Thank you for considering Whole Journey Services. We consider our services an invaluable investment in keeping your mind, body and spirit whole.

Please read before filling out intake packet

- Please fill out every prompt/question. If something doesn't apply to you, write "N/A."
- If you have a session fee, co-payment, or coinsurance, it is expected upon each visit. Please verify deductible amounts and out-of-pocket maximums for your "outpatient behavioral health" benefit. It is your responsibility to ensure insurance coverage and you will be responsible for a balance if your coverage was not in effect or insufficient. A credit card is required to be placed on file to cover session fees, as we are using contactless methods as much as possible.

Self-Pay Rates for Non-insurance and Out-Of-Network Clients

Licensed-Masters-Level Clinician	**Pre-licensed Master's Level Clinician**
$125 for Initial Evaluation	$85 for Initial Evaluation
$110 per 45-52 minute session	$85 per 45-52 minute session
$110 per 53-60 minute session	$85 per 53-60 minute session
$75 per 30 minute session	$60 per 30 minute session

*Couples Counseling is a self-pay service. Insurance cannot be utilized for these sessions.

Required Intake Forms:

- Intake forms are required. Please return intake forms to your assigned provider via email at their assigned email address, **one day prior** to your appointment. Your provider may ask for additional forms to be completed, depending on your needs.

- Return of the forms assists our therapists, with session preparation and having initial feedback to support you. We understand that it is not always possible to return forms prior to your appointment. If you are unable to submit them and need support during the first appointment, please understand a review of our intake process will be billed as your initial assessment.

Here are some common reasons people contact us:

- Struggling Kids: Maybe they are not acting like they should. They may be angry, frustrated, don't follow your rules, or have other behavioral or emotional issues in other settings. Also, kids and teens process death, loss of family, foster care, adoption, suicide, divorce or even new people joining the family in different ways. They may become withdrawn, angry, or begin showing new behaviors that are troubling. We can help.

- Stressed Professionals: Sometimes the stress of life, parenting, work or money can get in the way of you living your best life. We work to help you restore the balance in your life, get unstuck, experience more meaning, and feel better about the direction of your life.

- Everyone Else: We work with people that are dealing with depression, anxiety, feel alone, have lost themselves along the way, and that want better relationships.

We look forward to talking with you and walking with you along your journey!

Client Face Sheet

Last Name:	First Name:	MI:
DOB: Age:	SSN:	
Parent/Guardian Last Name:	Parent/Guardian First Name:	
Parent/Guardian DOB: Age:	Parent/Guardian SSN:	
Billing Address:		
City:	State:	Zip code:
Home Phone:	Cell Phone:	
Email Address:		

Gender:
☐ Male ☐ Female ☐ Unknown

Gender Identity:
☐ Male ☐ Female ☐ Transgender Male/Trans Male/FTM
☐ Transgender Female/ Trans Woman/MTF ☐ Genderqueer/neither exclusively male nor female ☐ Additional gender category/ other: please provide

Marital Status:
☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Domestic Partnership ☐ Widowed ☐ Other ☐ I choose not to disclose

Sexual Orientation:
☐ Lesbian, Gay or Homosexual ☐ Straight or Heterosexual ☐ Bisexual ☐ Unknown
☐ I choose not to disclose ☐ Something else please describe:

Ethnicity:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ I choose not to disclose

Employer:	Phone:
Insurance Company:	Policy Number:
Policy Holder Name:	DOB:
Secondary Insurance Company:	Policy Number:

How did you hear about us? Whom can we thank?
☐ Psychology Today ☐ Google ☐ Good Therapy
☐ Brighter Vision ☐ Word of Mouth Who? ☐ Whole Journey Website

May we add you to our Newsletter mailing list? ☐ Yes ☐ No

Emergency Contact Information:

Name:	Phone Number:
Relationship to client:	Address:

Do you give consent for us to contact your identified emergency contact in the case of an emergency, in which you are incapacitated? ☐ Yes ☐ No

Client Medical Information Form		
Illness/Diagnoses		
Type	Current/Past	Provider/Facility
Surgeries/Hospitalization		
Type (specify left/right)	Date	Location/Facility
Allergies		
Allergy	Allergic Reaction	
Medications		

Medications (Please list ALL)	Dose (Mg., pill, etc.)	Times Per Day

Personal Medical History					
DISEASE/CONDITION	PERSONAL	FAMILY	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse					
Asthma					
Cancer (type:					
Depression/Anxiety/Bipolar/Suicidal					
Diabetes (type:					
Heart Disease					
High Blood Pressure (hypertension)					
High Cholesterol					
Hypothyroidism/Thyroid Disease					
Developmental Delays:					
Other:					

Exercise	Do you exercise regularly? Y N (If you answered no, please move to Sleep)	☐ Yes	☐ No
What kind of exercise?		**Duration:** How long (min.):_____How often: _____	
Sleep	How many hours, on average, do you sleep at night (or during the day, if working night shift)?		
Diet	How would you rate your diet	☐ Good	☐ Fair ☐ Poor
Tobacco Use	Smoke Cigarettes? (If you never smoked, please move to Alcohol /Drug Use)	☐ Yes	☐ No
Current: Packs/day_____# of Years _____		**Past:** Quit Date:_Packs/day_____# of Years _____	
Other Tobacco Use (check one)	Pipe	Cigar	Snuff Chew
Alcohol/Drug Use			
Alcohol/Drug Use	Do you drink alcohol	☐ Yes	☐ No
☐ Beer	☐ Wine	☐ Liquor	# of Drinks/week_____
Do you use marijuana or recreational drugs?		☐ Yes	☐ No
Have you ever used needles to inject drugs?		☐ Yes	☐ No
Have you ever taken someone else's drugs?		☐ Yes	☐ No

OTHER PROVIDERS/SPECIALISTS

Specialist	Name/Practice	Last Visit
☐ Primary Care Physician		
☐ Psychiatrist		
☐ Physical Therapist		
☐ Occupational Therapist		
☐ Neurologist		
☐ Other:		

Date of Last Physical:	Provider:

We encourage clients that have not had a routine physical within one year to consult with a medical professional in order to rule out any medical conditions that may be contributing to your current functioning. _____ Initial

Coordination of Care Recommendation: Due to our focus on client-centered care, we encourage clients about the opportunity to create a safer, more effective, and higher quality level of service delivery by organizing care among their treatment providers. You will receive the opportunity to sign an authorization to obtain records from other health care providers and/or notify other treatment professionals of your treatment at Whole Journey Services. You have the right to refuse service coordination.

Primary Care Physician Release:

☐ I consent to release information ☐ I decline to disclose information

Have you completed an Advance Directive for Health Care (ADHC) or Living Will?

☐ Yes ☐ No

If you require additional space, please use the back of this form. I certify that I have entered my current and past health information as accurately as possible, as I understand that it has implications on my mental health treatment and may require coordination.

Client's Signature:_____Date:_____

Client's Signature:_____ _Date:_____

Informed Consent for Treatment		
Client's Initials	**Client's Initials**	You must agree to all of the below to receive services. If you have any questions or concerns, please do not hesitate to speak to your clinician/service provider prior to signing.
		Benefits and Risks of Counseling and Psychotherapy: Counseling and psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. It is normal for people to feel worse before they feel better. Therapy is undoubtedly hard work and is truly a process – it is hard to predict how quickly it will "work" or what specific effects it will have. However, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to reduced stress and anxiety, improved self-esteem, better relationships, solutions to specific problems, and significant reductions in feelings of distress. It is important to note that there are no guarantees of what you will or will not experience.
		Consent for Treatment: You consent to receive treatment from a clinician employed or contracted with Whole Journey Services, PLLC.
		Understanding of Confidentiality and Confidentiality Limits: You will be given a chance to sign Releases of Information, allowing you to specify whom we can talk to what about. For therapy, the information you share remains between you and your therapist, except for the following scenarios where we are required by law to reveal information obtained during any form of therapy to other persons or agencies. These situations are as follows: 1) If you are a threat of grave bodily harm or death to self or another person, 2) If your clinician becomes aware of a situation of neglect or harm of a minor or an elderly individual, 3) If a court of law issues a legitimate subpoena, and/or 4) You are a court-referred client. If your clinician believes there is risk of you harming someone else or self-inflicting harm, we are not mandated, but have an ethical responsibility to give this information to appropriate persons in order to obtain the best care for you and those you may harm. Additionally, information may be shared with others therapists associated with this corporation and/or with supervisors, all of whom are bound by the same confidentiality laws. Whenever possible, your clinician will let you know if he/she feels it is necessary to report something. Also, if you are seeing a clinician, your sessions will be discussed with his/her supervisor(s) and both your clinician and the supervisor(s) will uphold all confidentiality responsibilities
		Further, a clinician might find it helpful to consult other professionals about a case. During a consultation, the clinician makes every effort to avoid revealing your identity. The consultant is legally bound to keep the information confidential. If you do not object, the clinician will not tell you about these consultations unless they feel it is important to our work together. Objections must be provided in writing.
		Privacy for Minor Clients (under 18 years of age): Although the parent/guardian of a minor is the "holder of privilege," disclosing the content of sessions with minors to parents/guardian tends to undermine therapy. Reporting to parents/guardians is kept to general progress/issues or if the minor is involved in dangerous or harmful activities. I agree that I have legal custody to enroll the minor in services.
		Notice of Privacy Practices: When you give us permission to share your personal health information (PHI) with others, we may do so according to your instruction. You may take back this permission at any time, except if such sharing has already occurred. In addition to the circumstances listed under the Confidentiality section, we may also share information about you such as your identity, diagnoses, and treatment for the following reasons: scheduling, treatment coordination among Whole Journey employee/contractors, claims processing, administration, data analysis, utilization review, benefit eligibility, billing, practice management, other procedural processes, including the use of business associates, requests required by law, matters of public health, research and evaluation, as requested by oversight agencies, and in response to subpoenas. We will do our best to inform you of any such requests, and to limit shared information to the greatest possible extent. You may request to look at or have copies of your PHI and signed consents. You have the right to request that documents be amended and that restrictions be placed on sharing. These requests may not be granted based on their appropriateness and your best interest but the reasons will be provided to you.

I have initialed above where I consented or understood, as applicable, and have had any questions or concerns answered to my satisfaction.

Client's Signature:_____Date:_____

Client's Signature:_____Date:_____

		Informed Consent to engage in services with a clinician assigned to another family member: I hereby acknowledge that I have been made aware of potential ethical and boundary risks of engaging in individual therapy with a clinician who also provides the same service with a family member. Potential risks include but are not limited to: confidentiality breaches and therapeutic neutrality issues. Whole Journey Services will proactively provide treatment to reduce this risk, however your clinician will advise if this issue arises and if treatment from another clinician is recommended as a best practice measure.
		Due to COVID-19, telehealth has been determined as the safest way to prevent the transmission of COVID-19. However, there are risks with telehealth. Please communicate only through devices that you know are secure. For your safety, if you are experiencing a crisis or mental health issue that we cannot resolve or treat appropriately within our standards of care remotely, we may need to make a referral outside of our practice.
		Consent for Treatment by a Pre-licensed Clinician: You consent to receive treatment (coaching, support and therapy/counseling) from an unlicensed clinician to include but not limited to a Resident in Counseling, Supervisee in Social Work, and/or masters level clinician, which means that the clinician has earned her/his Master's Degree in a related field (psychology, counseling, social work, etc). This also means that the clinician's work is supervised by a licensed mental health clinician; therefore, the work she/he does with the client is discussed with the supervisor(s) for treatment and consultation purposes.
		Emergency/Crisis Policy: Whole Journey services checks emails and voicemails daily. Clinicians will make every effort to return your call within 24 hours of when you make it. Should you have a true clinical emergency and/or life-threatening emergency that requires immediate attention or action, you will need to call 911 or go to the nearest hospital emergency room. If a family member is threatening violence or suicide, you need to call 911. Your safety and well-being is our primary concern. Additional numbers you may find beneficial include: Child Abuse and Neglect Hotline: 1-800-552-7096 Community Services Board (Emergency Services) Chesapeake: (757) 547-9334 Community Services Board (Emergency Services) Virginia Beach: (757) 437-5760
		Coordination of Care Recommendation: Due to our focus on client-centered care, we encourage clients about the opportunity to create a safer, more effective, and higher quality level of service delivery by organizing care among their treatment providers. You will receive the opportunity to sign an authorization to obtain records from other health care providers and/or notify other treatment professionals of your treatment at Whole Journey Services. You have the right to refuse service coordination.
		Cancellation and No-Show Policy: If you cannot attend an appointment, you are expected to call at least 24 hours in advance of your scheduled appointment. If you need to cancel, you are strongly encouraged to reschedule. If you miss your appointment or cancel within 24 hours of your appointment and do not reschedule for that week, you will be charged a **no-show/late cancellation fee of $50.00.** (except for in emergencies, illness, or unforeseen circumstances). After a "no show" appointment (missing a session without prior, appropriate notice), clients will typically not be allowed more than one consecutive no-show. **Three no show appointments** within 60 days meets criteria for a client becoming ineligible for services for 60 days, at the clinician's and clinical director's discretion. **Three late cancellations** within 60 days, meets criteria for a client becoming ineligible for services for 60 days, at the clinician's and clinical director's discretion. Should a client be discharged due to ineligibility due to appointment compliance, efforts to make a more compatible referral and address barriers to compliance with the client will be made and documented.
		Professional Records Policy: The laws and standards of our profession require that we keep treatment records. These records include information about your reasons for seeking treatment, relevant diagnoses, treatment goals, progress towards those goals, medical and social history, treatment history, any past treatment records we receive from other treatment providers, documentation of any professional consultations, billing records, and copies of any professional documents generated during the course of treatment (e.g., informed consent forms, release of information forms, letters sent at your request). Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in your clinician's presence so that we can discuss the contents or that you have them forwarded to another mental health professional. Clients will be charged a fee of $10.00 for search and handling of records in addition to .50 per page up to 50 pages, and .25 per page after 50 pages.

I have initialed above where I consented or understood, as applicable, and have had any questions or concerns answered to my satisfaction.

Client's Signature:_____Date:_____

Client's Signature:_____Date:_____

Financial Policy Agreement		
		Insurance and Managed Care: *If you are relying on your insurance company to reimburse you for part or all of the charges for therapy, it is important that you have thoroughly reviewed and understand your insurance company's reimbursement policies, the amount of your deductible, the percentage your company will reimburse for you outpatient psychotherapy, and any limitations to treatment that may be a dimension of your policy. The contract for reimbursement is between you and the insurance company, rather than between the insurance company and Whole Journey Services. Whole Journey Services will submit requests for payment on your behalf. It is your responsibility to ensure insurance coverage and you will be responsible for a balance if your coverage was not in effect or insufficient.
		Fees and Payments: *If you have a fee, co-payment, or coinsurance, it is expected upon each visit. If you have a balance at the end of the month, you will be notified of your account status and will be asked to provide the payment due at that time. Returned Check Fee: If your check is returned by the bank due to insufficient funds in your account, there is a fee of $35.00 and you will not be allowed to provide that method of payment for 60 days.
		Delinquent Accounts/Collections: If your account has not been paid for more than 30 days and arrangements have not been agreed upon, Whole Journey Services, PLLC reserves the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim. By signing this agreement, you authorize Whole Journey Services to employ the services of a third party, outside collection agency or attorney to seek payment of all unpaid fees.
		Financial Policy for Minors: A parent or legal guardian must accompany minors at the time of initial visit, and this person becomes the responsible party. Unaccompanied minors at subsequent visits are still expected to make copayments and to update any changes to patient or insurance information. If parents are separated or divorced, accurate parent and insurance information is required at the time of service, and only with written consent can any parent become the responsible party. In the event of disputes, the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances. My No Show or Late Cancel Fee is: $50.00 per session. The No Show or Late Cancel fee is based on the philosophy that therapy and counseling represents a commitment made by both the client and the therapist to be present for sessions. A Late Cancel is cancelling a session with less than 24 hours notice.
		Other Professional Fees: There is a charge of $70.00 per hour for other professional services. The cost can be billed into 15-minute increments if work is completed for periods of less than one hour. Other service examples include: report writing, emails, texts, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals, preparation of records or treatment summaries, and time spent performing any other professional services requested.
		Collections: I understand if I have an unpaid balance to Whole Journey and do not make satisfactory payment arrangements, my account may be placed with external collection agency. I will be responsible for reimbursement of any fees from the Collection Agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney fees if so incurred during collection efforts. In order for Whole Journey or their designated external collection agency to service my account and where not prohibited by applicable law, I agree that Whole Journey and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre- recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

I have initialed above where I consented or understood, as applicable, and have had any questions or concerns answered to my satisfaction.

Client's Signature:_____Date:_____

Client's Signature:_____Date:_____

		Legal action: If legal actions occur in which your clinician is requested or subpoenaed to provide testimony (either by you or another party), you will be responsible to pay the clinician directly for the following services: (a) the time spent preparing for court, (b) the time spent for transportation to/from court, and (c) the time spent in court. Because of the difficulty of legal involvement, the clinician charges $70.00 per hour for preparation and attendance at any legal proceedings. Payment for the estimated number of hours is due 10 days prior to the court date.
Electronic Communication Policy		
		Email and texting offer easy and convenient ways for communication between clients and the clinician. We generally prefer to limit use of email and texts. It is important to be aware that email communication can be accessed by unauthorized people and hence compromise the privacy and confidentiality of the communication. Email and texts are not to be used as a substitute for sessions. Additionally, your clinician cannot be certain when your message will be read. They may be in session with another client, out of the office, away from a computer, or on vacation. If you send an email or text and do not hear from your clinician within 24 hours, please call and leave a voicemail message. Below are some considerations regarding e-mail and texting. Please initial and sign acknowledgement of the potential issues. We may utilize email and texts for appointment reminders. You have the option to refuse, however this may affect the continuation of service delivery in instances of late cancellations and no show appointments. **Refusal:** _____
		E-mail and texts are never appropriate for urgent or emergency problems. Please use the telephone to call 911 or go to a Hospital Emergency Room for emergencies.
		E-mail and texts are not confidential. We cannot guarantee the privacy of electronic communication.
		You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
		E-mail and text should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. Nor should they be used by clients to share information that you want kept private from other family members.
		E-mail may become a part of the client record; a copy may be printed and put in your chart.
		E-mail and texting are not substitutes for seeing your clinician. If you think that you might need to be seen, please call and book an appointment.
		Clients will be billed for time spent reading lengthy emails and those that require lengthy responses (beyond 15 minutes; please see Other Professional Fees agreement).
		Either party can revoke permission to use electronic communication at any time.
		Information disclosed in text messages and via email are subject to review by a clinician's supervisor, professional consultation or for an administrative procedure to include but not limited to quality assurance or billing).

Social Media Communication Policy		
We are committed to maintaining proper boundaries that include, but are not limited to, protecting the privacy and confidentiality of our therapeutic relationship. Therefore, we will not accept "friend" or contact requests from current or former clients on any social networking site.		
		Whole Journey Services, PLLC has a website. Newsletters that people can subscribe and blogs are used for informational purposes, not for assessment, diagnostic and treatment purposes. Please do not use social media sites to contact your clinician. Whole Journey Services has a Facebook page and may acquire additional social media accounts. These pages are used for informational purposes, to share articles or other interesting information related to mental health and well-being.
		Following: If you choose to follow Whole Journey Services, PLLC or a clinician online, please know it has a potential impact on our working relationship. Our primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow us on any social media. We hope you will keep in mind that you may be sharing personally revealing information in a public forum. You may want to create a pseudonym or refrain from posting in a public medium.
		Surveys/Reviews: We conduct feedback and evaluation surveys which allow for comments and feedback that may be published (on our website, within the agency, or on marketing materials). If you are comfortable and consent to your feedback comments being shared (anonymously/without your name), please initial below. **Refusal:** _____

I have read the above information and understand the limitations of security on information transmitted. I understand that my clinician may not be able to communicate with me electronically about my specific condition if there are concerns.

Client's Signature:_____Date:_____

Client's Signature:_____Date:_____

Suicidality Informed Consent

If you're presenting with some form of suicidality (i.e. suicidal thinking or a suicide attempt), it's important to recognize the risks inherent in treatment, as well as a decision not to seek treatment.

We will talk more specifically about the issue of suicidal thoughts and behavior in our sessions. A primary target in treatment will be the reduction of suicidal behaviors. An important element of therapy involves learning new skills that will help you to more effectively manage your emotions, reactions, and relationships with others without suicidal behavior. As you learn these new skills, you should begin to notice improvements in your mood and how you feel you are managing your life.

You should be aware that we will talk about some things that will be very painful for you. We will do this when both of us feel that you have acquired the skills to be able to deal with these emotions, and we will work together to help you benefit from these experiences.

In your therapy we will set up a safety/crisis plan that will include specific steps for you to follow when you begin to feel upset or in crisis. We will expect you to make every effort to carry out these plans, and we will process obstacles that come up when you try to use this crisis response plan. This is a very critical part of your treatment, and it is less likely that your treatment will be successful if you do not utilize this plan.

What is clear is that use of a safety/crisis plan and a willingness to fully engage in the treatment process will reduce risks and increase the effectiveness of treatment. Given the risk of problems in treatment for those with chronic suicidality, it's important to recognize and understand up front the potential need for family support and involvement in care. This might mean allowing your clinician to contact a family member during a suicidal crisis or community services. It's also critical to recognize the need for an honest and trusting relationship in treatment, one allowing for you to be direct and specific when problems with treatment compliance emerge.

Suicide/Safety Support Contact Information:

Name:	Phone Number (s) Please specify call, home or work:
Relationship to client:	Address:

Do you give consent for us to contact your contact person in the case of a suicidal crisis? ___Yes ___No

Client's Signature_____ Date:_____

Client's Signature_____ Date:_____

Clinician's Signature_____ Date:_____

Whole Journey Services Credit Card Authorization Form

Clients are required to place a credit card on file to ensure payment in the instance of insurance lapses, and to efficiently process session payments.

Please complete all fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until cancelled or the balance is paid in full.

Credit Card Information
Card Type: ☐ MasterCard ☐VISA ☐ Discover ☐ AMEX ☐ Other _____
Card Number: _____ Expiration Date (mm/yy): _____ 3 Digit Code: _____ Zip Code: _____
Cardholder Name (as shown on card): _____

I,_____, authorize Whole Journey Services, PLLC to charge my credit card above for professional services I have received at the agreed upon intervals identified above until my balance is paid in full. I understand that I do not have to be present for the payment to be processed. I understand that my information may be saved on file for future transactions on my account.

_____ _____

Client Signature Date

Client Rights and Privacy Notices:

These policies are provided to every client or client's legal guardian, is posted in our office, and is available on our website: www.wholejourneywellness.com.

1. You have the right to be treated with dignity and respect.
2. You have the right to ask questions about the process and course of therapy and services.
3. You have the right to participate in developing an individual plan or service or treatment.
4. You have the right to voice any concerns or complaints about our work together and to have them resolved.
5. You have the right to decide not to receive therapeutic assistance from your assigned clinician/service provider. If you wish, we will provide you with the names of other qualified professionals whose services you might prefer. You also have the right to a second opinion by a professional of your choosing at any time.
6. You have the right to expect that your clinician/service provider will maintain professional and ethical boundaries by not entering into other personal, financial, or other professional relationships with you, all of which would greatly compromise our work together.
7. You have the right to receive services without discrimination and to ensure equal treatment without **discrimination** or harassment on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, disability, marital status, citizenship, genetic information, or any other characteristic protected by law.

Uses and Disclosure of Protected Health Information: We are committed to protecting the privacy of your health and mental health information. Information regarding your health and mental health will be recorded and maintained in our office. We may, under certain circumstances, use or disclose information without your authorization. Subject to certain requirements, we may use information for: public health purposes, health oversight activities, suspected abuse or neglect, workers' compensation purposes, research purposes, mental health examiners, judicial and administrative proceedings. We may disclose your health and information when otherwise required by law, such as for law enforcement purposes under certain circumstances. Other disclosures will require your written authorization.

Rights Related to Your Protected Health Information: You have the right to access, review and copy Protected Health Information (PHI), including a copy in an electronic format. There may be a fee for medical records. In most cases, you have the right to correct, update, ask for limits on uses and a list of disclosures of PHI. You have the right to amend the health and mental health information we have regarding you, if you believe that information is incorrect or incomplete. You also have a right to receive a list of the instances in which your health and mental health was disclosed for reasons other than treatment, payment, or quality improvement and utilization management operations. You have the right to request how we communicate with you regarding your health and mental health information, for example by mail sent to your office. You have the right to request in writing that we not use or disclose your health and mental health information for treatment, payment, or our quality improvement and utilization management operations purposes, or to other persons involved in your care except when specifically authorized by you, except when required by law or in an emergency. We will consider your written request, but are not required to accept such a request. You may revoke a written authorization for the use or disclosure of your health and mental health information at any time. We will respond to requests for amendments within 60 days of receiving the written request. Denials to requests will be provided in writing with explanations and information regarding the process will be provided to you in writing.

We reserve the right to change the terms of this notice and to make the new notice provisions in effect for all health and mental health information that we maintain. We will post a copy of current practice and will include the effective date of the notice. You may also request a copy of the notice at any time by contacting your clinician.

Complaints: If you believe your rights have been violated, you may contact the persons listed below. You may also file a written complaint with the Virginia Board of Social Work or Virginia Board of Counseling. We truly welcome your feedback directly and under no circumstances will retaliatory action be taken against you.

Monique Fields
Quality Improvement and Compliance Officer
1736 South Park Ct. Suite 201
Chesapeake, VA 23320
(757) 296-0800

Nikissia Craig
Clinical Director
1736 South Park Ct. Suite 201
Chesapeake, VA 23320
(757) 296-0800

Please sign that you have reviewed your rights as a client and have received a copy of your client and privacy rights. I have initialed above where I consented or understood, as applicable, and have had any questions or concerns answered to my satisfaction.

Client's Signature:_____Date:_____

Client's Signature:_____Date:_____

Client Rights and Privacy Notices:

These policies are provided to every client or client's legal guardian, is posted in our office, and is available on our website: www.wholejourneywellness.com.

1. You have the right to be treated with dignity and respect.
2. You have the right to ask questions about the process and course of therapy and services.
3. You have the right to participate in developing an individual plan or service or treatment.
4. You have the right to voice any concerns or complaints about our work together and to have them resolved.
5. You have the right to decide not to receive therapeutic assistance from your assigned clinician/service provider. If you wish, we will provide you with the names of other qualified professionals whose services you might prefer. You also have the right to a second opinion by a professional of your choosing at any time.
6. You have the right to expect that your clinician/service provider will maintain professional and ethical boundaries by not entering into other personal, financial, or other professional relationships with you, all of which would greatly compromise our work together.
7. You have the right to receive services without discrimination and to ensure equal treatment without **discrimination** or harassment on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, disability, marital status, citizenship, genetic information, or any other characteristic protected by law.

Uses and Disclosure of Protected Health Information: We are committed to protecting the privacy of your health and mental health information. Information regarding your health and mental health will be recorded and maintained in our office. We may, under certain circumstances, use or disclose information without your authorization. Subject to certain requirements, we may use information for: public health purposes, health oversight activities, suspected abuse or neglect, workers' compensation purposes, research purposes, mental health examiners, judicial and administrative proceedings. We may disclose your health and information when otherwise required by law, such as for law enforcement purposes under certain circumstances. Other disclosures will require your written authorization.

Rights Related to Your Protected Health Information: You have the right to access, review and copy Protected Health Information (PHI), including a copy in an electronic format. There may be a fee for medical records. In most cases, you have the right to correct, update, ask for limits on uses and a list of disclosures of PHI. You have the right to amend the health and mental health information we have regarding you, if you believe that information is incorrect or incomplete. You also have a right to receive a list of the instances in which your health and mental health was disclosed for reasons other than treatment, payment, or quality improvement and utilization management operations. You have the right to request how we communicate with you regarding your health and mental health information, for example by mail sent to your office. You have the right to request in writing that we not use or disclose your health and mental health information for treatment, payment, or our quality improvement and utilization management operations purposes, or to other persons involved in your care except when specifically authorized by you, except when required by law or in an emergency. We will consider your written request, but are not required to accept such a request. You may revoke a written authorization for the use or disclosure of your health and mental health information at any time. We will respond to requests for amendments within 60 days of receiving the written request. Denials to requests will be provided in writing with explanations and information regarding the process will be provided to you in writing.

We reserve the right to change the terms of this notice and to make the new notice provisions in effect for all health and mental health information that we maintain. We will post a copy of current practice and will include the effective date of the notice. You may also request a copy of the notice at any time by contacting your clinician.

Complaints: If you believe your rights have been violated, you may contact the persons listed below. You may also file a written complaint with the Virginia Board of Social Work or Virginia Board of Counseling. We truly welcome your feedback directly and under no circumstances will retaliatory action be taken against you.

Monique Fields
Quality Improvement and Compliance Officer
1736 South Park Ct. Suite 201
Chesapeake, VA 23320
(757) 296-0800

Nikissia Craig
Clinical Director
1736 South Park Ct. Suite 201
Chesapeake, VA 23320
(757) 296-0800

Please sign that you have reviewed your rights as a client and have received a copy of your client and privacy rights. I have initialed above where I consented or understood, as applicable, and have had any questions or concerns answered to my satisfaction.

Client's Signature:_____Date:_____

Client's Signature:_____Date:_____