



Client Information, Part A

Client's Name: _____ Age: _____ Date of Birth: _____ Sex: _____

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

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

Please mark which phone(s)/email number that you give the counselor permission to call.

Marital Status: _____ Year married: _____ Spouse: _____

Church: _____ Referred by: _____

If client is a child:

Mother's name: _____ Contact # _____

Father's name: _____ Contact # _____

Children or Siblings:

Name	Age	Sex	School

Please briefly describe the reasons for seeking counseling at this time.

HIPAA

Health Insurance Portability and Accountability Act

- I authorize **Wellspring Counseling** and any member of its staff to call or write me through the following methods to discuss medical information, including but not limited to lab results, procedures results, follow up, appointment reminders, outstanding bills, termination of relationship, etc. as needed regarding my treatment. According to HIPAA regulations, please be informed that cell phone, skype, or other electronic conversations may not be considered confidential.

Home Phone: _____ Work Phone: _____

Cellular: _____ Email: _____

Fax: _____

Mailing address: _____

- I authorize **Wellspring Counseling** to exchange verbal and/or written information with the below named persons/agencies as deemed by the therapist to be contributory to my (the client's) long-term welfare.

Name _____ Relationship _____

Agency and address _____

Address _____ Phone number _____

Check one: Up to 90 days. For the duration of the therapeutic relationship. Other: _____

Name _____ Relationship _____

Agency and address _____

Address _____ Phone number _____

Check one: Up to 90 days. For the duration of the therapeutic relationship. Other: _____

- I give permission to **Wellspring Counseling** to add my name to a Wellspring Information Email list using the following email:

Email address: _____

Patient Information:

Name _____ Date of Birth _____

Patient Signature _____ Date _____

Witness _____ Date _____

This authorization can only be changed by a signed, written and dated request from the patient.

Consent for Treatment

I, _____ hereby authorize **Wellspring Counseling** or its designated agents to provide **psychotherapeutic treatment** to myself, child or family member and agree to participate in individual, group and/or family psychotherapy/counseling sessions. **Testing and/or assessment** for psychological, social, educational, or occupational purposes may also be administered.

- I have received and reviewed the Policies statement for Wellspring Counseling, including information regarding confidentiality, emergency procedures, and termination.
- I have received and signed the HIPPA notice of privacy practice.
- I have received a copy of my Client Rights
- I have read this consent form and have had an opportunity to ask questions about this material and agree to the rules and guidelines herein presented.

Signature _____ Date _____

Signature _____ Date _____

Initial Verbal Agreement for Therapy

This portion will be discussed with your therapist in your first appointment.

I have agreed to pay _____ for each individual hour of therapy,
and _____ for each EMDR session (typically 1 ½ hours).

We are expecting to meet for _____ sessions in order to meet my goals of

_____.

Our appointments are _____

I have also agreed to _____
