Wellsprings
PSYCHOLOGICAL RESOURCES®

Office: 63 Springs Station Drive, GA 30639
Mail: P.O. Box 157, Franklin Springs, GA 30639
Phone: (706) 246-0733
Fax: (706) 246-0722

Client Information Form for a Child

** You must be the LEGAL GUARDIAN of the client to complete this packet. **

Child's Name: Last _____ First_____ M.I.____ Nickname_____

Date of Birth: ____/_____/_____ **Age**: _____ **Gender**: M___ F____
MM DD YYYY

Parent/Guardian's Name: Last _____ First _____ M.I. _____

Relationship to Child: _____ **Your Marital Status**: Single___ Married___ Divorced___ Widowed___ Other___

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Home Phone: (____) _____-_____ **Work Phone**: (____) _____-_____ **Cell Phone**: (____) _____-_____

Person to call in case of emergency: _____ Emergency Phone #: (____) _____-_____

Name of School: _____ **Current Grade**: _____

Primary Physician: _____ **Physician's Phone**: (____) _____-_____

Primary Insurance: _____ **Policy/Group #**: _____

Insured's Name (if different than client)**:** _____ Insured DOB**:** ____/____/_____
MM DD YYYY

Secondary Insurance _____ Policy/Group #: _____

Please provide the best phone number and email address for appointment confirmations:

Phone number: (____) _____-_____

Email address: _____

I hereby authorize the release of any medical information to process this claim and request payment of medical benefits to Wellsprings Psychological Resources for services rendered. I understand that I am responsible to pay non-covered services.

_____ _____/____/_____
Signature of Parent/Guardian Date

_____
Printed name of Parent/Guardian

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Background History of Child

Siblings

Name: _____ Date of Birth ____/____/_____ Age_____ M / F

Name: _____ Date of Birth ____/____/_____ Age_____ M / F

Name: _____ Date of Birth ____/____/_____ Age_____ M / F

Name: _____ Date of Birth ____/____/_____ Age_____ M / F

Biological parents of child are: Married___ Divorced___ Separated___ Never married___ Single Parent___

Who has legal custody of child? _____ Child lives with: _____

Biological Mother's/Guardian Information

Name _____

Address _____

City, State, Zip _____

Phone _____

Employment _____

Work Phone _____

Biological Father's/Guardian Information

Name _____

Address _____

City, State, Zip _____

Phone _____

Employment _____

Work Phone _____

1. Has the child ever been in any type of counseling before? ____ Reason: _____

2. What is the primary reason for this office visit? _____

_____

3. Has the child ever been hospitalized for any type of mental health problems? If so, please give date and location:

_____

4. Is there a history of alcohol or drug abuse in the child's family? If yes, please explain:

_____

5. Is there a history of mental illness in either side of the child's family? If yes, please explain:

_____

6. Does the child have a history of medical problems? If so, please list:

_____

7. Has the child been diagnosed previously with a mental illness? If so, please explain:

_____

8. Is the child currently taking medication? _____Yes _____No

Name of medication: _____ Dosage: _____

Prescribing physician: _____ Start date: _____/_____/_____

Name of medication: _____ Dosage: _____

Prescribing physician: _____ Start date: _____/_____/_____

_____ _____/____/_____

Signature of Parent/Guardian Date

_____

Printed name of Parent/Guardian

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Guardianship Information

** You must be the LEGAL GUARDIAN of the client to complete this packet. **

1. Child's name: _____
2. Your name (please print): _____
3. Your relationship to child (**circle one**):
   Parent Stepparent Guardian Grandparent DFCS Caseworker Other_____
4. Has there been legal action taken regarding the custody of the above-named child? (**Circle one and initial**):
   Yes_____ No_____

If legal action has been taken, please answer questions 5 through 7:

5. I have the following **legal custody** (**circle one and initial**):
   Joint_____ Sole_____ Other (please specify):_____
6. I have legal right to obtain treatment for the above-named child (**circle one and initial**):
   Yes_____ No_____
7. Does anyone else have legal custody and legal right to access medical records? (**Circle one**):
   Yes_____ No_____
   If yes, who? _____
   Date of Birth: _____
   Phone number: _____

8. In instances of divorce, DFCS custody, or other legal custodial arrangements, the legal custodian must grant permission for mental health services by signing all paperwork. In certain situations, Wellsprings may request legal custody documentation.

We can only provide mental health services with permission from the legal custodian.

Would you like anyone else to have permission to schedule, access payment information, and/or communicate with the therapist in regard to your child's treatment?

Contact Info:
Name: _____
Date of Birth: _____
Phone Number: _____
Permissions (check each that apply):
_____ Scheduling
_____ Payment
_____ Communication with the therapist in the office

By signing below, you are indicating that you have read, understood, and agree to these policies.

_____ _____/____/_____
Signature of Parent/Guardian Date

_____
Printed name of Parent/Guardian

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Consent for Treatment/Evaluation

Confidentiality: All information disclosed within therapy sessions is confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. Disclosure may be required under the following circumstances: 1) where there is a reasonable suspicion of child or elder abuse; 2) where there is reasonable suspicion that the client presents a danger of violence to others; 3) where the client is likely to harm himself or herself unless protective measures are taken, or 4) where the client discloses sexual contact. Disclosure may also be required pursuant to a legal proceeding.

Psychotherapy with children: If I am bringing my child for psychotherapy, I agree to allow my child to have some degree of privacy in his or her relationship with the therapist. It is my expectation that I will be made aware of my child's general progress in therapy, but I understand that I will not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

Release of Information to Others: Often the treatment plan for children may include a multi-professional team approach. Please list below other professionals (school counselor, DFCS workers, other counselor) with whom consultation may occur regarding your or your child's case. **Note that proper release of information forms must be signed before receiving or releasing information on your child.**

Fees: Fees are usual and customary and will be discussed prior to or at the initial visit. Insurance companies offer a wide variety of plans with various requirements. Some require pre-approval or preauthorization, particularly before mental health services will be covered. To ensure you receive your maximum benefit from insurance, you are encouraged to review your plan and contact your carrier prior to your first visit. If the therapists at Wellsprings do not participate with your insurance company, **you will be expected to pay in full at the time services are rendered, including your first visit.** Psychological evaluation fees are based on the kind of assessment, time involved, etc. Please see the **Financial Policy Form.**

Spirituality Preference: If you would like to have a Christian perspective (including prayer, use of Bible, application of Christian principles for living, suggested devotional materials, recommendation of Christian literature) included in your child's counseling sessions, please indicate here: **Yes ____ No _____**

Cancellation of Appointments or No Shows: Please see the Late Cancellation or Missed Appointment Policy.

In case of Emergency: In case of emergency, report to the emergency room of the nearest hospital and ask them to contact our office.

By signing below you are indicating that you have read, understood, and agree to these conditions.

_____ _____/____/_____
Signature of Parent/Guardian Date

_____
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Financial Policy for our Clients

Clients with Insurance

As a courtesy to our clients, we do accept and file claims for some insurance companies. However, it is your responsibility to be familiar with your insurance benefits (whether or not they pay for outpatient counseling or psychological services) and their requirements for claims. You are to present a valid insurance card at every visit and as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. Maintaining the insurance policy is the client's responsibility. Lapses in coverage will result in you being responsible for the total amount of the fees that are not covered by your insurance.

Medicare and Medicaid: Our office is a Medicare and Medicaid participating provider and we will bill for you. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered service will be due as service is rendered. Any outstanding balances, co-payments and deductibles are due **prior to** your appointments.

Self-Pay Clients

Self-Pay Clients are required to pay for all portions of services due in full at the time services are provided. Client agrees to the fee of $_____ for the initial consultation and $_____ for the 45-minute therapy sessions.

The client is ultimately responsible for all fees for services. If not paid according to terms, the client understands that our office will report to an outside collection agency. In the event that your account is turned over for collections, client agrees to pay all additional agency and attorney fees assessed in the collection of the debt.

Methods of payment accepted in our office: Cash, Personal Check, Debit Card, Visa, MasterCard, Discover

Automated Payment Authorization

Our office offers an Automated Payment System which allows us to charge your debit/credit card automatically after each appointment. A separate authorization form will be required. Please check your preferred option:

- ☐ **I DO want Wellsprings to automatically charge my card after each appointment.**
- ☐ **I do NOT want my card to be automatically charged after each appointment**

By signing below, you are indicating that you have read, understood, and agree to the above financial policy for payments of professional fees.

_____ _____/____/_____
Signature of Parent/Guardian Date

_____
Printed name of Parent/Guardian

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Late Cancellation or Missed Appointment Policy

We at Wellsprings want your counseling experience to be positive and helpful in all ways. Because counseling is most effective when appointments are kept consistently, it is critical that both you and your therapist attend your scheduled appointments and to be on time. When you schedule your appointment, we have reserved this time in our schedule and we have placed it aside to meet with you.

If you or your therapist must cancel or change your appointment, we each agree to contact each other **at least 24 hours in advance**. This allows our staff to contact clients on our waiting list and to offer them this appointment time. If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits (before 24 hours), **you will be assessed a $25 missed appointment fee with a second or succeeding missed appointment**. **(Note: The first missed appointment is allowed for a last-minute emergency beyond your control. More than one missed or late canceled appointment will be assessed the $25 fee, except with documentation as noted below.)**

The only exceptions to this policy are appointments missed due to last minute medical attention, funerals, and deaths in the family (with a doctor's note, receipt, or other verification). You should note that insurance companies do NOT reimburse members for such charges. **Payment for missed appointments is due by the day before your next scheduled appointment, or that appointment will be canceled.**

As a courtesy, our scheduling system sends out reminder emails, calls, and texts before your appointments to remind you of your appointment times. **However, this is a courtesy call only**. You are still responsible for remembering your appointment and attending. Not receiving the calls, emails, and texts does not excuse you of this responsibility.

Termination Policy

Termination of therapy can be initiated by either the client or the therapist. If you are dissatisfied with the therapeutic care you are receiving, we hope you will discuss it with your therapist or the office staff or Executive Director so that we can make any changes necessary.

Wellsprings reserves the right to terminate therapy if you missed appointments without notifying us as outlined above in our Cancellation Policy. **Two no show appointments will result in cancellation of any future appointments. Two late cancellations or no shows may result in termination of therapy, in addition to the $25 missed appointment fee.**

If you request further treatment, we may be able to provide you with a recommendation to other practitioners for follow-up care. Should you request further services from Wellsprings after you have been terminated for failure to follow the Cancellation Policy, if you have paid all of your fees, you could be placed on a "Same Day Call Back" and we will call you whenever we have last minute appointment slots available.

By signing below, you are indicating that you have read, understood, and agree to these policies.

_____ _____/____/_____
Signature of Parent/Guardian Date

_____
Printed name of Parent/Guardian

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HIPAA 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.

Wellsprings Psychological Resources is committed to maintaining the privacy of your protected health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to third parties for purposes of treatment, payment, and health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is individually identifiable health information about you as it relates to your past, present or future physical or mental health condition and related health care services regardless of the form in which it is maintained (electronic, paper, oral format, etc.)

Use and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician or therapist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician or therapist's practice, and any other use required by law.

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your doctor may share your health information with a specialist, referring physician or therapist, or hospital staff that will assist in your treatment. Your protected health information may be provided to a physician or therapist to whom you have been referred or who is providing on-call coverage to ensure that the physician or therapist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information will be provided directly or through a billing service to appropriate third party payers, pursuant to their billing and payment requirements. For example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company, managed care company, health plan, or Medicare.

Healthcare Operations: We may use or disclose as-needed, your protected health information in order to support the business activities of your physician's or therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, outside storage of medical records and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician or therapist is ready to see you. We may use or disclose your protected health information, as necessary, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Note: Genetic information is protected by law and is not considered part of Healthcare Operations.

Sharing Your Health Information: In addition to Treatment, Payment, and Healthcare Operations, there are other situations when we are permitted or required to disclose health information without your authorization. Wellsprings may use and/or disclose your PHI, without a written authorization from you, in the following instances:

1. De-identified Information – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.
2. Business Associate – To a business associate, who is someone the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and/or health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate and their subcontractors will appropriately safeguard your PHI.
3. Personal Representative – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
4. Public Health Activities – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

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5. Federal Drug Administration – If required by the Food and Drug Administration to report adverse events, product defects, problems, biological product deviations, or to track products, enable product recalls, repairs or replacements, or to conduct post marketing surveillance.
6. Abuse, Neglect or Domestic Violence – To a government authority, if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes the disclosure is necessary to prevent serious harm or if the Practice believes you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.
7. Health Oversight Activities – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.
8. Family and Friends - Unless expressly prohibited by you, the Practice may disclose PHI to a member of your family, a relative, a close friend or any other person you identify, as it *directly* relates to that person's involvement in your health care. If you do not express an objection or are unable to object to such a disclosure, we may disclose such information, as necessary, if we determine that it is in your best interest based on our professional judgment.
9. Judicial and Administrative Proceeding – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.
10. Law Enforcement Purposes – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.
11. Coroner or Medical Examiner – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.
12. Organ, Eye or Tissue Donation – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
13. Research – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board, the de-identification of your PHI before it is used, and the requirement that protocols must be followed. Individuals have the option to 'opt out' of certain types of research activities.
14. Avert a Threat to Health or Safety – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
15. Specialized Government Functions – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.
16. Inmates – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.
17. Workers' Compensation – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
18. Disaster Relief Efforts – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

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19. Marketing - Face to face communication directly with the patient, treatment and coordination of care activities, refill reminders or communications about drugs that have already been prescribed, or promotional gifts of nominal value do not require authorization as long as the Practice receives no financial remuneration for making the communication. All other situations require separate authorization.
20. Required by Law – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

Required Uses and Disclosures: Uses and/or disclosures, other than those described above, will be made only with your *written* Authorization. These authorizations may be revoked at any time; however, we cannot take back disclosures already made with your permission. Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information require your written authorization. All other uses and disclosures not described in our Notice of Privacy Practices will be made only with your signed consent or authorization.

Your Rights under the Federal Privacy Standard

You have the right to inspect and copy your protected health information. Fees may apply. Under limited circumstances that are defined by law, we may deny you access to a portion of your health information.

You have the right to request restriction on uses and disclosures of your health information for treatment, payment, and healthcare operations as provided by law. However, Wellsprings is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply. If the practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment. If your physician or therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You may also restrict disclosures to your health plan when you have paid out-of-pocket in full for health care items or services provided by the practice.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must submit your written request**.** Wellsprings will accommodate all reasonable requests.

You have the right to request that your physician or therapist amend/correct your protected health information. To request an amendment, you must submit a written request the Practice that includes a reason that supports your request. If we deny your request for amendment/correction, you have the right to file a statement of disagreement which can be attached to your records. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of non-routine disclosures of your protected health information. To request an accounting, you must submit a written request to the Practice which contains the time period desired. Fees may apply.

You have the right to revoke your consent or authorization to use or disclose health information except to the extent that we have taken action in reliance on the consent or authorization.

You have the right to obtain a paper copy of this Notice of Privacy Practices. Although we have posted a copy in prominent locations throughout the facility and on our website, you have a right to a hard copy upon request.

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Our Responsibilities under the Federal Privacy Standard

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

We have a responsibility to maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.

We have a responsibility to provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.

We have a responsibility to abide by the terms of this notice.

We have a responsibility to train our personnel concerning privacy and confidentiality.

We have a responsibility to implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.

We have a responsibility to notify you if there has been a breach of your unsecured protected health information and mitigate (lessen the harm of) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How to Get More Information or Report a Problem

If you have questions and/or would like additional information, you may contact our Privacy Officer at 706-246-0733. If you feel that your privacy rights have been violated by us, you may file a complaint with Wellsprings' Privacy Officer. All complaints must be submitted in writing. If your complaint is not resolved to your satisfaction, you may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights. Our Privacy Officer will furnish you with the address and appropriate complaint form upon request. **We will not retaliate against you for filing a complaint.**

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR YOUR ENTIRE PHI THAT IT MAINTAINS. IF WE CHANGE OUR INFORMATION PRACTICES, WE MAY MAIL A REVISED NOTICE TO THE ADDRESS THAT YOU HAVE PROVIDED UPON YOUR REQUEST.

This notice was published and becomes effective on or before **9/23/2013**.

Signature below is acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____/____/_____
Signature of Parent/Guardian Date

_____
Printed name of Parent/Guardian

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Authorization to Release Information to Primary Care Physicians

Wellsprings is required by many insurances to communicate with your primary care physician. Please provide the doctor's information with whom you wish us to share or receive information

Client's Name: _____ **Date of Birth**: ____/_____/_____
MM DD YYYY

Parent/Legal Guardian: _____ **Relationship**: _____

I hereby authorize Wellsprings Psychological Resources to exchange information with:

Primary Care Physician/Agency Name: _____

Mailing Address: _____

Phone Number: (____) _____-_____ **Fax Number**: (____) _____-_____

- ☐ **I do not have a primary care physician.**
- ☐ **Please do not release information to my PCP.**

I authorize the release of information, for the purpose of coordination of care and consultation, with the above-mentioned physician or agency.

I understand that:

- This Authorization is voluntary and that I have the right to refuse to sign it.
- This release is in effect until a change of information or until I provide Wellsprings notice otherwise.

I have had the opportunity to review and consider the contents of this authorization. By signing this form, I am confirming that the information above is correct.

_____ _____/____/_____
Signature of client (or personal representative) Date

_____
Printed name of client (or personal representative and his/her relationship to patient)