Waves Counseling Services
100 Professional Pl Suite 302
Carrollton GA 30117-7837
4702442574

1. Welcome Letter-Child

Welcome to Waves Counseling Services, LLC, and thank you for allowing me to work with your child. Before your appointment, please read the following practice policies and complete the attached paperwork: Informed Consent to Treat, Privacy Practices, Practice Policies, Consent for Electronic Communication, brief standard questionnaire. When completing the questionnaire, please complete this as it pertains to your child (not you) with exception of the family portion. It's important these are completed and turned in prior to your first appointment. I'm happy to discuss the details with you and answer any questions you may have before we begin our initial session. Counseling is personal, powerful process which empowers and heals. My office is located on in Suite 302. When you walk through the main door, my office will be to your right; however, please wait in the waiting area and I will greet you there. I look forward to meeting with you, Danyale Weems, LCSW, CCTPWaves Counseling Services, LLC

Instructions for Completing Packet

In the next few pages you will be provided with policies and procedures, consent for services and be offered the opportunity to provide information on you, your child and/or family. Where it says name please put the name of who will be receiving therapy. All information on the forms pertain to the person receiving therapy. Therefore, if it is your child, then your child's information will go on the form. There are some sections which may not apply to you or your child. It is okay to leave these sections blank. If you do not know the answers, please feel free to leave this information blank. If the information has been reported in a previous form, please feel free to leave blank or put "see other form". I welcome any feedback related to the intake pack as I am seeking to make this as simple and easy for you.

2. Informed Consent to Treat

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy for you, your child or family. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself/ child or family.

Risks and Benefits

Psychotherapy can have benefits and risks. As with most other forms of treatments, results cannot be guaranteed.Participation in therapy can result in a number of benefits to you, including increased insight into your patterns of feeling, thinking, behaving and relating to others; improvement in your relationships; solutions to specific problems you bring forward in therapy; and improvement in symptoms of distress. Benefits to therapy require openness on the part of the therapy client. When information about your feelings, thoughts, behaviors, relationships, or other difficulties are withheld, it is not possible for the therapist to help you with them or to help you understand how they may be related (or not) to the issue for which you are seeking treatment. Benefits also require consistent attendance in therapy and work both in and outside of therapy sessions. Since evaluation and/or therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, helplessness, etc. When these feelings come up, it is important to talk to your therapist about them. They may be a natural, tolerable, and expected reactions to your work in psychotherapy. Other times it may be necessary or preferable to change the pace of your therapeutic work if the feelings are too uncomfortable. Or, if the treatment is not helping, it is important to talk about other treatment options.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena with a judges signature.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. naming Waves Counseling Services, LLC or it's affiliates in a law suit; claiming emotional harm or damages in a law suit with another entity; or by a court order signed by a judge.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. To maintain ethical standards and credentials I seek supervision from more qualified professionals. Your name and/or child's name will be shared along with other pertinent information. This supervision allows me to provide the best quality care.

In regards to your child/adolescent, their progress notes and information shared in their session is kept with the same confidentiality and rights as an adult. Although you as parent/legal guardian will have to provide legal consent for information to be shared or released, this does not give you the right to their information without their consent. The Clinician will share general information with you and address concerns as necessary within a family therapy session. It is the Clinician's discretion to share progress notes with you and/or your child/adolescent and must be beneficial and age appropriate. Only a judges order and/or your signature will release documents; exceptions listed above not withstanding.

(Please consider the limits of confidentiality in electronic communications, outlined in more detail later.) Additionally, communication with your clinician via any online or electronic means (e.g. email, text, video chat) is limited in security and thus your confidentiality may not be guaranteed. In the event of an injury, illness, or other unexpected emergency situation that results in your clinician becoming unavailable, your basic contact information (name and contact numbers or email) may be provided to a fellow clinician or associated professional. This will allow for your timely notification of appointment cancellations, as well as provide you with an opportunity to obtain further information regarding your continued care. *Considering all of the above exclusions, if it is still appropriate, upon your request, your clinician will release information to any agency/person you specify unless he/she conclude that releasing such information might be harmful in any way.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Confidentiality of Email, Chat, Cell Phone, Video, and Fax Communication

iTherapy email, chat, and video exchanges are secure. By signing this document, you agree to work with iTherapy online email, chat, video services determined to be suitable by iTherapy. If you choose to use your personal email account, please limit the contents to administrative issues such as cancellation or change in contact information to protect your confidentiality. If you call, please be aware that unless we are both on landline phones, the conversation is not confidential. Likewise, text messages can not be guaranteed to be confidential. If you are working online, we ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors, and friends. You are encouraged to communicate through a computer that you know is safe (i.e. Wherein confidentiality can be ensured). Be sure to fully exit all online counseling sessions and emails before leaving your computer.

Consultation:

I consult regularly with other professionals regarding my clients; however the client's name or other identifying information is never disclosed. The clients' identity remains completely anonymous and confidentiality is fully maintained.

Discussion of Treatment Plan

Your first session/s will involve an evaluation of your needs. While evaluation is ongoing, the initial phase of evaluation will result in a discussion of your therapy goals and recommendations about how you might reach those goals. You and your clinician will work together to reach a shared understanding of where your problems come from and what factors in your life contribute to keeping those problems in place. This information guides how you will move forward in resolving them. Should you or your clinician determine that the clinician, type of treatment she/he can offer, or the mode of treatment is not a good fit for you, your clinician will share recommendations for the right type of treatment and provider. If you have unanswered questions about any of the procedures used in the course of your therapy, their possible risks, the clinician's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. Therapy may also involve recommendations or referrals to additional services that support your wellness (e.g. psychiatrist, neuropsychologist, physician). In some cases these treatments are so vital and central to your recovery that your clinician is unable to ethically continue providing therapy without your concurrent treatment with these providers. Failing to follow these recommendations may result in impaired treatment progress, suicidal thoughts or actions, deteriorating medical condition, termination of treatment with this clinician or even death. Most often, however, these are recommendations not requirements.

Limitations of Online Psychotherapy

Telephone, chat, and video sessions have limitations compared to in-person sessions. It is important to consider if those limitations may impact your therapeutic progress and select an in-person provider if so. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice. Online psychotherapy providers, like many in-person providers, do not provide 24-hour crisis services. If a life-threatening crisis should occur, contact a crisis hotline, call 911, or go to a hospital emergency room. Should your clinician determine that you are at risk, he/she may call local police to assess your safety in person. iTherapy and your clinician follow the laws and professional regulations of the state in which the provider is licensed and the sessions will be considered to take place in the state in which the provider is licensed.

Dual Relationships

Not all dual relationships are unethical or avoidable. However sexual involvement between therapist and client is never part of the therapy process, nor are any other actions or dual relationship situations that might impair your clinician's objectivity, clinical judgment or therapeutic effectiveness, nor that could be exploitive in nature. In addition, your clinician will never acknowledge working therapeutically with anyone without his or her written permission. In some instances, even with permission, the clinician may choose to preserve the integrity of the therapy relationship. For this reason, your clinician will not accept any invitations via social networking sites nor will he/she respond to blogs written by clients. Your clinician will not build a relationship with you outside of sessions, which means that outside of session communications will be limited to scheduling purposes.

Practice and Payment

Length of Sessions

Your initial session can last 60-90 minutes depending on whether you complete the initial intake paperwork ahead of time. Individual sessions are typically 45-55 minutes depending on age of individual. Family sessions are typically 60-90 minutes long

Other Professional Fees

The session charge of $130 will be used to calculate other professional services you may need, and will be broken down

into 15 minute increments when services are provided for periods of time outside of those detailed above. Other services include report writing, telephone conversations lasing longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for all professional time even if your clinician it so testify for another party. Please refer to the Court Policy for specific fees. Please take note of your agreement to avoid involving your clinician in legal proceedings (below).

Billing and Payments

You will be expected to pay-in-full for each session immediately after the session; you are of course welcome to pay prior to the session. Payment of other professional services will be agreed upon when they are requested. In circumstances of unusual financial hardship, your clinician may be willing to negotiate a fee adjustment or a payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your clinician has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, it's costs will be included in the claim. In most collection situations, the only information we release regarding a clients' treatment is his/her name, the nature and dates of services provided, and the amount due.

Divorced Parents

A copy of your court order will need to be provided during your intake. The presenting parent is responsible for payment. You have the option to go through other options to collect your portion. I do not bill multiple guarantors. I am happy to provide receipts/statements to each parent as needed to reflect who made payments. If payment is not received at time of service, future appointments will not be scheduled until payment is received. I am happy to keep billing cards on file and make arrangements to charge half or share session costs.

Lateness

If you're going to be more than 15min late please understand that you may continue to attend the remainder of your session. You will still be responsible for your full rate. You are welcome to reschedule your session; however, you will still be responsible for the cancellation fee which is the session rate of $130.00.

Contacting your clinician

Clinicians are often not immediately available. Please call during normal business hours. Your call will be returned as soon as possible. If you are ever experiencing a life-threatening or harm-producing emergency please call "911" or go to your nearest emergency room. Your clinician does not generally communicate via text with clients. Occasionally, scheduling issues or basic procedural issues may be discussed over text is that is the preferred method by the client and the limits of confidentiality are understood. Similarly, the scheduling software will send you reminders of appointments via text (or email) should you choose to receive them. Email is also acceptable to discuss scheduling or to transfer documents when mutually agreed upon, however client communication regarding clinical issues or concerns via email (or texting) should be avoided as the delivery of any electronic communication can be intercepted, misdirected, or delayed.

Discharged from care

Psychotherapy is best ended with a process of termination and a scheduled final appointment. This will allow you to review therapeutic gains achieved during treatment; develop a plan of action to maintain those gains; identify what other services or activities may still be needed; and to process any emotions that may exist regarding the ending of the therapeutic relationship. If you decide to end therapy without engaging in the process of termination by not scheduling appointments or by not returning at least two telephone calls, it will be assumed that you are no longer a client of your

clinician and you are, therefore, discharged from care. Both the therapist and the client have the right to end counseling at any time.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

Mediation and Arbitration

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as a pre-condition of, the initial of arbitration. The mediator shall be a neutral third party chosen by agreement of iTherapy, your clinician and you (the client). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case or arbitration, the arbitrator will determine that sum.

Agreement

Your signature indicates that you have read this contact; that you understand all that it contains; that you agree to abide by it's terms; and that you voluntarily consent to treatment. Additionally, your signature below indicates that you understand that Waves Counseling Services, LLC and it's affiliates; iTherapy, and associated providers are not responsible for or involved in your (the client's) care or treatment unless you directly contracted with that provider.

Who Can Be involved

Please provide names of those people you would like to be involved:

3. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
c. For my use in defending myself in legal proceedings instituted by you.
d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
e. Required by law and the use or disclosure is limited to the requirements of such law.
f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
g. Required by a coroner who is performing duties authorized by law.
h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example,

home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

4. Consent for Electronic Communication

Risks of Using E-Mail/Text to Communicate with your Therapist

Transmitting client information by e-mail or text message has a number of risks that clients should consider before using e-mail to communicate with your therapist. These include, but are not limited to, the following risks: Can be circulated, forwarded and stored in numerous paper and electronic files. Can be immediately broadcast worldwide and be received by unintended recipients. Senders can easily type in the wrong email address or phone number. Is easier to falsify than handwritten or signed documents. Backup copies may exist even after the sender or the recipient has deleted his or her copy. Employers and online services have a right to archive and inspect e-mails transmitted through their systems. Can be intercepted, altered, forwarded, or used without authorization or detection. Can be used to introduce viruses into computer systems. Can be used as evidence in court.

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Waves Counseling Services, LLC or it's affiliates there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messagesYour employer, if you use your work email to communicate with Waves Counseling Services, LLC or it's affiliates.Third parties on the Internet such as server administrators and others who monitor Internet trafficIf there are people in your life that you don't want accessing these communications, please talk with your clinician about ways to keep your communications safe and confidential.

Client Obligations When Consenting to Email/Text

Use e-mail or text messaging for general client information only. Do not use for medical emergencies, other time sensitive matters, or for non-general medical information. Follow-up with the Provider if you have not received a response within 5 business days. Take precautions to preserve confidentiality. Use screen savers and safeguard your computer password. Inform Provider of any changes to your e-mail address and/or phone number. Withdraw consent to email/text client information through hardcopy written communication to Provider. I understand that I may also communicate with a the Provider via telephone or during a scheduled appointment and that the e-mail/text is not a substitute for the care that may be provided during an office visit. Appointments should be made to discuss any new issues as well as any sensitive information.

Types of Email/Text Transmissions that client agrees to send and/or receive

The types of information that can be communicated via e-mail/text with the Provider include: appointment scheduling requests, billing and insurance questions and client education. The Provider will not engage in e-mail/text communication that is unlawful, such as unlawfully practicing therapy across state lines.If you are not sure if the issue you wish to discuss should be included in an e-mail/text, you should call the office to schedule an appointment.

Hold Harmless

I agree to indemnify and hold harmless the Provider, Begin Within Counseling & Coaching Services, Inc. and its trustees, officers, agents, website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider or the use of the Provider's web-site, any arrangements you make based on information obtained by the Site, any products or services obtained through the Site, and any breach by me of these restrictions and conditions. The Provider does not warrant that the functions contained in any materials provided will be interrupted or error-free, that defects will be corrected, or that the Provider's website or server that makes such site available is free of viruses or other harmful components.

Termination of the Email/Text Relationship

The Provider shall have the right to immediately terminate the e-mail/text relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable. The e-mail/text relationship between the Provider and the client will terminate in the event the Provider, in their sole discretion, no longer wishes to utilize e-mail/text to communicate with their clients.

Forwarding Email

I understand that there may be times in which the Provider must forward the information I have provided via e-mail to a third party for treatment, billing and payment purposes. I expressly provide my consent to allow the Provider to forward these e-mails to a third party under these conditions and evidence my consent

Enter title:

Client Acknowledgement and Agreement

I have discussed with the Provider and acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail/text messages between the Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that the Provider may impose to communicate with clients by e-mail/text. Any questions I may have had were answered. I consent to allow Waves Counseling Services, LLC to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- ☐ nformation related to the scheduling of meetings or other appointments
- ☐ nformation related to billing and payment
- ☐ Information that is clinical in nature (e.g. treatment summaries, diagnosis)

Enter title:

5. Consent for Photos/Pictures

I give permission for myself/child/family to be video taped, audio recorded and/or pictures to be taken. I understand this information will be shared for educational and/or training purposes only. I give consent to discuss my family situation and to share video clips of my child/self or family session when appropriate. No taping will occur without prior written consent and video will be destroyed after supervision/consultation. Confidentiality will be honored at all times and information shared during consultation/supervision will be treated with the utmost respect. I understand I have the right to revoke this authorization at any time. I also understand that my provider will provide me with feedback or specific recommendations when such are generated.

6. Court Policy Notice

COURT POLICY

Court PolicyPlease be advised that should the therapists and/or therapist interns of WAVES COUNSELING SERVICES, LLC be requested to write a letter on any court related matter, that they will not be stipulating in writing or in person as to an opinion. Therapists and/or interns may only provide observations and feedback. At no time will any therapists or therapist interns of WAVES COUNSELING SERVICES, LLC make a recommendation in regards to custody or any other court related matter. If a court order is served and is requesting that a therapist or therapist intern of WAVES COUNSELING SERVICES, LLC be present in person and or there is a request for records, the client's consent will be requested before turning over confidential information. When obtaining this consent, the client will be told exactly what has been requested by court and there is no guarantee that the information will be kept confidential. This includes a client's mental health history; current status and inclusive records and may not be in the best interest of the client. The therapist client relationship does not render the therapist as an advocate. The therapist will withhold any opportunity to engage in a dual relationship with the client.

COURT POLICY & FEES

Please be advised that should a therapist or intern from WAVES COUNSELING SERVICES, LLC be ordered by court to write a letter to the court, the time shall be billed at $130 per hour. Please be advised that should a therapist or intern from WAVES COUNSELING SERVICES, LLC be court ordered to appear in court, the fee stipulation is as follows: $800.00 per day plus $130 per hour for travel to and from the court. $130.00 per hour for preparation. All therapist's and interns of WAVES COUNSELING SERVICES, LLC will NOT be ON-CALL at anytime. Should a case be trailed, or continued, the therapist will be paid in full for each day as well as an additional $400.00 per day as it hinders the therapist's or intern's ability to be available to their other clients. All court fees must be received by WITHIN 5 BUSINESS days prior to the court date. Should the Court calendar the hearing for another date, the therapist or intern must be re-issued a new subpoena with the new court hearing date.Should the therapists or interns be on vacation, the party initiating the court order must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. By signing and dating below, you understand and agree to the above stated court policy and stipulation, including but not limited to the fee structure for all related court matters. Should you need other arrangements for payment and/or are unable to make the payment in full within 5 business days of the court day, an addendum will be agreed upon.

7. Emergency Contact

Name:

Relationship:

phone number:

physical address:

By signing, you agree we may contact in the event of an emergency without a release of information

8. Emergency Contact 1

Name:

Relationship:

phone number:

physical address:

By signing, you agree we may contact in the event of an emergency without a release of information

9. Demographic

Full Legal Name for person being seen:

Date of Birth:

Social Security Number:

Physical Address:

Mailing Address:

Enter title:

Emergency Contact:

Race:

Relationship Status:

Sexual Orientation:

if transgender please specific:

Insurance Policy (include Group and ID numbers):

Religious/Spiritual:

Employment :

House hold Income and number of people annually:

Brief description of concerns:

10. Child/Adolescent History Assessment

Referral Source:

Reason for Referral:

What concerns do you have about your child?:

When did this concern begin?:

Whats been tried to resolve this concern?:

What are your child's strengths?:

Who resides in the home,? (Include names, ages, relationship to child and education level):

Does your child reside part-time, at a different location with another family member:

Who lives in that home? (Include names, ages, relationship to child, and education level):

Mother's occupation & health status (if known):

Father's occupation and health status (if Known):

Describe your child's relationship with each parent:

Describe your child's relationship with each sibling:

List any relocation; include places and dates of move:

What are your child's responsibilities/chores in the household, if any:

Does he/she complete these chores?:

Without prompting?:

List any family medical illness, mental illness and/or substance abuse concerns or history? Include both biological mother and fathers side (aunts, uncles, grandparents):

For Blended, Separated, Divorced Families

When did the divorce/separation occur?:

Who is the custodial parent?:

Where is the non-custodial parent?:

How often does your child see the non-custodial parent?:

According to the custody order (if applicable) do both parents have independent decision-making rights with regard to medical/mental health needs?:

Do both parents agree to initiate therapy services with our practice, Waves Counseling Services, LLC?:

If yes, please explain:

List dates of all previous marriages for both mother and father?:

List all of the mother's children and fathers children (include name and date of birth):

If not remarried does the mother have a significant other? How long?:

If not remarried does the father have a significant other? How long?:

Describe your child's relationship with step siblings, half siblings and stepparents.:

Developmental and Health History

Was your child from a planned pregnancy?:

Was your child adopted?:

If yes from where and at what age?:

Describe any problems during pregnancy, delivery and/or first 3 months?:

Did your child reach all developmental milestones at expected ages? If yes, list details below:

Describe any difficulties with speech development.:

Describe any difficulties with sensory input e.g. picky eater, irritation to tags or certain clothes, restricted food intake etc. :

List any diseases your child had and include ages. Any previous or current medical concerns and medications, please include dosage:

Describe previous and current difficulties with sleep, such as falling asleep or staying asleep. include night mares and night terrors, bed wetting etc. Include average of hours sleeps per night.:

Describe previous and current mental health treatment. Include dates of service, name of provider, diagnosis and medications. Include hospitalizations for emotional difficulties, reasons why. :

What are your child's extracurricular activities, include length of time (months, years) involved:

(If Applicable) Describe your child's relationship with coaches, mentor, band directors, church members, etc. :

Describe your child's friendships and any concerns you have with social skills?:

Describe any risky behavior you are concerned about e.g. running away, self injury (cutting), etc. :

Has your child had any legal involvement? If So, please describe :

Has he/she ever talked about suicide, attempted suicide. If so, are there triggers. Please provide as much detail as you can:

Adolescent History (12-18)

Does he/she drive?:

Does he/she date?:

Has her menstrual cycle began? If so, when:

Has your child identified as gay, lesbian, transgender, bisexual, pans-sexual, queer, a-sexual or any other sexual orientation? If so what?:

Is she/he in a relationship with a significant other? If yes, how long?:

Check all that apply (to the best of your knowledge)

- ☐ sexually active
- ☐ been involved in sexting
- ☐ been pregnant
- ☐ does he/she use drugs
- ☐ does he/she use alcohol
- ☐ does he/she use tobacco

Academic History

List the Schools your child has attended: (include name, city/state, grade(s), problems):

Has your child repeated a grade?:

Has your child ever taken advanced placement classes?:

Has your child ever had (or do they) have a 504 plan or an Individualized Education Plan (IEP):

If yes, list school accommodations, and type of plans?:

Please describe any school discipline and details (suspicions, expulsions etc):

Please describe your child's relationship with peers::

Please describe your child's relationships with teacher(s)::

List all evaluations (Psychological testing, academic testing etc.) Include place and dates. (we will need a copy of all evaluations):

Symptom Checklist (please circle all that have occurred within the past month)

- ☐ trouble concentrating
- ☐ loss of appetite
- ☐ Enter title
- ☐ trouble getting out of bed
- ☐ trouble sitting still
- ☐ anxiety/worry/panic
- ☐ mood swings
- ☐ aggression/physical fighting
- ☐ trouble making friends
- ☐ loss of interest
- ☐ temper tantrums
- ☐ threats of suicide (killing self) or statements about wishing to be dead
- ☐ difficult mornings
- ☐ late to school
- ☐ difficulty with homework
- ☐ dizziness
- ☐ excessive appetite
- ☐ tearfulness
- ☐ opposition to authority
- ☐ trouble being alone
- ☐ obsessions/compulsions
- ☐ headaches/migraines
- ☐ hears voices
- ☐ difficulty at bedtime
- ☐ school refusal
- ☐ lower grades
- ☐ upset stomach/pain
- ☐ feelings of sadness
- ☐ irritability/anger
- ☐ irrational fears
- ☐ withdrawn/isolates
- ☐ substance use
- ☐ self-harm/cutting
- ☐ see's visions

11. About Release of Information

Please complete a Release of Information for Child Advocacy Center if you were referred by them. Please complete a Release of Information for Primary Care Provider (PCP), Psychiatrists, Psychologists and other previous mental health providers. If you would like me to coordinate services with your child's school please complete a release of information. You may complete a release of information in person if there are not enough forms in your intake packets.

12. Release of Information

Name:

Date of Birth:

By signing below, I authorize that I am the legal guardian and have the authority to release the information including diagnosis, records, examination, assessments rendered to me or my child. This information may be released to

Name, address, phone number:

☐ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call

☐ my home

☐ my work

☐ my cell

Permissions

If unable to reach me

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

other:

Best time to reach me is:

13. Release of Information 1

Name:

Date of Birth:

Parent/Legal Guardian:

By signing below, I authorize that I am the legal guardian and have the authority to release the information including diagnosis, records, examination, assessments rendered to me or my child. This information may be released to

Name, address, phone number:

This Release of Information will remain in effect until terminated by me in writing or for the time necessary to complete my treatment or one year whichever comes first.

I understand that I may revoke this release at anytime and will need to do so in writing.

Messages

Please call

- ☐ my home
- ☐ my work
- ☐ my cell

Permissions

If unable to reach me

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call

other:

Best time to reach me is:

14. Release of Information 2

Name:

Date of Birth:

By signing below, I authorize that I am the legal guardian and have the authority to release the information including diagnosis, records, examination, assessments rendered to me or my child. This information may be released to

Name, address, phone number:

☐ Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call

☐ my home

☐ my work

☐ my cell

Permissions

If unable to reach me

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

other:

Best time to reach me is:

0. Standard Intake Questionnaire

Complaint

What are you seeking help for? Provide a brief description of current concerns:

Have you had previous treatment?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Current Symptoms

(check all that apply)

- ☐ Anxiety
- ☐ Appetite Issues
- ☐ Avoidance
- ☐ Crying Spells
- ☐ Depression
- ☐ Excessive Energy
- ☐ Fatigue
- ☐ Guilt
- ☐ Hallucinations
- ☐ Impulsivity
- ☐ Irritability
- ☐ Libido Changes
- ☐ Loss of Interest
- ☐ Panic Attacks
- ☐ Racing Thoughts
- ☐ Risky Activity
- ☐ Sleep Changes
- ☐ Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

Current Medications:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you/your child adopted? If yes, at what age?:

How is the relationship with your/their mother?:

How is the relationship with your/their father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grown up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuanna

- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Stimulants (Pills)
- [ ] Ecstasy
- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the doctor to know?:

0. Welcome Letter-Adult

Welcome to Waves Counseling Services, LLC, and thank you for allowing me to work with you. Before your appointment, please read the following practice policies and complete the attached paperwork. Informed Consent, Privacy Practices (HIPPA), Standard Questionnaire (to decrease amount of time gathering information) and allow me to more time to get to know you. Consent to electronic communication and Policies and Practices. It's important this is completed and turned in at your first appointment. I'm happy to discuss the details with you and answer any questions you may have before we begin our initial session. Counseling is powerful and healing. It requires commitment and is a process. There is yes quick fix as problems do not usually occur singly or overnight. I will work as hard as you will work to meet your goals and I know it takes courage to seek out help. My office is located on the 3rd floor, suite 302. When you enter the doors, please feel free to sit in the lobby. I will be out momentarily to greet you. I share this space with other individuals. I look forward to meeting with you, Danyale Weems, LCSW, CCTP Waves Counseling Services, LLC

Instructions for Packet

In the next few pages you will be provided with policies and procedures, consent for services and be offered the opportunity to provide information on you, your child and/or family. Where it says name please put the name of who will be receiving therapy. All information on the forms pertain to the person receiving therapy. Therefore, if it is your child, then your child's information will go on the form.There are some sections which may not apply to you or your child. It is okay to leave these sections blank. If you do not know the answers, please feel free to leave this information blank. If the information has been reported in a previous form, please feel free to leave blank or put "see other form". I welcome any feedback related to the intake pack as I am seeking to make this as simple and easy for you.