



**Confidential Client Data Form**

***CONTACT INFORMATION***

Date: \_\_\_\_\_

Name: \_\_\_\_\_

D.O.B: \_\_\_\_\_

Street Address:

\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

OK to send mail?  Yes  No

OK to call?  Yes  No Which number? \_\_\_\_\_

OK to leave message?  Yes  No Which number? \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

OK to email?  Yes  No

Please provide a name and phone number of whom to call in case of an emergency:

***DEMOGRAPHIC INFORMATION***

Gender: \_\_\_\_\_

Relationship Status: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Education / Degrees: \_\_\_\_\_

***REFERRAL INFORMATION***

Current reason(s) for seeking therapy:

Estimate the severity of the above problem:

Mild     Moderate     Severe     Very Severe

How did you hear about our practice?

***HEALTH INFORMATION***

Do you have any current medical conditions?

Are you currently taking any medications? (Please list names, dosages, and prescriber):

Have you ever been hospitalized for psychiatric reasons? (If yes, please provide details):

Have you previously been in psychotherapy? When and for what issues?

Was it helpful?

Have you ever had or do you currently have any suicide attempts, self-destructive behaviors, or violent behaviors?

List any past/present drug and alcohol use.

### ***RELATIONSHIPS***

Do you live with others?

Are there any other current relationships that are a significant focus in your life right now? Please describe:

### **Other**

What are your main worries or fears?

What do you consider your main strengths?

Please add any additional information that may be helpful to our work together:



### **Acknowledgment of Notifications**

I acknowledge that I have received Wellspring Psychology's Office Policies and Consent for Psychotherapy Services and I understand, and agree to comply with these policies. I understand that these policies will always be available to me at [www.WellspringPsychology.com](http://www.WellspringPsychology.com), and that I may always request a hard copy if I am unable to access them.

I understand that my clinician is operating under a valid license in the state of California.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Printed Name

I also acknowledge that I have received the HIPAA Notice of Privacy Practices for my review. I understand that the HIPAA form will remain available at [www.WellspringPsychology.com](http://www.WellspringPsychology.com), and that I may always request a hard copy if I am unable to access it.

\_\_\_\_\_ Signature

\_\_\_\_\_ Date

\_\_\_\_\_ Printed Name



## Agreement to Pay for Professional Services

I request that a clinician from Wellspring Psychology provide professional services to me and agree to pay \$ \_\_\_\_\_ per session for such services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services, or until I inform him/her that I wish to terminate treatment. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account. Medicare patients please be advised that per CMS guidelines, patients are responsible for the full fee of phone sessions.

I also understand and agree to Wellspring Psychology's 48-hour cancellation policy. I understand that if I am unable to provide this notice, I will be charged for the full fee of the missed session.

\_\_\_\_\_ Signature of client

\_\_\_\_\_ Date

\_\_\_\_\_ Printed name

**Assignment of Benefits:** I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Wellspring Psychology. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

\_\_\_\_\_ Signature of client

\_\_\_\_\_ Date

\_\_\_\_\_ Printed name



WELLSPRING  
PSYCHOLOGY

## Credit Card on File

Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

CVV code: \_\_\_\_\_

Zip Code of Billing Address: \_\_\_\_\_

Signature of client: \_\_\_\_\_

Printed name: \_\_\_\_\_

Date : \_\_\_\_\_

If you plan to bill your insurance company for sessions, please provide your therapist with your insurance card at this time to make a copy for our records.



### Authorization to Release Information

I, \_\_\_\_\_, the undersigned, give permission to Wellspring Psychology to release and provide the following information (check all that apply)

- participate in my treatment as collateral
- my attendance in therapy
- my diagnosis
- my treatment plan
- information relevant to coordinating care
- other (please explain in detail)

\_\_\_\_\_

to:

(Name) \_\_\_\_\_

(Address) \_\_\_\_\_

(Phone Number) \_\_\_\_\_

(Fax Number) \_\_\_\_\_

I understand that that this release is valid for a period of 1 year. I further understand that I may revoke this authorization at any time in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

\_\_\_\_\_ Name

\_\_\_\_\_ Date