



WellSprings Counseling Services, PLLC

Sondra R. Brumett, LPCC/LCMHC
305 E. Union St., Suite B-115
Morganton, NC 28655
Phone 859-230-2552

NEW CLIENT AND INSURANCE INFORMATION

Client Information

Today's Date: _____

Name: _____ Birthdate _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Can we leave a message? Yes No Best Place to Leave a Message (____) _____

E-mail address: _____

Who were you referred by? _____

Level of Education: HS College Graduate School Other

College/Graduate School Major _____ FT or PT; Will complete degree in _____

Employment: FT PT Unemployed Not working while in school On Medical Leave

Place of Employment _____ How long? _____ FT or PT; If unemployed, how long: _____; What type of work do/did you do? _____

Marital Status: Single In a serious/committed relationship Live with partner; # of years: _____

Married; # of years _____ Divorced; # of years _____ Widowed; # of years: _____

Spouse's/Partner's Name: _____

Spouse's/Partner's Occupation: _____

Number of children: _____ Age (s) _____

For couple's therapy, Spouse/Partner's E-mail: _____

In Case of Emergency Notify: _____ Phone: _____

Relationship: _____

Primary Insurance Policy Holder and Responsible Party Information

Please bring health insurance card to first session.

Name of Primary Policy Holder: First: _____ MI _____ Last: _____
Relationship to Client: _____

Home Address: _____

Phone: (____)-____-____ DOB: ____/____/____ SS# ____/____/____

Employer: _____

Primary Insurance Carrier: _____ ID#: _____

Group# _____ Start/End Dates of Current Policy _____ to _____

Co-Pay Amount for Outpatient Behavioral Health Sessions _____

Deductible Y N _____ Deductible Amount _____ /Session Deductible Met to Date _____

Post Deductible Co-Insurance Percentage _____

Employee Assistance Program (EAP)? Y or N; Name of EAP Program: _____

of EAP sessions authorized: _____; Authorization code: _____; Start and End Dates of Authorization
_____ to _____.

Mental and Physical Health Information

Have you ever been hospitalized for psychiatric reasons? Y N Dates of Hospitalization: _____

If yes, what were the circumstances? _____

When was your last full physical/medical exam? _____

Medical/Physical problems: _____

Sleeping issues? Y N How many hours of sleep do you get each night? _____

Do you exercise? Y N If yes, what kind of activity and how often? _____

List any medications you are presently taking and dosage: _____

Name(s) of prescriber(s): _____

Current Nicotine Use (Cigarettes, chewing tobacco, snuff, or E-Cigs) Y or N; Amount/Frequency: _____

Current Alcohol Use: Y or N; Amount/Frequency: _____; Treatment Concern: Y or N

Alcohol Abuse: Y or N; Amount/Frequency: _____; Treatment Concern: Y or N

Current Drug Use: Y or N; Amount/Frequency: _____; Treatment Concern: Y or N

Drug Abuse: Y or N; Amount/Frequency: _____; Treatment Concern: Y or N

Previous Substance Abuse Treatment: _____

Please list any family members (include parents, siblings, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, psychosis, etc): _____

List family members with any problems with alcohol or drug use/abuse/addiction issues:

Alcohol: _____ Drugs: _____

Mental Status

Do you have current thoughts of suicide? Yes No If so, do you have a plan? Yes No

Have you ever had thoughts about suicide? Yes No; Have you ever attempted suicide? Yes No

If yes, how many times? ____; What were the circumstances: _____

Primary deterrents: _____

Have you ever engaged in self-harming behavior? Yes No What type: _____

Reasons for seeking counseling at this time? _____

Current/Recent Stressors in your life: _____

Goals for Counseling: _____

Have you ever been in counseling before? Yes No If yes, when, for what concerns, and for how long?

Was it helpful? Yes No Please explain: _____

Please Check Any of the Following Issues/Symptoms That Currently Apply to You and Describe:

- Anxiety/Nervousness _____
- Stressed/Overwhelmed _____
- Fearful _____
- Phobia _____
- Depression _____
- Mood Swing _____
- Suicidal _____
- Loneliness _____
- Low Self-esteem _____
- Shyness _____
- My Appearance/Body Image _____
- Feelings of Inferiority _____

- Fatigue/Lethargy _____
 - Lack of Motivation _____
 - Lack of Exercise _____
 - Feel Need to Exercise Too Much _____
 - Lack of close friends/confidants _____
 - Lack of close family relationships _____
 - Marital/Relationship Conflict _____
 - Anger/Temper _____
 - Guilt and/or Shame _____
 - Financial Problems _____
 - Insomnia _____
 - Hypersomnia (sleeping too much) _____
 - Nightmares _____
 - History of Physical, Emotional, or Sexual Abuse (circle which ones apply) _____
-
- Trauma History _____
 - Domestic Violence _____
 - Sexual Problems _____
 - Lack of Appetite/Undereating _____
 - Overeating _____
 - Other: _____

Please check and explain any of the following that you have experienced:

- Death of a spouse/partner Bad break-up with/ Divorce from significant other
- Death of a loved one Family Issues (with children/parents/in-laws)
- Major illness/injury of self Financial issues Move to another city or state
- Major illness/injury of relative Legal Problems Significant job dissatisfaction Loss of job
- Other _____

Who do you consider to be your close family: _____

Religious/Spiritual/ Faith Information:

Describe your religious/spiritual upbringing: _____

Describe any specific religious/spiritual beliefs/values you feel strongly about: _____

What gives your life meaning: _____

What are your sources of strength? _____

What coping skills have you found to be helpful when you are struggling in life? _____

What are your hobbies? _____

How do you spend time relaxing? _____

Print Name: _____

Date: _____

Client Signature

Parent/Guardian Signature

Consent For Evaluation and Treatment

Limits of Confidentiality

The verbal and written contents of a therapy session between a therapist and a client are confidential. No information will be released without your written consents or the written consent of your legal guardian, as mandated by law. In some instances, the therapist has a duty to warn, notify, or disclose information to your family, possible victims, and/or legal authorities. Possible exceptions to confidentiality include, but are not limited to the following situations:

- Child abuse or harmful neglect of children.
- Abuse of the elderly or disabled or vulnerable adults.
- Admitted prenatal exposure to controlled substances that could be harmful to the child or mother.
- The filing of a complaint with a licensing board or other state or federal regulatory authority.
- If you disclose a plan or threat to harm yourself or harm another person.
- Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
- Insurance companies and other third-party payers are given information that they request regarding services to the clients such as: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, etc.

By signing this Consent, you are giving your consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental healthcare services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Print Name: _____

Date: _____

Client Signature

Parent/Guardian Signature

Service Fees and Cancellation Policy

Session Rates Without Insurance Coverage

\$175 for initial session and \$150 per session thereafter
\$175 for all couples and family sessions

Insurance

Sessions may be covered in full or in part by your health insurance or employee benefit plan. I accept most private insurance and Employee Assistance Plans (EAP). I am **unable** to accept Medicaid or Medicare plans.

Records, Forms, and Letters

Medical Records: First copy free and \$.50 per page thereafter.
\$25-\$50 for completed forms
\$25-\$50 for completed letters

Legal Fees

In any legal matter in which I need to hire an attorney or seek legal counsel to respond to any legal documents such as a subpoena or court order (for records, deposition, or a court appearance) or legal action brought against this office/clinician related to your case, clients will be responsible for attorney's fees and related costs.

Court Appearance (Fees due prior to court appearance): \$500 plus \$150 per hour

Deposition: \$250 plus \$150 per hour

Payment

Cash, checks, debit/credit cards, and HSA cards are accepted for payment.

Returned Check Fee: \$50 for checks that do not clear due to insufficient funds.

Cancellation Policy

Your appointment time is specifically reserved for you. If you are unable to attend an appointment, your counselor requests that you provide at least 24-hours advanced notice. For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or for a scheduled appointment that is completely missed, your card on file will be charged a \$75 cancellation fee within 24-48 hours of missed appointment since your counselor is unable to schedule this time for another client.

I have read, understand, and agree to the terms of the Service Fees and Cancellation Policy form in its entirety.

Print Name: _____ Date: _____

Client Signature

Parent/Guardian Signature

Authorization for Credit Card Use

All credit card information will remain confidential. This information will only be used in the following instances: To cover charges/fees for missed appointments that were not cancelled within 24 hours (or with proper notification) within 24-48 hours of missed appointment; To cover client's outstanding balance that is not covered by health insurance company. Clients will receive monthly statements/bills if there is an account balance. Cards on file will be charged to cover outstanding balances that are not paid within 90 days of original service. Therapist will attempt to collect balance from client at sessions and by phone/mail prior to charging card on file.

The following is to be completed by the card holder:

Date: _____

Name on Card: _____ Relationship to Client: _____

Billing Address: _____

Street Address/P.O. Box

City

State

Zip code

Credit Card or Debit Card

Type of Card: Visa Mastercard AmEx

Credit Card Number: _____

Expiration Date: _____ 3 or 4 Digit Card Identification Code (on back of card): _____

I authorize Sondra R. Brumett, LPCC/LCMHC, Owner of WellSprings Counseling Services, PLLC to charge my card on file to cover service fees not covered by my insurance/EAP plan and fees from missed counseling appointments without giving proper cancellation/notice.

Card Holder Printed Name

Card Holder Signature

Date

Client Printed Name (if different from card holder)
(or Parent/Guardian if client is under age 18)

Client Signature

Date

Authorization for Electronic Communication

As a convenience to me, I authorize Sondra R. Brumett, owner of WellSprings Counseling Services, PLLC, to communicate with me regarding my treatment via electronic communications (email or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, Sondra R. Brumett, LPCC/LCMHC, shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information to and/or from me, the client.

Text Communication: Yes No

List authorized phone number if different from number provided on page one of New Client Paperwork: _____

Email Communication: Yes No

List e-mail if different from client e-mail provided on page one of New Client Paperwork:

Other: Yes No

Authorized service(s): _____

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time.

I understand that may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Sondra R. Brumett, LPCC in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

Patient Name (print)

Patient Name (sign)

Date

CONSENT FOR TELEHEALTH/TELETHERAPY COUNSELING SESSIONS

WellSprings Counseling Services, PLLC
Sondra R. Brumett, LPCC/LCMHC
305 E. Union St. Suite B-115, Morganton, NC 28655
859-230-2552/844-648-5885 fax

1. I understand that my therapist, Sondra R. Brumett, LPCCc/LCMHC, is offering me the option of counseling via telehealth/teletherapy vs. in-person counseling.
2. I understand that teletherapy using video conferencing technology will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I also understand that I am responsible for a) providing a necessary computer or tablet with video/audio capacity for videoconferencing and internet access for my teletherapy session; and b) arranging a location on my end with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions.
4. I understand there are potential risks to this technology despite reasonable efforts on the part of my therapist, including but not limited to: internet interruptions and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/session if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that I have a right to ask my therapist any questions in regard to this procedure as to any risks, benefits, and any practical alternatives. I CONSENT TO USE THE TELEHEALTH system Doxy.me which is the HIPPA Compliant technology service we will use to conduct telehealth videoconferencing appointments.
6. I understand that my health insurance plan will be billed for Telehealth sessions and that I will verify with my insurance company that TeleBehavioral Health counseling sessions are covered by my plan. I agree that if my insurance does not cover TeleBehavioral Health counseling session that I will be responsible for any outstanding balance. (Therapist is willing to work with each client on a payment plan should insurance coverage be an issue.)
7. I understand that the Fail To Keep policy remains the same and that the fee for cancellation of a teletherapy session without 24 hours' notice is \$75, although exceptions may be made at the discretion of my therapist.

By signing this document, I acknowledge:

- A. Telehealth by Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
- B. Though my therapist and I may be in direct, virtual contact through the Telehealth Service, and Doxy.me Telehealth Service does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
- C. I do not assume that my provider has access to any or all of the technical information in the Telehealth by DOXY Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by DOXY Service.

E. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment and I will ensure that I have adequate privacy to conduct my session with confidentiality.

By signing this form, I certify: a) That I have read or had this form read and/or had this form explained to me; b) That I fully understand its contents including the risks and benefits of the procedure(s); and c) That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Print Name: _____

Date: _____

Client Signature

Parent/Guardian Signature