General Information

Suzanne M. James, Psy.D., LLC
Licensed Psychologist
305 Artillery Park Dr. Ste. 102
Fort Mitchell, KY 41017
859-426-0200

Patient Information: Date:_____

Patient Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip:_____

Phone Home:(_____)_____-_____Cell:(_____)_____-_____ Work:(_____)_____-_____

OK to leave message at this number? (Y/N) Home:_____ Cell:_____ Work:_____

Email: _____ OK so send email to this address? Y/N: _____

Patient Social Security #: _____ Date of Birth:_____-_____-_____

Gender: [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] NA (children)

Employment Status: [ ] Employed [ ] Student [ ] Unemployed

Primary Care Physician:_____ Phone:_____
Is it ok to contact your primary care physician to share information or receive information:

YES _____ NO _____

Informed Consent for Receipt of Psychological Services

_____ **Purpose and Background:**
The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.

I am aware that psychological assessment is not an exact science and results are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by WellSpring Psychological Services. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

_____ **Confidentiality:**
I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

_____ **HIPAA**
I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of WellSpring Psychological Services' "Notice of Privacy Practices", that were effective of as their start of business on March 1st, 2004. I acknowledge I was offered this policy statement on the date indicated by my signature below.

_____ **Contact Information:**
The office address is 2128 Chamber Center Lane, Fort Mitchell, Ky 41017. I understand that for routine appointments and information I may call (859) 331-4447. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible by my therapist. If I have an after-hours crisis or need assistance more quickly I can call my therapist at the crisis contact number provided in their regular voicemail box, however, I understand this number is for crises only. If I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room.

_____ **Complaints Procedure:**
If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through your therapist's state licensing agency, which may be contacted in Frankfort, KY 40602.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.

I release and hold harmless WellSpring Psychological Services, and its staff and agents from any action or liability arising out of my participation in treatment.

_____ _____
Signature of client Date

_____ _____
Signature of Witness Date

Consent To Bill Third Party Payer

As a part of receiving psychological services through Dr. Suzanne James, I understand that

_____will be responsible for the financial expenses incurred as the result of my participation in treatment. I will be required to consent to the release of information for billing purposes. This will definitely mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and at times may constitute the release of treatment planning information.

_____ _____
Signature of Client/Responsible Party Date

_____ _____
Signature of Witness Date