INDIVIDUAL ADULT INTAKE FORM

PERSONAL DETAILS

Name: _____ D.O.B.: _____ Age: _____ Gender: ____

Place of Birth: _____ Immigration Status: _____

P.O. Box _____ Postal Code: _____ Street Address: _____

Country of Residence: _____ City or District: _____

Phone: (H):_____ (W):_____ (C):_____

Please give us any special restrictions for leaving a message at the numbers provided:

☐this is a private number and you may leave message freely OR

☐ only leave a name/no. to call back OR ☐ do not leave any messages

Preferred Email: _____

Relationship Status:

- ☐ Single/Never Married
- ☐ Previously Married for: _____ years, name of spouse: _____
- ☐ Separated: Year _____
- ☐ Divorced: Year _____
- ☐ Widowed: Year _____
- ☐ Currently Married for: _____ years, name of spouse: _____
- ☐ In Significant Relationship for: _____ years
- ☐ No. of Biological Children: _____ Names & Ages: _____
- ☐ No. of Other Children: _____ Names & Ages: _____

EMPLOYMENT/EDUCATION DETAILS

Employer: _____ Years of Service: _____

Position Held/Occupation: _____

Education last completed: Primary School / High School/ University/ Vocational School/

Graduate School (please specify type, _____) / Other: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____ Email: _____

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P.O. Box 10462, KY1-1004

REFERRAL INFORMATION:

How did you learn about The Wellness Centre?

- ☐ Self
- ☐ Media (please circle): Yellow pages/TV Show/Radio Show/Newspaper article
- ☐ Friend / Family Member
- ☐ Employer/Co-worker
- ☐ Doctor
- ☐ Lawyer
- ☐ Priest/Pastor
- ☐ Other Counsellor
- ☐ Other, _____

Please explain; _____

Have you had any previous mental health counselling or treatment, if so, please mark below? If necessary, separate consent will be obtained for permission for us to contact and correspond with treatment providers *(Please circle all that apply)*:

- ☐ N / A
- ☐ Individual counselling / Pastoral Counselling / Group counselling / Marital or Couples Counselling / Family counselling / Psychiatric Hospitalisation, Treatment or Medication / Other: _____

Please explain when, with whom, and for what reason(s) you were in treatment:

_____

_____

_____

PRESENTING CONCERN:

What has brought you to seek counselling services at this time? What are the most significant stressors/challenges in your life at this time?

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_____

_____

_____

_____

HISTORY

Have you experienced any of the following (Please circle all that apply):
Physical abuse/emotional abuse/sexual abuse (under 18)/sexual assault (over 18)/suicide attempt/mental health illness/alcoholism/drug use:
Explain:

_____

_____

Has anyone is your family had a history of (Please circle all that apply):
Physical abuse/emotional abuse/sexual abuse (under 18)/sexual assault (over 18)/suicide attempt/suicide completion/mental health illness/alcoholism/drug use. Explain:

_____

_____

_____

Describe any significant recent life events, changes, emergencies, or crises, either positive or negative? _____

_____

Are you currently involved in any matters of the Court? If so, please indicate them here:_____

MEDICAL INFORMATION

Name of Primary Physician: _____

Approximate date of last physical exam: _____

Any major health concerns or medication(s) (please indicate dosage): _____

_____

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Any recent medical illnesses/emergencies/hospitalizations/accidents:

_____ _____

_____

Any chronic health illnesses/disabilities:

_____

_____

List allergies: _____

Please list all medication/remedies you are taking at present (Name/Dose/am / pm):

1._____2._____

3._____4._____

OTHER PROFESSIONALS INVOLVED

Please provide information regarding any other professionals who may be involved in assisting with your current situation.

- ☐ Family Doctor: _____
- ☐ Psychiatrist: _____
- ☐ Priest or another religious figure: _____
- ☐ Other Mental Health Professional: _____
- ☐ Other Professional: _____
- ☐ N /A

What do you hope will change by coming to counselling? Or, how could you be healthier, happier, or more successful?

_____

Describe any self-improvement you have already achieved and any attempts you have made to overcome these difficulties thus far: _____

_____

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How do you cope with stress generally (circle all that apply)?

Praying /Attending church / Avoiding the problem / Exercising / Eating / Shopping
Having sex with significant other / Having casual sex / Bottling up feelings
Isolating yourself / Spending time with friends / Smoking Cigarettes / Drinking Alcohol
Recreational Drugs / Self-harm / Sleeping / Music / Art / Leisure / Meditating / Reading
Watching TV / Other: _____
_____

Insurance Assignment

Insurance Company: _____

(Please provide copy of both sides of insurance card

Policy Holder: _____

Insurance ID Number: _____

I, _____ (print name) do hereby give full permission and authorize The Wellness Centre to bill my health insurance company for services rendered by The Wellness Centre.

Signature: _____

Date: _____ (mm/dd/yy)

Thank you for taking the time to complete this form to the best of your ability. Your openness is appreciated and will assist your treatment provider in developing a treatment plan best suited to your needs.

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ADULT INFORMED CONSENT

Your rights to information about us

All our mental health professionals are registered, certified, or licensed as required by law and are held to the highest of legal and ethical standards. We are committed to your rights of information regarding office policy, non-discrimination, confidentiality, consent, and competent service.

If you have any questions or concerns, please do not hesitate to tell us. For further information please visit our website www.wellnesscentre.ky or call us at 949-9355.

1. **Child Safety Policy**
   The Wellness Centre Ltd operates an open-door policy as it relates to the service of children under the age of 18 years. Although most therapeutic services are conducted behind closed doors between a child and their primary therapist, if at any time a parent wishes to do so, they may enter their child's therapy session without knocking or advanced notice.

2. **Confidentiality**
   Unless you grant us permission to do so in writing, we will not inform anyone that you are receiving therapy, nor will we disclose the content of your treatment. Additional consent will be required for The Wellness Centre to provide treatment to minors and to exchange information to a third party.

   Family matters will also require consent from all primary adults involved before treatment materials will be released. You may revoke your permissions in writing at any time.

   Please note client records will remain property of The Wellness Centre for a period of 10 years, after which time they will be destroyed. We function as a clinical team at the Wellness Centre and therefore utilize internal peer supervision and consultation regularly as well as professional external consultation and supervision as needed.

   Any para-professionals, administrators, or interns are also bound by our strict ethical code of confidentiality; they are bound by a written declaration of fidelity to confidentiality.

   However, there are few circumstances when we have a legal obligation to disclose information without your written permission:

   1) **Harm to a Child/Elderly Person/the Disabled**: If we are made aware that a vulnerable person is in direct danger, we are legally obligated to make our concerns known to the appropriate authorities;

   2) **Harm to Self or Others**: If at any time it is our clinical assessment that your actions or intentions are of a threatening nature to yourself or others, we have a legal obligation to make these concerns known to the appropriate authorities.

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3) **Order of the Court**. The Court of the Cayman Islands may at any time request information regarding your treatment where it is applicable to current or pending criminal case proceedings.

4) **Professional Supervision**. The Wellness Centre operates as a team structure and performs professional best practices such as clinical meetings, supervision, and consultations to ensure the most beneficial care in collaboration with internal practitioners. No outside professionals will be involved. Any conflicts of interest will be identified and may be avoided upon request.

3. Corporate Partners

All employees of our Corporate Partners receive individual, family, and couples counselling at no cost to them. Family members of employees may also receive free services or a Corporate Partner discount depending on the company. Corporate Partner employees also receive a discount for specialized services. Please identify yourself as an employee of one of our Corporate Partners at the time of booking.

4. Complaints

If at any time you believe your rights have been violated or you have concerns about the quality of service received, you are encouraged to speak to your therapist. If you are not able to resolve your concerns, you may contact the Director, Shannon Seymour, in writing.

Client Satisfaction Surveys are available at your request. If no course of action has been helpful to you, you have the right to speak to a member of the Health Practice Commission www.dhrs.ky/hpc/contact.php

The Cayman Islands Council for Professionals Allied with Medicine has set out a code of practice and guidelines for the provision of counselling services for your protection.

By signing below, you indicate you are fully informed and agree to the preceding information and consent to treatment. By signing below, you also agree that if you or someone in therapy with you makes an allegation against this agency, or any employee acting in the capacity of the agency for a legal or ethical violation we have the right to release information sufficient to our own defense against the charges made.

Signature of Client: _____

Print Name: _____

Date (dd/mm/yy): _____

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Client Financial Responsibility Agreement

Client Name: _____

Date of Birth: _____

The following is an explanation of The Wellness Centre's payment policy for all clients (including minors). It aims to minimize any misunderstanding about payment for services.

1. All invoices / receipts are presented in **Cayman Island Dollars**;
2. We accept cash, credit and debit cards for payment;
3. US$ cheques are accepted at the exchange rate of .82;
4. US$ cash, credit cards, and wire transfers are accepted at the exchange rate of 0.80;
5. Sessions may be suspended if your account is more than 30 days in arrears;
6. Your sessions may be terminated if your account is more than 90 days in arrears;
7. **The full-service fee will be charged for missed appointments;**
8. A missed appointment is one not cancelled PRIOR to 24 hours before the scheduled appointment time, or in the case of a Monday appointment, not cancelled by the corresponding appointment time of the preceding Friday. If the office is closed a voice mail message may be left on The Wellness Centre message system;
9. Cancellations made at the time of a scheduled appointment or after a scheduled appointment will be considered as a missed appointment;
10. If covered under a Corporate Wellness Contract, please note it does not cover missed appointment fees or late cancellation fees, the full fee will be charged directly to the client for all missed appointments;
11. Insurance companies will not pay for missed appointment fees or late cancellation fees;
12. The credit card held file will be charged for all amounts greater than 30 days old as per the credit card authorization form. If no credit card is held on file services must be paid pay in full at the time received;
13. Payment in full is expected at the time services are rendered if any of the following circumstances apply:
    a. You are a self-pay patient (you do not have insurance);
    b. You do not wish to have your insurance billed;
    c. You have not provided us all the current/correct information required to file an insurance claim including a current referral;
    d. Your insurance benefits do not cover the service(s) rendered.
14. If health insurance covers services in full or in part, the you will need to provide:
    - Insurance Card, Medical Referral and a form of photo ID;
15. It is your responsibility to confirm coverage with your insurance provider;

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16. The Wellness Centre will not be held responsible or liable for inaccurate information provided by the insurance provider;
17. You are responsible to inform The Wellness Centre of changes in your insurance before the time of service;
18. You are responsible for the full fee for services rendered but not covered by insurance;
19. At the time of service, you must pay co-pays, coinsurance, deductibles, and any services not covered by insurance;
20. You are responsible for obtaining and providing current referrals;
    a. Referrals are valid for 90 days;
    b. You are responsible for payment should the referral expire, and service(s) are provided during any period when a referral is not active;
    c. You are responsible for the balance of any claims not paid within 30 days;

The Wellness Centre reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys at the client's cost.

The client expressly waives privileges concerning disclosure of all information necessary to proceed with collection activities and acknowledge an itemized account history, showing services rendered, fees charged, and payments received may be filed as an exhibit.

It is the client's financial responsibility for any additional services such as phone calls, letter writing, completion of forms, and administrative meetings in or out of the office. These services will be billed at the usual rate and will remain the client's obligation to pay.

The Client will notify The Wellness Centre immediately of any changes in the client's billing address / telephone and/or health insurance coverage.

This entire authorization is valid for all sessions and/or services rendered by The Wellness Centre. A copy of which may be used in place of the original.

The Wellness Centre and / or therapist(s) may release any information as necessary to process claims to a health insurance company.

I have read, understand, and agree to the above policies

Signature: _____

Date; _____ (mm/dd/yy)

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