3790 Old US Hwy 41 N, Suite A
Valdosta, GA 31602
Office No: (229) 262-1000
Fax No: (229) 262-1085
enspirecounselingandwellness@gmail.com
www.enspirecounselingandwellness.com

Dear Client,

You have just taken a courageous and positive step by deciding to seek counseling, psychiatric services, and improve your overall wellness. We are ecstatic and humbled you have chosen *EnSpire Counseling & Wellness* and want to take a moment to tell you a little about our remarkable and unique agency including its policies and expectations.

EnSpire Counseling & Wellness is a comprehensive and innovative counseling and wellness center serving our local and surrounding communities; it is comprised of a diverse clinical staff trained and ready to assist you on your journey to improve your psychological, physiological, and spiritual wellness. At EnSpire, we believe in both preventative and restorative care and treatment. We offer a multitude of services tailored to meet our clients' individual needs including the collaboration of medical, counseling, and wellness services.

We continue to take new patients. However, we have started a waiting list for patients who may have to wait several weeks before being seen either face to face or via teletherapy/telehealth. Due to the increased number of clients needing to be seen, we are having to enforce our *cancellation and no-show policy*. It is imperative that you contact our office as soon as possible, within 48-24 hours before your appointment to reschedule or cancel your appointment**. Late cancellations (less than 24 hrs.) *and/or* no-show appointments are billed to the client in the amount of $50.00.** Therefore, your provided card on file will be charged for late cancellations and/or no-show appointments.

Please note that **ALL intake paperwork** including copies of insurance card and drivers license must be provided 72 hours before your initial appointment. This will ensure the provider has adequate time to review your chart and will give our billing specialist time to confirm coverage. Please let us know if there is any issue with not returning your paperwork prior to your appointment. If the paperwork is not returned within 72 hours before your initial intake, your appointment may be cancelled or rescheduled. We do understand there are exigent circumstances in crisis situations. Please contact our office with any concerns or questions.

Some insurance and/or EAP plans do not charge a copay, other insurance plans do charge a copay. Therefore, we will place a card on file to obtain payment *(See attached Payment Consent Form)*. The card's information on file will be taken during your initial appointment. If you choose to modify the card on file, please contact our office's billing coordinator to update the card information.

It is also the patient's responsibility to confirm insurance coverage is active and update their coordination of benefits for claims to be processed correctly. Please note if there are any insurance or coordination of benefits issues, the **patient/guarantor** is responsible for the bill and remaining balance. In addition, some insurance companies are no longer paying for teletherapy services. It is the patient's responsibility to confirm their individual insurance plan will continue to pay for said service. A patient will be responsible for the fee upfront for the telehealth appointment if they are unsure if the service is covered. As of January 1st, 2022 our practice will no longer be filing secondary insurance. We will only file primary insurance. Please see our staff if you have any questions or concerns.

We truly believe therapy and mental health wellness are personal and should be treated as such. Thank you for allowing us to be a part of your self-reflective, self-discovery, and restorative journey, your inspirational path to wellness. Thank you for CHOOSING to allow us to Encourage, Empower and Enlighten you and your family. Thank you for CHOOSING EnSpire!

EnSpire Counseling & Wellness

"Good Faith Estimate for Mental Health/Counseling/Psychiatric Services"
Under the No Surprises Act

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient SSN:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference:	[ ] By mail	[ ] By email
Primary Service(s) or Item Requested/Scheduled *Mental health/Counseling/Psychiatric services; Individual, Family, and/or Couple* **Provider/Clinician will determine diagnosis based on initial evaluation and follow-up sessions.*		

Date of Good Faith Estimate _____/_____/_____
See the attached itemized estimate of costs of services rendered including insurance and self-pay rates. *Ins = Insurance, SP = Self-pay* **The estimated costs are valid for 12 months from the date of the Good Faith Estimate. Any additional services will be discussed with the and acknowledged by the patient and/or guardian.*

Insurance (Ins) _____Initial if filing

Primary Insurance: _____

Member Policy No: _____

Signature: _____

ECW will no longer file secondary insurance as of 1/1/22

Self-pay (SP) _____Initial

Subscriber Name: _____

Subscriber DOB: _____

Provider Name:

Susan Bradshaw, LMFT, TBRI ____

Leah McMillan, LMFT, CFRC ____

Chelsea Nelms, LMFT ____

Allison Owen, LMFT, RPT ____

Martha Giddings, PhD, LCSW ____

Rachael Dudley, LCSW ____

John Klimko, Jr., LMFT____

Lauren S. Darby, LMSW____

Estimated Total Cost for Therapy services (per session)

Initial Evaluation: $175 (Ins)/$95 (SP)

Follow-up Therapy sessions varies:

$150-$95 (Ins)/$75 (SP)

Teletherapy: $175-$95 (Ins)/$75 (SP)

Group Therapy sessions:

$25-$35 (in-office) $10 (virtual) (SP)

**Collaborative Nurse Practitioner(s) are by referral only. Billing will be provided through NPs company. Billing services for NPs not provided by ECW. NPs offer telehealth services.*

EnSpire Counseling & Wellness, LLC

Multi-Specialty Mental Health & Wellness Center

3790 Old US Hwy 41 N, Ste A
Valdosta, GA 31602

Phone
(229) 262-1000

Email
enspireproviders@gmail.com

Each Provider/Clinician is an Independent Contractor

ECW Taxpayer Identification Number
83-2842234

By signing below, I acknowledge I have reviewed and agreed to the "*Good Faith Estimate of Expected Charges" Policy*

Client(s) Name/Signature: _____ Date: _____

Parent/Guardian Signature, if Client is a Minor: _____

Payment Consent Form

I authorize EnSpire Counseling & Wellness, LLC. to charge my credit/debit/health account card for professional services rendered. I may update my card's information at any time by contacting the billing coordinator. I understand the office will provide me with an itemized receipt upon request for all charges.

Due to increase in transaction fees, there will be a convenience charge (3.5%) added effective January 1, 2023. We apologize for any inconvenience this may cause. Please contact our office or speak to your individual therapist if you have any questions or concerns.

Credit Card Information:

Name on Card: _____

Card No: _____

Exp. Date: _____ CVV Code: _____

Zip Code: _____ Phone No: _____ (for receipts)

Email address: _____ (for receipts)

I verify the credit/debit card information, provided above, is accurate to the best of my knowledge, and agree to notify the office in the event this information changes. If this information is incorrect, fraudulent or if my payment is declined, I understand I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form all delinquent balances will be sent to collections. EnSpire Counseling & Wellness, LLC utilizes Squareup.com for all electronic credit/debit/health account card payments.

Current Name(s)/Client(s) Card is to be used for: _____

_____

_____

_____ _____
(Cardholder Signature) Date

_____ _____
Name/Signature of Client, (Guardian if minor) Date

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Adult Intake Information

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City/State/Zip: _____

Main Phone: _____ Other Phone: _____

E-mail: _____

Do we have permission to e-mail and leave a message on main phone number? (initial if yes): _____

Employer/phone #: _____

Profession: _____ Highest level of education: _____

Are you currently enrolled in school? If yes, where: _____

How did you hear about us? _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Relationship: _____ Phone: _____

Alt. Phone: _____ Address: _____

Do you authorize EnSpire Staff to discuss care or treatment with this individual in the event of an emergency?

(Please initial yes or no) Yes _____ No _____

SELF-PAY SERVICES

Please Initial if you are choosing to be **Self-Pay** for Therapy services _____

Please Initial if you are choosing to be **Self-Pay** for Psychiatric/Medication services _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder: _____

Holder Relation: _____ Policy Holder DOB: _____

Policy Number: _____ Group Number: _____

Co-pay: _____ Deductible amount: _____

Have you met your deductible? Yes _____ No_____

**Note: As of January 1, 2022, ECW will NO LONGER file Secondary Insurance. Your Primary Insurance will be the only insurance filed by ECW.*

WELLNESS INFORMATION

How can we help you at this time? What would you like to address?

_____

MENTAL HEALTH HISTORY

Have you ever been hospitalized for psychiatric reasons? _____ Yes _____ No

If yes, when and where: _____

Are you currently seeing a psychiatrist? Yes _____ No _____

Have you seen a psychiatrist in the past? Yes _____ No _____

If yes, name, location, dates: _____

Have you seen a counselor in the past? Yes _____ No _____

If yes, name, location, dates: _____

GENERAL HEALTH INFORMATION

Primary Physician: _____ Phone #: _____

Name/Address/Zip: _____

Current Medical Conditions: _____

_____

Historical Medical Issues:

_____

SOCIAL/EMOTIONAL HISTORY:

Describe your use of alcohol, tobacco, vaping, recreational drugs, and/or prescription drugs: _____

_____

Are you concerned about your alcohol, vaping, tobacco, or substance use, including prescription drugs?

_____

Legal involvement: _____

Child custody and/or divorce case: _____

Who has primary custody? (name & relationship): _____

Family history of medical/mental health conditions: _____

_____

Current medications: _____

_____

Medication allergies: _____

Who do you consider your support system? _____

Other household members:

Name:	**Age:**	**Relationship:**	**Is this a positive (+) or negative (-) relationship?**

Are you currently in a romantic relationship? Yes _____ No _____

Spiritual and/or religious beliefs:_____

Sexual Orientation: _____ Gender Identity:_____

What are your hobbies? _____

_____

What are your best attributes? _____

EnSpire Counseling & Wellness Psychiatric Medication Assessment & Management Policy

Participation in psychiatric treatment can result in several benefits to you; however, working toward these benefits, requires effort on your part. Active involvement in your treatment, honesty, and openness are necessary to modify your thoughts, feelings, and/or behavior, and decrease your symptoms. Your provider will ask for your feedback on your treatment and its progress and will expect you to respond openly and honestly. Your provider will discuss the risks and benefits of the medication prescribed during your appointment. Please feel free to address any concerns at that time.

Medications

Your prescribing provider/NP may give you a prescription the day you are here. You may or may not be given another prescription without seeing the prescribing provider/NP again. This is for your protection and well-being.

• It is important for you to notify us if you change pharmacies. You will not be given another prescription without seeing the prescribing provider again.
• Take your medication as directed. Keep up with your quantity. Be certain you have enough to last until your next appointment.
• At times, our office may call to reschedule an appointment because your prescribing provider/NP has an emergency. If we should call you, check your medications to be sure you have enough to last until the date you return. It may take up to 24 hours to get your prescription refilled (longer on Fridays).
• After your initial visit with the prescribing provider, you will be scheduled for follow-up with your prescribing provider/NP to refill your medications and discuss any concerns about your medications that you may have.
• We do not participate with discount drug programs.
• If you are in a situation that you cannot afford your medication, do not stop taking your medication. Look and ask until you find assistance, for example, (i) check with your local mental health office, (ii) check with your pharmacist to see what programs they may have available, and (iii) call your local Department of Family and Children Services
• Minors: Must be accompanied by a biological parent/legal guardian. We cannot prescribe medications or initiate treatment without a parent or legal guardian present.

Controlled Substance Policy

As part of your treatment, your prescribing provider may order medications for you. Many of these medications can have serious side effects if they are not managed properly. You will be made aware of any side effects from medications that we have prescribed for you. PLEASE LET THE PRESCRIBING PROVIDER/NP KNOW IMMEDIATELY IF YOU ARE PREGNANT OR SUSPECT YOU MAY BE PREGNANT.

Please read the following agreement CAREFULLY and ask your prescribing provider/NP if you have any questions:

1. I agree to follow exact dosing instructions prescribed by my prescribing provider.
2. I agree to keep all appointments required by my prescribing provider. If I miss an appointment, I understand that a follow-up must be made before any prescriptions will be refilled or changed.
3. I agree to maintain all prescriptions at the same pharmacy unless reasonable circumstances occur.
4. Refill requests are to be made during office hours only. Mon-Thurs 9:00 am to 4:00pm. Fridays 9:00 a.m. to 11:00 a.m.
5. Refill requests must be made in ADVANCE (7 days). If my prescribing provider/NP is out of the office, I understand that my prescription will not be filled until they return.
6. NO CONTROLLED SUBSTANCES WILL BE FILLED DURING EVENINGS, WEEKENDS OR HOLIDAYS!
7. If a prescription is lost or stolen, it will NOT BE REFILLED. It is your responsibility to keep track of your medications.
8. I understand that any misuse of my medications will be reported to the appropriate authorities and I can be terminated from the practice.

I agree that I have read and fully understand this *Psychiatric Medication Assessment, Management, and Controlled Substance Policy*. I will ask my prescribing provider/NP if I have any questions regarding the potential risk of dependency, addiction and side effects of the medications given to me.

I do understand that a breach of this policy will result in my termination from EnSpire Counseling & Wellness, LLC.

_____ _____
Client's Name Date of Birth

_____ _____ _____
Pharmacy Name Phone No. Address

Acknowledgement of Understanding and Review of ALL EnSpire Counseling & Wellness Policies including HIPAA Disclosure Policy:

By signing below, I acknowledge I have been advised of EnSpire Counseling & Wellness, LLC being HIPAA compliant in its handling of protected health information. I have been advised that a copy of the HIPAA Notice of Privacy Practices is attached and is also available upon my review.

By signing below, I acknowledge I have reviewed the following policies from EnSpire Counseling & Wellness, LLC:

Client-Patient Agreement & Financial Responsibility
Consent to Treatment
No Show, Late Cancellation, & Co-Payment Policy
Payment Consent Form
Social Media Policy
HIPAA Disclosure Policy
Client Privacy, Confidentiality, Process, & Authorization and Consent for Telehealth/Teletherapy
Psychiatric Medication Assessment, Management, & Controlled Substance Policy
"Right to Receive a Good Faith Estimate of Expected Charges" Policy

_____ _____
Client(s) Name/Signature Date

_____
Parent/Guardian Signature, if Client is a Minor

_____ _____
Witness Name/Signature Date

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male __ Female __ Date:_____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	