on the VIPMHLC Website; and verbal communication will be grounds for enforcement. Clients are held responsible for late charges and collection costs, and our collection agency does report bad debt. Services may be put on hold if payments are past due. Rates not predetermined on this form will be assessed at Prevailing Rates in accordance with those established by the AZ Dept of Health Services.

Payment is due prior to each session, and to enforce this policy, this payment agreement will serve as your written authorization for VIPMHLC to charge your debit or credit card.

- We do not work with insurance companies, but if you ask, we can provide paperwork ("Superbill") to you so that you can submit for reimbursement yourself.
- We charge $240 for intakes, which usually last between one and two hours. There is a 40% discount for Electronic Sessions (E-Sessions). Cash discounts may be negotiated.
- We charge $120 for individual sessions. There is a 40% discount for Electronic Sessions. Cash discounts may be negotiated. Sessions last 45-50 minutes. If we go over, the fee will be prorated.
- We charge $50 PER HOUR for psychoeducational classes and group therapy. There is a 40% discount for Electronic Participation. Cash discounts may be negotiated. Special community presentations may be offered at different (usually higher) rates.
- We charge a flat fee of $800 per month for comprehensive E-DBT. This includes a weekly 1:1 E-Therapy session, a weekly 2-hour Skills Training E-Class and learning materials, telephone coaching for crisis, and consultation if necessary. We are DBTNCAA Certified. There may be a supplemental fee for excessive ancillary services, but it will be discussed with you first.
- If you late cancel or no-show, you will be charged anyway.
- If we obtain or utilize any services on your behalf, such as consultation and legal services, we will pass those charges on to you.
- We charge $2.50 per day for late fees, beginning 30 days from date of last service, until such time where the account is assigned to an outside collection agency, where a 30% collection fee over the new balance will be assessed. If your account becomes past due, we prefer that you communicate with us so that we can arrange payment terms for you, and avoid the collections process.
- We are charged a 3-5% surcharge for using debit and credit cards, and we pass them on to you
- We charge $140 per hour for all other services

CLASS GUIDELINES

In accordance with DBTNCAA Guidelines

1. Weekly Skills Class attendance is REQUIRED for DBT participants. Your therapist may drop you from DBT at her sole discretion based upon excessive (3) absences from therapy or the Skills Class. If you are going to be late or out, please call with the reason. No Show/Late Cancel fees will apply.

2. DBT Classes are held twice per week as scheduled. You may participate in either class if you let the Skills Class Facilitator know ahead of time. Switching classes is limited to current openings.

3. Do not come to Skills Class or Individual Therapy under the influence of alcohol or illegal substances. Remove yourself from the room if you are going to use your cell phone, even to text.

4. Suicidal and self harming behaviors are not to be discussed in the Skills Class or with other Skills Class members. It may help to use the idea of "PG13" as a guideline for what is appropriate to disclose in the Skills Class. Anything stronger than that may be a trigger for other participants. The Skills Class Facilitator reserves the right to discontinue any line of discussion that she deems irrelevant or inappropriate to the content or participants of the current class, without explanation at that time. You may request clarification after class.

5. Everything that is said within the Class STAYS within the Class.

6. Sexual partners are not allowed within any Class.

7. When you are in crisis, you can call your therapist's crisis number at any time-- unless you have self harmed or attempted suicide. Then call 9-1-1 and you must wait 24 hours before talking to your therapist. Crisis phone calls are only for the purpose of getting coached with Skills Generalization. They are not a substitute for or a supplement to therapy, and they will not exceed a few minutes. Your crisis number will be provided. Texts are most effective.

8. Diary Cards are used to help track targeted behaviors and Skills Application and are REQUIRED. Targeted behaviors will be followed up in session with a detailed Chain Analysis so that you can learn from your experience.

9. Skills Class Participants are asked to voluntarily participate in periodic Pre- and Post- Testing for the purposes of monitoring progress, and building a statistically credible database for VIPMHLC to use to advocate for other clients. Identifying information remains permanently confidential. You may ask to see the results of this testing. VIPMHLC absorbs the costs of these tests; you will not be asked to pay for their administration.

10. OTHER: ____