Wellsprings Center for Counseling Services

Promoting Happiness, Healing and Hope

PATIENT INFORMATION FORM

Today's Date ___/___/___.

Client's Name _____

Home Address _____City_____State_____Zip_____

Phone: Home _____Work _____Cell _____

I give my permission to be contacted at the phone numbers listed above. _____
Initials

SSN _____ - _____ - _____ Date of Birth _____Age _____ Circle One: Male /Female

Single Married Divorced Separated Other

Please CLEARLY PRINT phone number for appointment reminder: _____

Person completing the packet _____ Rel. to patient _____

Referred by _____

IN CASE OF EMERGENCY, CONTACT _____AT_____

Reason for seeking therapy _____

_____

_____

CONSENT FOR TREATMENT

I authorize Wellsprings Center for Counseling Services to provide psychological services for myself and/or my child. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient or Policyholder _____ Date _____

2115 Teakwood Lane, Suite 400 ● Plano, Texas 75075 ● Phone (972) 985-9579 ● Fax (972) 985-1949

www.wellspringsccs.net

ADDITIONAL INFORMATION FOR CHILD / ADOLESCENT

Child / Adolescent's Name _____

D.O.B. _____ Age _____ SSN _____ - _____ - _____ Circle one: Male/ Female

School _____ Teacher _____ Phone _____

Custodial Parents _____

Home _____ Work _____ Cell _____

If Divorced,* Non-Custodial Parents _____

Home _____ Work _____ Cell _____

Year Divorced _____ Age of Child at Divorce _____

** Please provide documentation from Divorce Decree stating who has legal authority to consent to psychological treatment.*

Please list all siblings:

_____ Age_____ Male / Female

_____ Age_____ Male / Female

_____ Age_____ Male / Female

_____ Age_____ Male / Female

Reason for seeking therapy _____

_____

_____

GUARDIAN'S CONSENT FOR TREATMENT

I acknowledge that I, _____, am the legal guardian of _____.
I hereby give my consent for him/her to receive counseling services at Wellsprings Center for Counseling Services. Treatment may include any of the following: Individual Therapy and/or Family Therapy. I realize that at all times the nature and content of such services must remain confidential.

Signature of Parent or Guardian _____ Date _____

GROUP & PRIVATE HEALTH INSURANCE
Assignment and Instruction for Direct Payment to Provider

Name of Insured _____ Date of Birth ___/___/____

Home Address _____ City_____ State_____ Zip_____

Phone: Home _____ Work _____ Cell _____

Circle One: Male /Female Single Married Divorced Separated Other

SSN _____ Email _____

Relationship to patient _____

Insurance Company Name or Mental Health Network * _____

Phone Number from Insurance Card _____
(Note: Your card may have a separate phone number for mental health/substance abuse.)

Member ID Number _____

Group Number _____

Name of Employer _____

* Please attach an enlarged copy of your insurance card (front and back) and an enlarged copy of your driver's license.

I hereby instruct and direct the insurance company named above to pay by check made payable to: Wellsprings Center for Counseling Services, 2115 Teakwood Lane, Suite 400, Plano, TX 75075; the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS FROM THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assigned, and I agree to pay any balance of said professional services charges over and above this insurance payment at the time service is rendered.

I also authorize the release of any information pertinent to my case to any insurance company. A photocopy or facsimile of this Assignment shall be considered as effective and valid as the original.

Signature of Patient or Policyholder _____ Date _____

CANCELLATION POLICY

As a courtesy, we agree to confirm your appointment by an automated reminder call to your primary phone number two days before your scheduled appointment. You will at that time have the opportunity to cancel, confirm, or contact someone in our office to re- schedule. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call.

If you do not show up for your scheduled therapy appointment and you have not notified us 24 hours in advance, you will be billed a $60 No Call/ No Show fee. If you notify us to cancel or reschedule your appointment on the same day, you will be billed a Late Cancellation fee of $30.

Please CLEARLY PRINT phone number for appointment reminder: _____

Regardless of the email reminder, you are accountable for your appointment time.

PAYMENT POLICY

Full payment for each session is required at the time the service is rendered. Payment may be made by cash, Visa, MasterCard, American Express, or Discover Card. If filing with insurance, a co-payment is due prior to the rendering of services. If the client is a child under the age of 18, the parent bringing the child is responsible for payment.

Filing of insurance is a courtesy provided by this office. While every effort will be made to collect you're your insurance carrier, you are ultimately responsible for payment. Any account balances exceeding $250, or any amount 90 past due is your responsibility. Secondary insurance is not filed by this office.

By signing below, I am acknowledging that I am aware and accept the financial responsibility for fees assessed to my account for services rendered, and for failing to provide a 24 hour cancellation notice of any scheduled appointment at Wellsprings Center for Counseling Services.

Signature of Patient or Policyholder _____ Date _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

I understand 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 you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

Patient Name _____

Signature of Patient or Guardian _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature to acknowledge this Notice of Privacy Practices Acknowledgment but was unable to do so as documented below.

Date _____ Initials _____ Reason_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be properly kept confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We 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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to remove it in writing.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2000, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information we maintain. We will post a copy in our office, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775