WellSpring
Psychological Services

Mary Gina Connor, MSW, LCSW
1655 Burlington Pike Suite 101
Florence, KY 41042
Phone: (859) 342-6444, ext. 3
Fax: (859) 342-0999

Thank you for choosing me as your treatment provider.

Attached is the intake paperwork. Please print it, fill it out, **in its entirety**, and mail to:

mgadmin@wellspringky.com - 1 week prior to your session.

NOTE: If there is an active DVO or EPO in your case, please notify me BEFORE your first session.

Also, please be aware we have limited staff so the phones often go to voicemail. 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.

WellSpring Psychological Services is comprised of independent mental health practitioners who share office space and physical resources. Each practitioner is SOLELY responsible for their own clinical and business practices.

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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 (____)_____-_____

Were you court ordered to attend Co-pareneting counseling? ____Yes ____ No

If You ansewerd yes to the above:

Please bring a copy of the Court Order to your first session.

Who is your attorney?

Name: _____
Address: _____
City/State/Zip _____

Phone Number _____
Cell Phone Number (if known) _____
FAX: _____
Email Address: _____

Is there currently, or has there there been an EPO's between you and your Co-Parent? ____ Yes ____No
If yes, please explain

_____
_____

Is there currently, or has there there been a DVO's between you and your Co-Parent? ____ Yes ____No
If yes, please explain

_____
_____

If thre is an active EPO or DVO, please bring a copy to your first session.

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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 **MARY GINA CONNOR, 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 Mary Gina Connor, msW, lcSW 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.

_____ **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.

_____ **AUDIO/VIDEO TAPING** Audio or Video taping of phone calls and/or sessions is strictly prohibited. Doing so is considered a violation of this agreement and may result in termination of services.

_____ **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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Fee Agreement

Co-Parenting therapy is **not** insurance reimbursable and is billed at a rate of $200 per hour.

Payment ***must be made at time of service*** and will be split 50/50 between the parties unless otherwise Court Ordered.

A deposit must be made at the intital appointment to cover any ancillary services incurred by Ms. Connor in your case.. (see Attached)

I. CANCELLATION POLICY

A. Appointments cancelled with **less than 1 full business day notice** will be charged the full amount of the scheduled time for the appointment.

B. Appointments cancelled **between 1 and 2 full business days** will be charged half of the scheduled time for the appointment.

C. There is **no charge** for appointments cancelled with **more than 2 full business days'** notice.

D. An appointment is considered missed if the parties have not arrived 20 minutes after the scheduled start time of the session.

E. Charges for missed appointments or late cancellations **will be paid by the person who misses and/or cancels the appointment.**

Signature of Client/Responsible Party _____ Date _____

Signature of Witness _____ Date _____

ii. CLAIMS FILED IN COURT

Any claims filed in court arising from the Parties' work with Mary Gina Connor, MSW, LCSW, including but not limited to fee disputes, shall be heard in Family Court.

Signature of Client/Responsible Party _____ Date _____

Signature of Witness _____ Date _____

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ADULT INTAKE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

If additional space is needed to answer any of the questions, please use the back of the page.

1. Briefly describe why you are coming in today?
   _____
   _____
   _____

2. What do you see as your own contribution to difficulites in Co-parenting?
_____
_____
_____

3. What have you tried to do to resolve parenting difficulties and were your efforts successful?
_____
_____
_____

4. What are your strengths as a parent?
_____
_____
_____

5. What are your weaknesses as a parent?
_____
_____
_____

6. What do you see as your Co-parents strengths as a parent?
_____
_____
_____

7. Are you remarried or in a significant relationship? _____ Yes _____ No

Parner's name _____
Length of Relationship _____

Do you consider your significant other to be supportive of your Co-parenting relationship with your Co-Parent? _____ Yes _____No

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8. Who resides with you in your home? Briefly describe your children

Name	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. If you could wave a magic wand and you and your co-parent were able to be effective as co-parents, what would this look like? Please be as specific and detailed as possible:

_____
_____
_____
_____
_____
_____

10. What is the best form of communication between you and your Co-Parent?

_____

11.. Have you and your Co-parent ever participated in counseling before? ____ Yes ____No
If yes, was it helpful? Why or Why not? (If it was helpful, please explain what was helpful.)

_____
_____
_____

12. Have you ever received Mental Health services in the past? (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/use):

_____
_____
_____

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13. 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:

_____
_____
_____

14 . 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 _____

15. Educational Background (highest grade completed): _____

16. Do you work outside of the home? If yes, please briefly describe your current job:

_____
_____
_____

17. Medical History:
Health (describe your general health as well as any chronic conditions including pain) _____

_____
_____
_____

Who is your primary care physician? _____

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:

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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18. 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? _____

19. Abuse History: 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 _____	

20. Religious/Spiritual History:
Do you have an identified religious preference? _____

21. 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:_____
_____