WELLSPRING Renewal Center

Client Information Form

Please read and complete all information requested.

Appointment Date: _____

Full Name: _____

Address: _____

City, State and Zip: _____

Birth date: _____ Age: _____ Gender: _____

Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ In a relationship ___

Best phone # to reach you at: _____ Cell ☐ Work ☐ Home ☐

Alternate Phone #: _____ Cell ☐ Work ☐ Home ☐

Email: _____

Please PRINT in the following information for any 3rd party that is responsible for client payments
*** ***This section is required for clients who are minors*** ***

Full Name: _____ Relationship: _____

Address: _____

City, State and Zip: _____

Preferred way to receive session reminder messages: Text ____ Email ____ Phone Call ____

How did you hear about us? _____

Religious Affiliation (if any): _____

Occupation and Employer: _____

Student: Full-time _____ Part-time _____

Emergency Contact & Phone: _____

Primary Care Doctor: _____

Please state briefly your reason for seeking counseling: _____

_____

_____

_____

Where everyone is welcome, and healing happens.

101 N Woodrow, Little Rock, Arkansas, 72205 | 501-265-0046 | www.WellspringRenewalCenter.com | 501-265-0057 (fax)

Are you currently taking any medications, prescription or over the counter? _____ Yes _____ No

If yes, specify type, dose and reason for taking: _____

_____

If prescription, who prescribed them? _____

Medical Concerns: _____

Have you seen a therapist in the past? If so, who and when? _____

_____

Self-Description Checklist (Please check all that apply):

__ alcohol abuse
__ anger
__ anxiety
__ apathetic
__ ashamed
__ changes in weight
__ cheerful
__ compulsions
__ concentration problems
__ confused
__ crying spells
__ dangerous
__ depression
__ difficulty with decisions
__ disappointment
__ distrustful
__ drug use/abuse
__ eating disorder
__ energetic
__ faith/religious problems
__ fatigued /low energy
__ feeling abandoned
__ feeling inferior
__ feeling misunderstood
__ frequent pain
__ fretful
__ guilt feelings
__ happy
__ hearing strange voices
__ history of abuse
__ hopeless
__ hurt
__ impulsive concerns
__ inadequate
__ indifferent
__ irrational thoughts
__ irritability
__ isolated
__ jealous
__ legal difficulties
__ loneliness
__ loss of appetite
__ marital conflict
__ meaninglessness
__ memory problems
__ money problems
__ mood swings
__ mourning
__ nausea
__ obsessive thoughts
__ optimistic
__ panic
__ parent conflict
__ perfectionism
__ physical illness
__ poor motivation
__ poor sex drive
__ relationship difficulties
__ resentful
__ restlessness
__ sexual problems
__ shyness
__ sleep problems
__ social withdrawal
__ specific fears
__ stress
__ suicidal
__ suspicion
__ thoughts of hurting others
__ treated unfairly
__ troublesome thoughts
__ unhappy
__ unusual thoughts
__ unusually sensitive
__ violent
__ work conflict
__ worry
__ no concern

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INFORMED CONSENT

I am voluntarily seeking counseling for my particular issue(s) and I am committed to working with my therapist to successfully resolve my issue(s). I realize that counseling can be beneficial both for me and those with who I am in relationship, but that it comes with no guarantees. While self-disclosure of relevant information is beneficial to the counseling process, I also understand that counseling may involve discussing relationship, psychological and/or emotional issues that may, at times, be distressing. I am aware of alternative treatment methods available to me.

My therapist/counselor will meet with me regularly, listen attentively, work with me to accomplish mutually stated and agreed upon goals. My counselor will treat me with respect and dignity. I understand that my counselor is bound by the legal and ethical standards of his/her profession. This includes confidentiality, which means that my counselor will not reveal any information about me except in the following situations:

- Medical Emergency
- Threats of Suicide, Bodily Harm to Self or Others
- Suspected Child Abuse or Neglect; Suspected Abuse of the Elderly

I understand that I have a right to review my records at any time, and that if I have questions or concerns I can reach my therapist through the contact information provided for me. In case of an emergency, I will call 911. Should my therapist become incapacitated, an authorized person will contact me and may refer me to another therapist. My records will continue to remain confidential unless otherwise authorized by me.

Payment is expected on the day that services are rendered. I will notify my counselor at least 24-hours before my appointment if I need to cancel or reschedule my session, otherwise I will be billed for that appointment at a reduced rate of $40. I give my therapist permission to contact me through the information I have provided on my Client Information Form. I understand that e-mail correspondence may not always be a secure/confidential means of communication.

My therapist has answered all my questions about counseling satisfactorily. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave counseling at any time, although I have been informed that this is best accomplished with my therapist.

I have read, understood and agree to the above.

_____ _____

Client Date

_____ _____

Parent/Guardian if client is a minor Date

I have reviewed the above information with my client.

_____ _____

Therapist Date

CLIENT INSURANCE INFORMATION

Client Name: _____

Insurance Company: _____

Member ID: _____ Group Number: _____

Effective Date: _____ Social Security Number: _____

Referring Physician (if needed): _____

Insured Person Information Client's Relationship to Insured: Self ☐ Spouse ☐ Child ☐

Full Name of Insured Party: _____

Address of Insured Party (if different from client): _____

_____

Insured's Date of Birth: _____ Insured's Phone Number: _____

Deductible Amount: $_____ Co-pay Amount: $_____

Are you wanting to use EAP's from your employer? If so, which provider: _____

Other Information: _____

_____

Filing for services is no guarantee of payment. Should your insurance deny the claim for reimbursement, the client is responsible to pay the remainder of the fee for services rendered. When/if that situation arises, our center will invoice you for the balance. Should your insurance company accept the claim and reimburse our center for services, Wellspring will not bill you for the difference but will accept whatever your insurance provider reimburses as payment in full.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

☐ **I do not wish to file insurance.**

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Appointment Policy

We appreciate the trust you have in us and will provide the quality and confidential care you expect. We do value and know that your time is important. Therefore, you can expect to be treated with respect and we will do our best to keep your appointment on time.

We understand that circumstances occur that interfere with you keeping certain appointments; however, we do kindly ask that you give our ***office 48-hour notice prior to your appointment cancellation.*** This will allow us to take your reserved time and offer it to someone else. If missing or canceling your appointment becomes excessive, we may not be able to reappoint a reserved time for your visit. After three or more missed appointments, we do reserve the right to terminate our therapist-client relationship.

Although we do have an appointment reminder service in place, it is still your responsibility to remember your appointment. ***All no-shows and cancellations within 24 hours of appointment will be charged $40.***

Please feel free to contact our office at any time if you should have any questions or concerns.

Signature: _____

Dated: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly
- Conduct normal healthcare operations

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: _____

Legal Guardian (if client is a minor): _____

Relationship to Client: _____

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

101 N Woodrow, Little Rock, Arkansas, 72205 | 501-265-0046 |
www.WellspringRenewalCenter.com | 501-265-0057 (fax)

Notice of Privacy Practices

What is medical information?
The term "medical information" is synonymous with the terms "personal health information" and "protected health information" for purposes of this Notice. It essentially means any individually identifiable health information (either directly or indirectly identifiable) whether oral or recording in any form or medium, that is created or received by a health care provider (counselor at Wellspring), health plan, or others **and** 2) relates to the past, present or future mental or physical health or condition of an individual (you); the provision of health care (mental health) to an individual (you); or past, present or future payment for the provision of health care to an individual (you).

Wellspring uses therapists (LAC, LPC, LMFT, LCSW, etc) who are professionally trained and licensed by the state of Arkansas. Our staff creates and maintains treatment records that contain individually identifiable health information about you. These records are generally referred to as "medical records," and this notice, among other things, concerns the privacy and confidentiality of those records and the information contained therein.

Uses and Disclosures without your Authorization – for Treatment, Payment, or Health Care Operations
Federal privacy rules (regulations) all healthcare providers (Wellspring counselors) who have a direct treatment relationship with the patient (you) to use or disclose the patient's personal health information, without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. The healthcare provider (Wellspring) may also disclose your protected health information for the treatment of activities of any health care provider. This too can be done without your written authorization.

An example of a use or disclosure for treatment purposes: If the healthcare provider (Wellspring) decides to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist me in the diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard because physician and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care among health care providers or by a health care provider with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

An example of a use or disclosure for payment purposes: If your health plan requests a copy of your health records, or a portion thereof, in order to determine whether or not payment is warranted under the terms of your policy or contract, Wellspring is permitted to use and disclose your personal health information.

An example of a use or disclosure for health care operations purposes: If your health plan decides to audit Wellspring or any of our therapists in order to review our competence and performance or to detect possible fraud or abuse, your mental health records may be used and disclosed for those purposes.

Please note: Your therapist or one of our staff members acting under Wellspring authority, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your prior written authorization is not required for such contact.

Wellspring may be required or permitted to disclose your personal health information (e.g. mental health records) without your written authorization.

Your Rights Regarding Protected Health Information

You have the right:

- to request restrictions on certain uses and disclosures of protected health information about you
- to receive confidential communication of protected health information by alternative means
- to inspect and copy protected health information about you by making a specific request in writing
- to amend protected health information in my records by making a request to do so in writing that provides a reason to support the requested amendment
- to receive an accounting from Wellspring of the disclosures of protected health information made by the center in the six years prior to the date on which the accounting was requested
- to obtain a paper copy of this notice from Wellspring upon request

The Duties of Wellspring

Wellspring is required by law to maintain the privacy and confidentiality of your personal health information. This notice is intended to let you know of our legal duties, your rights and our privacy practices with respect to such information. We are required to abide by the terms of the notice currently in effect.

At any time, if you believe your privacy rights have been violated you may complain in writing to Wellspring or to the Secretary of the U.S. Department of Health and Human Services. Wellspring will not retaliate against you in any way for filing a complaint against Wellspring, our therapists or with the Secretary.

If you would like other information related to this Notice or its contents, please feel free to contact Wellspring or discuss it with your therapist. Wellspring and our staff will do our best to answer questions and to provide you with additional information.

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Client Rights and Responsibilities

Welcome to Wellspring! We are committed to providing quality services designed to enhance, strengthen and support individuals, couples and families. We strive to offer an atmosphere of respect and dignity to all our clients. Our therapists are here to provide help for a wide range of issues.

You may contact the center at 501-265-0046 during regular office hours to set up an appointment. We do not provide emergency psychiatric care, intensive psychiatric treatment, or residential/inpatient treatment. If you need any of these services we suggest that you call 911, visit a local emergency room, or call a 24-hour crisis hotline, 888-274-7472 or the Little Rock Community Mental Health Center at 501-686-9300.

As a client of Wellspring you have certain rights which include:

- The right to be fully informed about your treatment/counseling and the right to withdraw from that treatment at any time
- You have the right to refuse treatment and our center's personnel will inform you of potential consequences of such refusal
- The right to seek disclosure from your therapist about his/her qualifications and, if necessary, the right to request a referral to another therapist
- The right to access client grievance procedures

  A written complaint addressed to:

  Arkansas Board of Examiners in Counseling
  101 East Capitol, Suite 202
  Little Rock, AR 72201

- The right to review your records by making a request in writing. Should you desire to do this, a staff member or your therapist will give you information on how to make this request
- The right to confidentiality (see below)

Confidentiality means that what you tell your therapist will be kept confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and/or federal statutes, and as part of the professional practice of this center. Exceptions to confidentiality include: Medical emergency, threats of serious bodily harm to self or others, suspected child abuse or neglect, and suspected abuse of the elderly. All Wellspring therapists abide by the American Counseling Association Code of Ethics. http://www.state.ar.us/abec/abec_code_ethics.html

As a client of Wellspring your responsibilities include:

- Arriving on time to your appointments
- Giving at least a 24-hour notice should you need to cancel your appointment, or in case of an emergency, as soon as is feasibly possible. **If an appointment is missed or cancelled with less than a 24 hour notice, you will be charged for that session at a reduced rate of $40.**
- Giving a two-week notification of your plans to terminate treatment
- Participating fully in your treatment goals and outcomes, including completing all assignments given by your therapist
- Prompt payment of fees on the day services are provided