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, LAMFT ____

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*

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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.

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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Child/Adolescent Intake Information

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City/State/Zip: _____

Main Phone: _____ Other Phone: _____

E-mail: _____

Employer/phone #: _____

Are you currently enrolled in school? ____ Yes or ____ No If yes, what grade _____

What school do you attend? _____

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

Current Pediatrician and/or Primary Physician: _____ Phone #: _____

Name/Address/Zip: _____

Current Medical Conditions: _____

_____

Historical Medical Issues:

_____

SOCIAL/EMOTIONAL HISTORY:

Do you have _____ +/healthy peer relationships or _____ -/unhealthy peer relationships? Is it _____ easy or _____ difficult for you to make friends? Do you consider yourself social or shy? _____

Do you experience separation anxiety from your parents/guardians/family members? _____ Yes _____ No

Have you experienced bullying? ___ Yes ___ No Have you ever been accused of bullying? ___ Yes __ No

Are you involved in extracurricular activities? _____ Yes _____ No

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? _____

Have you ever used alcohol, tobacco, recreational drugs, and/or prescription drugs? ____ Yes _____ No

Are you or has anyone else ever been concerned about your alcohol, vaping, tobacco or substance use, including prescription drugs? ____ Yes _____ No Please describe: _____

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?**

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 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Relationship with the child: _____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes	❑ No		❑ Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes	❑ No		❑ Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes	❑ No		❑ Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes	❑ No		❑ Don't Know		
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	❑ Yes	❑ No		❑ Don't Know		
	25.	Has he/she EVER tried to kill himself/herself?	❑ Yes	❑ No		❑ Don't Know		