WELLSPRING
Counseling Center

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NEW CLIENT INTAKE FORM

Client Information

First Name _____ MI ____ Last _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone _____ ☐ Yes ☐ No

Work Phone _____ ☐ Yes ☐ No

Birth Date _____ SSN _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

Email _____ Is it okay to email? ☐ Yes ☐ No

Primary Physician _____ Phone _____

Insurance Information

Do you have insurance? ☐ Yes, Plan Name _____

☐ No, Self Pay Amount _____

Insured's Name _____ Insured's Birth Date _____

Insured's ID # _____ Insured's SSN _____

Insured's Group # _____ Insured's Employer _____

Insured's Phone _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

** All insurance information must be filled in even if a copy is made of your insurance card.*

Agreement

I accept financial responsibility for all charges for myself and/or family members receiving services from Wellspring Counseling Center, Inc. I understand that the fee schedule is as follows unless a different fee is agreed upon with therapist. This fee is written in Self Pay box above. (**Standard Fee Schedule:** First Evaluations Session: $185; Standard 50 minute Session: $150)

Our billing service verifies insurance benefits as a courtesy. We cannot guarantee accurate benefit information has been received from your insurance company until the claim is processed. I am responsible for payment of deductible, co-payment, and balance not covered by my insurance company. It is my responsibility to notify Wellspring Counseling Center of my insurance information and any change that may occur.

If I do not show for a scheduled appointment or do not cancel with in 24 hours I will be charged $75.00 for that session. I understand that my insurance company will not reimburse me for this fee.

Signature (Client or Guardian) Date

Consent for Treatment

I, the undersigned, consent to admission and treatment by the counselors, physicians and staff at Wellspring Counseling Center, Inc. I consent to participate in an individual evaluation and to work with the staff to develop a treatment plan deemed professionally appropriate to my treatment needs and goals.

I, the undersigned, consent to admission and treatment by the counselors, physicians and staff at Wellspring Counseling Center, Inc. I consent to participate in an individual evaluation and to work with the staff to develop a treatment plan deemed professionally appropriate to my treatment needs and goals.

Wellspring Counseling Center is a privately owned and operated corporation. Fees are assessed by the corporation and to be paid directly to Wellspring Counseling Center.

I understand that I have a right to read and ask questions about the Client Bill of Rights. If you have not received a copy, please ask your therapist for one.

The nature and purpose of this treatment including possible alternative methods, and its risks and complications have been explained to me by a staff member.

All Wellspring Counseling Center staff members are Christian counselors. While no one will impose his/her beliefs or values on you, they may provide therapy that is distinctly Christian. You should be aware that other treatment is available in the community that does not involve this perspective. If you would like a referral please discuss this with your therapist. Otherwise you understand and desire that Christian-oriented interventions and materials be used in counseling.

I certify that I have read and fully understand this consent.

Signature (Client or Guardian) Date