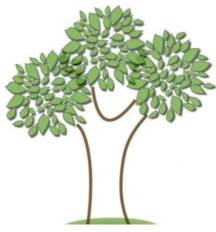

Weigel Counseling Associates

2819 Willow Street Pike, Suite N, Willow Street, PA 17584
Phone: 717-464-1450 Fax: 717-464-0890

INTAKE PACKET

Part 1: Basic Information (about whomever is receiving services)

Name: ________________________________ Pronouns: _____________ DOB: _____________

Legal Name on Insurance Card (if different): ____

Address: _________________________________ City/State/Zip: _________________________

Phone: (_______) _______-__________ Email: ____

SS number: _______-_______-_________ Gender (as recognized by insurance co): ____________

Referral Source: _______________________ Employer: _________________________________

Primary Care Physician/Practice: ____

Part 2: Insurance Information

Primary Insurance Co: ____

Insurance ID #: ___________________________ Insurance Group #: ______________________

EAP Name (if applicable): ____________________________________ EAP # of Sessions: ______

Secondary Ins Info (if applicable): ____

Part 3: Information about Insurance Policy Holder

Is the insurance policy holder the one receiving services? Circle one.

YES (skip to Part 4.1) NO

Name: ________________________________ Pronouns: _____________ DOB: _____________

Legal Name on Insurance Card (if different): ____

Address: _________________________________ City/State/Zip: _________________________

Phone: (_______) _______-__________ Email: ____

SS number: _______-_______-_________ Gender (as recognized by insurance co): ____________

Relation:________________ Employer: ____

Part 4: Family Information

4.1. Information about Spouse/Partner (if applicable)

Name: ______________________________ Pronouns: _____________ DOB: _____________

Address: _______________________________ City/State/Zip: ________________________

Phone: (_______) _______-__________ Email: ____

SS number: _______-_______-_________ Employer/School: _____________________________

4.2. Information about Family (skip if client is at least 18 years old)

Parent Information

Name: _____________________________	Name: ____________________________
Address: ___________________________	Address (if different): ________________
City/State/ZIP: _____________________	City/State/ZIP: ______________________
DOB: ______________________________	DOB: _______________________________
SS#: ________-________-______________	SS#: ________-________-______________
Employer: _________________________	Employer: __________________________
Step Parent: _____________________	Step Parent: ________________________

Name/Age of Children or Siblings: ____

____

Part 5: Office Policies and Consent

Please read the following pages carefully. Initial at the bottom of this page and sign at the bottom of page three, indicating your consent to treatment under these conditions. If you do not initial and sign we cannot treat you.

APPOINTMENTS: Appointments are scheduled in advance with efforts made to agree upon mutually convenient times and places. In the event or need to cancel or reschedule an appointment, please notify the therapist as soon as possible so the appointment can be offered to someone else. No charges will be made for cancellations that allow ample time for the therapist to reschedule the appointment. At the discretion of the therapist, charges will be incurred for missed sessions.

Initials of Responsible Person:__________

FEES

* 60 Minute Counseling Session: $135
* 45 Minute Counseling Session: $120
* 30 Minute Counseling Session: $70
* Family Counseling Session: $135
* Initial Counseling Session: $145
* AD/HD Psycho-social Evaluation: $200
* AD/HD Full Evaluation: TBD
* Interactive Services: $35 (per quarter hour)
* Co-Parenting Counseling Session: $150
* Psychological Evaluation: TBD

The services of Transworld Systems are used for any unpaid balances (collection fees will be applied at the time and need for this action). Fees and co-pays are expected at the time of the service. Cash and checks are preferred with checks payable to Weigel Counseling Associates.

HEALTH INSURANCE: Weigel Counseling Associates accepts most health insurance benefits. Please be aware of the terms of your specific plans and be prepared to provide all necessary information for the timely filing of the claims. Each client is ultimately responsible for the payment or non-payment of service fees.

CONFIDENTIALITY: All psychological services are legally regarded as privileged communication between a person and their therapist. The person holds the privilege of maintaining this confidence (the age of consent is 14). In order for the therapist to release any information about a personal situation or presence in therapy, a consent must be signed by the person (parent or legal guardian for those younger than 14). The exception to this, as defined by law, is in the case of suspected child abuse or potential danger to others or self. In such cases, notification to the proper authorities will be made.

EMERGENCIES: Due to the nature of private outpatient therapy, there may be times when therapists are not easily available. Each therapist has a system for after-hours needs, which can be accessed through their voicemail system. Please be sure to have your therapist's contact information. If you are experiencing an emergency, please contact Lancaster County Crisis Intervention at 717-394-2631 or call 911.

CONSENT TO USE/DISCLOSE HEALTH INFORMATION: This form is an agreement between you and Weigel Counseling Associates. When we diagnose, evaluate, treat, or refer you we will be collecting what is legally referred to as Protected Health Information (PHI) about you. We need this information to decide what treatment is best for you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it and we will comply with your wishes about using or sharing your information from that time on, even though we may have already shared some of your information.

I certify that the above information is true. I agree to receive services with Weigel Counseling Associates under the above policies and consent to the above conditions.

Signature of Responsible Person: ____________________________________ Date: ________________

Weigel Counseling Associates Telehealth Form

This section (two pages) must be completed prior to any telehealth sessions.

Part One: Telehealth Crisis Plan

Weigel Counseling Associates Therapists has determined that telehealth services are clinically necessary. The following plan will be followed:

Name: ____ DOB: ________________________

Phone Number: _______________________ Email Address: _______________________________________

Crisis Plan

Therapist will attempt to contact the client via the phone number provided above. If the therapist is unable to reach the client, the therapist will contact the above listed emergency contacts. Therapist and client will review the immediate concern and determine if a session needs to be scheduled, crisis intervention needs to be called, a visit to the emergency room is necessary, or 911 needs to be called.

Therapist will contact 911 when one or more of the following events have occurred:

- Client disconnects session and does not respond to therapist's attempts to communicate
- Therapist is unable to establish contact with emergency contact(s)
- Therapist establishes communication with emergency contact but emergency contact is unable to determine the safety of the client
- Any other time in which the therapist feels that the client is at risk

Comments and additions to crisis plan (if necessary): ____

____

____

Emergency Contacts - Personal Relations - Must identify at least 1 contact

Name: _________________________________ Phone Number: ______________ Relation: _____________

Name: _________________________________ Phone Number: ______________ Relation: _____________

Emergency Contacts - Professional Resources

Therapist Phone Number: _______________________ Suicide and Crisis Lifeline:_____________________

Crisis Intervention County:___________________ Crisis Intervention Phone Number:__________________

Other Resources:____

Signature of Responsible Person: _____________________________________ **Date:** ________________

Signature of Therapist: ____ **Date:** ________________

(please read and sign next page)

Telehealth Form Part Two: Telehealth Terms and Conditions

Telehealth services involve the delivery of health care services using electronic communications, information technology or other means between a health care provider at Weigel Counseling Associates and a client who are not in the same physical location. Telehealth provided at Weigel Counseling Associates is performed using HIPAA compliant software. Our providers will utilize this software to communicate with their clients via video to conduct therapy sessions including but not limited to diagnosis, treatment, follow-up and/or education.

Important Information:

- The client must have access to a webcam and/or smartphone to utilize such service.
- The client must use a secure internet connection rather than public/free Wi-Fi.
- It is important for the client to be in a quiet, private space that is free from distractions.
- It is important to be on time. If you need to cancel or reschedule your session, please notify your provider in advance. You may be charged a no-show fee for a missed telehealth session.
- In the event of technical issues, your provider will contact you by phone to discuss next steps, including rescheduling or attempting to solve the technical issues. Providers may also contact WCA staff for technical assistance when necessary.

By accepting this consent to Telehealth services, you acknowledge your understanding and agreement to the following:

- I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to telehealth services.
- I agree to complete any and all additional paperwork as necessary or required by Weigel Counseling Associates, my insurance company, and/or my employee assistance program (EAP).
- I agree and authorize Weigel Counseling Associates and my provider to share information regarding my telehealth appointment with my insurance company or employee assistance program (EAP) for payment of services.
- I understand that my provider may determine that my condition is not suitable for treatment using telehealth and that I may need to seek treatment in person or from an alternative source.
- I have read the consent to telehealth services and have discussed this with my provider. All of my questions have been answered and I give my informed consent for use of such services.

Signature of Responsible Person: ____________________________________ Date: ________________