Kerrie L Brittingham, LCSW
Licensed Clinical Social Worker

Burlington Executive Center
1655 Burlington Pike Suite 101
Florence, KY 41042
Phone: 859-640-2379

Fax: 859-342-0999

Kerrie@WellSpringKY.com

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 or cancel your appointment time.

Please be aware we have no office staff, phones only get answered when there is a therapist available between sessions. Please 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.

If services are for a child (under 18), please do not bring the child to the first appointment. Service recommendations and scheduling will take part during initial appointment.

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 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.)

Our office has a separate entrance and is located on the far left side of the building, past the trash receptacles.

I look forward to meeting you!

Kerrie L Brittingham, LCSW

INITIAL CLIENT INFORMATION

Client Information:

First_____MI_____Last_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ Work (_____) _____ Cell (_____) _____

SS#_____ DOB_____ Age_____ Sex ____M ____F

Would you like me to contact your Primary Physician? ☐No ☐ Yes Name:_____ Phone:_____

Are you currently seeing a psychiatrist? ☐No ☐Yes Name:_____ Phone:_____

Emergency Contact_____**Phone No.**_____

Responsible Party Information: ☐ Self

First_____MI_____Last_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ Work (_____) _____ Cell (_____) _____

SS#_____ DOB_____ Relationship to Client _____

Primary Insurance Information (found on your Insurance card):

You must complete this section in full.

Ins. Co._____ Plan Name_____

Policy #_____ID#_____Group #_____

Insured's Employer_____ Relationship to client ☐Self ☐Spouse ☐Parent ☐Other

Insured's Name_____

Address_____City_____ ST_____Zip_____

Phone (_____) _____ SS#_____ DOB_____

I**nsurance Benefit/Authorization Information (You *must* call your carrier for this information):**

If insurance is not verified, the full amount of the intake will be due at the time of service.

Ins. Rep. Name _____ Phone Number:_____

Date Called: _____ Office Co-pay: _____Deductible $_____ (if any)

Deductible met $_____ Co-insurance % $_____/session

Number of visits allowed per calendar year _____ Number used this year: _____

Authorization Needed: ☐No ☐Yes: Authorization Number _____

Number of visits authorized _____ Effective Dates: From _____to _____

Kerrie L Brittingham, LCSW
OFFICE POLICIES

Initials

_____ **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 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 Kerrie L Brittingham, LCSW. 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 Kerrie L Brittingham, LCSW, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, Kerrie L Brittingham, LCSW, 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 Kerrie L Brittingham, LCSW's "Notice of Privacy Practices", as 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 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.

_____ **Child Supervision Policy:**
I understand that neither WellSpring Psychological Services nor Kerrie L Brittingham, LCSW can accept responsibility for unattended children. I will make arrangements for proper supervision and be considerate of others in the waiting area.

_____ **Contact Information:**
The office address for WellSpring Psychological Services is1655 Burlington Pike Suite 101, Florence KY 41042. I understand that for routine appointments and information I may call (859) 640-2379 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 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.

_____ **Termination from Treatment Policy**
As a client, you have the right to terminate treatment at any time, unless otherwise ordered by the Court. Providers also reserve the right to terminate clients from the practice for any reason we deem appropriate and/or necessary including, but not limited to verbal abuse to staff or other clients, physical assault or threat to assault staff, partners, personnel, clients, property, refusal to follow essential treatment recommendations that could result in harm to yourself or others, repeated no shows or late cancellations, and/or other individual reasons

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 and Kerrie L Brittingham, LCSW, from any action or liability arising out of my participation in treatment.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Date

Kerrie L Brittingham, LCSW
Payment and Consent to Bill Third Party Payer

Initial

_____ **I understand that payment is expected at time of service.** If I wish to pay for services out of pocket, or for the purposes of making my co-payment should I elect to use my insurance, I may make payments via cash, check (made payable to Kerrie L Brittingham, LCSW), credit, debit, or HSA card.

_____I understand all checks returned unpaid will be subject to a $35.00 service fee.

_____I understand all balances are due prior to continuation of services. Balances remaining on an account 30 days from the date of service will be considered past due and will accrue 5% every 30 days.

_____**I understand my account may be turned over to a collection agency for the purpose of recovering funds if a balance is due for more than 90 days.**

Standard Fee Schedule
(Contracted insurance rates not reflected)

Initial Intake Interview	$195.00
Individual Psychotherapy	$175.00
Family Psychotherapy	$175.00
The following services are not generally insurance reimbursable:	
Reports/correspondence (e.g., letters, etc)	$15.00 – $35.00
Phone calls (lasting longer than 10 minutes)	$1.00/minute
Phone sessions	$3.33/minute
Billing/Processing fee (assessed on payments not made at time of service)	$25.00
Return Check Fee	$35.00
Copying Records	$1.00/page, plus postage
Record Review	$75.00/hour
Court: preparation/testimony/reports/letters/deposition	$175.00 hour
Half day court attendance (4 hours or less)	$600.00
Full day court attendance (over 4 hours)	$1,200.00

*A deposit of 50% of expected fees is required at time of scheduling
* 24 hour cancellation notice must be given or deposit will be forfeited

Use of Insurance and Authorization for Treatment:

As a client of Kerrie L Brittingham,LCSW, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and may additionally constitute the release of treatment planning information.

If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits**. I understand I will be charged $75.00 for missed or cancelled appointments unless notification is given 24 hours prior to the scheduled time of the appointment.** ***I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.***

I, _____,
(Client Name)

Please check one:

❑ **wish** to use my medical insurance to off-set the cost of treatment, and in so doing give my therapist permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

❑ **do not** wish to use any medical insurance benefit to cover services I receive through my therapist. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service.

_____ _____
Signature of Client Date

_____ _____
Signature of Therapist Date

Kerrie L Brittinham, LCSW

Consent of Non-Secure Forms of Electronic Communication

Electronic communication, via email and/or text, between you and your therapist may not be secure. By signing below, you are acknowledging that you realize that email and text communication does not provide a completely secure means of communication. While your therapist will take reasonable efforts to protect your confidentiality, there is some risk that any protected health information contained in email or text may be disclosed or intercepted by unauthorized third parties.

Your treatment will not depend on you giving consent. You also have the right to terminate this agreement at any time.

Use of more secure communications, such as phone or fax, are always an alternative that are available to you if you elect to not give consent to the following forms of communication.

I give permission for my therapist to contact me using non-secure methods regarding reminders, scheduling, or other relevant matters, and I understand the risks involved.

Text communication: ☐ No ☐ Yes, phone number:_____

Email communication (including email appointment reminders) :

☐ No ☐ Yes, Email:_____

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date

Kerrie L Brittingham, LCSW

CLIENT SURVEY- ADULT

Client's Name: _____ Date: _____

IDENTIFY STRENGTHS

We all have strengths that we use in our daily interactions. Identifying your strengths is a good way to start your counseling experience.

I consider the following to be my strengths: (check all that apply)

- ☐ My ability to form interpersonal relationships
- ☐ My physical fitness/attributes
- ☐ My ability to identify and express my feelings
- ☐ My creativity/talents
- ☐ My ability to bounce back/resiliency
- ☐ My spirituality/faith
- ☐ My ability to think critically
- ☐ My friends/family/relationships
- ☐ My work ethic
- ☐ My ability to think before I act

Others:_____

_____

FAMILY INFORMATION

Family Member's Name	Age	Relation to You	Lives With You
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
Significant Others			
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

Sexual Orientation Status: ☐ Heterosexual ☐ Lesbian/Gay ☐ Bisexual ☐ Other:_____

Marital Status: ☐ Married ☐ Never Married ☐ Widowed ☐ Single
☐ Divorced ☐ Separated ☐ Living together as partners

If married, date of present marriage::_____

Previous marriages (dates and how ended):_____

EDUCATION AND WORK

Highest level of education obtained:_____

Schools attended: _____

Areas of Study/Majors:_____

Current Employment:_____

Satisfaction/Concerns:_____

Length Employed: _____ Previous Employment: _____

PRESENTING CONCERN

Please check any of the following for which you are seeking help:

- ☐ Aging Issues
- ☐ Sleeping Difficulty
- ☐ Fearfulness/Nervousness
- ☐ Social withdraw
- ☐ Depression/Sadness
- ☐ See/Hear things not real
- ☐ Drug/Alcohol Use
- ☐ Stress
- ☐ Sexual Concerns
- ☐ Eating/Food Concerns
- ☐ Aggression
- ☐ Temper outbursts
- ☐ Irritability
- ☐ Adjustment concerns
- ☐ Financial Stress
- ☐ Uncontrollable crying
- ☐ Thoughts of hurting self
- ☐ Legal concerns/illegal activities
- ☐ Significant weight gain/loss
- ☐ Difficulty in social situations
- ☐ Problems concentrating
- ☐ Hyperactivity
- ☐ Destructive behavior
- ☐ Employment concerns
- ☐ Prolonged grief
- ☐ Homicidal thoughts
- ☐ Frequent Illness

Other: _____

Have you ever experienced: ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse

If yes, by whom: _____ though what age? _____

Have you ever sought help for these concerns before? ☐ No ☐ Yes

If yes, from: _____

What have you done to address these concerns? _____

_____

What are your goals for treatment? _____

_____

_____

SOCIAL INTERACTIONS

Do you interact with other people? ☐ Yes ☐ No

If yes, are they: ☐ My age ☐ Older ☐ Younger

Do you: ☐ make friends easily ☐ have few friends ☐ have friends, but keep them at a distance

Do you participate in organized religion: ☐ No ☐ Yes, describe: _____

LEGAL HISTORY

Is attending this counseling session court mandated? ☐ No ☐ Yes, describe:_____

_____

Is there current involvement in the family by Social Services? ☐ No ☐ Yes

If yes, name of worker:_____

Reason for involvement:_____

Other legal involvement? ☐ No ☐ Yes, describe: _____

_____

Counselor Notes: _____

_____

_____

MEDICAL

Have you previously seen another **mental health** professional? ☐ No ☐ Yes, please list:

If yes, who? _____

Service provided? _____

Are you currently taking **mental health** medication? ☐ No ☐ Yes, please list:

Medication Name Prescriber Diagnosis/Reason Taking Start/End Date

_____

_____

_____

When was your last physical examination/doctor's appointment? _____

Are you currently on medication? ☐No ☐ Yes, please list:

Medication Name Prescriber Diagnosis/Reason Taking Start/End Date

_____

_____

_____

_____

_____

Did you have any major illnesses in the past five years? ☐ No ☐ Yes, describe: _____

_____

Other health related concerns: _____

_____

How would you describe your **physical health** currently? (Please check one)

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

How would you describe your **emotional health** currently? (Please check one)

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

OTHER INFORMATION

Other information you would like your counselor to know: _____

_____

_____

_____

Completed by (signature): _____ Date: _____

Counselor Notes:_____

_____

_____

_____

Signature of Clinician _____ Date:_____