Three Oaks Wellness
PLLC

NEW CLIENT INTAKE PACKET

Insurance Information

This information must be obtained prior to your initial appointment.

When calling your insurance company, please specify that you are requesting information regarding your **outpatient mental health benefits**.

Insurance Carrier: _____

Member ID #: _____ **Group #**: _____

Insurance Contact Number: _____

Questions to Ask

- Is telehealth covered? □ Yes □ No
- Is preauthorization required? □ Yes □ No
    - Authorization #: _____
- Do I have an annual deductible? □ Yes □ No
    - Deductible Amount: $_____
- Have I met my deductible? □ Yes □ No
    - Remaining Amount: $_____
- Copay Amount: $_____
- Coinsurance Amount: _____%
- Number of sessions covered: _____

- Is coverage based on a calendar year or plan year?
- Does my provider need to submit treatment requests? □ Yes □ No

- Electronic Payer ID (if available): _____

Claims Address: _____

Today's Date: _____

Three Oaks Wellness
PLLC

REGISTRATION FORM

Client Full Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Sex: _____ Age: _____

Date of Birth: _____

Email Address: _____

Preferred Contact Method: □ Phone □ Email □ Text Message

Employer/School: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact

Name:
_____

Relationship to Client: _____

Phone Number: _____

Insured/Responsible Party Information

Name of Insured: _____ Relationship to Client:_____

DOB: _____ Social Security Number: _____

Home Address: _____

Phone Number: _____

Three Oaks Wellness
PLLC

Employer Name: _____

Primary Insurance Company: _____

Member ID: _____

Group Number: _____

Secondary Insurance Company: _____

Member ID: _____

Group Number: _____

BILLING, PAYMENT, AND CANCELLATION POLICY

By signing below, I acknowledge the following:

1. I authorize Three Oaks Wellness, PLLC to submit insurance claims on my behalf.
2. I authorize release of information necessary to process insurance claims.
3. I understand I am ultimately responsible for payment of services rendered.
4. I authorize insurance benefits to be paid directly to Three Oaks Wellness, PLLC.
5. I understand I am responsible for deductibles, copays, coinsurance, and non-covered services.
6. I authorize a copy of this form to be used in place of an original.

• It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance at the time of services rendered.

• There will be a $30 service charge on all returned checks.

• In the event that your account goes to collections, there will be a 25% collection fee added to your balance.

• There is a 24-hourcancellation policy that requires that you cancel your appointment 24 hours in advance to avoid being charged. Cancellations may be made by phone or email.

There is a $100 out-of-pocket expense for late cancellations or missed appointments.

Three Oaks Wellness
PLLC

I understand and accept all of the terms regarding billing, insurance, and cancellation policies.

Signature: _____ Date: _____

Three Oaks Wellness
PLLC

TELEHEALTH INFORMED CONSENT

Three Oaks Wellness, PLLC offers secure telehealth services through **SimplePractice**, a HIPAA-compliant platform approved by insurance companies.

Call your insurance company and verify Telehealth is covered as part of your Outpatient Mental Health Benefits. Your insurance will automatically be billed for these services. ***Should this not be verified and a claim is denied, you will be responsible for paying for this service in full, out of pocket.***

Telehealth is available to Three Oaks Wellness clients. The telehealth option will/can be used in the following circumstances:

- Contagious Illness: Should you, your child, or the therapist not feel well and are unable to attend the session in person.
- Inclement Weather
- Scheduling conflicts: If an appointment reschedule occurs at a time your therapist does not have access to office space.
- Preferred method to conduct session.

Risks of Telehealth

Potential risks may include:

- Technology interruptions
- Internet connection failures
- Potential limitations in observing non-verbal communication

Client Responsibilities

I agree to:

- Participate from a private location whenever possible
- Use secure internet access
- Inform my therapist if someone else is present
- Maintain updated contact and emergency information

Telehealth sessions will be conducted by a Three Oaks Wellness, PLLC therapist in a private area to maintain your confidentiality.

Three Oaks Wellness
PLLC

Telehealth is being offered as a viable and secure option to keep your scheduled appointment in the event of unforeseen circumstances. Should telehealth be covered by your insurance company and you choose to voluntarily opt-out of this service; it will be treated as a Missed Appointment and the $100 out of pocket Missed Appointment fee will apply.

I understand and accept all the terms regarding telehealth billing, insurance, opt-out and cancellation.

Responsible Party Signature: _____

Date: _____

Three Oaks
Wellness
PLLC

Emergencies

Telehealth is not appropriate for crisis situations. If experiencing a mental health emergency:

Call 911

Go to the nearest emergency room

Suicide & Crisis Lifeline
Call or text 988

Fairfax-Falls Church Community Services Board Emergency Services
703-573-5679 (24 hours)

Fairfax Detoxification Center
703-502-7000

Crisis Text Line
Text HOME to 741741

Responsible Party Signature: _____

Date: _____

Three Oaks Wellness PLLC

CREDIT CARD POLICY & AUTHORIZATION FORM

Three Oaks Wellness, PLLC requires a valid credit or debit card to remain on file. This card will be used for session fees as well as balances due. Card on file may be charged for:

- Copayments
- Deductibles
- Coinsurance balances
- Self-pay session fees
- Late cancellation/no-show fees
- Professional service fees authorized by the client

I authorize Three Oaks Wellness, PLLC to securely maintain my payment information and charge fees consistent with office policies.

Responsible Party Signature: _____ Date: _____

PAYMENT INFORMATION

Cardholder Name: _____

Card Type: □ Visa □ Mastercard □ Discover □ American Express

Billing Address: _____

City: _____ State: _____Zip:_____

Card Number: _____

Expiration Date: _____ CVV: _____

Signature:_____

Date: _____

Three Oaks Wellness
PLLC

CLIENT HISTORY & SELF-ASSESSMENT QUESTIONNAIRE

Client Name: _____ Age: _____ Marital Status: _____

Date Completed: _____

PRESENTING CONCERNS

What brings you to counseling at this time?

_____

_____

_____

What are your primary treatment goals?

_____

_____

_____

_____

CURRENT SYMPTOMS

Please check any symptoms you have experienced and indicate how long they have been present.

Anxiety/Worry	☐	
Panic Attacks	☐	
Excessive Fear	☐	
Nervousness	☐	

Restlessness	☐	
Racing Thoughts	☐	
Difficulty Relaxing	☐	
Depression	☐	
Sadness	☐	



Three Oaks Wellness

PLLC

Crying Spells	☐	
Hopelessness	☐	
Low Motivation	☐	
Feelings of Worthlessness	☐	
Guilt	☐	
Mood Swings	☐	
Irritability	☐	
Anger Outbursts	☐	
Difficulty Concentrating	☐	
ADHD Symptoms	☐	
Impulsivity	☐	
Memory Problems	☐	
Sleep Difficulties	☐	
Nightmares	☐	
Fatigue	☐	
Low Energy	☐	
Appetite Changes	☐	
Weight Changes	☐	
Social Withdrawal	☐	
Loneliness	☐	

Relationship Difficulties	☐	
Family Conflict	☐	
School Difficulties	☐	
Workplace Stress	☐	
Sexual Identity Concerns	☐	
Gender Identity Concerns	☐	
Grief or Loss	☐	
Trauma Symptoms	☐	
Flashbacks	☐	
Hypervigilance	☐	
Obsessive Thoughts	☐	
Compulsive Behaviors	☐	
Hearing Voices	☐	
Seeing Things Others Do Not See	☐	
Self-Harm Urges	☐	
Suicidal Thoughts	☐	
Homicidal Thoughts	☐	
Other	☐	



Three Oaks
Wellness
PLLC

SUICIDE / SELF-HARM RISK ASSESSMENT

Have you ever experienced thoughts of suicide? □ No □ Yes If yes, when?

Have you experienced suicidal thoughts within the past 30 days? □ No □ Yes

Have you ever attempted suicide? □ No □ Yes

If yes, please describe:

_____

_____

Have you ever engaged in self-harm (cutting, burning, scratching, etc.)?)? □ No □Yes

If yes, describe:

_____

Date of most recent incident:

_____

_____

HOMICIDAL THOUGHTS

Have you ever experienced thoughts of harming another person? □ No □ Yes

If yes, explain:

_____

Any history of aggressive behavior? □ No □ Yes

If yes, explain: _____



Three Oaks Wellness
PLLC

TRAUMA HISTORY

Have you experienced any of the following?

Type	Yes	No	Type	Yes	No
Physical Abuse	□	□	Serious Accident	□	□
Emotional Abuse	□	□	Natural Disaster	□	□
Sexual Abuse	□	□	Military Combat Exposure	□	□
Neglect	□	□	Bullying	□	□
Domestic Violence	□	□	Community Violence	□	□
Other Traumatic Event	□	□	Other Traumatic Event	□	□

If yes, please explain only to the extent you feel comfortable:

_____

_____

_____

SUBSTANCE USE HISTORY

Do you currently use alcohol? □ No □ Yes

Average number of drinks:

Per Week: _____

Per Month: _____

Age First Used Alcohol: _____

Have you ever felt your alcohol use was problematic? □ No □ Yes



Three Oaks Wellness
PLLC

CURRENT OR PAST SUBSTANCE USE

Substance	Never	Past	Current	Frequency
Alcohol	□	□	□	_____
Marijuana	□	□	□	_____
Cocaine	□	□	□	_____
Heroin	□	□	□	_____
Methamphetamine	□	□	□	_____
Prescription Pain Medication	□	□	□	_____
Benzodiazepines	□	□	□	_____
Hallucinogens	□	□	□	_____
Ecstasy/MDMA	□	□	□	_____
Nicotine/Tobacco	□	□	□	_____
Vaping	□	□	□	_____
Other	□	□	□	_____

Have you ever received substance abuse treatment? □ No □ Yes

If yes:



Three Oaks Wellness
PLLC

OTHER ADDICTIVE OR COMPULSIVE BEHAVIORS

Check any that apply:

□ Internet Use
□ Social Media
□ Gambling
□ Shopping/Spending
□ Pornography
□ Gaming
□ Exercise
□ Food/Binge Eating
□ Work
□ Other_____

Please describe any concerns:

_____

_____

_____

MEDICAL HISTORY

Primary Care Physician: _____

Current Medical Conditions:

□ None
□ High Blood Pressure
□ Diabetes
□ Thyroid Disorder
□ Chronic Pain
□ Migraines
□ Seizure Disorder
□ Heart Condition
□ Sleep Disorder
□ ADHD
□ Other
_____



Three Oaks Wellness
PLLC

Past Hospitalizations:

Past Surgeries:

Known Allergies:

CURRENT MEDICATIONS

MEDICATION	DOSE	REASON	START DATE	

MENTAL HEALTH HISTORY

Have you previously participated in counseling or therapy? □ No □ Yes

If yes:

Provider Name: _____

Approximate Dates:_____

Reason for Treatment: _____

Have you ever been psychiatrically hospitalized? □ No □ Yes

If yes: _____



Three Oaks Wellness
PLLC

FAMILY HISTORY

Who currently lives in your household? _____

_____

_____ Current Relationship Status:

_____

□ Single

□ Dating

□ Married

□ Separated

□ Divorced

□ Partnered

FAMILY MENTAL HEALTH HISTORY

Please identify family members who have experienced any of the following:

Depression		Substance Abuse	
Anxiety		Alcohol Abuse	
ADHD		Suicide Attempt	
Bipolar Disorder		Suicide Death	
PTSD		Schizophrenia	

LEGAL HISTORY

Any current legal involvement? □ No □ Yes

If yes: _____



Three Oaks
Wellness
PLLC

EDUCATIONAL / EMPLOYMENT HISTORY

Highest level of education completed: _____

Current School/Employer: _____

Any educational or occupational concerns? _____

SPIRITUAL / CULTURAL CONSIDERATIONS

Are spiritual, religious, cultural, or family beliefs important to your treatment? □ No □ Yes

If yes:

_____

_____

STRENGTHS

Share some personal strengths? _____

_____



Three Oaks
Wellness
PLLC

Outpatient Services Agreement

Welcome to our practice. This document contains important information about our professional services and the company's business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

THERAPEUTIC SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, you should always feel free to consult with another mental health professional.

CONTACTING US

Our telephone is answered by a voice service. Please leave a message with questions you have and/or requesting services. E-mail is used for scheduling purposes and can also expedite contact. If e-mail is not an option, we will make every effort to return your call on the same day you make

Initial_____

it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you are available. If you are unable to reach us and you feel that you can't wait for us to return your call, contact your family physician, psychiatrist, or the nearest emergency room.

SESSIONS

We normally conduct an evaluation that will last from 2-4 sessions. During this time, you and your therapist can both decide if he/she is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 60 minute session per week at a time we agree on. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless you and your therapist both agree that you were unable to attend due to circumstances beyond your control). The fee for missing a scheduled appointment is $100.

The $100 missed appointment/late cancellation fee is an out-of-pocket expense, it cannot be submitted to your insurance company. You are responsible for the full amount.

PROFESSIONAL FEE (EXCLUDING LEGAL FEES)

My Initial Appointment fee as a Licensed Clinical Social Worker (LCSW) is $200 and all subsequent appointments are $175. In addition to weekly appointments, we charge this amount for other professional services you may require, though we will break down the hourly cost in 15 minute increments if we work for periods of less than one hour. Other services include letter writing, clinical telephone conversations lasting longer than 5 minutes, other correspondence with professionals you have authorized, preparation of records, and the time spent performing any other service you may request of us.

BILLING AND PAYMENTS

You will be expected to pay for each session/co-pay on the day it occurs, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. You are required to have a current credit card on file for all balances. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a payment installation plan. If the installation plan is not adhered to, your credit card will be charged for the outstanding balance. If your account has not been paid and your credit card cannot be charged, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small

Initial:_____

claims court. If such legal action is necessary, those costs will be included in the claim. In the event that your account goes to collections, there will be a 25% collection fee added to your balance. In most collection situations, the only information we release regarding a client's treatment is his/her name, the nature of services provided and the amount due.

NSF FEE: There will be a $30 service charge on all returned checks.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be happy to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as a treatment plan or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. Once we have all of the information about your insurance

Initial: _____

coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you and your therapist feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above (unless prohibited by contract).

COURT TESTIMONY AND LEGAL FEES

We do not perform court-related evaluations for child custody nor do we testify in hearings involving child custody issues. In addition, we do not appear voluntarily at any court or administrative hearing. If you or your attorney chooses to subpoena Three Oaks Wellness, PLLC and/or its therapist, or other personnel for court testimony, including depositions or administrative hearings, you will be charged a flat non-refundable fee of $2500 pre-paid two (2) weeks in advance. In addition, you will be charged $300 per hour for any preparation time Three Oaks Wellness, PLLC personnel spend getting ready to appear, traveling to and from court, waiting to appear, and/or testifying. These charges will apply even if we are ultimately excused from testifying. By signing this agreement, you agree to pay these charges. Should it become necessary for Three Oaks Wellness, PLLC to commence collection proceedings or retain an attorney to collect any fees hereunder, you agree to pay any and all attorney's fees and costs incurred by Three Oaks Wellness, PLLC.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Patients will be charged a Professional fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to require an agreement from parents that they agree to give up access to your records. It is important for minors to have a trusting environment to increase the possibility of therapeutic effectiveness. **By signing the informed consent and by agreeing to undergo treatment it is understood that minors' records will be kept confidential, we will provide parents only with general information about our work together,**

Initial:_____

unless we feel there is a high risk that the minor will seriously harm himself/herself or someone else. In this case we will notify the parent/legal guardian of our concerns.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and therapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a person's treatment. For example if we believe a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

We may occasionally find it helpful to consult with other professionals about a case. During our consultation, we make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. We will be happy to discuss these issues with you, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

ETHICAL OBLIGATIONS

Should you attend your therapy session under the influence of any substance that would impair your ability to safely operate a motor vehicle and upon departure from Three Oaks Wellness, PLLC, you choose to do so against your therapist's advice; we have an ethical obligation to report this to the local authorities.

Your signature below indicates that you have read the information contained in Three Oaks

Initial: _____



Three Oaks
Wellness
PLLC

Wellness, PLLC's Outpatient Services Agreement and agree to abide by all of its terms during our professional relationship.

Signature of Patient: _____

Printed Name of Patient: _____

Date: _____

Signature of Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian:_____

Date: _____

Three Oaks
Wellness
PLLC

CONSENT

Please read Three Oaks Wellness, PLLC's Notice of Privacy Policies

Consent to use and disclose your health information

This form is an agreement between you,_____ and me/us, **Three Oaks Wellness, PLLC**. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment of other business or government functions.

By signing this form you are agreeing to let us use your information here. 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 do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share information and so may our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at (703) 261-9270, or in person from our privacy officer.



Three Oaks
Wellness
PLLC

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 (by writing a letter telling us you no longer consent) and we will comply with your wishes about using and sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Signature of client or his/her representative:_____ Date:_____

Printed name of client or personal representative:_____

Relationship to client:_____