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 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.

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.

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 Indianna:

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 (Child)

This form is to document that I, _____ give voluntary permission and consent for my child, _____ to receiving psychological services from _____, 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 WellSpring Psychological Services. 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 $60 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 is1655 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 for any reason I cannot reach 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.

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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Consent to Bill Third Party Payer

Use of Insurance:
As a client at WellSpring Psychological Services, 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.

Charges for Services:

Diagnostic Assessment	$ 195.00
Psychotherapy Session	$ 175.00
Medication Management	$ 90.00

The following services are NOT generally insurance reimbursable:

Medication Management (per 15 minute)	$ 35.00
Billing/Processing fee (Assessed For initial insurance authorization)	$ 25.00
Billing/Processing fee (Assessed on payments not made at time of service)	$ 20.00
Missed Appointment/Late Cancellation	$ 75.00
Return Check Fee	$ 30.00
Phone calls (lasting longer than 10 minutes)	$ 1.00 / minute
Letter Writing	$ 35.00 / page
Copying Records	$ 1.00 /page plus postage
Disability/Workmans Compensation	
FMLA paperwork/phone calls	$ 35.00
Records Review	$ 75.00 / hour
Court Preparation and Court Reports	$ 150.00 / hour

*Half Day Court Attendance (4 hours or less)	$ 600.00	(retainer payment due at time of scheduling)
*Full Day Court Attendance (over 4 hours)	$ 1,200.00	(retainer payment due at time of scheduling)

* 24 hour cancellation notice must be given or retainer will be forfeited.

Payment:
I understand that payment is expected at time of service. Payments not made at the time of service will incur a $20.00 billing/processing fee per occurrence. 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 my provider), credit or debit card. I understand all checks returned unpaid will be subject to a $30.00 service fee. If I have a balance due for more than three months, my account may be turned over to a collection agency for the purpose of recovering lost funds.

Use of Insurance and Authorization for Treatment:
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 $60.00 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, _____,

❑ 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 Witness Date

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CHILD INTAKE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

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

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. Who is primarily responsible for the care of your child? List all that apply.

Name	Relationship to Child:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Who resides with you in your home?

Name	Relationship to Child:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. What are the most common disciplinary techniques used in the household? (Verbal reprimands, yelling, ignoring, grounding, removal of privileges, spanking, etc…) _____
_____
_____
_____

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9. Are disciplinary techniques used consistently and with good follow-through?
❑ No ❑ Yes

10. Are current disciplinary techniques effective at controlling undesirable behaviors?
❑ No ❑ Yes

11. Does your child respond to one parent or care-taker's disciplinary measures better than another?
❑ No ❑ Yes: If yes, who _____

12. Has your child experienced any of the following?

❑ Parental Divorce	❑ Parental Separation	❑ Death of Parent
❑ Death of Sibling	❑ Death of Grandparent	❑ Death of Close Friend
❑ Financial Problems	❑ Parental Alcoholism	❑ Parental Drug Abuse
❑ Domestic Violence	❑ Physical Abuse	❑ Verbal Abuse
❑ Sexual Abuse	❑ Family Bankruptcy	❑ Prolonged Marital Discourse

13. Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism? ❑ No ❑ Yes If yes, please provide further details.
_____
_____

14. Was your child born premature? ❑ No ❑ Yes _____

15. Birth Weight: _____ lbs. _____ oz.

16. Approximate age when your child first began:
Walking: _____ Talking: _____ Toileting: _____

17. Does your child have any immediate health problems (colds, injuries)?
❑ No ❑ Yes _____

18. Does your child have any chronic (long-term) health problems (asthma, seizures, allergies, etc.)?
❑ No ❑ Yes _____

19. Has your child ever sustained any serious head injuries (unconscious, auto accident, fight, etc.)?
❑ No ❑ Yes _____

20. Does your child have any developmental disorders (mental retardation, learning disabilities, hearing disabilities, speech problems, etc.)?
❑ No ❑ Yes _____

21. Is your child currently under the care of a physician? ❑ No ❑ Yes

If yes, Doctors Name: _____ Phone: _____

Conditions being treated: _____
_____

22. Is your child currently on any medication? ❑ No ❑ Yes

Medication	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____

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23. Please list all previous mental health medications:

Medication	Dosage	Date Started	Date Stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

24. Please rate the nutritional value of your child's diet. Good ___ Fair___ Poor___
If fair or poor, please explain: _____

Check any of the following that apply.
- ❑ Significant weight gain/loss in lat 6 months
- ❑ Problems chewing or swallowing
- ❑ Food/drug allergies
- ❑ Dieting
- ❑ Overeating or eating too little

If any box is checked please explain: _____

25. Has your child had a recent vision check? ❑ No ❑ Yes: If yes, describe results: _____

26. Has your child had a recent hearing exam?
❑ No ❑ Yes: If yes, describe results: _____

27. What grade is your child currently in? _____

28. Where does your child attend school? _____

29. Circle any grade(s) failed. K 1 2 3 4 5 6 7 8 9 10 11 12 None

30. Circle any grades skipped. K 1 2 3 4 5 6 7 8 9 10 11 12 None

31. What grades does your child normally get in school? (Circle all that apply)
A B C D F

32. Have there been any tendencies toward improving or deteriorating school performance over the years? ❑ No ❑ Yes: If yes please provide further details.
_____

33. What are your child's **strongest** subjects in school? (Circle all that apply)
Math History English Reading Spelling Science Social Studies N/A

34. What are your child's **weakest** subjects in school? (Circle all that apply)
Math History English Reading Spelling Science Social Studies N/A

35. Has your child ever been:

Reprimanded at school:	❑ No	❑ Yes
Served detention:	❑ No	❑ Yes
Been suspended:	❑ No	❑ Yes
Been expelled:	❑ No	❑ Yes

If yes to any, please explain: _____
_____

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36. Has the school ever performed psychological or educational testing on your child?
❑ No ❑ Yes
If yes, describe results: _____
_____

37. Does your child have many friends? ❑ No ❑ Yes

38. Does your child make friends easily? ❑ No ❑ Yes

39. What are the most common activities that your child engages in? (bike riding, playing with friends, TV, etc.) _____
_____
_____

40. Has your child ever been in trouble with the law? ❑ No ❑ Yes
If yes, please explain. _____
_____

41. To your knowledge, does your child use tobacco? ❑ No ❑ Yes

42. To your knowledge, does your child drink alcohol? ❑ No ❑ Yes
If yes, how often, how much, and for how long? _____
When was the last time? _____ How many drinks? _____

43. What problems has your child suffered as a result of his/her drinking?
❑ Arrest ❑ DUI ❑ Peer problems
❑ Public intoxication ❑ Financial problems ❑ Arguments
❑ None of the above

44. To your knowledge, has your child ever tried drugs? ❑ No ❑ Yes: If yes, what drug/s? ____

45. To your knowledge, does your child regularly us any drugs?
❑ No ❑ Yes: If yes, how often, how much and for how long?
_____
When was the last use? _____ What drug/s was used? _____

46. To your knowledge, is your child sexually active? ❑ No ❑ Yes

47. Does your child have concerns about his/her sexual orientation or sexual experiences?
❑ No ❑ Yes

48. Is your child pregnant or the parent of a child? ❑ No ❑ Yes

49. Who has legal custody of your child?
❑ Both parents ❑ Mother only ❑ Father only ❑ Other guardian: _____

50. Other information: _____
_____
_____