

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE NO. _____ WORK PHONE NO. _____

E-MAIL ADDRESS: _____ SOCIAL SECURITY NO.: _____

MARITAL STATUS: S / M / W / DIV / SEP / SEX: FEMALE MALE

CLIENT'S EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE/ZIP _____

IN CASE OF EMERGENCY, CONTACT: _____ PHONE: _____

SPOUSE'S NAME: _____ SPOUSE'S SOCIAL SECURITY NO.: _____

SPOUSE'S EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ CITY: _____ STATE/ZIP _____

SPOUSE DATE OF BIRTH: _____ WHO REFERRED YOU TO OUR PRACTICE? _____

IF THE CLIENT IS A MINOR

MOTHER'S NAME: _____ HOME PHONE NO.: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____ WORK PHONE NO.: _____

MOTHER'S ADDRESS: _____ CITY _____ STATE/ZIP _____

MOTHER'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY _____ STATE/ZIP _____

HOW LONG EMPLOYED? _____ OCCUPATION: _____

FATHER'S NAME: _____ HOME PHONE NO.: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO.: _____ WORK PHONE NO.: _____

FATHER'S ADDRESS: _____ CITY _____ STATE/ZIP _____

FATHER'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY _____ STATE/ZIP _____

HOW LONG EMPLOYED? _____ OCCUPATION: _____

INSURANCE INFORMATION (IF WE COPIED YOUR CARD, SKIP THIS SECTION)

PRIMARY INSURANCE _____ EFFECTIVE DATE: _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH: _____

POLICY NO.: _____ GROUP NO.: _____

SECONDARY INSURANCE: _____ EFFECTIVE DATE: _____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH: _____

POLICY NO.: _____ GROUP NO.: _____

I give consent for my therapist to contact my physician, Dr. _____ Initial _____

BILLING INFORMATION AND INSURANCE AUTHORIZATION

In order to control our cost of billing we request that charges be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

Authorization: I hereby authorize this facility to furnish information to insurance carriers concerning my treatment, and I hereby irrevocably assign to Wellspring Healthcare Associates, all payments for services rendered, when applicable. I understand that on occasion insurance companies may determine that services rendered were not reasonable or necessary despite the fact that they were prescribed by my therapist and performed by professional personnel with my well-being in mind. I understand that I am financially responsible for all charges whether or not covered by insurance I authorize the release of pertinent information to my referring physician when appropriate.

Responsible Party Signature

Date

Witness

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, and credit cards. We will be happy to help you process your insurance claim form for your reimbursement.

Returned checks and balances older than 30 days may be subject to collection. Charges will also be made for broken appointments and appointments cancelled without 24 hours advance notice. (Those charges are not billable to your insurance company.)

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.. Our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area. Not all services are a covered benefit in all contracts. PLEASE VERIFY COVERAGE WITH YOUR INSURANCE COMPANY. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not with your insurance company. While the filing of your insurance claims is a courtesy that we extend if needed to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may effect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please ask us. We are here to help you.

I have read the above policy and agree to these terms.

Signature of PATIENT or LEGAL GUARDIAN

Date: _____



**CONSENT TO USE OR DISCLOSE INFORMATION FOR
TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
(TPO)**

Client Name _____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) for your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as “health care operations”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client: _____ Date _____

**ACKNOWLEDGEMENT OF RECEIPT OF “HIPAA NOTICE OF
PRIVACY PRACTICES”
AND
“OFFICE POLICIES & GENERAL INFORMATION
AGREEMENT FOR PSYCHOTHERAPY SERVICES”
(INFORMED CONSENT)**

I have read the HIPAA Notice of Privacy Practices and the Office Policies & General Information Agreement For Psychotherapy Services. I understand them and agree to comply with them.

Client Signature: _____

Client Signature: _____

Parent or Guardian (if client is a minor): _____

Date: _____

WHAT MEDICAL ILLNESSES OR OPERATIONS HAVE YOU HAD, AND WHEN?

WHAT MEDICATION(S) ARE YOU CURRENTLY TAKING?

DO YOU HAVE ANY ALLERGIES?

PLEASE CHECK THE FOLLOWING THAT APPLY TO YOU OR ANY RELATIVE THAT YOU KNOW OF:

	YOU	RELATIVE	RELATIONSHIP	DID THIS REQUIRE TREATMENT?
DEPRESSION				
MANIC DEPRESSION				
SCHIZOPHRENIA				
PARANOID THINKING				
HALLUCINATIONS				
ALCOHOL				
DRUG ABUSE				
SEVERE ANXIETY				
PHOBIAS				
BULIMIA				
ANOREXIA NERVOSA				
SUICIDE ATTEMPTS				
SEXUAL ABUSE				
CAFFEINE INTAKE DAILY				
TOBACCO DAILY				
CONVULSIONS/SEIZURES				
OTHER				

PLEASE CHECK THE FOLLOWING CHANGES THAT APPLY TO YOU.

- | | |
|--|---|
| <input type="checkbox"/> SLEEP | <input type="checkbox"/> RACING THOUGHTS |
| <input type="checkbox"/> APPETITE | <input type="checkbox"/> POOR JUDGEMENT |
| <input type="checkbox"/> ENERGY LEVEL | <input type="checkbox"/> RACING HEART |
| <input type="checkbox"/> CONCENTRATION | <input type="checkbox"/> DIFFICULTY BREATHING |
| <input type="checkbox"/> MEMORY | <input type="checkbox"/> SWEATS / CHILLS |
| <input type="checkbox"/> SADNESS | <input type="checkbox"/> NUMBNESS & TINGLING IN FINGERS OR LIPS |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> LIGHTHEADEDNESS |
| <input type="checkbox"/> ENJOYMENT OF USUAL ACTIVITIES | <input type="checkbox"/> FEARS OF DYING OR GOING CRAZY |
| <input type="checkbox"/> HOPELESSNESS | <input type="checkbox"/> CHEST DISCOMFORT |
| <input type="checkbox"/> GUILT | <input type="checkbox"/> EXCESSIVE WORRY |
| <input type="checkbox"/> ELEVATION (FEELING ON TOP OF THE WORLD) | <input type="checkbox"/> COMPULSIVE BEHAVIOR |
| <input type="checkbox"/> INCREASED TALKING | |



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RELEASE OF INFORMATION

The purpose of this form is to provide us with your preferences on who we can and cannot release information to. This will allow us to provide you with the best care while maintaining your privacy.

May we call you at home? Yes No

May we communicate with you by mail sent to your home address? Yes No
(HIPPA regulations allow us to mail statements to you)

May we leave a message on your answering machine at home asking you to contact our office if we need to get in touch with you?
 Yes No

May we call you at work? Yes No

If your employer calls about you, can we release information to them? Yes No

May we release information to your spouse? Yes No

Is there anyone you specifically do not want any information released to?

If so, whom? _____

Signature of Patient or Responsible Party

Date

Please list two telephone numbers where you may be reached:

1.) _____

2.) _____

If there are any changes in the information above, it is your responsibility to let our office know so that we may update our records.

Thank You.