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): _____

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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P.O. Box 10462, KY1-1004

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 in 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):

Smith Road Centre, 150 Smith Road, 3rd Floor, George Town, Grand Cayman
P.O. Box 10462, KY1-1004

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:

Smith Road Centre, 150 Smith Road, 3rd Floor, George Town, Grand Cayman
P.O. Box 10462, KY1-1004

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 a 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.

Smith Road Centre, 150 Smith Road, 3rd Floor, George Town, Grand Cayman
P.O. Box 10462, KY1-1004

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 with 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 a few circumstances when we have a legal obligation to disclose information without your written permission.

Smith Road Centre, 150 Smith Road, 3rd Floor, George Town, Grand Cayman
P.O. Box 10462, KY1-1004

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.

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, Dr. 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

Smith Road Centre, 150 Smith Road, 3rd Floor, George Town, Grand Cayman
P.O. Box 10462, KY1-1004

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): _____

Smith Road Centre, 150 Smith Road, 3rd Floor, George Town, Grand Cayman
P.O. Box 10462, KY1-1004

Client Financial Responsibility Agreement

The following document explains The Wellness Centre's payment policy and financial responsibility for all clients (including minors). It aims to minimize any misunderstanding about payment for services.

Client Name		**Client Email**	
		Client Cell	
Parent/Guardian Name (if Under18)		**Parent Email**	
		Parent Cell	
Payment Method	Self-Pay | Health Insurance | Corporate Wellness Benefit		
Insurance Details	Insurance Company:		
	Primary Policy Holder		
	Group Number		
	Client Policy Number		

FINANCIAL RESPONSIBILITY

- I accept full responsibility for all costs associated with the services I receive from The Wellness Centre.
- I accept that I may utilize my health insurance coverage and that The Wellness Centre may verify my coverage as a courtesy however, The Wellness Centre cannot be held responsible or liable for inaccurate information provided by myself or 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 provider's deadlines.
- I accept responsibility for the full fee(s) for services rendered but not covered by my insurance provider.
- I accept that any co-pay, coinsurance, deductible, and/or service not covered by my insurance plan must be paid at the time of service.
- I accept that The Wellness Centre and/or therapist(s) may release any information as necessary to process claims to my health insurance company.
- I accept that I am responsible for obtaining and providing any required medical referrals. It is my responsibility to meet the referral requirements of my insurance provider.
- I accept full responsibility for the payment due on services that are provided during any period when a referral is not active and/or expired.
- I accept full responsibility for the fees associated with missed appointments and/or late cancellations. (**The full-service fee will be charged for no-show appointments, and a partial payment will be charged for appointments cancelled with late notice less than 24 hrs)**.
- I accept that no Corporate Wellness Contract or health insurance plan can be utilized to cover the fees associated with missed or late cancellations.
- I accept full 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.
- I accept the responsibility to immediately update The Wellness Centre of any changes to the credit/debit card associated with my payments.
- I accept the responsibility to immediately update The Wellness Centre of any changes in physical/billing address and contact information

The Wellness Centre, Smith Road Centre, 3rd Floor, 150 Smith Road, George Town
P.O. Box 10462, KY1-1004

- I accept the responsibility to ensure that any **direct bank transfers** are made accurately and in a timely manner, to ensure The Wellness Centre is in receipt of funds on their respective due date.
- I accept that 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.
- I accept that I am expressly waiving 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.
- I accept that this Financial Responsibility Agreement 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 agreement signed.

All invoices/receipts are presented in **Cayman Islands Dollars** and payments by USD cash, credit/debit cards, and wire transfers are accepted at the exchange rate of 0.80. **Services may be suspended if your account is more than 30 days in arrears.**

PAYMENT DETAILS

DIRECT DEPOSIT / ELECTRONIC FUND TRANSFER: When making an online or direct deposit please ensure the CLIENT's name is noted in the narration/memo so that the deposit can be accurately applied to the account.
Bank: Cayman National Bank | **Branch**: Elgin Avenue
Account Name: The Wellness Centre Ltd.
Account Type: KYD Chequing
Account Number: 011-09070

CREDIT CARD AUTHORIZATION: I authorize The Wellness Centre to charge a credit/debit card for service fees delivered.

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

I have read, understand, and my signature below indicates my agreement with the above policies.

Print Name		
Signature		
Date		

The Wellness Centre, Smith Road Centre, 3rd Floor, 150 Smith Road, George Town
P.O. Box 10462, KY1-1004

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 list 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	☐ Medication Mgmt.	☐ Medical Reports
☐ Treatment Plan	☐ Drug/Alcohol Testing	☐ Legal Consultation
☐ Diagnosis/analysis	☐ Work/School Performance	☐ Case Notes
☐ Psychological Reports	☐ Case Management	☐ 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:_____

The Wellness Centre, Smith Road Centre, 3rd Floor, 150 Smith Road, George Town
P.O. Box 10462, KY1-1004