Your Journey to Wellness Begins Here!

Welcome to Well Life! Well Life is an outpatient mental health private practice in Baltimore, Maryland. Our mental health team has the expertise to treat the holistic client. Our approach to mental health treatment encompasses a multidisciplinary approach, as health care is multi-dimensional. We embody the expertise to diagnose and treat a variety of emotional, behavioral, and psychiatric conditions in children, adolescents and adults.

Depression and anxiety are highly prevalent mental health conditions that affect a significant portion of the population. Unfortunately, the symptoms associated with these disorders are often overlooked or misunderstood, leading to delayed diagnosis and treatment. Unfortunately, societal stigma and misconceptions surrounding mental health often contribute to the underestimation and dismissal of these symptoms. Some people who struggle with their mental health may be reluctant to seek help due to fear of judgment, lack of awareness about available treatments, or a belief that their symptoms are a personal weakness rather than a legitimate medical condition.

To address this issue, it is essential to foster open and supportive conversations about mental health. By increasing awareness, educating the public, and promoting early intervention, we can ensure that individuals experiencing challenges with their mental health receive the support and care they need. Timely recognition of symptoms, accurate diagnosis, and access to evidence-based treatments such as therapy and medication can significantly improve outcomes and enhance the overall well-being of affected individuals. Thank you for trusting Well Life to guide you through your journey to mental health!

New Patient Intake Form

Patient Information:

Full Name: _____

Date of Birth _____Gender: _____

Address: _____

City: _____ State: _____

ZIP Code: _____Phone (Home): _____Phone (Mobile): _____

Email: _____

Emergency Contact Name: _____

Relationship to Patient:_____Phone: _____

Insurance Information:

Primary Insurance Provider: _____Policy Holder_____

Insurance ID Number: _____Group Number: _____

Medical History:

Please provide information regarding any current or past medical conditions, surgeries, or hospitalizations:

Mental Health History:

Please indicate any mental health diagnoses you have received in the past:

Please list any current medications you are taking, including dosage:

Do you have any known allergies to medications or other substances? If yes, please provide details:

Please briefly describe the reason you are seeking mental health treatment at Well Life:

Please provide any other relevant information that you believe would be helpful for our clinicians to know:

Consent and Signature:

By signing below, I acknowledge that the information provided on this form is accurate and complete to the best of my knowledge. I understand that this information will be used for diagnostic and treatment purposes by the clinicians at Well Life.

Patient Signature: _____ electronic signature

Date: _____

Consent for Treatment

I,_____, hereby consent to receive outpatient mental health treatment from Well Life. I understand that mental health treatment may include, but is not limited to, diagnostic testing, evaluation, psychotherapy, medication management, and other related services.

I understand that the goal of mental health treatment is to improve my emotional and mental well-being, and that there is no guarantee that treatment will be successful.

I understand that I have the right to participate in the development of my treatment plan and to ask questions and receive answers about my treatment.

I understand that I have the right to refuse any treatment at any time and to request a second opinion if I have concerns about my treatment.

I understand that my mental health provider will maintain the confidentiality of my mental health information in accordance with federal and state laws and ethical standards.

I understand that my mental health provider may need to disclose my mental health information to others, including but not limited to, other health care providers, insurance companies, and legal authorities, in certain circumstances as required by law.

I understand that I am responsible for paying for mental health services rendered by Well Life, and that I am responsible for any copayments or deductibles required by my insurance plan.

I acknowledge that I have read and understood this consent for treatment form, and I have had the opportunity to ask questions and receive answers about my treatment.

Patient/Guardian Name:_____

Patient/Guardian Signature: _____ Date: _____
electronic signature

Telehealth Consent Form

I, _____, hereby consent to participate in telehealth services provided by the mental health provider at Well Life.

Telehealth services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. I understand that the same standard of care applied to a telemedicine visit as applies to an in-person visit.

I understand that telehealth services involve the use of electronic communication technologies, including video conferencing, audio communication, and secure messaging, to provide mental health services remotely. These services may not be as secure as in-person services, and there is a potential risk of breach of confidentiality.

I acknowledge that telehealth services are an appropriate form of treatment for my condition and that my mental health provider has explained the risks, benefits, and limitations of telehealth services to me. I have the right to refuse telehealth services at any time and that I may choose to return to in-person services at any point.

I understand that the mental health provider may need to terminate a telehealth session or recommend in-person services if they believe that the telehealth services are no longer appropriate for my care. If it is determined that the videoconferencing equipment and/or connection is not adequate, my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

I understand that I will be responsible for any out-of-pocket costs such as copayments or that apply to my telemedicine visit and that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

I understand that my mental health provider will document all telehealth sessions in my medical record and will maintain the confidentiality of these records in accordance with applicable laws and ethical standards.

I acknowledge that I have read and understood this telehealth consent form, and I have had the opportunity to ask questions and receive answers about telehealth services.

Patient/Parent/Guardian Name: _____

Patient/Parent/Guardian Signature: _____ Date: _____
electronic signature

Notice of Privacy Practices

Effective Date: May 1, 2023

This Notice of Privacy Practices explains how we collect, use, and disclose your personal information in the course of providing mental health services, and describes your rights as a patient. We use your personal information to provide you with mental health services, communicate with you about your treatment or services, bill and collect payment from you or your insurance company, and comply with legal or regulatory requirements. We may share your personal information with other healthcare providers who are involved in your treatment (with your consent), insurance companies or government agencies for payment purposes, healthcare oversight agencies for regulatory purposes, and law enforcement authorities when required by law. We take reasonable measures to protect your personal information from unauthorized access, disclosure, or destruction. We use physical, technical, and administrative safeguards to ensure that your personal information is secure.

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may “opt-out” and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. You can find more information about CRISP medical record sharing policies at www.crisphealth.org.

You have the right to access your personal information, correct any inaccuracies in your personal information, request restriction of your personal information, request confidential communications, request amendment of your personal information, and file a complaint with our office or with the U.S. Department of Health and Human Services. To exercise these rights, please contact our office.

We reserve the right to change this Notice of Privacy Practices at any time. We will provide a copy to you upon request. If you have any questions or concerns about this Notice of Privacy Practices, please contact our office.

Authorization for Release of Information

I, _____, authorize Well Life to release and/or exchange my confidential health information with the following individual/organization:

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

I understand that the information to be released may include, but is not limited to, information related to my diagnosis, treatment, medications, and psychotherapy notes.

I understand that this authorization is voluntary and that I may revoke it at any time by submitting a written request to Well Life. I understand that the revocation of this authorization will not affect any disclosures of my information that were made prior to the revocation.

I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to receive mental health treatment from Well Life.

The authorization is valid for one year from the date of signature.

Patient/Guardian Signature: _____ Date: _____
electronic signature

Notice to Clients

Welcome to Well Life. We are committed to providing you with high-quality mental health treatment. Before we begin our work together, we want to ensure that you understand and agree to the terms of our treatment agreement. Please read this notice carefully:

As a client, you have certain rights related to your mental health treatment. We want to make sure that you are aware of these rights, which are outlined in the Maryland Mental Health Bill of Rights. You can access a copy of the bill of rights at any time during your treatment with us. Your Well Life provider may diagnose and treat mental health disorders. We will work collaboratively with you and other members of your healthcare team to develop a treatment plan that meets your needs and goals.

Appointments and Cancellations:
We will work with you to schedule appointments that are convenient for you. Please give at least 48 hours notice if you need to cancel or reschedule your appointment.

Confidentiality:
We take your privacy very seriously. We will keep all information that you share with us confidential, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and Maryland state law. However, there are some exceptions to confidentiality, such as in cases where there is a risk of harm to yourself or others. We are required by law to report certain information to the appropriate authorities. This may include information about child abuse, neglect, or exploitation; suspected criminal activity; and threats to harm oneself or others. In some cases, mental health treatment may be court-ordered. If this applies to your situation, we will work with you and the court to ensure that your treatment needs are met.

Treatment of Minors:
Clients under the age of 18, we may need to obtain consent from a parent or legal guardian before beginning treatment.

Email and Text Communication:
We may communicate with you via email or text message for appointment reminders or other administrative purposes. Please note that these forms of communication are not secure and may be intercepted by others. We may use electronic communication (such as video conferencing) to provide mental health treatment. Please be aware that there are potential risks associated with electronic communication, such as technological errors or breaches of confidentiality.

Limits of Availability for Emergency Coverage:
We are not available 24/7 for emergency coverage. If you experience a mental health emergency, please contact your local crisis response, call 911 or go to your nearest emergency room.

Termination of Services:
When a client no longer meets the eligible criteria for outpatient services, Well Life will notify the client in writing prior, to their last scheduled appointment, of the decision to terminate services and the reason(s) for the decision. Please ask our office for more information about eligibility for outpatient mental health treatment at Well Life.

By signing below, you acknowledge that you have read and understand the terms of this notice, and you agree to abide by them throughout the course of your treatment at Well Life.

Parent/Guadian Name:_____

Parent/Guardian Signature:_____Date:_____
electronic signature