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: ______________________________

Smith Road Centre, 150 Smith Road, 3rd Floor, George Town, Grand Cayman
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 AGREEMENT

Client Name		**Client Email**	
		Client Cell	
Parent/Guardian Name		**Parent Email**	
		Parent Cell	
Payment Method	Time of Service Advance Self-Pay Monthly Self-Pay Insurance /co-pay		
Insurance Details	Insurance Company:		
	Primary Policy Holder		
	Group Number		
	Client Policy Number		

DIRECT DEPOSIT / ELECTRONIC FUND TRANSFER: When making an online or direct deposit please ensure the CLIENT name is noted in the narration/memo so that the deposit can be accurately applied to account.

Bank: Cayman National **Branch**: Elgin Avenue
Name: The Wellness Centre **Type**: KYD Chequing
Account#: 011-09070

CREDIT CARD AUTHORIZATION: To have The Wellness Centre charge a credit/debit card for service fees complete the information below and return by hand directly to the Billing Administrator.

Client Name			
Cardholder Name			
Card Number			
Expiry Date		**CCV**	
Card Type	☐ Visa ☐ Mastercard	**Currency**	☐ KYD ☐ USD

AUTHORIZATION: I hereby authorize The Wellness Centre Ltd to charge the credit/debit card listed above for the following: **select one**

- ☐ SELF-PAY | Fees for services on date of appointment (courtesy discount applied)
- ☐ SELF–PAY | Invoiced Monthly fees
- ☐ Insurance Co-Pay charged on date of service, insurance claim to be submitted by The Wellness Centre.
- ☐ SELF-PAY | PAYMENT PLAN: Overdue balance as of ______ day of _______, 20___ is KYD$_______________. _____ payments of KYD$__________ will be applied on the 1st day of each month ending ________ day of _________, 20___.

FINANCIAL RESPONSIBILITY

- ☐ I accept full responsibility for all costs associated with services outlined herein received from The Wellness Centre.
- ☐ If paying by **credit card**; I accept the responsibility to update The Wellness Centre if card details change.

- ☐ If paying by **direct bank transfer**; I accept responsibility to ensure transactions are made accurately and in a timely manner to ensure deadlines of receipt of funds.
- ☐ With acceptance of **insurance coverage**, I understand The Wellness Centre may verify my coverage as a courtesy; but The Wellness Centre cannot be held responsible or liable for inaccurate information provided by my insurance provider.
  - ☐ I accept responsibility to confirm coverage with my insurance provider and communicate to The Wellness Centre any changes in my insurance coverage or policy immediately so that claims can be filed within the insurance providers deadlines. I accept responsibility for the full fee for services rendered but not covered by my insurance carrier.
  - ☐ I understand co-pays, coinsurance, deductibles, and any services not covered by my insurance plan must be paid at time of service.
  - ☐ I am responsible for obtaining and providing any required medical referrals. It is my responsibility to meet the referral requirements of my insurance provider.
  - ☐ Should my referral expire and service(s) are provided during any period when a referral is not active, I am responsible for payment.
  - ☐ Insurance companies will not pay for missed appointment fees or late cancellation fees, I accept responsibility for these fees.
  - ☐ I am responsible for the balance of any insurance claims not paid within 30 days.

NAME FINANCIALLY RESPONSIBLE PERSON____

SIGNATURE: ____

Dated the _____ day of ____________, 20_____.

TheWellnessCentre

ADULT RELEASE OF INFORMATION

Name: ______________________________ D.O.B.:_________ Age:______ Gender: ________
P.O. Box _________ Postal Code: ______________ Street Address: ________________________
Country of Residence: ________________________ City or District: ________________________
Phone: (H/O):________________________ (W):____________________ (C):____________________
Please give us any special restrictions for leaving a message at the numbers provided:
☐do not leave a message OR ☐do not leave specific information regarding purpose
Preferred Email: ____

I authorize ***The Wellness Centre Ltd.*** to RELEASE and/or OBTAIN information in regards to the counselling, assessment, behavioural and/or psychological services (☑ affirms ☒ deletes):

☐TO/FROM ____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐TO/FROM ____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

☐TO/FROM ____

NAME or ORGANIZATION / Relationship EMAIL NUMBER

Information released / obtained may include (☑ affirms ☒ denies):

- ☐ Attendance
- ☐ Treatment Plan
- ☐ Diagnosis/analysis
- ☐ Psychological reports
- ☐ Medication Mgmt.
- ☐ Drug / Alcohol Testing
- ☐ Work / School Performance
- ☐ Case Mgmt
- ☐ Medical Reports
- ☐ Legal Consultation
- ☐ Case Notes
- ☐ Other: ________________

Please list any special instructions or delimitations for consent:

____

By signing below, I understand that consent shall remain valid for the duration of services at The Wellness Centre and not longer than 90 days from the date of the last contact. I have been informed that I may revoke consent by written communication to The Wellness Centre at any time. If conjoint, both parties must consent to exchanging information and only one party is required to rescind this consent. I certify that this form has been fully explained to me and that I understand its contents.

Client Name: ____________________ Signature:_________________ Date:______________

Witness Name: ___________________ Signature:_________________ Date:______________