Mary Gina Connor, MSW, LCSW

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 48 hours notice if you need to change your appointment time.

Also, please be that we do not always have office staff available to answer the phones.. If you have questions, you can 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.

Mary Gina Connor, MSW, LCSW

Office Location:
Burlington Executive Center
1655 Burlington Pike Suite 101
Florence, KY 41042
(859) 342-6444 X3

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.)

Look for "WellSpring" on the door!

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

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 (____) _____-_____ Work (____) _____-_____ Cell (____) _____-_____
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 _____-_____-_____

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 complete this information, you will be required to pay the full amount of your session. Our billing company will call your insurance company 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: _____

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 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 48 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 X3 . 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. If I have an after-hours crisis, 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

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

The following services are NOT generally insurance reimbursable:

E-mails that require a response	$ 25.00
Billing/Processing fee (Assessed for initial insurance authorization)	$ 25.00
Billing/Processing fee (Assessed on payments not made at time of service)	$ 10.00
Missed Appointment/Late Cancellation	$ 75.00
Return Check Fee	$ 30.00
Phone calls (lasting longer than 05 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/page/ $150/hour
Records Review	$ 150.00 / hour
Parent Coordination/Co-Parenting	$ 150.00 / 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)

* Plase ask for additional information regaring court appearences.

Payment:
I understand that payment is expected at time of service. Payments not made at the time of service will incur a $10.00 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 out to Mary Gina Connor), 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 choose 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 48 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 Wiittness Date

Mary Gina Connor, MSW, LCSW

ADULT INTAKE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

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

_____

_____

2. How long has this been an issue and has anything happened recently to make the problem worse?_____

_____

_____

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

_____

_____

4. What are your goals for counseling?_____

_____

_____

5. What do you like most about yourself?_____

_____

_____

6. What do you dislike most about yourself?_____

_____

_____

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

_____

_____

8. 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:

_____

_____

9. Significant relationships:

Marital Status: Married _____ Paraqmour _____ Divorced _____ Single _____ Other _____

Spouse/significant other's name: _____ Age_____

Spouse/Signiicant other's occupation/employer: _____

How long have you been married/together? _____

What do you like most about your partner? _____

What do you like least about your partner? _____

Major aeras of conflict with your partner? Any additonal information you feel would be helpful:

_____

_____

_____

Prior significant relationships and marriages? (describe briefly)

_____

_____

Who resides with you in your home?

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

10. Legal History:

Are you currently involved in any type of legal action? If yes, please explain _____

_____

_____

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 _____	

11. Medical History:

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

_____

_____

_____

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:

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

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

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

12. 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: _____

13. Financial Problems: _____

14. Educational Background (highest grade completed): _____

15. Employment History

Do you have specialized training in a particular field? _____

Please describe current job briefl):_____

How long hav you been at your current job? _____Are you satisfied? Y N

16. Military Service: _____

17. 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 _____

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. 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) _____

_____

_____

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:_____

_____

Please use this space for any additional information that you feel may be helpful in your treatment:

_____

_____

_____

_____

_____

_____

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_____

_____