Wellspring Counseling Center

603 West F Street ~ Oakdale, CA 95361
209-607-1887 ~ fax 209-848-8825

Intern Registration Form

CLIENT INFORMATION:

Name____ Date of Birth____________ Male / Female

Street Address____________________________________ City ____________________ State ______ Zip Code ___________

Home Phone ( ) __________________ Work Phone ( ) _________________ Cell Phone ( ) __________________

If other than client, Name of the Responsible Person/Guardian____

Mailing Address (If different from above) ____

Home Phone ( ) _________________________ Work Phone ( ) _______________________________

Place of Employment: ____

Emergency Contact: ____ Phone ( ) ______________________________

Are you currently taking any medication? If so, please list here. ____

Education: (Circle highest grade completed) Elementary 1 2 3 4 5 6 7 8 High School 1 2 3 4 College 1 2 3 4+

For Minors Only: Mother's Name: _______________ Father's Name: _____________ Name of School: ____________________

MARITAL & FAMILY INFORMATION:

Children's Name(s) & Ages, if applicable: ____

Spouse's Name, if applicable: ____

Date of marriage: _________________________ Age at Time Of Marriage: Husband _____________ Wife _________________

How long did you know your spouse before marriage: ___________________ How long was your engagement?________________

Have you ever separated? ___________________ If so, how many times, and how long each time? _________________________

Have either of you ever filed for divorce? ____________________ If so, who?____

Were your previously married?________________ How many times?______________ Length of Marriage(s)?_________________

Reason(s) you are no longer married to former spouse(s):____

With whom do you currently live? ____

Parents still living? Yes or No If applicable: Date of death of: Father_______________ Mother______________________

If alive, do parents live together now? ______________________________ If no, why not?_________________________________

When did they separate (year)? ______________________ How old were you at time of separation?__________________________

Ethnic/Cultural Background? ____

As a child, who did you feel closest to? ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Other _____________

Rate your childhood: ☐ Very happy ☐ Happy ☐ Average ☐ Unhappy ☐ Very unhappy

How many siblings do you have? Brothers_______________ Sisters________________ All living?____________________

If no, give name(s) and age of deceased:____

I hereby give permission for mental health treatment for the client above. I agree to pay for expenses that the insurance company does not cover if allowed by the insurance contract with my therapist. I understand that the use of treatment tools like workbooks, horse rental or play therapy materials is a separate charge, entirely voluntary and not a condition of treatment. I also authorize the release, to the insurance company and/or billing service, of any counseling information necessary to process the counseling claims. I acknowledge that I have read and received a notice of Privacy Practices.

____ ___________________________

Signature (Parent/Guardian if client is a minor) Date

Wellspring Counseling Center
603 West F Street ~ Oakdale, CA 95361
209-607-1887 ~ fax 209-848-8825

Financial Policies

Thank you for contacting our office for counseling services. Listed below are our financial policies. If you have questions, please ask your therapist for clarification of these policies or additional information regarding services. We look forward to working with you.

1. The standard fee for a 45 minute individual session is $75 payable at the beginning of each meeting. The charge for couple's therapy or groups of two or more persons is $150 per 45 minute session.

2. Payment for therapeutic services is to be given to the therapist at the beginning of each visit with cash or checks made payable to Wellspring. Credit cards are not accepted. Clients receiving psychological testing will be assessed a fee depending on the type and/or extent of testing. If you are the recipient of a church funded grant or scholarship, please indicate by checking below.

   Recipient of a church-funded grant will be responsible for a copay of $___________.

3. Please notify the counselor of cancellations at least 24 hours in advance of your scheduled appointment. No shows and sessions not cancelled according to these guidelines will be charged to your account at full fee and you will be responsible for payment. If you are the recipient of a church funded grant or scholarship, additional appointments cannot be scheduled until the balance is paid in full. More than one missed appointment may terminate the grant or scholarship.

   _____ By initialing here, I am indicating that I understand the cancellation/no show policy.

4. If phone consultations, psychological reports, or treatment summaries are necessary, they will be charged to your account at a rate equivalent to your hourly $75 per hour therapy fee. If you are receiving a grant or scholarship for counseling, the scholarship or grant does not cover any services other than counseling.

5. We will make every effort to respond to your psychological needs during our normal business hours. Because we are not a crisis facility, we are unable to respond to emergencies which occur after our normal business hours. Local crisis facilities include but are not limited to: Doctors Behavioral Health Center, 1501 Claus Road, Modesto. (209) 557-6300.

5. Any legal matters requiring the therapist's time will be billed at the rate of $250.00 per hour. This includes but is not limited to preparation time for depositions and travel. This applies to those receiving grants and scholarships.

I have read and understand the financial policy. I agree to make payment at the beginning of each visit.

____ ______________________________
Client's Signature (Parent/Guardian if Client is a Minor) Date

_____ I am the recipient of a grant or scholarship ___________________________________
Client (Please Print)

Wellspring Counseling Center
603 West F Street ~ Oakdale, CA 95361
209-607-1887 ~ fax 209-848-8825

Limits of Confidentiality

Each individual's rights to confidentiality need to be clearly explained. By professional ethics and by law, you have the right to confidentiality, and the therapist is prohibited from revealing to any other person what you have said to him/her without your written permission. There are three (3) instances in which your right to privacy must be set aside *without* your permission:

1. If your therapist is given information that leads to reasonable suspicion of sexual, physical, or severe emotional abuse to a minor, an elderly, or developmentally disabled person, the therapist must call the protective services immediately and submit a follow-up written report ASAP.

2. If your therapist believes, from the information that you disclose, that you are in danger to yourself or to someone else, he/she must notify the local authorities and person(s) in danger.

3. If a court orders the therapist to release information.

Failure to comply with the law relating to items 1-3 above can render the therapist liable to punitive action such as loss of license, imprisonment, fine(s) or civil lawsuit for malpractice.

Clients should be aware that the use of insurance requires his/her agreement (by right of the insurance carrier) to free access to the therapist's records. This represents a compromise of a client's right to confidentiality since insurance companies may place this information in a larger industry-wide computer data base. Any concerns in this regard should be addressed to your insurance carrier. Clients should also understand that text messaging or emailing can also compromise confidentiality. Please initial here if you give permission to give and receive information through email or text. _____

For more specific information, please refer to the Notice of Privacy Practices, available from your therapist.

By signing below, I hereby acknowledge *the above Limits of Confidentiality*

Client Name:____ Date of Birth: ____________________
(Please Print)

____ _______________________________
Signature of Client Date

Parent/Guardian's Name (if client is a minor): ____
(Please Print)

____ _______________________________
Signature of Parent/Guardian if Client is Minor Date

Wellspring Counseling Center
603 West F Street ~ Oakdale, CA 95361
209-607-1887 ~ fax 209-848-8825

Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Effective Date: March 1, 2004

My Legal Duty:
I understand that your health/mental health information is personal, and I am committed to protecting this information. I am required by applicable federal and state law to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 (H.I.P.A.A.), also requires that I give you this Notice about my legal duties, my privacy practices, and your rights concerning this Notice while it is in effect.

Individually, identifiable information about your past, present, or future health/mental health or condition, the provision of health/mental health care to you, or payment for the health/mental health care is considered “Protected Health Information (PHI).” Whenever possible, the PHI contained in your record remains private. In some circumstances, it is necessary for me to share some of the PHI contained in your record (or your child’s record). In all but certain specified circumstances, I will share only the *minimum necessary* PHI to accomplish the intended purpose of the use or disclosure.

How I May Use and Disclose Health/Mental Health Information About You:
The following categories describe different ways that I use and disclose your PHI. For each category, I explain what I mean, and offer an example. In some instances a written authorization signed by you is required in order for me to use or disclose your PHI; in others, it is not. I have tried to identify which instances do not require your signed authorization and which do.

Uses and Disclosures of PHI for Which No Signed Authorization is Required:

For Treatment: I may use/disclose your PHI (or your child’s) to provide you with mental health treatment or services. For example, I can disclose your PHI to physicians, psychiatrists, and other licensed health care providers who provide you with health care services or are involved in your care. If a psychiatrist is treating you, I can disclose your PHI to your psychiatrist in order to coordinate your care.

For Payment: I may use/disclose your (or your child’s) PHI in order to bill and collect payment (from you, your insurance company, or another third party) for services provided by me. For example, I may send your PHI to your insurance company to get paid for the services provided to you or to determine eligibility for coverage.

For Health Care Operations: I may use/disclose your (or your child’s) PHI to your health care service plan or insurance company for purposes of administering the plan, such as case management and care coordination.

Appointment Reminders or Changes in Appointments: I may use/disclose your (or your child’s) PHI to contact you as a reminder that you have an appointment. I may also contact you to notify you of a chance in your appointment. For example, if I am ill, I may have someone in my office contact you to notify you that the appointment is cancelled. *If you do not wish me to contact you for appointment reminders or changes in appointment times, please provide me with alternative instructions (in writing).*

When Disclosure is Required by State, Federal or Local Law; Judicial or Administrative Proceedings; Or Law Enforcement: I may use/disclose your (or your child’s) PHI when a law requires that I report information about suspected child, elder, or dependent adult abuse or neglect; or in response to a court order. I must also disclose information to authorities that monitor compliance with these privacy requirements.

To Avoid Harm: I may use/disclose limited PHI about you when necessary to prevent or lessen a serious threat to your health or safety, or the health and safety of the public or another person. If I reasonably believe you pose a serious threat of harm to yourself, I may contact family members or others who can help protect you. If you communicate a serious threat of bodily harm to another, I will be required to notify law enforcement and the potential vi

Law Enforcement Officials: I may disclose your (or your child's) PHI to the police or other law enforcement officials as required or permitted by law, or in compliance with a court order, or grand jury, or administrative subpoena.

For Health Oversight Activities: I may disclose PHI to a health oversight agency for activities authorized by law. For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

Specialized Government Functions: I may disclose you (or your child's) PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

Disclosure to Relatives, Close Friends and Other Caregivers: I may use/disclose your PHI to a family member, other relative, a close personal friend, or any other person that you indicate is involved in your care or the payment of your care unless you object in while or in part. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance. I may exercise my professional judgment to determine whether a disclosure is in your best interest. If disclosing PHI to a family member, other relative or a close personal friend, I would disclose only information that I believe is directly relevant to the person's involvement with your health care or payment related to your health care.

Workers' Compensation: I may disclose your PHI as authorized by and to the extent necessary to comply with California Law relating to workers' compensation or other similar programs.

As Required By Law: I may use and disclose you (or your child's) PHI when required to do so by any other law not already referred to in the preceding categories.

Uses and Disclosures of PHI for Which a Signed Authorization is Required*:* For uses and disclosures of PHI beyond the areas noted above, I must obtain your written authorization. Authorizations can be revoked at any time in writing to stop future uses/disclosures (except to the extent that I have already acted upon your authorization).

Your Rights Regarding You, or Your Child's, Protected Health Information (PHI):

You have the following rights regarding your PHI, or that of your child's, that I maintain:

Right to Inspect and Copy: You have the right to inspect and copy your (or your child's) health/mental health information upon your written request. However, some mental health information may not be accessed for treatment reasons and for other reasons pertaining to California or Federal Law. I will respond to your written request to inspect records.

Right to Request Restrictions: You have the right to ask that I limit how I use or disclose your PHI. I will consider your request, but I am not legally required to agree to the request. If I do agree to your written request to inspect records. A charge for copying, mailing and related expenses will apply.

Right to Amend: If you believe that there is a mistake or missing information in my record of your health/mental health information, you may request in writing, that I correct or add to the record. I will respond to your request within 60 days of receiving it. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request to amend information that was not created by me, not part of my records, not part of the information that you would be permitted to inspect and copy or is accurate and complete.

Right to an Accounting of Disclosures: You have a right to get a list of when, to whom, for what purpose, and what content of your (or your child's) PHI has been disclosed. This applies to disclosures other then those made for purposes of treatment payment, or health care operations. Your request must be in writing and state a time period (which may not be longer than six years and may not include dates before December 1, 2012). I will respond to your request within sixty (60) days of receiving it. The first list you request within a 12 month period will be free. There may be a charge for more frequent lists. In such a case, I will notify you of the cost involved and you may choose to change or withdraw your request before any costs are incurred.

Right to Request Confidential Communications: You have a right to request that I communicate with you about health/mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing. Please specify how or where you wish to be contacted. I will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

Complaints:
If you think that your privacy rights have been violated you may contact me at (209) 322-9801, or your may file a complaint with the Secretary of the United States Department of Health and Human Services, at 200 Independence Avenue S.W., Washington, D.C. 20201. You will not be penalized for filing a complaint.

Wellspring Counseling Center

603 West F Street ~ Oakdale, CA 95361

209-607-1887~ fax 209-848-8825

Authorization for Disclosure of Confidential Mental Health Information (HIPAA)

Name: ____ Date of Birth: __________________________

My therapist, __________________________________, is authorized to release and disclose information to:

____

(*Name of Person or Organization)*

If applicable, ________________________________ (*Name of Person or Organization)* is authorized to release and disclose information to: ___________________________________

Specific Information to be Released/Obtained (Please select only one):

_____ All health/mental health information including diagnosis and treatment received.

_____ Only the following records or type of information ____

Please specify if any information is to be excluded: ____

This authorization shall become effective on ____/____/____ and will not expire without your written request. A photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected. California law prohibits recipients of your health information from re-disclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this authorization.
- You may revoke this authorization only by delivering your revocation in writing to: ______________________ (therapist). Your revocation will be effective when your therapist receives it. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this authorization.
- You may need to inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to provide this authorization.

____ ____________________

Signature of Client/Parent/Guardian/Conservator Date

Relationship to Client: __________________________