**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!**

WellSpring Psychological Services

# 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:_____

**Emergency Contact:**_____**Phone:** _____

**Guardian Information:**

First_____MI_____Last_____

Address_____City_____ ST_____Zip_____

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

Relationship to Client _____

**Primary Insurance Information (found on your Insurance card):**

*Please 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_____

**Insurance 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 $ this calendar year_____ 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. I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise and may do so at anytime during treatment.

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 Jay Smith MS, LPCC-S. 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 Jay Smith MS, LPCC-S, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, Jay Smith MS, LPCC-S 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 Jay Smith MS, LPCC-S'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 Jay Smith MS, LPCC-S 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 Jay Smith MS, LPCC-S is 1655 Burlington Pike Suite 101, Florence, KY 41042. I understand that for routine appointments and information I may call (859) 391-9929. 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 my child is in 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 child's pediatrician 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, The Board of Professional Counselors, which may be contacted at 911 Leawood Drive, Frankfort, KY 40601.

_____ **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

**Office Structure**
_____ I understand that WellSpring Psychological Services is comprised of independent mental health practitioners who share office space and physical resources. Each practitioner is SOLEY responsible for his/her own clinical and business practices.

**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 office policies and consent to treat.**

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.

_____
Child's Name

_____ _____
Signature of Guardian Date

_____ _____
Signature of Therapist Date

# Kerrie L Brittingham, LCSW

## CONSENT TO TREAT A MINOR

Initials

_____ **Consent to Provide Treatment**
I hereby provide my consent to Kerrie L Brittingham, LCSW to provide therapeutic services to me or my dependent. I understand this authorization will be in effect until such time as this psychotherapeutic relationship is terminated, by myself or the therapist.

_____ **Confidentiality**
I understand that I have the right to information concerning a minor child in therapy, except where otherwise stated by law. I also understand that this therapist believes in providing a minor child with a private environment in which to disclose himself/herself to facilitate therapy. I therefore give permission to this therapist to use her discretion, in accordance with professional ethics and state and federal laws and rules, in deciding what information revealed by my child is to be shared with us.

**Divorced Parents/Custody Arrangements:**

☐ Not Applicable

_____ I will provide a copy of any custody agreement or court order at the first appointment and anytime thereafter that it changes.

_____ As the parent requesting services, I will notify the other parent (birth or adoptive) that treatment is being sought.

_____ As the parent requesting services, I understand that I am solely responsible for payment, regardless of our arrangement. I will seek reimbursement from the other party as needed.

_____ I understand that this therapist does not seek to keep information provided by one parent from the other, if custody is joint. Information important to the well-being of our child will be openly discussed and shared. Step-parents may be asked to participate in evaluations and treatment, when appropriate and agreed upon by custodial parent(s).

Please briefly describe custody arrangement: _____

**This is my written consent for the mental health assessment and treatment of**

**_____ under the terms stated above.**
(Child's Name)

_____ _____
Signature of Parent/Guardian 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), 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 <u>NOT</u> generally insurance reimbursable:** | |
| Reports/correspondence | $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

**<u>Use of Insurance and Authorization for Treatment:</u>**

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, _____,
(Guardian/Responsible Party 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/Responsible Party Date

_____ _____
Signature of Therapist Date

# Kerrie L Brittingham, 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 appointment reminders):

☐ No ☐ Yes, email:_____

_____ _____

Signature of Guardian/Responsible Party Date

_____ _____

Signature of Therapist Date

# Kerrie L Brittingham, LCSW

CHILD INFORMATION

Client's Name: _____ Date: _____

## IDENTIFY STRENGTHS

*Let's start by identifying your child's strengths. These are the building blocks from which change can take place. Please indicate if your child has the ability to:*

- ☐ describe feelings, ask somebody for feedback
- ☐ says good things about self, looks forward to things
- ☐ follow example of role models, learn from experiences
- ☐ keep trying, takes steps to achieve goals
- ☐ forgive, cooperate, get along
- ☐ remember info, handle belongings
- ☐ congratulate others, offer help, express concern
- ☐ wait turn, adjust to change in plans

Others:_____

## FAMILY INFORMATION

*Please identify all those people who currently live with your child.*

| Name | Age | Relation to Child |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*Other family members or persons important in your child's life that was not mentioned above, include all siblings:*

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child ever lived with anyone else or been in foster care? ☐ No ☐ Yes

If yes, please elaborate:_____

Marital History of Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

If divorced or separated, what age was the child? _____months/ _____ years old

Please describe visiting/custody arrangements: _____

Parent's Occupations: _____

Family Strengths:_____

Family Needs:_____

How would you describe your child's interactions with family members? _____

_____

Please list any person(s) who died that played an important role your child's life: _____

_____

## PRESENTING CONCERN

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

- ☐ Nightmares
- ☐ Sleeping Difficulty
- ☐ Fearfulness/Nervousness
- ☐ Social withdraw
- ☐ Depression/Sadness
- ☐ See/Hear things not real
- ☐ Drug/Alcohol Use
- ☐ Parental Stress
- ☐ Sexual Promiscuity
- ☐ Aggression toward adults
- ☐ Aggression toward peers
- ☐ Temper outbursts
- ☐ Irritability
- ☐ Not obeying rules
- ☐ Running away from you
- ☐ Constant crying
- ☐ Threatens to hurt self or others
- ☐ Legal concerns/illegal activities
- ☐ Significant weight gain/loss
- ☐ Does not get along with peers
- ☐ Problems concentrating
- ☐ Hyperactivity
- ☐ Destructive behavior
- ☐ Clingy behaviors
- ☐ Fire setting
- ☐ Homicidal thoughts or threats
- ☐ Suicidal thoughts/self harm

Other: _____

How long have these behaviors been a concern? _____

Have you ever sought help for these concerns before? ☐ No ☐ Yes, describe:_____

_____

What has been done to address these concerns? _____

_____

Is your child taking any medications for Mental Health: ☐ No ☐ Yes, Prescriber, Medication and dosage:

_____

Has your child ever experienced: ☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse

Please describe: _____ though what age? _____

Has your child ever witnessed domestic violence? ☐ No ☐ Yes

If yes, between whom? _____ though what age? _____

Has your child experienced a traumatic event: ? ☐ No ☐ Yes, describe:_____

_____

## SOCIAL INTERACTIONS

Does your child regularly interact with other people? ☐ No ☐ Yes

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

Your child: ☐ makes friends easily ☐ has few friends ☐ has friends, but fights frequently

How well does your child get along with his/her siblings?

☐ Better than average ☐ Average ☐ Worse than average ☐ Not applicable- no siblings

How does your child react to strangers: ☐ No fear ☐ Hesitant ☐ Panics around new people

Are you concerned with your child's use of technology or social media? ☐ No ☐ Yes, explain: _____

_____

Child's favorite pastimes are: _____

Child participates in clubs, teams, groups: ☐ No ☐ Yes If yes, please identify: _____

Child participates in organized religion: ☐ No ☐ Yes If yes, please identify: _____

## SCHOOL HISTORY

Name of current school attending: _____ Current grade: _____

Dates attended:_____ Previous schools attended: _____

What is your child's favorite subject in school? _____

Does your child have problems at their current school? ☐ No ☐ Yes

If yes, describe:_____

Has your child had problems in the past? ☐ No ☐ Yes, describe:_____

Has your child ever been suspended? ☐ No ☐ Yes, describe: _____

Has your child ever been expelled? ☐ No ☐ Yes, describe: _____

What kind of grades does your child get most often?

☐ A ☐B ☐C ☐D ☐F

Does your child have an IEP or accommodations to assist in their education? ☐No ☐ Yes

If yes, please describe :_____

## LEGAL HISTORY

Is attending this counseling session court mandated? ☐ No ☐ Yes

If yes, please describe:_____

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

If yes, name of worker:_____

Reason for involvement:_____

Has there ever been involvement with the family and Social Services? ☐ No ☐ Yes

If yes, list reason and outcome: _____

Other legal involvement for family or child? _____

_____

_____

## OTHER INFORMATION

Other information you would like your counselor to know: _____

_____

_____

_____

_____

_____

Completed by (signature): _____ Date: _____