WATER'S EDGE
PSYCHOTHERAPY & WELLNESS CENTER

47 Maple Street, Suite 330
Burlington VT 05401

REGISTRATION FORM

Client Name: ____ Date of Birth: ______/______/______ M/F

Address: ____ Social Security Number: ______-_____-________

(Street)

Address:____ Email Address_____________________________

(City/State/Zip)

Home Phone: (______)________-___________ Cell Phone: (______)________-___________

Work Phone: (______)________-___________ Can we leave a message at any of these numbers? H C W (circle)

Primary Care Physician: _______________________________ Phone number: (______)_______-___________

Name of Guardian/Parent (if applicable): _______________________________

Emergency contact: _______________________________ Phone: (___) ______ - ________

How did you hear about our practice? ____

FIRST INSURANCE INFORMATION

Plan Name: ____________________________________ I.D. Number: ________________________________

Co-pay amount $_________ HSA? yes/no (circle one) High-deductible? yes/no (circle one)

Address: ____ Group Number: ________________________

Policy Holder: _______________________________________ Effective Date: _________________________

Policy Holder's Social Security #: _______-______-_________ Policy Holder's Date of Birth: ______/______/______

SECOND INSURANCE INFORMATION

Plan Name: ____________________________________ I.D. Number: _______________________________

Policy Holder: ____________________________ Co-pay amount $_______ Group Number: ______________

Policy Holder's Social Security #: ______-______-_________ _ Policy Holder's Date of Birth: ______/______/______

PERSON RESPONSIBLE FOR BILL

Guarantor Name: _________________________________ Date of Birth: ______/______/_____

Relationship to Client: (check one): ( ) self, ( ) spouse, or ( ) parent/guardian Phone Number: (___) ______________

Address (if different from client): ____

(Street) (City/State/Zip)

Signature: ____

PERSON(S) WHO HAVE LEGAL CUSTODY

Name(s)____

Signature: ____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Water's Edge Psychotherapy. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: ____ Date: ______/______/______

Therapist_________________________ DX:____________________ 1st Date of Service: ______/______/______

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Adult Intake

Client Name: ____ Date of Birth: _______/_______/_______

Relationship Status: ( ) Single ( ) Married ( ) Civil Union ( ) Divorced ( ) Domestic Partner ( ) Other

Occupation:___________________________ Education:_____________________ Religion:__________________

Are you a veteran? ( ) yes ( ) no Dates of service___________________________ Are you retired? ( ) yes ( ) no

Are you a full-time student? ( ) yes ( ) no School:____

Members in present Household	Relationship to you	Age	Sex	Occupation

Other family members	Relationship to you	Age	Sex	Occupation	Location

Have you **or** someone significant in your life had any problems with the following areas?

	Who? (*i.e. Self*)	When?
Marital		
Relationship		
Family		
Children		
Employment		
School		
Financial		
Legal		
Death		
Pregnancy/miscarriage		
Abortion		
Physical/sexual abuse		
Changes in living situation		
Experiences you cannot explain		
Feelings difficult to handle		
Alcohol/drugs		
Depression/anxiety		
Trauma		
Eating disorder		

What is your primary care physician's name? ____

When was your last physical? _____________________________________ Where?_____________________________

Client Name: ____ Date of Birth: ______/______/______

Presenting problem____
____
____

History of presenting problem ____
____
____

Reasons for seeking therapy now?____
____
____

What are your strengths/supports for handling this problem?______________________________________
____
____

Current suicidal thoughts ( ) yes ( ) no plan ( ) yes ( ) no attempts ( ) yes ( ) no self harm ( ) yes ( ) no

History of suicide attempts or self harm ____

Explain____

Previous Therapy: Include outpatient treatment, psychiatric hospitalization, dates, therapist names, and reasons
____
____
____

Significant Medical Information: List any major medical problems, indicting hospitalization and dates of treatment
____
____

Current health problems____

Medication (over the counter/prescribed)	Dosage	Reason	Effect	MD

Allergies current/past____ Drug allergies_______________________

Tobacco use: ______________________________ How much:_________________ How often:_________________

Caffeine intake ____________________________ How much:_________________ How often:_________________

Alcohol use:_______________________________ How much:_________________ How often:_________________

Drug use:_________________________________ How much:_________________ How often:_________________

Does someone significant in your life drink/use drugs? What ______________________________________

How much:______________________________________ How often: ______________________________________

Client Name: ____ Date of Birth: ______/______/______

Family and Social History

Members in house you grew up in	Relationship to you	Age	Occupation	Location

Where did you grow up? ____

Has any member of your family had a serious medical problem?

Family Member	Problem

Has any member of your family had a serious emotional problem?

	Family Member	Problem
Depression		
Anxiety		
Anger, violence, legal		
Physical, sexual abuse		
Substance abuse		
Suicide		
Divorce		
Other problems		

Difficulties in your family growing up ____

____

Key events or longer term experiences that have had a significant impact on your life__________________________

____

____

Current relationship with family members____

____

Emergency Contact Information

Name____ Relationship____________________________

Address________________________________ City____________________ State______ Zip____________

Home Phone (______)______-________ Cell Phone (______)______-________ Work (______)______-________

Welcome to Water's Edge Psychotherapy & Wellness Center

This information described below is offered to anticipate the most frequently asked questions about our professional services and business practice. Pleaser read carefully. If you have questions, it is important that you clarify them with your therapist prior to signing.

Appointment & Fees: Therapy sessions are 50-60 minutes. This time is set aside specifically for you. In the event that you must cancel your appointment, please call your therapist at least 24 hours in advance. Failure to give adequate notice will result in you being billed our full appointment fee of $135 (excluding Medicaid covered clients). Insurance companies can not be billed, nor will they reimburse for this cost.

PLEASE NOTE THE FOLLOWING LIST OF OUR PROFESSIONAL FEES
1st Session $150, Follow-up Sessions $135; Group Sessions-$60

Miscellaneous Service Charges: Please be advised that therapists time spent on client-related professional services outside of the therapy session are not billable to insurance. These services include, but are not limited to report others exceeding 15 minutes; face to face consultations with others such as attending school IEP meetings (exceeding 15 minutes), etc. Utilizing the above rates as a guide, this time is billed directly to the client and is pro-rated in quarter hour units (with the minimum of 15 minutes) charged at the quarter hour rate. *This excludes time spent writing customary treatment plans or other similarly related paperwork required by insurance.*

Confidentiality: Privacy and confidentiality are important to the relationship between client and therapists. There is legal and ethical protection for the information that you share with your therapist and it cannot be released without your express written consent. This also covers our written record. There are also expectations to privacy/confidentiality which may include, but are not limited to: when Water's Edge clinicians provide collegial case coverage and case consultation; when there is reason to believe that you intend to harm yourself or another person; when a child, elder or disabled adult has been or might be abused or neglected; or if information has been requested by court order. Additionally, in the even that your therapist is unavailable, a colleague will be covering. If you have any questions about confidentiality, please raise them with your therapist.

Confidentiality and Insurance Companies: If you will be using benefits under a managed care plan including Medicaid, Water's Edge Psychotherapy may be required to provide information related to your case to the managed care reviewer and your primary care physician, in writing and verbally. Water's Edge will follow these procedures unless otherwise notified by you in writing.

If your insurance coverage changes, you are responsible for notifying Water's Edge of the change.
You are ultimately responsible for fees not covered by insurance.

Consent for Treatment: I voluntarily consent to clinical evaluation/treatment for myself or my minor child. I understand that there are both benefits and risks involved with engaging in psychotherapy that there are no guarantees about the outcome.

My signature below indicates that I have had the opportunity to ask and have my questions answered about the above information and I have read, understand and agree to abide by all of the about outlined terms.

Signature ______________________________ ______________________________ Date____________
Print Name of Client Client Signature

Signature ______________________________ ______________________________ Date____________
Print Name of Client Client Signature

Witness Signature ___________________________ ___________________________ Date__________
Print Name of Client Client Signature

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wackerman1@comcast.net

Linda Wackerman
LICSW

Education

M.S.W.	Boston University	Boston, MA	1982
B.A.	University of Vermont	Burlington, VT	1977

Professional Licensure

Licensed Independent Social Worker

State of Vermont #089-0072560	2010
State of Washington #LW 00006726	2001

Licensed Marriage and Family Therapist

State of Washington #LF00001668	2001

Professional Memberships

National Association of Social Workers
American Association of Marriage & Family Therapy
International Academy of Eating Disorders

Specialties

Individual and Family Therapy
Couples and Group Therapy
Children, Adolescents, College Students
Parenting Consultations
Eating Disorders Treatment
Women's and Relationship Issues
Anxiety, Depression, Grief, Stress, Transitions, Trauma
Supervision/Case Consultation

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DISCLOSURE OF INFORMATION

In this packet is the following information:

1. Professional qualifications and experiences for Linda Wackerman, Licensed Independent, Clinical Social Worker.

2. A list of actions that constitute unprofessional conduct according to Vermont statues.

3. The methods for making a consumer inquiry or filing a complaint with the Office of Professional Regulations.

4. Notice of Mental Health Policies and Practices to Protect the Privacy of Your Health Information.

My signature acknowledges that I have been given the professional qualifications and experiences of Linda Wackerman, L.I.C.S.W., a listing of actions that constitutes unprofessional conduct according to Vermont statues, and the methods for making a consumer inquiry or filing a complain with the Office of Regulations.

My signature below acknowledges that I have received the "Notice of Mental Health Policies and Practices to Protect the Privacy of Your Health Information" from Water's Edge Psychotherapy & Wellness Center.

Any questions that I have regarding this information have been asked and answered by my therapist.

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent or Guardian Signature (if applicable) Date

______________________________ ______________
Witness Signature Date

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Primary Care Physician Consent Form

Communication with your primary care provider (PCP) can be important to make sure all care is complete and well coordinated. This form allows for that exchange of information. We do not release information without your signed authorization.

Name ____________ SS Number or ID Number ____________ D.O.B ___/___/___

Insurance ____________ First Date of Service ____________

Name of Physician ____________ Facility/Practice Address ____________

Phone Number ____________ Fax Number ____________

I, ____________
(PRINT Name of Patient/Client)

Client Please Check One:

- ☐ Do **NOT** release any applicable information to my primary care physician.
- ☐ Release applicable information to my primary care physician.

Signature of Client ____________ Date Signed ____________

OR

I/We, ____________ on behalf of, ____________
(PRINT Name of Parent(s)/Legal Guardian(s)) (PRINT Name of Child)

Parent or Legal Guardian Please Check One:

- ☐ Do **NOT** release applicable information to the child's primary care physician.
- ☐ Release applicable information to the child's primary care physician.

Signature of Parent or Legal Guardian ____________ Signature of Parent or Legal Guardian ____________ Date Signed ____________

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, 45 C.F.R. parts 160 & 164 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), and any further disclosure for the purpose of treatment, payment, or health care operations, if permitted by state law. I understand that I may be denied services if I refuse to consent to a disclosure for other purposes. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I also understand that I may revoke this consent at any time by notifying the provider in writing (except to the extent that action has already been taken in reliance on it). This release will automatically expires twelve months from the date signed below or upon the date specified here.

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TELE-HEALTH CONSENT FORM

I consent to the following parameters regarding participation in tele-therapy with Linda Wackerman from Waters Edge Psycotherapy. Ms. Wackerman and I have discussed these. I understand that I can discontinue tele-therapy at any time, with simple notification to Ms. Luce.

1. In practicing tele-therapy, Ms. Wackerman shall comply with all the rules of professional conduct and with requirements incurred in state and federal statutes relevant to the practice of psychology.
2. The client and Ms. Wackerman have agreed that tele-therapy is the most appropriate method to conduct therapy given the following specific limitations for practicing psychotherapy in office.
3. Ms. Wackerman has determined that the condition being diagnosed and/or being treated is appropriate for tele-therapy.
4. The tele-therapy will be conducted using a video-conferencing platform that is encrypted in order to protect the client's privacy. It is possible that client privacy may be compromised if the video-conferencing platform is compromised, an event out of the control of Ms. Wackerman.
5. If the client requires urgent contact with Ms. Wackerman, the client will contact Ms. Wackerman through phone numbers provided rather than the video-conferencing platform.
6. If the client experiences a life-threatening emergency, the patient will contact emergency services or go to the nearest hospital emergency department.
7. The client's clinical file will be kept secure and separate from the video-conferencing program.
8. My signature allows Ms. Wackerman to bill my insurance when appropriate for tele-therapy.
9. I understand that text messaging is only for making or cancelling appointments.

Client signature__________________________________Date___________________________

Client printed name___________________________ Therapist__________________________