Wendy Iglehart, MA, LCPC, LLC
443-824-0222
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New Patient Information

Patient's Name: _____

Date of Intake: _____

Address: _____

Email: _____

Date of Birth: _____ Age: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Referred By: _____

Previous Mental Health Treatment: _____

_____

Primary Care Physician & Last Date of Physical: _____

Phone of PCP: _____

Allergies, serious accidents, illnesses, or hospitalizations: _____

_____

Medications: _____

Emergency Contact Information:

Name: _____

Phone Number: _____

Revised 9/2022

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Welcome Packet and Contract

Welcome to my practice. This document contains important information about the services and business policies. Please read this carefully and ask any questions you might have. When you sign this document, it will represent an agreement between us.

Psychotherapy Services

Psychotherapy varies depending on the personalities of the therapist and the client and the particular problems you bring forward. I will utilize many different approaches to deal with the problems that you hope to address. You play an active role in the therapy process with the commitment of time and energy.

There are benefits and risks in participating in psychotherapy. You could experience uncomfortable feelings like sadness, guilt, anger, and so on while discussing difficult or unpleasant aspects of your life or situation. On the other hand, psychotherapy has also been shown to have benefits for those who go through it successfully. It could lead to better relationships, a reduction in feelings of distress, and solutions to specific problems.

The first few sessions will involve an evaluation of your needs and determining how we work together. After the initial interview, I will provide you with some first impressions of what our work will include and treatment goals. During our time together, I will keep you informed of the progress and process of our work.

(Occasionally, I could provide a referral which is given with best intentions. However, I am not liable for outcome of referral.)

Telehealth Therapy

Telehealth therapy is the use of electronic information and communication technology to deliver services when the patient is located at a different site than the provider. I can provide this service only in Maryland as governed by state law. Overwhelming or potentially dangerous challenges are best met with face to face support and telehealth therapy does **not** provide emergency services. Therefore, I reserve the right to recommend face to face service should I deem appropriate.

The benefits of telehealth are: 1) improved access, 2) saved time, 3) convenience, 4) provided comfort reducing stigma, and 5) reduced cost such as childcare or missed work. The risks could include disrupted or distorted technical failures and transmission of your medical information could be interrupted by unauthorized persons. You are responsible for information security on your computer and being in a private location as to avoid the

risk of being overhead by anyone near you or being interrupted. If you elect to use telehealth services, you will be required to execute a separate consent to such services.

Couple Psychotherapy

Information discussed in couple therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. By signing the contract, it is agreed upon that I will not be subpoenaed for or against either party or to provide records in a court action. There will be times when I may appear on either person's side, but it is really on the side of the relationship and/or marriage. If the relationship terminates and either or both of you wish to re-contract with me for individual psychotherapy, the decision with whom I continue working is at my discretion. In some circumstances, a referral will be made. If I see either member of the couple for individual sessions during couple treatment, secrets will not be kept, and I reserve the right to pass on information that furthers therapeutic goals.

Meetings

I recommend weekly sessions, which are usually 55-minute durations. We will determine the length of treatment depending upon the situation and problems that need to be addressed. Once the appointment is scheduled you will be expected to pay for the service unless you provide 24-hour advance notice of cancellation. Should you not show for an appointment or cancel without 24-hour notice, you will be charged the fee of the session, which will be due at the next scheduled session. Exceptions could be made for sudden illness, emergencies, or inclement weather. I will also try to find another time to reschedule the appointment during the week.

Professional Fees

My hourly fee varies depending on the type of service and the duration of the session.

Individual initial evaluation (90791), 55-minutes - $190.00
Individual session (90837), 55-minutes - $190.00

Couple/marriage/family initial evaluation (90791), 55-minutes - $260.00
Couple/marriage/family session (90847), 55-minutes - $260.00

Court fees, composing documents per hour - $400.00 (copies per page of records - $3.00)

Billing and Payments

You will be expected to pay for each session at the time of service it is held unless we agree otherwise. I will accept only accept credit cards. In circumstances of unusual financial hardship, I will be willing to negotiate a payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is the patient's name, the nature of service, and the amount due.

Insurance Reimbursement

You are responsible for reimbursement if you have mental health coverage. You must bring the forms for reimbursement, and I will complete the paperwork for you. However, I do not accept assignments and you must submit and collect benefits under your coverage from your insurance company. I will also provide receipts of services rendered.

Contacting Me

I am often not available by telephone when I am with a patient. Before or after hours, I will make every effort to return your call within 24 hours or same day apart from weekends and holidays. If you are difficult to reach, please inform me of times when you will be available. If you are unable to reach me and feel that your condition is such that you cannot wait for me to return your call, **contact your family physician; or contact the nearest emergency room and ask for the crisis counselor on call; or contact the Maryland Crisis Hotline at 1-800-422-0009 or the National Hotline 9-8-8**. *Although I have a business email address, the best way to contact me or leave a message is via my phone.* If I will be unavailable for an extended time, I will provide you with the name and number of a colleague to contact, if necessary.

Professional Records

The laws and standards require that I keep treatment records. You are entitled to receive a copy of your records or I can prepare a summary. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests. If you request a change in such records, I will determine whether to make such change in accordance with all applicable law.

Confidentiality

Precaution is taken in protecting confidentiality of visits, communication, and clinical records. I can release information about our work to others only with your written permission. To ensure quality of care, peer consultation may be obtained.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings, involving your emotional

condition, a judge may order records or my testimony if the judge determines that the issues demand it.

However, there are a few exceptions. In some situations, I am legally obligated to take action to protect you or others from harm. If I believe that a child, an elderly person (over the age of 65) or a disabled person is being abused who is under your care, I am required by law to file a report with the appropriate state agency. Also, if you have been physically or sexually abused in the past and the abuse had not been reported to the proper authorities, I must report even if the perpetrator is deceased.

If I believe that a client is threatening seriously bodily harm to another (including deliberate intent spread of HIV/AIDS), I may be required to take protective actions. These may involve notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself, I may be obligated to seek hospitalization for the patient, to contact a family member or others who can help provide protection.

I, the patient, have read, understand, and accept the above business policies, and agree to be responsible for all charges incurred. Furthermore, I, the patient, regarding telehealth therapy, agree that any dissemination of any personally identifiable images or information from the telehealth therapy interaction to any entities shall not occur without Wendy Iglehart, LCPC, LLC's written consent.

I, the patient, have been provided with a copy of the Notice of Privacy Practices of Wendy Iglehart, LCPC, LLC and have been given the right to review the Notice of Privacy Practices prior to signing this document.

I, the patient, consent to psychotherapy services and treatment for myself and have voluntarily {given}{not given} consent to the use and disclosure of my protected health information by Wendy Iglehart, LCPC, LLC for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct Wendy Iglehart's, LCPC, LLC health care operations.

_____ **(SEAL)** _____
Signature of Patient Date

_____
Printed Name of Patient

Informed Consent for Teletherapy Services

I hereby consent to engaging in distance counseling with WENDY IGLEHART, LLC, LCPC (the "**Practice**") and any of its providers as part of the treatments provided by the Practice. I understand that distance counseling includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Teletherapy means the use of interactive audio, video, or other telecommunications or electronic media by a counselor to deliver services. Teletherapy does not include an audio-only conversation between the therapist/medication prescriber(s) and the client, an electronic email message between the therapist/medication prescriber(s) and the client, or a text message or other type of message sent between the therapist/medication prescriber(s) and the client. Teletherapy services may be provided by the Practice using the following modalities: live video.

I understand that the inability to have direct, face-to-face communication between myself and the person providing services on behalf of the Practice (the "**Provider**") is a primary difference between teletherapy and direct in-person service delivery.

I understand that the Provider may determine that teletherapy is not clinically appropriate and request that a patient come for an in-person encounter. Please note that, despite safety precautions, face to face service can expose you to the risk of communicable diseases, including COVID-19, transmitted by other patients in the waiting room or by staff. By signing this contract, you agree to assume this risk.

I represent that at all times I engage in teletherapy services, I will be in the State of Maryland. I understand that I will have to confirm that I am the State of Maryland during each session, and that my session will be considered cancelled if I am not in the State of Maryland.

I understand that the Practice strongly recommends that I communicate only through a computer or device that I know is safe (e.g. has a firewall, anti-virus software installed, is password protected, and is not accessing the internet through a public wireless network).

I understand that I have the following rights with respect to distance treatment (please initial on each line provided):

— I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

— The laws that protect the confidentiality of my medical information also apply to distance treatment. As such, I understand that the information disclosed by me during the course of my treatment is treated the same way as my other confidential information. I also understand that the dissemination of any personally identifiable

images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

— I understand that there are risks and consequences from distance counseling, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by the Practice's use of a HIPAA-compliant service which is encrypted for video teletherapy communications. Further, the contents of the Practice's computers are encrypted. I understand that the Practice will timely inform me of any data breach and the steps the Practice is taking to remedy the problem.

— I understand that I may exclude anyone from any site during the teletherapy service.

— I understand that I may benefit from distance counseling, but that results cannot be guaranteed or assured.

I, the patient, authorize the Practice to record the teletherapy encounter and maintain and store the recording in accordance with medical retention requirements under state and federal law, if the Practice records the teletherapy encounter.

I, **the patient**, have read, understand, and accept the above business policies, and agree to be responsible for all charges incurred.

I, **the patient**, have been provided with a copy of the Practice's privacy policies and have been given the right to review the privacy policies prior to signing this document.

I, the patient, consent to **teletherapy** services and treatment for myself and have voluntarily given consent to the use and disclosure of my protected health information by the Practice for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the Practice's operations.

_____ (SEAL) _____

Signature of Patient Date

_____

Printed Name of Patient