Wellness Institute for *Self Enhancement*

Admission Packet

ADMISSIONS: General Information

Counseling Services include: individual, couples, family, and group counseling, intensive outpatient, and day programs. Regardless of the type of approach used, clients seen at the Wellness Institute for Self Enhancement are believed to possess resources and abilities to effect changes in their lives. Counselors, Dietitans and clinicians-in-training use a variety of theoretical approaches to assist clients in this process of growth. Some common approaches used in the treatment of mood, eating and related behavioral issues include dialectical behavioral therapy, exposure therapy, EMDR, psychodrama, existential approach, and acceptance and commitment therapy.

Behavioral therapy is an empirically-driven behavioral treatment that focuses on producing a change in behavior through applications of behavioral principles such as reinforcement, contingency management, and counter conditioning procedures.

Cognitive/behavior therapy is goal-focused and client-driven therapy that deals directly with client's presenting problems by addressing deficient or distorted thinking or behavioral responses. This form of therapy may include self-instruction/self-management, social problem-solving, perspective taking, affect labeling, or relaxation techniques. Focus is on conditions necessary for therapeutic change. The goal in resolving presenting problems as quickly as possible provides clients with access to skills and abilities that they possess to cope with future difficulties.

Group Counseling: WISE programs provide counseling and psychoeducational groups. These groups are provided depending on client/member need and staff expertise. Psychoeducational groups tend to involve structured group sessions with specific goals and objectives. The individuals in group are often assigned specific tasks to be completed either in group or outside of the session. Groups often use peer and group reinforcement as well as a group context in which to practice new skills.

Assessment services include intellectual and diagnostic tests, personality assessment, and behavioral assessments, and other forms of psychological evaluation. Some assessments are based on diagnostic interviews, while other assessments are based on standardized testing. Behavioral assessments may include observations, interviews, or structured interactions. Following are descriptions of types of assessments conducted in this program.

Psychoeducational assessment may include: (1) diagnostic measure, (2) an achievement measure, (3) structured personality measure, (4) a conference in which results are reviewed with client.

Personality/behavioral assessment includes: (1) client interview, (2) family interview, (3) self-report measure, (4) direct observation, (5) subjective personality measure.

Wellness Institute for *Self Enhancement*

CONFIDENTIALITY POLICY AND RELEASE OF INFORMATION FORMS

Client Confidentiality

Any person who comes to WISE for services is considered to be a member. Any persons, paid workers, volunteers, or students who work in the center must protect information learned about the member.

Protected Information Includes:

1. The fact that the person is, has been, or has never been a member.

2. Any information given to the center through administrative or clinical staff.

3. Any personal data about the member.

Two Categories of Protected Information:

1. The record - the actual member record and any computerized information about the member.

2. Informal information - any communication of a staff member about a member that is not a direct representation of the record.

It is the policy of WISE that all information regarding clients will be held in the strictest confidence. No information of any kind will be released to any external persons or agencies, by any staff, without proper authorization from the member and/or the legal guardian and authorization from the Director. **Such confidential information includes acknowledging that a person of a particular name or description is or has been a member.** Written consent of the client is required before information can be released to any third-party payor.

Confidentiality will be maintained in regard to clients, client contacts, and client records. Clients are not to be identified nor discussed with individuals, groups, or agencies not directly affiliated with WISE including spouses, relatives (except parents or legal guardians of minor clients), and friends of counselors and clients. To maintain confidentiality, it is important that members'/clients' names are not discussed in public or quasi-public places such as restaurants, hallways, or in public areas of the facility.

Release of Client Information. The content of the information released from our records to other agencies/persons may put the client at risk. For example, giving someone technical, medical/psychological diagnoses or treatment information regarding a client may not only be misused but may be misinterpreted and misunderstood. Any information leaving the facility must be considered in this light and may be tailored to the needs of the specific recipient.

Consent Form. The "Consent for Release of Information" form used by WISE is in compliance with all current applicable state and federal standards. It should, therefore, be accepted by any other agency from whom we request records. This form or its specific equivalent must be completed and received before any records or information are released to any other agency or person. Information will **not** be released when 1) a release is received which is incomplete, does not bear the client's original signature, does not conform to the standards set out below, or 2) when the form received is falsely signed or is known to be fraudulent in any manner. The staff must complete all necessary paperwork involved in sending or requesting client information.

Disclosure Without the Client's Consent. Disclosure to medical personnel is authorized without the consent of the client when and to the extent necessary to meet a bona fide medical emergency (i.e., when the life or health of a client may be endangered by an error in the manufacture or packaging of a drug, when the client is incapacitated and information concerning the treatment being given by a program is necessary to make a sound determination of emergency treatment needed, or for notification to family or others when the individual is suffering from a serious medical condition receiving treatment).

It is important to understand that confidentiality may be broken under the following conditions:

1.In cases where child or elder abuse or neglect (including sexual abuse) are suspected.

2.When a client threatens to harm her/himself.

3.If a client threatens to harm another person, reasonable care must be taken to protect the potential victim.

4.In case of a medical emergency, when transport of a client to a medical facility must be arranged, others would likely become aware that the client is receiving services at the facility.

5.If we receive a court order, we may be required to provide written or verbal information about the client's counseling.

6. Confidentiality cannot be guaranteed in the group setting. All clients and participants, by signing this form, agree to protect the confidentiality of all clients, including information that may be overheard, viewed, or otherwise received.

NOTE: CONFIDENTIALITY IS EVERYONE'S RESPONSIBILITY. BREACHES WILL NOT BE TOLERATED. A breach of confidentiality may result in your discharge from this program.

Participant/Client/Guardian Signature **Date**

Admission Counselor Signature **Date**

Wellness Institute for *Self Enhancement*

AUTHORITY TO RELEASE INFORMATION

I hereby consent to:

A. The exchange of information between _____
(Name of Agency/Individual)

and _____

(Name of Agency/Individual)

for the specific purpose of coordination of services and ongoing treatment.

B. The release of any and all information pertaining to my treatment from

_____
(Agency/Individual Releasing Information)

to _____ (Agency/Individual Receiving Information)

I specifically consent to release/obtain medical records and/or mental health information pertaining to:

☐ Evaluations ☐ Case Notes ☐ Records

☐ Prognosis and/or Recommendations ☐ Identifying Information

☐ Other_____

I understand that I that I may revoke this consent at any time except to the extent that action has been taken. I further understand that this consent will expire in one year and cannot be renewed without my written consent.

_____

Client Signature Date

_____

Parent/Guardian Signature **Date**

NOTE TO PROGRAM RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected. Statutes/regulations prohibit you from making further disclosure of it without specific consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Wellness Institute for *Self Enhancement*

WHO TO CONTACT IN A CLINICAL EMERGENCY

If an emergency arises, the instructor, the Clinical Director or a licensed faculty member must be notified immediately. WISE should have available the following information regarding the phone numbers of key persons to contact:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

INSTRUCTIONS FOR COMPLETING INFORMED CONSENT

In completing this consent form, attention should be given to the following:

1. When parents are being seen with a child, parents must sign forms. Children, however, should give "assent" both verbally and in writing.
2. When couples or families are being seen, each person must sign a consent form (As before, child clients may give their written assent).

COUNSELING INFORMED CONSENT

WISE is a teaching facility for the promotion of wellness and provision of services for related behavioral health issues. Clinical staff includes a psychologist, social worker, counselors, dietitians and dietitians/counselors-in-training.

Counseling and psycho-educational services are aimed at helping clarify, resolve, and/or prevent problems related to thoughts, feelings, and behaviors. Services may involve tolerating uncomfortable feelings, recalling unpleasant and painful memories, facing fears, anxiety, anger, and helplessness. Generally, services will not have more serious risks; we can discuss your reactions as we go along.

Services include, but are not limited to, equine-assisted therapy, exposure therapy, experiential therapy, and recreational therapy/activities. Clients and residents will be able to participate in these groups where indicated.

Further, by nature of being in a home-like environment, there are potential dangers. These include, but are not limited to, slips/falls, outdoor/indoor critters, kitchen/cooking accidents, and the general risks inherent in being alive.

Additionally, clients/members may participate in recreational activities such as yoga, jumping on trampoline, swings, dancing games and other potentially physical movement activities. Clients/members may also attend outings when appropriate. This will involve transportation typically provided by staff in a facility or staff member's vehicle.

Wellness Institute for *Self Enhancement*

"I _____ (client or guardian) acknowledge that I understand the scope of the program including the potential for risk that can occur from program participation. I understand there are inherent risks of participation, and the Wellness Institute for Self Enhancement is not liable for injury or death that may occur while involved in the program or at any time on premises or with staff on outings. The participant assumes the risks including, but not limited to, bodily injury or physical harm to participants and/or spectators. In consideration of the privilege of participating in services and activities at the Wellness Institute for Self Enhancement, located at 4409 Kelly Elliot Rd, Arlington, TX 76017, the undersigned does hereby agree to hold harmless and indemnify Project Bliss, Board of Directors, Administrative staff, Clinical staff, and ancillary staff at Project Bliss. I further release Project Bliss and associated staff from any responsibility for accident, damage, injury or illness to the undersigned or any family member or spectator accompanying the undersigned on this premises and agrees to pay all expenses and attorney fees incurred in defending such claims, unless resulting from willful misconduct or gross negligence."

Client/Guardian signature Date

Inherent in the treatment of a person with any disorder, which is a complicated medical and psychological illness, is the risk of worsening conditions and even death. Those admitted to participate in the programming at the Wellness Institute for Self Enhancement may be required to provide recent medical records that indicate the client/member is appropriate for this level of non-medical treatment.

By signing this form, you are relinquishing the Wellness Institute for Self Enhancement, including staff, members, and any associations from any responsibility for accident, damage, illness or injury (including death).

Client/Resident signature Date

Parent/Guardian signature Date

Wellness Institute for *Self Enhancement*

Confidentiality

The contents of your counseling sessions will be held in strictest confidence and will not be revealed to any person or agency **except** under the following circumstances:

1. If you (or, if you are a minor, your parents) give written permission to release information.

2. If you are involved in a medical emergency, information may be given to medical personnel.

3. If research, management audits, financial audits, or program evaluations are conducted, information may be revealed but you will not be identified directly or indirectly.

4. If an appropriate court order is received by the director of the center.

5. If you reveal information, which, in the counselor's judgment, indicates that you intend to harm yourself or someone else.

6. If you reveal information that indicates the existence of past or present child or elder abuse.

I have read and understood the above statements and I agree to the following:

1. Counseling groups are subject to limits of confidentiality. All participants must sign this form agreeing to maintain the confidentiality of the identities of and information about other group members.

2. Licensed clinical staff and clinicians-in-training may discuss all elements of any client/resident's treatment.

3. Information revealed during counseling sessions, test results, and/or treatment records will be held in strict confidence. These will not be shared with anyone without prior written consent, except in the circumstances described in items one through six above.

4. Testing may be conducted if my counselor and I determine that it would be helpful to me.

5. The case records maintained with regard to counseling will be kept in a confidential file. They will be destroyed five years after the termination of counseling.

Client's Signature Date

Parent's/Legal Guardian's Signature (If Appropriate) Date

Wellness Institute for *Self Enhancement*

Wellness Institute for Self Enhancement - TREATMENT SERVICES AGREEMENT

I, the undersigned, am availing myself of services as a client at WISE and understand that some these services are provided by interns, under supervision, while these students are being trained as dietitians, social workers, counselors and psychologists. It is further understood, that some of these interns are engaged in a program and that they may be at the facility for a limited amount of time.

I do hereby give my permission to the interns/clinical staff at WISE, working under supervision, to provide counseling services, to observe, test, and evaluate me, and, with my written permission, to report information obtained to appropriate providers, institutions and insurance companies.

I also hereby release and discharge WISE, interns and staff members of WISE, and any associated personnel or entities from all claims, demands, and causes of action, either legal or equitable, which may hereafter arise as a result of, or in relation to treatment, therapies, psychological assessment, reports, or interventions thereof. I further agree that I will not ask for or seek reports, personal appearances, or statements from counselor(s) or supervisors in connection with legal or court matters in which I may be involved.

I understand that I will be charged a fee for services received at WISE, and I am responsible for this fee. Fees will be provided upfront by the client according to normal rates. Any insurance participation will provide reimbursement to the client for all or part of services. All other clients will be charged on a sliding scale. There are separate fees for outpatient services provided. I further understand, that if necessary, a collection agency may be used to collect unpaid fees.

I have read the above and understand its contents and agree to the conditions stated herein.

_____

Client's signature Date

_____

Parent/Guardian (if client is a minor) Date

* Payment is required at the time of admission.

Wellness Institute for *Self Enhancement*

Request For Services Form (Adult)

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully. If you have any questions, please ask for assistance.

Name_____ _____
Last First Middle

Information Checklist (Adult)

The following are common concerns of individuals who come to WISE. Please check all that apply to you. This will help us serve you better. Answer as honestly as possible. You can discuss your answers in detail during the initial interview.

1. My parents are: ___ married ___ separated ___ divorced ___ other

2. My family and I are:

___ in an unsatisfactory relationship other_____

___ unable to talk about personal issues

___ not emotionally close

___ emotionally close

3. My family has a history of (check all that apply)
___ poor communication
___counseling
___ depression / mental illness
___ abuse (physical, emotional, sexual)
___ eating and/or body issues
___ hospitalization
___ alcoholism
___ other addiction(s)

4. Currently, I live (check all that apply)

__ alone __dormitory __ with family-of-origin (parents) __ with a roommate

__ fraternity/sorority __ with a significant other __ with children

***___ I am not happy with my living arrangements.**

5. I am having

__ academic problems __ financial problems __ family problems

__emotional problems __transitional problems __medical problems

I've tried to control my weight with (if none, skip ahead to question 9):

__diets __ vomiting __ laxatives __ not eating

__ diet pills __ exercise __ other (describe) _____

6. I use under-eating behaviors: __ < once per day __> once per day (___x's) __daily

__ weekly __never __other_____

7. I exercise: __ less than once per day __ more than once per day (___x's)

___daily __ never ___other_____

describe type, length of time, goal of current exercise pattern:

---

8. The following have resulted, at least in part, from my current issues:

__ traffic violation __ dizzy/faint/black outs

__ fight with a friend __ ruined relationship

__ academic problems __ mood problems

__ health problems __ financial problems

___ I have been in trouble with the legal system.

___ I have had an unwanted sexual experience.

I have experienced: __ emotional abuse __ sexual abuse __ physical abuse

I have (seriously) thought about or tried to: __ harm myself (past) __ harm myself (present)

__ harm another person (past) __ harm another person (present)

__ At times, I have acted in a violent manner.

I have recently had problems with the following:

__ sleeping __ appetite __ fatigue ___ dizziness __ concentration

__ weight loss/gain __ mood shifts __ headaches __ nightmares

__ anxiety __ medical other problems (describe) _____

9. I have difficulty:

__ expressing my emotions __ controlling my anger __ handling stress

__ accepting myself __ accepting compliments __ making decisions

__ making friends __ relaxing __ maintaining boundries __enjoying life

__other_____

10. I have experienced a recent: __ death __ relationship that ended __ major move

___other type of change_____

11. ____ Sometimes I feel disoriented/disconnected.

12. I would like to discuss (in addition to or in contribution to my primary issues):

__ sexual concerns __ family troubles __ social/dating issues

__ medical problems __ academic problems __ relationship issues

__ vocational problems/concerns __ other_____

In order of importance, what are the primary issues you're experiencing? Please be as specific as possible.

1. _____

2. _____

3. _____

How many total sessions do you anticipate you will need to address these issues?

1 __ 2-4 __ 5-8 __ 9-12 __ 13-15 __ 16+ __

How long do you anticipate this will require?_____

Circle the number which best describes how much your present behaviors and concerns are interfering with your personal functioning.

Not at all 0 1 2 3 4 5 6 7 8 9 10 A great deal

Wellness Institute for *Self Enhancement*

HISTORY SUMMARY

Name: _____ Date :_____

I. Important Background Information:_____

II. Presenting Concerns (Duration, Frequency, and Severity):

III. Related Difficulties:

IV. Previous Attempts to Resolve Issues:

V. Additional Information: