ROOTED COUNSELING, LLC
860 Broad Street • Emmaus, PA 18049
Phone: 610-762-8690 • Email: shlbldwn@gmail.com

UPDATED OFFICE ADDRESS:
40 South Fourth Street
Emmaus, PA 18049
Driveway on the left side of the building & enter the back door.

CLIENT INTAKE PAPERWORK

Client Name _____ Date_____

Welcome! As part of beginning the therapy process, please take a few minutes to fill out these forms. The information provided will assist me in developing a deeper understanding of your situation, and will help to determine possible solutions for the difficulties you are currently experiencing. Please note that all of the information below is confidential.

Sources of Stress: What are the primary issues for which you are seeking therapy?

What are the most important things you think I should be aware of, in relation to these issues?

Do you have any particular concerns or fears regarding therapy?

What are your goals for therapy?

Lastly, if you were previously in therapy, when and with whom?

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CONTACTING ME

My office hours are Monday through Saturday by appointment only. I can be reached at (610) 762-8690 and in the event that I am unavailable, please leave a voicemail message and I will do my best to return your call in 24 hours. Any time that I will not be in the office, I will communicate with you prior to all appointments.

CANCELLATION POLICY

I will notify you at least 24 hours in advance if I have to cancel or reschedule a session for non-emergency purposes. In any other situation, I will make every effort to contact you for any emergency that would require rescheduling. If you cannot keep a scheduled appointment, please give me at least 24 hours notice in order for me to schedule accordingly.

NO SHOW/CANCELLATION POLICY

Appointment times are very important to people. Therefore, if you do not give me 24-hour notice that would allow me to fill the time adequately, the police is as follows:

First no show or cancellation without 24-hour notice: No cancellation fee and you will be rescheduled upon request.

Second no show or cancellation without notice: You will be responsible for a $25.00 missed appointment fee before being rescheduled.

Third no show or cancellation without notice: You will be responsible for a $50.00 missed appointment fee and will discuss future appointments, potential termination, and potential referral to another provider.

APPOINTMENTS AND FEES

Counseling sessions are approximately 45-50 minutes. I am in network with most insurance companies and also have a sliding scale for cash-paying clients. Full payment is expected at the time of service, though most insurance will cover a portion of your care. Ultimately, it is the client's responsibility to be aware of their insurance plans and coverage.

WHAT ARE YOUR RESPONSIBILITIES AS A CLIENT?

Counseling is most beneficial when a client and counselor work diligently on addressing the primary concern that brought you to therapy. Building a positive and professional relationship, willingness to challenge yourself, being honest, and following through with healthy changes will be discussed in session.

IN THE EVENT OF A CRISIS OR EMERGENCY

Call 911 or go to your local Emergency Room. Additional resources include:

Northampton County Crisis Intervention (610) 252-9060

Lehigh County Crisis Intervention (610) 782-3127

St. Luke's Hospital, 801 Ostrum Street, Bethlehem (610) 954-4500

St. Luke's Hospital, 1736 W. Hamilton Street, Allentown (610) 628-8383

Lehigh Valley Hospital-Muhlenberg, 2545 Schoenersville Road, Bethlehem (484) 884-2200

Lehigh Valley Hospital-Cedar Crest and I-78, Allentown (610) 402-8111

Easton Hospital, 250 S. 21st Street, Easton (610) 250-4002

Client's/Parent's Signature_____ Date_____

Clinician's Signature _____ Date_____

Rooted Counseling LLC

40 South 4th Street
Emmaus, PA 18049

Informed Consent Form

I understand that Mrs. Baldwin and/or her associates are not agreeing to be an expert witness or to testify on my behalf nor on the behalf of any other individual and will use discretion if it appropriate to share information in any deposition, court proceeding, or in any other way. I understand that Mrs. Baldwin and/or her associates may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at her sole discretion.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Signature _____

Date _____

Witness' Signature _____

Date _____

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Informed Consent Form: Child Therapy: Separated/Divorced Parent's Separated/Divorced Parent's Agreement Form

I have brought my child_____, age_____, to see Rooted Counseling, LLC for evaluation and/or treatment. I understand that my child is the patient – not me, any other sibling, or my spouse. This is true no matter who pays for the evaluation/treatment of my child.

I understand that Rooted Counseling, LLC's primary responsibility is in my child's best interest and that she may decide to involve me in my child's evaluation/treatment at her sole discretion. I understand that if payment is not received promptly for services rendered by Rooted Counseling, LLC to my child, the services may be suspended or teminated at Rooted Counseling, LLC's sole discretion, pursuant to the ethical guidelines governing therapeutic care.

I understand that Rooted Counseling, LLC is not agreeing to be an expert witness or to testify on my behalf nor on the behalf of any other individual, and will use discretion if it is appropriate to share information regarding my child in any deposition, court proceeding, or in any other way. I understand that Rooted Counseling, LLC may or may not meet with me, my attorney, or any other party or attorney in any custodial or divorce proceeding at her sole discretion. Rooted Counseling, LLC may also charge for the receipt of any correspondence or acceptance of any telephone calls or emails, other than those directly from the court or counsel for my child.

I have read the above paragraphs and understand them. By signing below, I agree to the above.

Signature_____ Date_____

Signature_____ Date_____

ROOTED COUNSELING, LLC
40 SOUTH 4TH STREET
EMMAUS, PA 18049
PC #00-9041
PHONE 610-762-8690 E-MAIL: SHLBLDWN@GMAIL.COM

NEW PATIENT INTAKE FORM

Last Name: _____ First Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/ _____ / _____

Phone: ( ) _____-_____

Employment Status: FT PT Unemployed Disabled Other: _____

Marital Status: Married Single Divorced Common Law

CONSENT TO TEXT/EMAIL

By signing below you consent to the use of text and/or email for purposes of communication. You are releasing me of any and all liability if there is a breach in private/confidential information as you understand that these modes may not and/or cannot protect your privacy to the fullest extent.

Signature: _____

INSURANCE INFORMATION:

Insurance Name: _____

Are You the Policy Holder? Yes No

If NO, Name of Policy Holder: _____

DOB of Policy Holder: _____/_____/_____

Address of Policy Holder, if Differs from yours:

Street: _____ City: _____ State: _____ Zip: _____

Client Signature: _____

Clinician Signature: _____

CONSENT TO TREATMENT AND TREATMENT POLICIES

Appointments: _____ (Initial)

Psychotherapy sessions are by appointment only. Because this appointment is reserved for you there is a $30.00 fee for appointments that are not canceled 24 hours in advance, unless in fact they are occasioned by circumstances that we would both define as an emergency. Please call or text to notify me if you are going to be more than 5 minutes late. If after 15 minutes I do not hear from you, your session may be forfeited to respond to a phone call or another client in need.

Phone Calls: _____ (Initial)

I do not accept phone calls during therapy sessions. Scheduled phone consultations are acceptable and often legitimate ancillary service, however they have to be scheduled in advance. Please be advised that if your insurance company does not reimburse for phone sessions, you will be financially responsible for the full charge. Calls lasting more than 10 minutes will be subject to a fee.

Text / Phone Messages: _____ (Initial)

You are permitted to text my cell phone ONLY in regards to scheduling, canceling, or informing me you will be late for an appointment. Please do not leave messages on my voice mail that are clinical or crisis related in nature.

Termination of Services: _____ (Initial)

May be initiated at any time by either you or myself. I do request that if you decide to terminate your therapy, you provide a two week closure period to explore and discuss reason(s) for termination.
Reasons for termination may include, Treatment goals are completed, pattern of cancelled/late cancelled/ no-show appointments, non payment for services, services not covered by insurance plan, minimal or no progress made in treatment goals and/or increased symptoms in which referral to higher level of care is required, hostile/threatening behavior by you including threats of physical harm, law suits, reporting to licensing board, defamation/slander, etc.

Records/Confidentiality: _____ (Initial)

All records are filed in an organized manner and kept in a locked file that allows for easy retrieval. Progress notes and assessments are maintained electronically which is password protected. All records are protected from public access. In accordance to PA State Psychological Board, records are retained for a minimum of five years (or longer in accordance with more restrictive law), after the last date of service rendered.

Exceptions to Confidentiality: _____ (Initial)

The following are exceptions to your confidential and protected health information. Please read the list below carefully and understand that laws governing your confidentiality and privacy do NOT apply to these circumstances.

- Clear and imminent danger to self; medical emergency
- Duty to warn/protect another person of threat of harm/danger
- You disclose any form of child abuse/mistreatment
- Threats or Acts Made against Therapist
- You have waived the right to privileged information or have compromised through actions including involvement in a lawsuit, legal involvement, or discussing information in the presence of a third party.
- Information released to your insurance company in order for reimbursement.
- Court ordered by a judge
- Purposes of Unidentified Peer Consultation

Payment Policy/Insurance Billing: _____ (Initial)

If your insurance plans not among those accepted at this practice, you will basked to file your own claim. I do not bill secondary insurances.

- As the insurance policy holder, it is your responsibility to check your insurance benefits and coverage, including copay, deductible, needed authorization, services covered (psychological testing, group psychotherapy). If your insurance requires an authorization, it is your responsibility to obtain that authorization prior to your initial appointment. Unpaid balances may be sent for further legal/collection action if needed.
- No-show/late cancellation costs must be paid prior to attending your next session
- All payment, including co-payment and/or deductible is due at time of session.

Insurance Fee Schedule: _____ (Initial)

Initial Consultation, Assessment and Diagnosis	(90791)	$200.00
Follow-up Psychotherapy Session	(90837)	$175.00
Group Therapy	(90853)	$150.00
No Show/Late Cancel Individual Session		$30.00
Returned Check Reprocessing Fee and Bank Charge		$35.00

Consent and Signature

The above consent for treatment and treatment policies have been thoroughly explained to me. I have read and agree to abide by all terms put forth. I understand that I am consenting to being under the psychological treatment of Rooted Counseling, LLC.

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

Copy Received: _____ Copy Declined: _____ Date _____

Patient Name: _____ Date of Birth: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE DISCLOSE HEALTH INFORMATION (PRIVACY POLICY)

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Rooted Counseling, LLC to use and disclose health information about you for your treatment, payment and health care operation purposes.

Notice of Privacy Practices: Rooted Counseling, LLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

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ACKNOWLEDGEMENT AND CONSENT
(Release of Patient Information)

PRINT or **TYPE** all information except signature

I have received the Notice of Privacy Practices for Rooted Counseling, LLC. Rooted Counseling, LLC is authorized to use and disclose health information about:

(X)_____ _____
(Signature of Patient or Patient's Personal Representative) Date

INSURANCE SIGNATURE ON FILE AUTHORIZATION FORM
(Benefit Assignment)

"I request the payment of authorized Medicaire/Medigap/Insurance Benefits be made either to me or on my behalf to the name of provider of service and/or supplier for any service furnished to me by that provider of service and/or supplier. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents/my Medigap insurer/my insurance company and information needed to determine these benefits or the benefits payable for related services."

"I understand that I am financially responsible for any allowable amount not covered by my insurance carrier such as a deductible or coinsurance."

"I understand that in the event I have no insurance, I am financially responsible for payment of services by Rooted Counseling, LLC."

"I understand that, effective August 1, 2010, any collection charges and/or fee for delinquent accounts will be the responsibility of the patient/guarantor."

"I authorize electronic claim submission of my charge to the appropriate insurance carrier."

"I authorize my medical record reports to any facility deemed necessary in the care of my treatment."

"I have fully read, and understand and agree to abide by the policies listed above."

PATIENT COMMUNICATION FORM

I authorize Rooted Counseling, LLC and/or her staff to communicate medical information pertaining to my care by the following methods as I will assume responsibility to notify them whenever this information changes.

Leave Appointment Message on:

❑ Answering Machine ❑ Office Voice Mail ❑ With Another Person ❑ Through Mail
❑ Via E-Mail _____

Leave other Medical Information on:

❑ Answering Machine ❑ Office Voice Mail ❑ With Another Person ❑ Through Mail
❑ Via E-Mail _____

Phone Numbers you ONLY wish to be contacted and receive messages at:

( ) _____-_____ (cell home work)

( ) _____-_____ (cell home work)

List person(s) we are authorized to communicate with in regard to your medical information:

_____

_____

Patient Signature:_____

MEDICAL AND MEDICATIONS

Date: _____/_____/_____

Last Name _____First Name_____

PHYSICIAN:_____

Phone Number: ( ) _____-_____ Fax: ( ) _____-_____

Address:_____

Medical Conditions & Medications:

_____

_____

_____

Do You Have Any Allergies To Medications? YES NO

If Yes, List Below:

_____ _____

_____ _____

RELEASE OF INFORMATION

Per my request, I _____ authorize Rooted Counseling, LLC to RELEASE/OBTAIN my protected information/records TO/FROM (below) for the purpose of treatment collaboration.

Name: _____ Specialty: _____

Phone: _____ Fax: _____

Address: _____

_____Clinical Assessment, Diagnosis & Recommendations

_____Drug & Alcohol Assessment

_____Specific Patient Forms:

_____Nutritionist Assessments & Recommendations, Weight Checks/Meal Plans

_____Psychiatry Assessment & Recommendations, Medications

_____Medical Assessments & Recommendations, Medications/Medical Conditions

_____Entire Patient File

_____Telephone _____Fax _____Text _____Email

Client Printed Name: _____

Client Signature: _____

Date: _____/_____/_____

Clinician Signature: _____

Date: _____/_____/_____

Copy Received _____

Copy Declined _____

I understand that I may revoke this release of information at any time in writing. This release shall be void after 90 days of treatment discharge. Prohibition of Re-disclosure. This information has been disclosed to you from records whose confidentiality is protected by Federal Law (42CFR Part 2), which prohibits you from making any further disclosure of this information except with specific written consent regulations. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

Ashley L. Baldwin, MA LPC NCC

860 Broad Street

Emmaus, PA 18049 Suite 102

Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications to enable mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to-face" psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order

to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. 11. I understand that different states have different regulations for the use of telehealth.

Payment for Telehealth Services will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a prompt pay discount is available. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Signature & Date_____

Printed Name _____

Witness's Signature & Date _____

Credit Card Information on File:

_____ Expiration Date: _____

CVV code:_____ Zip Code:_____

Signature:_____ Date:_____

*You are authorizing Rooted Counseling LLC to clear all balances using this credit card information on file.