*WellSprings Counseling Services, PLLC*
*"Your Path to Wellness"*


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114 Dennis Drive
Lexington, KY 40503
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; # 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: _________________________________________

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## 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: ____________________________________________________

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

- ☐ 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 <u>explain</u> 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

$150 for initial session
$135 per session thereafter

$150 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.

## Forms and Letters

$25 for completed forms
$25 for completed letters

## 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 it's 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, 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) Client Signature Date

(or Parent/Guardian if client is under age 18)

# 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, 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