SANDHILL
The Yoga Room

YOGA & HEALING ARTS
INTAKE PAPERWORK

Thank you for choosing Sandhill Counseling & Consultation. We look forward to working with you on your yoga practice and/or your healing arts treatment. Attached you will find new client paperwork. **Please print and complete all of the paperwork and bring it with you to the first session**. If you need assistance completing the paperwork, please don't hesitate to contact us.

YOGA
A few special reminders on yoga:

- Wear comfortable clothes that allow you to move freely such as shorts, sweat pants, yoga pants, t-shirts, and/or yoga tops.
- We practice barefoot, so no special footwear is required.
- You are welcome to bring your own yoga mat, otherwise, we have plenty of mats for students to use free of charge.
- Plan to arrive 10-15 minutes early.

HEALING ARTS

- Please remember that Healing Arts services offered at Sandhill are not submitted to your managed health care provider. All services rendered are considered private pay. All services and costs will be presented to you at your initial consultation.

The office address is: 801 South Woodlawn Avenue, Suite 15, O'Fallon, MO 63366. There are helpful driving and parking directions on our website: http://www.sandhillcounseling.com/contactus.html.

When you arrive, please make yourself comfortable in the waiting room. Your instructor or practitioner will greet you in the waiting room at the time of your scheduled class/appointment.

In the event that you need to reschedule or cancel your spot/appointment, please contact your instructor/practitioner directly as soon as possible, and at a minimum, 24-hours prior to your scheduled appointment. There are many clients seeking appointments and we want to be available to all clients in a timely manner.

Kindly,
Monica Lieser

Owner & Clinical Director
Sandhill Counseling & Consultation

FOR PRACTITIONER USE ONLY
PRACTITIONER'S NAME:
☐ Signed Informed Consent (p. 3) ☐ Signed Financial Agreement (p. 5) ☐ Listed Referring Source, if applicable (p. 7)

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INFORMATION, POLICIES, & INFORMED CONSENT – YOGA & HEALING ARTS

CONTACT INFORMATION

801 South Woodlawn Avenue, Suite 15, O'Fallon, MO 63366
Website: www.sandhillcounseling.com
Phone: 636.379.1779
Fax: 636.634.3496
Email: info@sandhillcounseling.com

EMERGENCY PROCEDURES

If you, or a family member, are in crisis, please call Behavioral Health Response at 314-469-6644 (www.bhrstl.org). If you or a family member is having a mental health emergency, such as feeling like you may hurt yourself or another person, please call 9-1-1 or go to the nearest emergency room for an immediate psychiatric evaluation.

GENERAL PRACTICE INFORMATION

For information regarding the licensed practitioners at Sandhill Counseling & Consultation, LLC (SCC) and our philosophy for yoga, healing arts treatments, and therapy, please visit our website at www.sandhillcounseling.com.

OFFICE HOURS & PHONE CONTACT

Office hours are practitioner-specific. Please speak with your practitioner to clarify work hours and scheduling. If your practitioner is not available to take your call, a confidential voice mail is available to leave a message. To contact your practitioner or reach their voicemail, please dial the main office phone number at 636.379.1779 then dial their extension. A directory of phone numbers is available by dialing '0' or can be found on our website at www.sandhillcounseling.com/therapistdirectory.

Making or changing appointments, discussing bills, etc., can be handled by leaving a message on your practitioner's confidential voice mail. Your call will be returned as soon as possible. For fees potentially associated with telephone contacts, see "FEES" below.

HEALING ARTS SESSIONS

Healing arts are intended to enhance relaxation and increase communication within your body and are not intended to replace your primary physician's care or medical intervention. A diagnosis is not given and medication is not prescribed. You agree to continue to have regular medical check-ups as part of your overall health care plan. Information exchanged during any session is educational in nature and is to be used at your own discretion. You assume full responsibility for your services and hold harmless both the practitioner and the facility/location where the services are provided. During the 24 to 48 hours following the services provided, you may experience 'healing reactions'. Your participation in healing arts treatments is voluntary and you may choose to end your participation at any time.

AromaTouch Technique

doTerra's AromaTouch Technique is a clinical approach to applying essential oils along energy meridians and visceral contact points of the back and feet. It is offered to fully clothed clients however the practitioner will need access to the back and feet. The session will take approximately 35 minutes.

Reiki

Reiki sessions are offered to fully clothed recipients who are lying on a treatment table or sitting in a chair. The practitioner offers light, non-invasive touch with the hands placed and held on a series of locations on the body. The session will take 60 minutes.

CONFIDENTIALITY

The privacy of your healing arts session is considered to be of the utmost importance to your practitioner. Your relationship with SCC and information in your case file will be kept private and confidential. The practitioners at SCC will have access to each client file. Consultation about cases is encouraged between all practitioners at SCC. An exception will be made if there is a dual relationship as defined by Codes of Ethics. As a client, you may also ask that your practitioner not consult with the other practitioners at SCC. This request must be in writing.

There are times when information must and /or should be shared with others outside of the practice. In some of these instances, a written release from you as the client(s) is not necessary. In situations where a written consent is necessary and there are multiple clients who are part of therapy/consultation (e.g., couple, family group, and other select instances), all clients will need to sign a written consent for the practitioner to release confidential information.

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INFORMATION AND POLICIES, & INFORMED CONSENT – *CONTINUED*

Legal and Ethical Issues – Missouri State Law *requires* all therapists and licensed practitioners to report any suspected or past cases of child or elder abuse to the Division of Family Services. In addition, whenever a therapist or practitioner has concerns that you may present a danger to yourself or others, legal and ethical standards require that steps be taken to ensure the safety of those in danger. Most of the time, this can be done within the privacy of the consultation office. However, there are occasions when your family, your doctor, hospital, the potential victim, or even the police must be notified. Finally, if a court of law issues a legitimate court order (signed by a judge), we are required by law to provide the information specifically described in that order. Your written consent is not necessary in these situations.

Physician Collaboration – Communication between your practitioner and your physician may be necessary for continuity of care. This communication is at the permission of you, and a signed consent form must be on-file with SCC.

Email – By providing SCC with your email address or contacting SCC via email, you give consent for communication between you and SCC for non-consultation communications including: scheduling appointments, sending statements, SCC newsletters and practice information, and client paperwork. SCC email communications are encrypted. Your email address will never be sold or shared with any other parties.

It should be noted that SCC cannot guarantee emails will be opened in a timely manner; however every effort will be made to open and respond to emails within 24 hours of receipt of email.
Email communications should not to be used for emergency or therapeutic matters. If you or family members are having an emergency, such as feeling like you may hurt yourself or another person, please call Behavioral Health Response at 314-469-6644, dial 9-1-1 or go to the nearest emergency room for an immediate psychiatric evaluation.

CLIENT RESPONSIBILITY REGARDING CONFIDENTIALITY
Please do not reveal any information about any client or other visitor you may see or meet at SCC. This will help protect the privacy and confidentiality of all clients and their families.

INFORMED CONSENT – YOGA & HEALING ARTS

After you have carefully read this information and have received satisfactory answers to any of your questions that may have surfaced, please sign this contract below. **Anyone over 18 years old must sign this form in order to be treated through Sandhill Counseling & Consultation, LLC. Parents or legal guardians must sign for persons under 18 years old.**

I have read and understand the above information and agree to these policies. I agree to receive yoga and/or healing arts services from the practitioners at Sandhill Counseling & Consultation, LLC and I understand that I am free to discontinue treatment at any time and I will be responsible for all sessions already completed and any unpaid balances.

____________________ Client Signature	____________________ Printed Name	__________ Date
____________________ (In the case of a minor) Responsible Party Signature	____________________ Printed Name	__________ Date
____________________ Practitioner Signature	____________________ Printed Name	__________ Date

FINANCIAL AGREEMENT – YOGA & HEALING ARTS

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility. PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING A CLINICIAN.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be obligated to pay to us, to cover the costs of using a collection agency, and additional amount equal to 30% of your total unpaid balance at the time a collection agency is brought in to collect your account. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS, or DISCOVER. THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

FEES

SERVICE	FEE
AROMATOUCH TECHNIQUE – 35-MINUTE SESSION	$30
AROMATOUCH TECHNIQUE + REIKI COMBINATION – 90 MINUTE SESSION	$80
REIKI – 60-MINUTE SESSION	$55
REIKI – 5-SESSION PACKAGE	$225
YOGA – 5 WEEK SERIES	$75
YOGA – PRIVATE LESSONS - 1 LESSON	$60
YOGA – PRIVATE LESSONS - 5-LESSON PACKAGE	$290
YOGA – PRIVATE LESSONS - 10-LESSON PACKAGE	$550

PAYMENTS

Payment must be made at the time of service, via cash, check or credit card. All Yoga and Healing Arts services are private-pay at Sandhill Counseling & Consultation. A receipt is available for all services rendered. Receipts will be issued electronically unless requested differently.

Checks

Checks are made payable to *Sandhill Counseling & Consultation*. Checks returned due to insufficient funds, will be billed to the client at a rate of $25.00 per returned check and checks will no longer be accepted from the client. Future payments must be paid in cash or by credit card at the time of service.

Credit Cards

It is our practice policy to keep a credit card on file for all clients in the practice. You may still choose to pay for your balances using another form of payment. Credit Card information is securely stored in our Electronic Health Records System.

ELECTRONIC STATEMENTS & BILL PAY

All client accounts are reviewed monthly. **If there is a balance due, not otherwise addressed by a credit card on file, a statement will be electronically delivered to the email address on file. Paper statements will be mailed to the address on file if there is no email address on file or if requested by the client.**

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FINANCIAL AGREEMENT – *CONTINUED*

To access your electronic statement, you will use a login and password, as your statement is considered Protected Health Information.

> **LOGIN:** Client's last name all lowercase
> **TEMPORARY PASSWORD:** Client's last name all lowercase followed by the last 4 digits of the primary phone number on the account. You will be asked to change your password after logging in for the first time.

CANCELLED OR MISSED CLASSES

An appointment is reserved for you. If you must cancel an appointment, **you must call the office and/or leave a message with your practitioner at least 24 hours in advance to avoid a Missed Appointment Fee**. **Messages must be left with your practitioner, not with the Intakes Manager or Clinical Director.**

The Missed Appointment Fee is $50.00 for Healing Arts clients. ***Credit card information previously stored in our secure records will be billed at the time of the missed appointment.*** Repeated missed appointments or late cancellations may result in your treatment being terminated.

Yoga classes are conducted in a 5-week series. A new series begins every 5 weeks. The $75 5-week series fee is paid at the beginning of a 5-week series. Missed or unused classes in a 5-week yoga series may not be rolled over to a new series.

Client/Guardian Signature: ____ Date: ________________

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CREDIT CARD AUTHORIZATION

Sandhill Counseling & Consultation, LLC uses an integrated electronic medical record-keeping system for client charts and billing. This form serves as an authorization to input your credit card information into our secure system and charge it when a balance on your account exists. This form is required for all clients. The following are examples of charges that we would run on your credit card: co-payments, deductibles, document preparation/report-writing fees, consulting services, late cancel and no-show fees and returned checks. *

REQUIRED FOR ALL CLIENTS

Type of Card (check one) ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER

Type of Card (check one) ☐ CREDIT or ☐ DEBIT

Name of Cardholder: ____

Card No. ____

Expiration date: ____________________ CVV Code: ________________

Billing address including zip code:

Street: ____

City: ______________________________ Zip Code: ____________________

Authorizing signature: ______________________________ Date: ____________________

Client name (printed): ____

Therapist's name: ____

***Should you choose not to pay for charges with a credit card, you may pay using cash or check.**

***You may also choose to store a Health Savings Account (HSA) card on file for fees billable to HSA accounts. Please note; missed session fees are not billable to HSA cards.**

OPTIONAL: HEALTH SAVINGS ACCOUNT (HSA) CARD

Name of Cardholder: ____

Card No. ____

Expiration date: ____________________ CVV Code: ________________

Billing address including zip code:

Street: ____

City: ______________________________ Zip Code: ____________________

Authorizing signature: ______________________________ Date: ____________________

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REGISTRATION AND INTAKE FORM – YOGA & HEALING ARTS

Thank you for providing the information requested on this form. This is considered confidential information.

Today's Date: ____________________

CLIENT CONTACT INFORMATION

Name: ____ Date of Birth __________________

Spouse/Partner Name: ____ Date of Birth __________________

Address: ____ City: ____________________State: _______ Zip Code: ________

Please indicate with an * which phone numbers we may NOT leave a message

Home phone ____________________________ Work phone ________________________Cell phone _______________________

Email address: ____

Please review Sandhill's "Information and Policies" regarding use of email correspondence. Statements will be sent electronically using the email address provided. Check the box if you prefer statements by mail. ☐

Person to contact in case of an emergency:

____

Name Phone # Relationship

REFERRAL INFORMATION

How did you find out about Sandhill Counseling & Consultation, LLC? (check appropriate box)

☐ Friend(s)/Neighbors ☐ Family Member ☐ Web Search/Internet ☐ School System

☐ Lawyer/Mediator ☐ Therapist ☐ Physician/Family Doctor ☐ Church/Synagogue

☐ Other (please specify) _____________________________

May we send a general thank-you note to this referring source? ☐ Yes ☐ No

If yes, to whom and where it should be sent? ____

APPOINTMENT REMINDERS

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have requested below. Missed appointment fees will still apply if the reminder message is not received.

Where would you like to receive an appointment reminder? (check one)

___ Via text message on my cell phone (normal text message rates will apply according to your contract)

___ Via email message to the address listed above

___ Via automated telephone message to my home phone

___ None of the above; I'll remember my appointments on my own

Signature: ____ Date: ____________________

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FOR YOGA STUDENTS ONLY

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

HEIGHT: ___________ in. WEIGHT: ___________ lbs. AGE: ___________

	Questions	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you perform physical activity?		
3	In the past month, have you had chest pain when you were not performing any physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?		
7	Do you know of any other reason why you should not engage in physical activity?		

If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.

GENERAL & MEDICAL QUESTIONNAIRE

	Occupational Questions	Yes	No
1	What is your current occupation?		
2	Does your occupation require extended periods of sitting?		
3	Does your occupation require extended periods of repetitive movements? (If yes, please explain.)		
4	Does your occupation require you to wear shoes with a heel (dress shoes)?		
5	Does your occupation cause you anxiety (mental stress)?		
	Recreational Questions	**Yes**	**No**
6	Do you partake in any recreational activities (golf, tennis, skiing, etc.)? (If yes, please explain.)		
7	Do you have any hobbies (reading, gardening, working on cars, exploring the Internet, etc.)? (If yes, please explain.)		
	Medical Questions	**Yes**	**No**
8	Have you ever had any pain or injuries (ankle, knee, hip, back, shoulder, etc.)? (If yes, please explain.)		
9	Have you ever had any surgeries? (If yes, please explain.)		
10	Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? (If yes, please explain.)		
11	Are you currently taking any medication? (If yes, please list.)		

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FOR HEALING ARTS CLIENTS ONLY

PRIMARY CONCERNS

List your primary concerns and discomfort level for each concern (LEVELS: 1 (hardly notice symptoms) to 10 (symptoms are unbearable).

____

____

____

Are you sensitive to perfumes or fragrances? ☐ Yes ☐ No If yes, please describe:

____

Are you sensitive to touch? ☐ Yes ☐ No If yes, please describe:

____

Please describe what you would like to accomplish with these treatments.

____

____

____

MEDICAL INFORMATION

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, physician's name? ____

List any medications, remedies and/or supplements that you are taking and reason for each.

____

____

____

Describe any significant accidents or injuries.

____

____

____

PLEASE CHECK ANY CONDITIONS THAT APPLY (PAST OR PRESENT):

☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Epilepsy
☐ Heart Disease
☐ H/L Blood Pressure
☐ Paralysis
☐ Stroke
☐ TMJ Dysfunction
☐ Varicose Veins

☐ Allergies:

☐ Genetic Disorders:

☐ Phobias:

☐ Surgery:

FOR HEALING ARTS CLIENTS ONLY

MEDICAL INFORMATION - CONTINUED

PLEASE CHECK ANY SYMPTOMS THAT YOU EXPERIENCE:

- ☐ Blurriness of Vision
- ☐ Carpel Tunnel Syndrome
- ☐ Cold in Hands & Feet
- ☐ Constipation
- ☐ Excessive Urination
- ☐ Faintness/Dizziness
- ☐ Fatigue
- ☐ Grinding of Teeth
- ☐ Headache
- ☐ Heavy Feeling in Limbs
- ☐ Indigestion
- ☐ Insomnia
- ☐ Irritated Bowel
- ☐ Loose Bowel Movements
- ☐ Lower Back Pain
- ☐ Menstrual Irregularities
- ☐ Nervousness
- ☐ Pains in Heart/Chest
- ☐ Poor Appetite
- ☐ Shoulder/Neck Pain
- ☐ Smoking (#/day:______)
- ☐ Tightness in Jaw
- ☐ Weak Body Parts
- ☐ Other:
- ☐ Are you pregnant? _________________

PLEASE CHECK ANY AREAS BELOW THAT YOU WOULD LIKE IMPROVEMENT IN:

- ☐ Ability to align body/mind for self-healing
- ☐ Ability to reach ideal weight
- ☐ Ability to relax
- ☐ Ability to take action
- ☐ Ability to use dreams as tool for problem solving
- ☐ Attitude and skills at work
- ☐ Belief in ability to achieve goals
- ☐ Beneficial relationships
- ☐ Breaking old habits
- ☐ Eliminate procrastination
- ☐ Increase learning ability
- ☐ Negative self-talk, self-sabotage
- ☐ Personal magnetism
- ☐ Prosperity (attract what you choose)
- ☐ Self-esteem
- ☐ Strengthen memory/concentration
- ☐ Release negative events
- ☐ Youthful vitality

Privacy Notice: No information about any client will be discussed or shared with any third party without written consent of the client or parent/guardian if the client is under 18.