Mosaic Unlimited, Inc. Therapy and Supervision Services

9 Junction Drive West, Suite 5, Glen Carbon, IL 62034

NEW CLIENT INFORMATION AND CONTRACT

This document contains important information about our services and business policies. Please read it carefully and make note of any questions so that we can discuss them.

CLIENT FULL NAME (Primary Insured)		CLIENT DATE OF BIRTH	GENDER MALE FEMALE
ADDRESS		CITY/ZIP	SSN
RELATIONSHIP STATUS SINGLE MARRIED WIDOWED SEPARATED DIVORCED OTHER		ACTIVE LEGAL ENFORCEMENTS? YES NO i.e. Restraining orders	EMAIL
HOME PHONE	LEAVE MSG? YES NO	STUDENT/WORK FT/WORK PT	
WORK PHONE	LEAVE MSG? YES NO	EMPLOYER/SCHOOL	
CELL PHONE	LEAVE MSG? YES NO	EMERGENCY CONTACT NAME/PHONE	
IF MINOR, PARENT OR GUARDIAN NAME AND RELATIONSIP			TELEPHONE NUMBER

HEALTH AND MEDICAL

Primary Care Physician:_____ Phone: _____

Psychiatrist: _____ Phone: _____

Please list any medical problems:

_____

_____

Please list all current medications below:

Name of Medication	Dosage

Have you been prescribed psychiatric medication in the past? ☐ YES ☐ NO

If so please list:

How did you hear about Mosaic Unlimited, Inc. and/or Renee Keller?

☐ Company Website

☐ Referral from physician: _____

☐ Psychology Today

☐ Newspaper _____

☐ Other Healthcare Professional: _____

☐ Rapid Resolution Therapy Website

☐ Search Engine: Google Yahoo

Other: _____

☐ Friend or Relative

How Can I Help You?

Please help me understand what you would like from me in therapy. Fill in any of the following that express your current interests.

"What I would like is…"

information about:
help in understanding
help in making decisions about
training in skills, particularly
support in
suggestions for how to solve a problem of
help with
I don't know what I want help with

"What are you doing, feeling, thinking or saying to yourself that you would like to change?"

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO

If yes, please provide details below:

_____

_____

_____

Are you currently suffering from any of the following?
Circle and then rate from 1-10 (1 is no problem; 5 some problems; 10 crisis point).

Nervousness	**Compulsive tendencies**	**Poor self-esteem**	**Time management**
Inability to relax	**Nail biting**	**Poor health**	**Social Anxiety**
Sleeplessness	**Nightmares**	**Cigarette smoking**	**Codependency**
Depression	**Childhood trauma**	**Alcohol abuse**	**Trouble focusing and concentrating.**
Sexual dysfunction	**Fear of heights**	**Drug abuse**	**Abusive work issue**
Sexual abuse	**Poor memory**	**Marital problems**	**Abusive home situation**
Recent divorce	**War trauma**	**Current illness**	**Teeth grinding**
Lack of energy	**Death of a loved one**	**Death of a pet**	**Lack of success**
Compulsive overeating	**Obsessive about eating**	**Emotional Abuse**	**Bipolar**
ADHD	**PMDD**	**Social Anxiety**	**Parenting Stress**

Family History: Has anyone in your family received treatment for any of the following? If yes, please indicate on the line which family member and, if applicable, whether on mother's or father's side.

____ Depression _____

____ Anxiety _____

____ Panic Attack _____

____ Post-traumatic Stress _____

____ Bipolar/Manic Depression _____

____ Schizophrenia _____

____ Alcohol Problems _____

____ Substance Use _____

____ ADHD _____

____ Suicide Attempts _____

____ Psychiatric Hospital Stay _____

Anything else you would like me to know about you? This may be strengths, interests, faith, passionate about something, etc.

_____

_____

_____

CONTRACT & FINANCIAL AGREEMENT

Mosaic Unlimited, Inc. is a business facility where a number of therapists engage in the practice of mental and behavioral health services through the delivery of psychotherapy and counseling. Your contract for services is with Mosaic Unlimited, Inc., which includes personal and clinical information that is confidential.

Rights and Risks: Please ask questions about any aspect of the therapy process. You need to be willing to discuss what troubles you and be open to change. You may remember unpleasant events, arouse intense emotions, and/or alter close relationships. The purpose of counseling is to facilitate your process. If a court or state agency referred you, you have the right to divulge only what you want included in a report.

Limits of Treatment: Your participation in psychotherapy is voluntary and you have the right to withdraw from treatment without adversity at any time. We encourage you to let your therapist know you wish to stop sessions so the last session is tailored to providing closure. There are rare circumstances in which a therapist may be obligated to make a unilateral decision to terminate therapy with a client. In such cases, the therapist will attempt to find a suitable referral. The therapist cannot be responsible as to whether this referral is accepted.

(INITIALS) _____ I read and agree with the Rights and Risks and understand the Limits of Treatment.

Appointments: All office visits are by appointment only. Your scheduled time is dedicated to your well-being as with other clients and their scheduled time. The usual length of an appointment is 40-45 minutes unless scheduled differently.

Cancellation Policy: Mosaic Unlimited, Inc. has the policy of charging for missed appointments and late cancellations (less than 24 business hours before scheduled appointment). **Business hours are Monday through Friday 9:00 AM to 5:00 PM. As long as you contact the office within 24 business hours, there is no charge. If you give a cancellation notice 23 business hours or less from your scheduled time, the fee is $60 and paid before or at the time of your next session**. It is difficult to schedule a new appointment with this short notice. Insurance companies do not pay for 'no show' charges or late cancellation fees. We can make no exceptions to this rule, including for reasons associated with illness, childcare issues, or work conflict.

(INITIALS) _____ I read, agree and understand the Appointments & Cancellation Policy.

Emergencies: **In a crisis, the best number to call is 911 or go to the nearest emergency room**. Once the doctor has seen you, please call your therapist to let him/her know what is going on. If you receive the voice mail, please leave a message.

Telephone Calls: Calls over five (5) minutes are billed at $25, per 15-minute increments. If your therapist is not able to respond to your question in a way that best serves you at that initial phone call, she will inform you of scheduling a telephone or individual session. Your therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays.

(INITIALS) _____ I read, agree and understand when to call 911 or go to emergency room but for a non-emergency question, and Telephone Calls.

FEES: Payments and copayments are required at the beginning of your session so please have your check, cash, or credit card ready. Your insurance may require pre-authorization; we us Kasa Solutions for all billing and scheduling and they assist clients in obtaining this information but it's not a guarantee of coverage. You are highly encouraged to use the Insurance Verification Form online mental health coverage will not pay for the session and you are then responsible for the session fee. *Insurance companies have implemented many changes over the last few months so we strongly encourage you to contact them regarding your benefits.

Credit Card: Mosaic Unlimited requires a credit card number to be on file for every client except EAP services that have an authorization number. We intend on offering credit card payment as an option. However, due to the rising credit card fees, we require **a minimum payment of $10** for each transaction. Returned checks will incur a minimum fee of $25 plus the original amount of the check.

(INITIALS) _____ I read, agree and understand Mosaic Unlimited Fee and Credit Card Policy.

VISA MASTERCARD AMERICAN EXPRESS DISCOVER	CARD NUMBER		
CARD HOLDER NAME ZIP CODE		EXP DATE	CVV CODE
I hereby give consent to have Mosaic Unlimited, Inc. charge my credit card above for any of the following: 1.) Arranged payment plans, deductibles, or co-payments at the time of service or scheduled date 2.) Financial obligation, according to the insurance company, in addition to the co-pay 3.) Outstanding balance that is past 30 days or balance exceeds $165. 4.) Telephone, Internet, or other services rendered that insurance does not cover. In the event that I cancel an appointment within 24 business hours or do not show my scheduled appointment, I hereby authorize Mosaic Unlimited, Inc. to charge my credit card the amount of the session fee.			
SIGNATURE (LEGAL GAURDIAN)			**DATE**

COUNSELING SERVICES FEES for Insurances

*Indicates services that most insurances cover
**Complexity fee added due to minor and/or additional tools necessary for session.

Diagnostic Evaluation	$165/$180**
*40 min Psychotherapy	$145/$160**
*55 min Psychotherapy	$160/$175**
*55 min Crisis first 60 min	$185
*30 min Crisis 30 min add on	$90
Group Psychotherapy	$75-110**

Sessions are scheduled for 45 minutes unless prior arrangements have been made.

SERVICES NOT COVERED BY INSURANCE

Hypnotherapy
60 minutes $150 and 90 minutes $210

Rapid Resolution Therapy & Clinical Hypnosis
$30 Consultation Fee that is applied to treatment cost.

(NEW!) High Impact Package pricing available

Analyzing/Scoring Tests $65+

Late Cancel/No Show $60

Telephone +5 min, 15 min increments $25+

Diagnosis letter and recommendations for other professionals, Tests, Consultation & document sharing with other agencies or schools $30+

School/Work absence letter given at time of appointment - $0

*****PRIVATE PAY CLIENTS may receive a discounted rate for therapy services.**

Consent to Treat and Confidentiality: I have read and/or received a copy of Mosaic Unlimited Inc.'s Privacy Policy and I may request a copy or obtain one off Mosaic's website**.** I am in agreement with the above policies. If desired, I discussed these policies with my therapist and all questions were answered to my satisfaction. **I understand that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I realize that my account may be sent to a collection agency after it is 60 days past due. The only information shared with a professional collection service is my contact information, date of birth, services rendered, dates of treatment and charges incurred. All clinical notes will not be shared in order to collect a debt.**

Client Signature: _____ Date: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	

	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	