



Connie Morris, MSW, LCSW

1655 Burlington Pike Suite 101

Florence, KY 41042

Phone: (859) 342-6444

Fax: (859) 342-0999

Thank you for choosing me as your treatment provider.

Attached is the intake paperwork. Please print it, fill it out and bring it to your first appointment along with your insurance card. **It is important that you complete this paperwork in its entirety and obtain any necessary authorizations from your insurance provider.** If you have questions, I will be happy to answer them at our first meeting. Please provide 24 hours notice if you need to change your appointment time.

Also, please be aware we have no office staff so the phones only get answered when there is a therapist available between sessions. Just leave a message in my confidential mailbox and I will return your call. If no one is available to greet you when you arrive, please have a seat in the waiting room and I will come out to get you at your scheduled appointment time.

**Burlington Executive Center
1655 Burlington Pike Suite 101
Florence, KY 41042**

Directions from the North:

Take I-71 S, I -75 S toward Lexington
Take exit # 181/Florence Burlington
Make right on Burlington Pike (KY – 18 East)
Office is located approx. 2.1 miles on the left,
Entrance is just past Oakbrook subdivision.

Directions from the South:

Take I-71 S, I -75 N toward Cincinnati
Take exit # 181/Florence Burlington
Make left on Burlington Pike (KY – 18 East)
Office is located approx. 2.1 miles on the left,
Entrance is just past Oakbrook subdivision.

Directions from the Indiana:

Take I-275 East to exit # 8 .
Turn right on KY – 237
Turn left on Burlington Pike
Destination is on the right (Just past Limaburg road – if you get to Oakbrook, you have gone too far.)

Office has a separate entrance and is located on the left side of the building.



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GENERAL INFORMATION
ALL INFORMATION MUST BE COMPLETED

Patient Information:

Date: _____

Patient Name _____ Gender: Male Female
Last First Middle

Primary Address _____ City/State _____ Zip _____

Phone Home (____) _____ - _____ Cell (____) _____ - _____ Work (____) _____ - _____
OK to leave message at this number? (Y/N) Home: _____ Cell: _____ Work: _____

Email: _____ OK so send email to this address? Y/N: _____

Patient Social Security # _____ Date of Birth _____ - _____ - _____

Marital Status Married Single Divorced Separated Widowed NA (children)

Employment Status Employed Student Unemployed

Primary Care Physician _____ Phone (____) _____ - _____

Emergency Contact: Name _____ Phone (____) _____ - _____

Insurance Information: *(The following must be completed for us to bill the insurance company on your behalf. If you do not obtain this information, our billing company will obtain them for you at a processing fee of \$25.00 – this cost will be your responsibility)*

Policy Holder's Information:

Name _____ Relationship to Client _____

Social Security # _____ Date of Birth _____ - _____ - _____

Insured's place of employment _____

If different from above:

Address _____ City/State _____ Zip _____

Home Phone (____) _____ - _____ Cell (____) _____ - _____

Insurance Information (Information found on Insurance Card)

Insurance Company Name _____

Member ID # _____ Group # _____ Effective Date _____

Claims Mailing Address: _____

Insurance Benefit/Authorization Information (You must call your carrier for this information)

Insurance Rep Name: _____ Date called _____

Phone # called _____ office co payment _____

Deductible \$ _____ (if any) Amount met \$ _____ Co - insurance % \$ _____ /session

of visits allowed per calendar year _____ # used this year _____

Authorization needed Yes No Authorization # _____

of visits auth'd _____ effective dates from _____ to _____

Are you seeking counseling related to a court order or legal proceedings? Yes No

Who referred you to our practice? _____

May we thank them: Yes No Phone: _____



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Informed Consent for Receipt of Psychological Services (Adult)

This form is to document that I, _____ give voluntary permission and consent to receiving psychological services from **Connie S. Morris, MSW, LCSW** at WellSpring Psychological Services.

_____ **Purpose and Background:**

The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.

While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by my therapist. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

_____ **Confidentiality:**

I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

_____ **HIPAA**

I understand that this consent form acknowledges my right to privacy and the limitations on my privacy; I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of WellSpring Psychological Services' "Notice of Privacy Practices", I acknowledge I was offered this policy statement on the date indicated by my signature below.

_____ **Attendance:**

I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of concern.

I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of \$75.00 per missed appointment. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice.

_____ **Contact Information:**

The office address for WellSpring Psychological Services is: 1655 Burlington Pike Suite 101, Florence KY 41042. I understand that for routine appointments and information I may call (859) 342-6444. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible by my therapist. If I have an after-hours crisis or need assistance more quickly, I can call my therapist at the crisis contact number provided in their regular voicemail box, however, I understand this number is for crises only. If I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room. In the event that I cannot reach my therapist, I understand that it is recommended that I call my primary care physician or 911 or go to the nearest emergency room.

_____ **Complaints Procedure:**

If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through your therapist's state licensing agency, which may be contacted in Frankfort, KY 40602.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.

I release and hold harmless all Clinicians at WellSpring Psychological Services from any action or liability arising out of my participation in treatment.

Signature of client Date

Signature of Witness Date



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ADULT INTAKE

Name: _____

Date: _____

Date of Birth: _____ Age: _____

1. Why have you come to WellSpring Psychological Services (Presenting issue for Client)?

2. How long has this been an issue? _____

3. What have you tried to do to resolve this issue? _____

4. What are your goals for counseling? _____

5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/use): _____

6. Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues and/or alcohol use or chemical dependency? Please explain:

7. Who resides with you in your home?

<u>Name</u>	<u>Relationship:</u>	<u>Age:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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8. Medical History:

Health (describe your general health as well as any chronic conditions including pain) _____

9. Who is your primary care physician? _____

When was your last complete physical exam by an M.D.? _____

Are you currently under the care of an M.D. for any condition? Yes____ No____

If yes, please explain: _____

Please list all current medications including over-the-counter and prescription medications:

<u>Name of Medication:</u>	<u>Dosage:</u>	<u>Date Started:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please prior medication for mental health issues, chemical dependency or alcohol use:

<u>Name of Medication:</u>	<u>Dosage:</u>	<u>Date Started:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Health Concerns

Please check any of the following that apply:

- Significant weight gain/loss in the last six months Dieting
 Food/drug allergies Overeating or eating too little Other

If any box is checked, please explain: _____

Do you have any functional limitations that affect your daily living (ex: physical impairments, problems with self care, speech, vision, or hearing)? Yes____ No____

If yes, please explain: _____

11. Legal History:

Please place an "N" for none, "C" for currently experiencing, or "P" for experienced in the past.

DUI _____	Bankruptcy _____	Divorce _____
Unemployment _____	Domestic Violence _____	Custody Dispute _____
Disability Claim _____	Workman's Compensation _____	

12. Financial Problems: _____

13. Educational Background (highest grade completed): _____

14. Employment History (Please describe current job briefly): _____

15. Military Service: _____

16. History of Abuse:

Please place an **"N"** for none, **"C"** for currently experiencing, or **"P"** for experienced in the past.

Verbal Abuse _____ Emotional Abuse _____ Childhood Abuse _____

Physical Abuse _____ Spouse Abuse _____

Sexual Abuse _____ Elder Abuse _____

17. Alcohol and Drug Use:

Do you drink alcohol? Yes ___ No ___ If yes, how often? _____

When was the last time you had a drink? _____

How much did you drink at that time? _____

Do you have any history of using or abusing drugs/medications? Yes ___ No ___

Do you currently abuse any drugs/medications? Yes ___ No ___

What substances have you used in the last 6 months? (check all that apply)

Marijuana/ "Pot" Cocaine Inhalants/ "Huffing"

LSD/ "Acid" Amphetamines/ "Speed" Other

Pain Killers Sedatives/ "Downers" None of Above

If "Other" is checked, explain: _____

Check any of the following that has occurred as a result of your drinking or drug use:

Arrest DUI Family Problems

Public Intoxication Financial Problems Arguments

Work Problems Health Problems Relationship Problems

Do you use Nicotine? Yes No Amount? _____

Do you use Caffeine? Yes No Amount? _____

18. Sexual/Affectionate History:

Are you satisfied with your sex life? Yes ___ No ___

Do you have any concerns or question about your sexual orientation or experiences? (If so, please explain) _____

19. Religious/Spiritual History:

Do you have an identified religious preference? _____



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20. History of Harm to Self or Others:

Do you currently have any urges/thoughts of hurting yourself?

Yes_____ No_____

Any current urges/thoughts of hurting another?

Yes_____ No_____

Any history of hurting self or suicide attempt?

Yes_____ No_____

Any history of physical aggression toward another

Yes_____ No_____

If yes on any of these questions, please describe:_____
