

Client Opening Packet

Prepared: February 04, 2026

Instructions: Please read each section, then complete the separate standalone Form 2: Unified Signature & Acknowledgment. **Only Form 2 should be returned by email**, (along with Form 3, Form 4, Form 5)

1) Welcome Letter

WELCOME TO THE PRACTICE

Thank you for choosing to begin counseling here. My goal is to offer a safe, calm, and respectful space where you can work on what matters most to you. I use a person-centered, trauma-informed approach. This means we work together at your pace, and your experiences and goals guide our sessions. I am here to support you, listen, and help you build skills that improve your well-being.

Services Not Provided

- Emotional Support Animal (ESA) letters
- Disability-related paperwork, including Family Medical Leave Act (FMLA) forms (best completed by your Primary Care Provider or treating medical specialist)
- Legal Functional Ability Assessments (typically completed by physicians, neuropsychologists, or other qualified professionals trained in legal-capacity evaluations)
- Custody evaluations
- Immigration evaluations
- Personal or character reference letters
- Any legal or forensic evaluations

ESA (Emotional Support Animal) Information

I do not provide ESA letters because they are considered disability-related documentation, which requires a medical or legal evaluation that I do not perform in my outpatient practice. I can provide treatment-verification letters when clinically appropriate, but I do not complete determination, disability, legal, or forensic letters. Administrative, documentation, or statement-related fees may be applied as outlined in the Administrative & Documentation Fees section within Financial Policies & Fees. Costs (if any) will be discussed in advance, and completion time may vary depending on workload.

Insurance Policies

Your insurance plan determines what services are covered. Please verify your benefits and keep your insurance information current. Copays, deductibles, and uncovered services are your responsibility. If insurance denies payment or retracts funds, the remaining balance becomes your responsibility. Please notify me promptly of any insurance changes.

Billing & Continuity of Care

Timely payment helps ensure uninterrupted services. If financial concerns arise, please discuss them with me so we can explore possible options.

I'm Glad You're Here

Thank you for taking this step. I look forward to working with you and supporting your well-being.

Practice contact information appears in the footer of each page.

2) Informed Consent & Practice Policies

INFORMED CONSENT & PRACTICE POLICIES

Thank you for choosing to work with me. This Informed Consent outlines: what psychotherapy is and is not; your rights as a client; benefits, risks, and alternatives; confidentiality and its limits; communication practices; emergency policies; consultation practices; billing and insurance responsibilities; telehealth information; and record-related rights.

Practice contact information appears in the footer of each page. You may ask questions at any time and may request a paper or electronic copy of these materials.

Credentials: LMHC = Licensed Mental Health Counselor in Massachusetts (authorized to provide psychotherapy services). MA = Master of Arts. CRC = Certified Rehabilitation Counselor. CAGS = Certificate of Advanced Graduate Studies.

1) About Mental Health Counseling (What It Is / What It Is Not)

Psychotherapy is a clinical, goal-directed, medically necessary service designed to reduce symptoms, improve functioning, and support emotional and behavioral health. Treatment is individualized and may include discussion, emotional processing, skill-building, and structured interventions.

Therapy is not crisis care, legal advice, medical care, or case management. Progress varies, and outcomes cannot be guaranteed.

2) Trauma-Informed Care & Your Right to Ongoing Consent

This practice is trauma-informed and paced according to your needs, stability, and readiness—especially when trauma, dissociation, anxiety, or complex stress responses are present.

- Safety (emotional, physical, relational)
- Choice and consent (you may pause or decline any intervention)
- Collaboration and transparency (I explain what we are doing and why)
- Empowerment (skills, strengths, agency)
- Cultural humility and responsiveness

Consent is ongoing. You may request changes, decline interventions, or end treatment at any time. Treatment goals are reviewed periodically.

3) Therapeutic Orientation (Including Transpersonal Options)

My practice integrates trauma-informed and culturally responsive approaches. A transpersonal lens may be incorporated based on your preference and may include exploration of meaning, identity, purpose, values, and inner resources. This work is non-denominational, client-directed, and integrated with evidence-informed care.

4) Modalities (Overview)

Modalities refer to the clinical treatment approaches I am trained to use. These reflect how we may work together through theoretical orientation, intervention style, and structured models of care. Approaches are selected collaboratively based on your goals and what feels most supportive.

- IFS-informed / Parts Work
 - DBT-informed skills
 - Solution-Focused Therapy & Motivational Interviewing
 - CBT (Cognitive Behavioral Therapy)
 - CPT (Cognitive Processing Therapy)
 - Mindfulness
 - Problem-Solving Therapy (PST)
 - EMDR (Eye Movement Desensitization and Reprocessing) – specialty focus
- EMDR is designed to help the brain reprocess distressing memories so they feel less overwhelming and reduce reactivity to triggers.

These modalities are examples and do not represent all available clinical approaches used in this practice.

5) Benefits, Risks, and Alternatives

Possible benefits (not guaranteed):

- Reduced symptoms (e.g., anxiety, depression, trauma-related distress)
- Improved emotional regulation and coping skills
- Enhanced communication and interpersonal functioning
- Better stress management and problem-solving
- Increased resilience, insight, and self-awareness

Possible risks: Psychotherapy may involve emotional discomfort; discussing difficult topics; temporary increases in symptoms; physical sensations during trauma processing; or changes in relationships or habits. You may pause or modify any intervention at any time.

Alternatives may include higher levels of care (IOP, PHP, crisis services), psychiatric evaluation/medication, community supports, or self-help strategies. Alternatives are reviewed as clinically indicated.

8) Communication (Including Electronic Communication)

Text, email, and mobile communication are offered for convenience but may not be secure. Confidentiality cannot be guaranteed. Messages may be delayed, and email is not checked daily. Electronic communication is for scheduling or brief administrative matters only, not for emergencies or clinical needs.

9) Emergency Policies & Crisis Resources

For emergencies or urgent safety concerns: Call 988 • Call 911 for any emergency involving imminent safety risk • Or call/text 988 (Suicide & Crisis Lifeline) for urgent mental health support.

This practice does not provide 24/7 emergency services. Voicemail, text, and email are not continuously monitored. If outpatient therapy becomes clinically inappropriate, referrals may be made to higher levels of care (e.g., crisis stabilization, IOP, PHP, inpatient). Safety planning may be completed when indicated.

11) Records, Retention, and Good Faith Estimate

Records are retained for at least seven years (longer for minors). A Good Faith Estimate is available for uninsured or self-pay clients.

12) Insurance Use & Client Responsibility

- Copays, deductibles, and coinsurance are due at time of service.
- Please notify the practice promptly of any insurance changes.
- Retroactive denials ("clawbacks") become the client's responsibility unless otherwise required by law or your specific plan.

Clients are responsible for verifying: in-network status; copay/deductible/coinsurance and session limits; prior authorization requirements; and any changes in plan or coverage.

13) Cancellation & No-Show Policy

- 48 hours' notice required
 - Late cancellations/no-shows result in a \$75 fee (not billable to insurance)
- A separate financial policy is included below for your review and acknowledgment.

16) Session Limits (Structure of Outpatient Care)

- Standard sessions are typically 45–60 minutes
- Frequency is determined collaboratively
- Insurance limits may apply; clients may self-pay if limits are reached
- Repeated late cancellations or gaps in care may require revisiting the treatment plan

17) Termination / Continuity of Care

The LMHC does not abandon clients. Termination may occur if safety concerns arise, fees remain unpaid, or insurance denies coverage and alternatives are recommended. Referrals and transition support will be provided when appropriate.

18) Telehealth Informed Consent

Telehealth is provided via secure video and/or audio platforms. It may improve access but carries risks such as reduced visual assessment, technology problems, or privacy limitations. You agree to provide your physical location at the start of each session for safety purposes. Telehealth is not appropriate for emergencies.

Telehealth consent (consent/decline) is indicated on the Unified One-Page Signature & Acknowledgment page.

19) Practice Policies (Office Information & Attendance)

Building Privacy & Security Cameras

The building has shared hallways and entrances. While privacy is prioritized, confidentiality cannot be guaranteed in shared spaces. Security cameras are located at entry points; therapy sessions are never recorded.

Appointments & Attendance

Arriving within 10 minutes of the scheduled time allows us to meet, though the session may be shortened. Arrivals beyond 10 minutes may require rescheduling. If an unexpected issue arises on my end, I will provide at least a 20-minute session or reschedule.

Questions, Concerns, and Grievances

You may discuss concerns directly with me. To file a complaint:

MA Board of Registration of Allied Mental Health and Human Services Professionals
1000 Washington Street, Boston, MA 02118

Phone: (617) 701-8683

Website: <https://www.mass.gov/orgs/board-of-registration-of-allied-mental-health-and-human-services-professionals>

3) HIPAA Notice of Privacy Practices (NPP) & Client Rights

NOTICE OF PRIVACY PRACTICES (HIPAA) & CLIENT RIGHTS

This Notice describes how your Protected Health Information (PHI) may be used and disclosed, and how you may access your information. Please review carefully.

Contact Information

For questions about this Notice or your privacy rights, contact Tracey Kelce using the contact information in the footer of each page.

You may request a paper or electronic copy of this Notice at any time.

1. Our Legal Duties

- Maintain the privacy and security of your PHI.
- Provide you with this Notice and follow its terms.
- Notify you if a breach of unsecured PHI may have affected your information.
- Apply updated versions of this Notice to all PHI maintained by the practice.

2. How We May Use and Share PHI (No Written Permission Needed)

Treatment

To provide, coordinate, and manage your counseling and related services.

Payment

To bill and obtain payment from insurers. Health plans may request a diagnosis code and limited clinical information to determine medical necessity.

Health Care Operations

For activities such as quality improvement, supervision/consultation, compliance, and work performed by business associates who must protect PHI.

Required by Law & Oversight

We may disclose PHI when required to comply with federal or state laws or authorized oversight activities.

Serious Threat to Health or Safety

To prevent a serious and imminent threat to health or safety.

Individuals Involved in Your Care

With your agreement—or if you do not object—we may share limited PHI with individuals assisting with your care or payment.

Additional standards: Minimum Necessary (only essential information is disclosed). Out-of-pocket restrictions: If you pay fully out of pocket and request that information not be shared with your insurer, we will comply unless disclosure is legally required.

3. Uses and Disclosures Requiring Written Authorization

- Psychotherapy Notes (when maintained separately)
- Marketing or Sale of PHI (we do not sell PHI)
- Any non-routine or not otherwise permitted use

You may revoke authorization at any time in writing, unless action has already been taken.

4. Your Rights

- Access your clinical record (excluding psychotherapy notes).
- Request amendments to information that is incomplete or inaccurate.
- Request confidential communication (e.g., to a specific phone number or address).
- Request restrictions on what we use or share (some limits may not be granted).
- Request an accounting of certain non-routine disclosures.
- Receive a paper copy of this Notice at any time.

5. Client Rights

- Be treated with dignity, respect, and without discrimination.
- Participate in treatment planning and ask questions.
- Receive information about diagnosis and treatment recommendations.
- Decline or withdraw consent at any time.
- Request access to your records and request corrections.
- Expect confidentiality except where disclosure is legally required.
- End treatment at any time (unless safety or legal obligations apply).
- File a grievance or complaint without retaliation.

6. Client Responsibilities

- Attend sessions on time and participate honestly.
- Notify the clinician of changes in symptoms, functioning, medications, or safety concerns.
- Use emergency resources (911/988) for immediate safety issues.
- Respect professional boundaries and follow communication, payment, telehealth, and social media policies.
- Provide accurate insurance information and report coverage changes.
- Ensure privacy, use secure devices, and provide session location during telehealth.

7. Massachusetts Confidentiality & Privilege

Massachusetts law provides additional protections for mental health communications.

The stronger law (state vs. federal) always applies.

Exceptions include mandatory reporting of child, elder, or disabled-adult abuse/neglect and situations involving serious and imminent risk of harm.

8. Telehealth & Electronic Communications

Email/text are for brief administrative issues only (e.g., scheduling). These methods may not be fully secure or immediately reviewed. Do not use email or text for urgent or safety-related matters.

9. Sensitive Information – SUD / 42 CFR Part 2

Substance Use Disorder (SUD) treatment records have heightened federal protections. They generally cannot be used or disclosed in legal proceedings without written consent or a qualifying court order. If you are not a Part 2 program, these protections apply only when applicable.

10. Questions or Complaints

For privacy concerns, contact the practice using the contact information in the footer of each page. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will not retaliate for filing a complaint.

Additional Notes

A reasonable cost-based fee may apply for record copies. We comply with requirements related to abuse/neglect reporting; court orders and subpoenas (minimum necessary; may move to quash when appropriate); emergencies or imminent risk; supervision/consultation (de-identified when possible); and insurance and medical-necessity documentation. Business associates (billing, EHR, scheduling, secure messaging, shredding) must legally safeguard PHI. We do not use PHI for fundraising.

Confidentiality & Limits of Confidentiality

PHI is confidential as required by law and ethics. Disclosure may occur only when legally permitted or required, including: risk of serious harm to self or others; suspected abuse or neglect of a child, older adult, or disabled person; court orders, subpoenas, or other mandated disclosures; insurance/payment operations (e.g., diagnosis, dates of service, medical necessity); and professional consultation or supervision (identifying information minimized). Only the minimum necessary information is disclosed.

Data Privacy & Security

Records are stored securely in compliance with HIPAA and Massachusetts standards. Access is limited to authorized individuals involved in your care. Electronic Risk Notice: No electronic method is fully secure. Risks include misdelivery, shared devices, carrier errors, server breaches, apps, and phishing. Avoid sending sensitive information by email or text.

Communication

Electronic communication is provided for convenience: confidentiality cannot be guaranteed; delivery may be delayed; and email is not checked daily. Use electronic communication only for non-urgent administrative matters.

Consultation / Supervision

To ensure quality of care, consultation or supervision may occur with minimal identifying information disclosed. Insurers may require diagnosis, dates of service, treatment progress, and documentation for authorization, audits, or utilization review.

Record Access

You may request copies of your records or request corrections. In rare cases, a summary may be provided if full access may be clinically harmful.

I may ask questions at any time and may request a paper or electronic copy of this Notice.

Social Media & Digital Boundaries

- I do not accept friend requests or follow clients on social media.
- Please do not tag me or reference our therapeutic relationship online.
- I cannot acknowledge clients or respond to online reviews.
- I will not search for your online content without your explicit request and consent.

4) Financial Policies & Fees

Service Fees

- 90791 – Diagnostic Evaluation: \$262.50
- 90837 – Individual Therapy (53+ min): \$187.50
- 90834 – Individual Therapy (45 min): \$150.00
- 90832 – Individual Therapy (20 min): \$75.00
- 90853 – Group Therapy (60 min): \$75.00 per person

Insurance & Client Responsibility

When using insurance, your health plan may require information such as your diagnosis, dates of service, treatment progress, or documentation for authorization, utilization review, audits, or payment.

Copays, deductibles, and other out-of-pocket costs are your responsibility and are typically due at the time of service. Please notify the practice promptly of any insurance changes to avoid billing issues or denied claims.

Disputes and appeals: You may request an explanation of benefits from your insurer and may pursue an appeal or corrected-claim review. You may also contact the Massachusetts Division of Insurance for support.

Payment Methods & Billing Policies

- **Payments may be made by cash, check, credit/debit/HSA/FSA cards (via Square), or Venmo when applicable.**
- **CASH is the preferred method of payment.**

"A \$3.00 convenience fee will be added to each transaction paid via **credit/debit card, HSA/FSA card, or Venmo**. This fixed fee offsets external processing costs. Cash and check payments do not incur this fee."

- **No surcharge** (distinct from a convenience fee) is added for credit/debit card transactions.
- **Returned checks incur a \$35 fee.**
- **Outstanding balances must be resolved before scheduling the next appointment.** Sessions may be paused until the balance is addressed. If needed, we can discuss a manageable plan while maintaining responsible billing practices.

Administrative & Documentation Fees

Certain non-clinical administrative services require time outside of therapy sessions and are not billable to insurance. The following fees may apply:

- **Letters & Treatment-Related Statements:** treatment-verification letters, attendance letters, and general participation statements. Fee: \$25–\$50 depending on complexity and time required (confirmed in advance).
- **Forms & Paperwork (Non-Insurance Forms):** Fee: \$25 per 10 minutes of clinician time.
- **Clinical Summaries/Reports:** requests that require review of records and written preparation. Fee: \$25 per 10 minutes of clinician time.
- **Medical Records Requests:** provided in accordance with HIPAA and Massachusetts law. A reasonable, cost-based fee may apply for copying/printing/mailing.

Important: This practice does not provide disability, legal, forensic, FMLA, ESA, immigration, custody, or capacity-related evaluations or determinations.

Please Note

To finalize your intake, complete the **Unified Signature & Acknowledgment Page** (Form 2), save it, and email it to **tkelce@unearthwellnesspllc.com**. This confirms you have reviewed the Client Opening Packet.

Please read all sections and return **only Form 2** by email.

Form 2 (**Complete and Return**) Client Opening Packet

Unified One-Page Signature & Acknowledgment

Name:

Client Acknowledgment: I have read, understand, and consent to the following:

- Services Not Provided
- Informed Consent & Practice Policies
- Notice of Privacy Practices (HIPAA) & Client Rights
- Financial Policies, Fees & Administrative & Documentation Fees
- A \$3.00 convenience fee will be added to each transaction paid via credit/debit card, HSA/FSA card, or Venmo.
- Cancellation & No-Show Policy

Telehealth Consent: ☐ I consent ☐ I do NOT consent

Emergency Disclaimer: If in crisis I will call 911 or 988.

Signature – Choose One Method

1. Typed Signature (Choose if typing your name)

Typed/ Handwritten (Wet) on paper Signature: _____

Date: _____

2. Electronic Signature (Choose if signing electronically)

E-Signature: (Insert electronic signature here)

Date: _____

Any of these signature methods is acceptable.

NEW CLIENT INFORMATION (Complete, Save and Email Back)

Effective Date: August 20, 2026

Name:

Note

Please complete this form, save and email back to me at tkelce@unearthwellnesspllc.com

1) Presenting Concerns & Functional Impact

Main concerns/goals for therapy:

Symptoms:

- ☐ Anxiety: general-overall ☐ Anxiety: social ☐ Panic ☐ Phobias, intense irrational fear
- ☐ Depression ☐ Sadness ☐ Lonely ☐ Lost interest ☐ Lost enjoyment ☐ Tearful ☐ Withdrawn
- ☐ Trauma: ☐ dealing with past ☐ dealing with current
- ☐ Life stress: ☐ major life changes ☐ grief and loss ☐ work-career
- ☐ relationship couples' issues ☐ relationship family issues ☐ stress from work ☐ other
- ☐ Addiction ☐ Substance Use: ☐ alcohol ☐ drug
- ☐ Mood swings: ☐ irritable ☐ pressured speech ☐ decreased sleep with good energy ☐ other
- ☐ Interpersonal dysfunction ☐ Emotion dysregulation ☐ Fear of abandonment ☐ Fear rejection
- ☐ Anger ☐ controlling intense emotional outbursts ☐ internal difficult to express outwardly
- ☐ Eating disorder: ☐ emotional eating ☐ binge eating ☐ bulimia ☐ anorexia
- ☐ Poor focus and concentration ☐ procrastination ☐ forgetful ☐ disorganized ☐ lack motivation
- ☐ Obsessive thoughts ☐ Compulsion-repetitive behaviors ☐ Germs, contamination ☐ Other
- ☐ Low self-esteem or self-worth ☐ Low confidence
- ☐ Managing mental health alongside physical pain, medical condition(s)

☐ Psychosis: ☐ auditory-hearing voices ☐ visual-seeing things others don't ☐ Other

How long have these concerns been present?

Impact on functioning (work/school, relationships, sleep, daily activities):

What improvement matters most right now?

2) Medical / Mental Health History

Primary Care Provider (PCP):

Phone:

May we coordinate with your PCP? ☐ Yes ☐ No

Medical conditions:

Current medications:

Allergies/adverse reactions:

Past counseling/therapy? ☐ No ☐ Yes

Psychiatric hospitalizations? ☐ No ☐ Yes

Recent ER/hospital visit? ☐ No ☐ Yes

Prior diagnoses (if known):

3) Safety Screen (Required)

Self-harm thoughts in the past month? ☐ No ☐ Yes

If yes, current? ☐ No ☐ Yes

Past attempts? ☐ No ☐ Yes

Thoughts of harming others? ☐ No ☐ Yes

Safety concerns at home? ☐ No ☐ Yes

Access to lethal means: ☐ None ☐ Firearms ☐ Medications ☐ Other:

Safe storage information (if applicable):

Protective factors (what helps you stay safe):

Emergency Guidance (Safety)

If you are in immediate danger or cannot stay safe, call 911. For urgent mental health support that is not life-threatening, call or text 988.

4) Substance Use

Alcohol: ☐ None ☐ Occasional ☐ Weekly ☐ Daily ☐ Concerns

Cannabis: ☐ None ☐ Occasional ☐ Weekly ☐ Daily ☐ Concerns

Other substances: ☐ None ☐ Yes (describe):

Nicotine: ☐ None ☐ Yes

Past treatment for substance use? ☐ No ☐ Yes

DUIs/legal issues related to use? ☐ No ☐ Yes

MAT provider? ☐ No ☐ Yes

5) Social / Family / Cultural

Household members:

Support system (people/resources):

Employment/school status: ☐ Employed ☐ Unemployed ☐ Student ☐ Leave ☐ Retired

Other:

Occupation/school:

Relationship status: Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
☐ Other:

Cultural/spiritual considerations you would like included (optional):

Trauma history: ☐ None ☐ Yes ☐ Prefer not to answer

Legal/court issues: ☐ No ☐ Yes

Family History: ☐ Mental Illness ☐ Addiction: ☐ alcohol ☐ drugs

Describe:

6) Communication Preferences

Text: ☐ Yes ☐ No

Email: ☐ Yes ☐ No

Voicemail: ☐ Yes ☐ No

Clinical content by text/email: ☐ No ☐ Yes (If yes: ☐ scheduling only ☐ brief updates only)

Other, anything else you would like me to know:

Optional Modules

☐ I completed the optional Cultural/Spiritual/Metaphysical Assessment module (optional-if applicable).

☐ I completed the ACE questionnaire.

Acknowledgment

Please acknowledge completion of this Clinical Intake on the Unified Signature Page.

ADVERSE CHILDHOOD EXPERIENCES (ACE) QUESTIONNAIRE

Effective Date: January 28, 2026

Name:

Instructions

This questionnaire screens for common childhood experiences before age 18. You may skip any item. If you feel distressed, you can pause and discuss support options.

Before age 18, did any of the following happen to you? (Select Yes or No for each item.)

1) A parent/adult in the home often swore at you, insulted you, put you down, or humiliated you.

☐ Yes ☐ No

2) A parent/adult in the home often pushed, grabbed, slapped, or threw something at you; or ever hit you hard enough to leave marks or cause injury.

☐ Yes ☐ No

3) An adult or person at least 5 years older ever touched you sexually, tried to make you touch them sexually, or forced sexual contact.

☐ Yes ☐ No

4) You often felt that no one in your family loved you or thought you were important, or that your family did not support/protect each other.

☐ Yes ☐ No

5) You often felt you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you; or caregivers were too intoxicated or otherwise unable to care for you.

☐ Yes ☐ No

6) Your parents were separated/divorced, or you experienced loss of a parent due to separation or abandonment.

☐ Yes ☐ No

7) You lived with someone who had problematic alcohol or drug use.

☐ Yes ☐ No

8) You lived with someone who had significant mental health difficulties or who attempted suicide.

☐ Yes ☐ No

9) You witnessed violence in the home (e.g., a parent/stepparent was pushed, grabbed, slapped, kicked, or otherwise assaulted).

☐ Yes ☐ No

10) A household member went to jail or prison.

☐ Yes ☐ No

Scoring (Optional)

Count the number of “Yes” responses (0–10). Higher scores are associated with increased health risks but are not diagnostic.

ACE Total Score (0–10): _

Notes / Follow-up (optional):

Acknowledgment

Acknowledgment/signature is not required for this screening tool. If used, completion may be acknowledged on the Unified Signature Page.

CLIENT-INFORMED CULTURAL, SPIRITUAL & METAPHYSICAL ASSESSMENT (ADULTS)

Effective Date: January 28, 2026

Name:

Purpose

Optional. Share only what feels relevant. You may skip any question. If you prefer not to include these topics in treatment, you may leave this form blank.

1) Cultural Identity & Lived Context

- ☐ I want culture included in my care.
- ☐ I prefer culture not be included in my care.
- ☐ I am not sure yet.

How do you describe your cultural identity?

Cultural strengths, practices, or supports:

Cultural or identity-related stressors:

2) Spiritual or Religious Orientation

- ☐ Spiritual
- ☐ Religious
- ☐ Both
- ☐ Neither
- ☐ Unsure

Tradition(s) / path(s) / community affiliation (if any):

Current involvement: ☐ Active ☐ Occasional ☐ Not currently ☐ Avoiding due to past harm

Beliefs or values that guide your life:

3) Practices & Supports

Practices that help me cope, heal, or feel grounded (check any):

☐ Prayer ☐ Meditation ☐ Mindfulness ☐ Time in nature ☐ Ritual/ceremony ☐ Energy work (e.g., Reiki) ☐ Yoga/movement ☐ Journaling ☐ Community worship ☐ Ancestor/heritage practices ☐ Sound healing ☐ Other: _____

Spiritual or community supports (people, groups, communities):

4) Metaphysical Beliefs & Experiences (Optional)

☐ Yes ☐ No ☐ Unsure

Examples (check any that resonate):

☐ Energy/vibration in people/places ☐ Karma/destiny/life path ☐ Ancestors/spirit guides ☐ Intuition/inner knowing ☐ Premonitions/prophetic dreams ☐ Synchronicities/signs ☐ Astrology/cosmic influence ☐ Past lives/reincarnation ☐ Visions/altered states ☐ Energy centers (chakras/aura) ☐ Divination (tarot/oracle/etc.)

Describe in your own words (optional):

These experiences feel: ☐ Supportive ☐ Neutral ☐ Mixed ☐ Distressing

5) Impact, Boundaries & Preferences

How do these beliefs/identities/experiences influence your daily life?

Anything you would like your therapist to avoid, honor, or be mindful of?

Would you like these topics integrated into therapy? ☐ Yes ☐ No ☐ Maybe/depends

6) Safety Check

Have any experiences ever felt frightening or overwhelming? ☐ No ☐ Yes

If yes (share only what feels comfortable):

Clinician Summary (clinician completes)

Strengths, supports, and resources:

Agreed-upon boundaries & approach to integration:

Acknowledgment

If you complete this optional form, please acknowledge it on the Unified Signature Page.

TRACEY KELCE, MA, CRC, CAGS, LMHC

Licensed Mental Health Counselor

Office/Mailing: 205 W Grove Street, Unit A

Middleboro, MA 02346

Tel: (774) 206-6635

Fax: (774) 228-4441

Email: tkelce@unearthwellnesspllc.com

TWO-WAY RELEASE OF INFORMATION (ROI)

Authorization to Disclose and Obtain Protected Health Information (PHI)

1) Client Information

Client Name: _____

Preferred Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Address: _____

City/State/ZIP: _____

2) Parties Authorized for TWO-WAY Information Exchange

LMHC Provider: Tracey Kelce, MA, CRC, CAGS, LMHC

Other Individual/Agency: _____

3) Purpose of TWO-WAY Information Exchange

- ☐ At my request
- ☐ Care coordination/treatment planning
- ☐ Referral/consultation
- ☐ Benefits/insurance/payment
- ☐ Legal/administrative purposes

4) Information to Be Exchanged

- ☐ Dates of service
- ☐ Attendance history
- ☐ Diagnosis
- ☐ Treatment plans
- ☐ Progress summaries
- ☐ Risk/safety assessments
- ☐ Medication lists
- ☐ Billing information
- ☐ Discharge summaries

Sensitive Information (Client Initials Required)

- Trauma history (Initials: _____)
- HIV/STD information (Initials: _____)
- Reproductive/Sexual health (Initials: _____)
- Domestic violence (Initials: _____)
- Genetic information (Initials: _____)
- Other: _____ (Initials: _____)

• Office/Mailing: 205 W Grove Street, Unit A • Middleboro, MA 02346
• Phone/Text: (774) 206 6635 • Fax: (774) 228 4441 • Email: tkelce@unearthwellnesspllc.com

5) Method of TWO-WAY Exchange

☐ Encrypted electronic communication

☐ Fax

☐ Mail

☐ Phone/Verbal

6) Expiration

Date: _____

Event: _____

One year from signature

Client Signature

Client Signature: _____

Date: _____

Psychotherapy Notes Addendum (Separate Authorization Required)

Psychotherapy notes for dates: _____

Purpose: _____

Expiration Date/Event: _____

Client Signature for Psychotherapy Notes: _____

Date: _____

42 CFR Part 2 Addendum (Substance Use Disorder Records)

Client Initials acknowledging SUD disclosure: _____

Name of Part 2 Program: _____

Description of SUD info to be disclosed: _____

Purpose of disclosure (must be specific): _____

Expiration Date or Event: _____

Right to Revoke: I may revoke this consent at any time except where already relied upon.

Required Warning: "42 CFR Part 2 prohibits unauthorized use or disclosure of these records."

Client Signature for Part 2 Authorization: _____ Date: _____