800 Dawson Village Road, Unit 10, Dawsonville, GA 30534
Office: 706.265.2244 • Facsimile: 866.718.3107
www.wellspringcounselingnga.com

PATIENT REGISTRATION FORM

First Name: _____ Last Name: _____ Middle Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Telephone #: _____ Alternate Telephone #: _____

Date of Birth: _____/_____/_____ Social Security No.: _____-_____-_____ Sex: _____ Age: _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Other: _____

Responsible Party: _____ Relationship: _____

Occupation: _____ Work Telephone: _____

Employer and Address: _____

Patients Spouse or Parent (If Minor): _____ Telephone #: _____

Emergency Contact: _____ Relationship: _____Telephone #: _____

May we contact you via:

Home Phone _____	Yes	No
Work Phone _____	Yes	No
Cell Phone _____	Yes	No
E-mail Address _____	Yes	No

□ How were you referred to our office?
_____

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Wellspring Counseling North Georgia, LLC for services rendered. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that if I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 24 hours of the scheduled appointment time. I authorize Wellspring Counseling Center to file a claim for these services (and to refile as necessary to collect) with the patient's insurance(s) and bill the patient for any amounts for which they are responsible. I further authorize Wellspring to sign said claim(s) or any refiled claims on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fee and collection expenses.

Name: _____ Signature: _____ Date: _____

INSURANCE INFORMATION

Company Name: _____ Telephone #: _____

Member ID Number: _____ Group No.: _____

Policy Holder's Social Securtiy No. (if different from Patient): _____-_____-_____ Policy Holder Date of Birth: _____

Policy Holder (if different from Patient): _____ Relationship: _____

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Client Intake Information Form

First Name: _____ Last Name: _____ Date of Birth: _____

Today's Date: _____

Counseling Concerns

Why are you seeking help now?

_____

_____

_____

What would you like to see happen as a result of counseling or psychotherapy?

_____

_____

_____

Medical & Psychological History

Physician's Name:_____Physician's Phone:___

Date of last Physical:_____

List Physical illnesses or symptoms: check if none _____

_____

_____

_____

Current Medication Dosage Frequency Prescribing MD

_____

_____

_____

Psychiatrist's Name:_____ Psychiatrist's Phone: _____

Have you ever had counseling or psychotherapy in the past? Yes No

If yes, when?_____ With Whom_____

Check which of the following you use and note the amount and frequency of each:

Caffeine:_____ Tobacco (Type/Frequency):_____

Coffee • Sodas • Other drinks • Pills • History of alcohol and/or other chemical substances: _____

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CHECKLIST OF CONCERNS

(Please check all that are applicable)

First Name: _____ Last Name: _____ Date of Birth: _____

Today's Date: _____

Thoughts/Feelings/Mood

☐ Anger/frustration/hostility
☐ Inattention
☐ Depression
☐ Excessive worry
☐ Fear
☐ Grieving (death, divorce, etc.)
☐ Hallucinations
☐ Intrusive thoughts
☐ Judgement problems
☐ Memory difficulties
☐ Negative thoughts
☐ Obsessive thoughts
☐ Panic attacks
☐ Sadness
☐ Self-esteem
☐ Shyness
☐ Stress
☐ Sudden mood changes
☐ Suicidal or Homicidal thoughts

Other Concerns

_____
_____
_____

Behavior

☐ Abuse
☐ Aggression, violence
☐ Alcohol use
☐ Argumentative
☐ Compulsive behavior/rituals
☐ Controlling
☐ Decreased/lack of sexual interest
☐ Destruction of property
☐ Eating problems
☐ Financial problems, debt
☐ Hyperactivity
☐ Internet problems
☐ Isolation
☐ Legal problems
☐ Codependency
☐ Lying
☐ Not able to relax
☐ Eating Disorder
☐ Self destruction/sabatoging
☐ Self-neglect
☐ Sexual dysfunction
☐ Stealing
☐ Weight, gain/loss
☐ Withdrawal from others
☐ Loss of interest in former pleasures
☐ Sleep difficulty

Family & Relationships

☐ Affair
☐ Childhood issues (your childhood)
☐ Divorce/Seperation
☐ Interpersonal conflicts
☐ Parenting
☐ Relationship
☐ Problems/Differences

Addiction

☐ Abuse of alcohol
☐ Abuse of drugs
☐ Dependency
☐ Drug use—prescription, over-the- counter, street
☐ Gambling
☐ Pornography
☐ Preoccupation with sex

Work & School

☐ Absenteeism
☐ Career concerns, goals, choices
☐ Difficulty with coworkers
☐ Difficulty with supervisor
☐ Performance
☐ Tardiness
☐ Procrastination
☐ School problems

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First Name: _____ Last Name: _____ Date of Birth: _____

Today's Date: _____

CONFIDENTIALITY

X_____ Confidentiality and privileged communication remain the right of all clients of counselors according to Georgia State Law. I understand that information concerning treatment or evaluation may be released only with the sole authorization and consent of the person treated or evaluated, or such person's parent/guardian, and with the agreement of the counselor. There are exceptions to the confidentiality of information in the following circumstances (as provided by law): (1) Where there is a clear and imminent danger to the client or others, the counselor may take reasonable personal action or inform the responsible authorities; such as in, suspect of child abuse or suicidal ideation or homicidal ideation will be reported; and (2) if the counselor is required by a court to give information. Except as required by law, you, the client/parent/guardian must sign an authorization to release clinical records to the counselor to talk to or share clinical records or information with anyone, including referred doctors, insurance companies, or family members. All people attending sessions would be required to sign a consent to authorize release of clinical records. Counselors will be discreet if it is necessary to contact you at home or work. In keeping with generally accepted standards of practice, counselor frequently consults with other mental health professionals regarding the management of cases. The purpose of this consultation is to insure quality care. Every effort is made to protect the identity of clients, including any financial records (including payment via credit/debit card information).

ACKNOWLEDGMENT OF DISCLOSURE

X_____ The client/parent/guardian has the responsibility and right to (1) choose their therapists and the treatment modality that best suits their needs; (2) discuss with the counselor any concerns about treatment; (3) request a change in approach; (4) request referral to another therapist; and/or (5) discontinue therapy. The counselor can make no guarantees of results. The counselor follows the ethical guidelines set forth by the Georgia Counselors Association and the Georgia Composite Board of Professional Counselors.

X_____ You have the right to obtain a paper copy of this notice from us, upon your request, even if you have agreed to accept this notice electronically. You are also agreeing that you have read the Notice of Privacy and agree with it, and a copy of your signature will be on file in your records

INFORMED CONSENT

X_____ Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear and anger. Intense feelings of anxiety, depression, loneliness, or helplessness may also be aroused.

X_____ The benefits from psychotherapy may be that you will be better able to handle stressful situations, improve self confidence and relate better to your family, teachers, and peers, thus experiencing more satisfaction from those relationships. Another possible benefit may be a better understanding of your personal goals and values; this may lead to greater maturity and growth as a person.

X_____ You should know that your therapist is not a physician and cannot prescribe or provide you with any drugs or medication or perform any medical procedures. If medical treatment is indicated, your therapist can recommend a physician or psychiatrist for you or you can choose a health care professional you wish to see.

CANCELATION POLICY AND FEES

X_____ If you must cancel your appointment, please phone at least 24 hours prior to your scheduled time. Please understand that you are responsible for the time reserved and for notifying your counselor when a change in appointment time is needed. You will be charged a flat fee of **$50.00** for any appointment that does not meet this specification. The **exception** is in case of **extreme emergency**, meaning serious illness or an impossible situation; however, each counselor has the right to use discretion as to what an emergency entails. Part of effective therapy to meet your goals is to be accountable for keeping your appointments.

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CREDIT CARD ON FILE FOR UNPAID SERVICES

Cardholder Name (as written on credit card): _____
Credit Card Billing Address: _____
City, State & Zip _____
Credit Card Type: □ Visa □ Mastercard □ Discover □ AmEx
Credit Card Number: _____
Expiration Date: _____
Card Identification Number (CVV): _____

I authorize Wellspring Counseling North Georgia, LLC to charge to my credit card provided herein any amounts due on my account. I agree to have Wellspring Counseling North Georgia, LLC maintain my credit card information on file and automatically charge my credit card when payments are due. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement. I agree to inform Wellspring Counseling North Georgia, LLC within 15 days of any changes in credit card information, and I agree to pay any fees in the event my credit card is declined.

Cardholder – Print Name, Sign and Date Below:
Signed: _____
Dated: _____
Name: _____

RELEASE OF INFORMATION

X_____ To be compliant with HIPPA, we must have your written consent to release any of your mental health records to ANYONE. Please list the names and a contact phone number for anyone you give permission to have your records released to if needed.

Name Phone Number Relationship

_____

_____

_____

I have read and understood the prior statements including the confidentiality form, the disclosure information, the informed consent information, the appointment cancellation policy, and the information regarding consent to release records. My signature indicates that I hereby give my consent for counseling services. I authorize Wellspring Counseling North Georgia, LLC to render counseling services to the following:

_____
Client's Name (Print)

_____ _____
Client's Signature Date

_____ _____
Signature of Parent/Guardian Date

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Addendum to Patient Registration Form
Informed Consent
Payment of Fees for Denied and/or Non-Covered Services

I, _____, understand that some services may not be considered eligible benefits (e.g., services and/or supplies may be determined to not be medically necessary, non-covered or investigational) by my health insurance provider.

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services.

Examples of these non-covered items include, but are not limited to, multiple visits in one day, court documentation, depositions, report writing, in person or phone conferences and/or meetings and supplies.

Examples of Standard Fees:

Court Appearance (must be paid PRIOR to scheduling) - $1,200.00

Depositions (must be paid PRIOR to scheduling) - $150.00/per hour

Patient Phone Consults (unrelated to scheduling matters) - $50.00/per hour (billed at a minimum of 15 minutes)

Multiple visits in one day - Your contracted insurance allowable rate for same service type

I agree to be financially responsible for any and all related charges if they are not covered by my health insurance.

_____ Date:_____
Patient/Guardian Name – Please print

_____
Signature

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Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicates that you have been given the opportunity to review and retain a copy of our Notice of Privacy Practices (Notice) on the date indicated below.

If you have any questions regarding the information in the Notice of Privacy Practices, please do not hesitate to contact our office at any time.

Patient Name (Printed):
_____

If Patient Representative, Name (Printed):
_____

If Patient Representative, Relationship to Patient (Printed):
_____

Account # or Medical Record #:
_____

Signature:
_____

Date Notice Received:
_____

Social Media Policies

Please be advised our counselors do not accept "friend" or contact requests from current or former patients on any social/professional networking site (Facebook, LinkedIn, Twitter, Instagram, etc.). These sorts of connections may compromise your confidentiality and our respective privacy. These connections also may blur the boundaries of our therapeutic relationship and potentially have unforeseen negative consequences for you as my patient.

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Medicaid/Medicaid CMO Missed Appointment Addendum

Attention all Medicaid, Amerigroup, Wellcare and Cenpatico Patients

Please be advised that if you are a Medicaid or Medicaid CMO recipient, and you miss three (3) appointments, your care is subject to termination at the discretion of your provider. It is very important that you show up timely to all appointments scheduled, and to remember to reschedule if necessary.

If you have any questions regarding this standard, please do not hesitate to contact our office at any time.

Patient Name (Printed):
_____

If Patient Representative, Name (Printed):
_____

If Patient Representative, Relationship to Patient (Printed):
_____

Signature:
_____

Date Notice Received:
_____

(The information requested in this form will be kept confidential)