Primary Client Information

Date: _____

Primary Client Name:

_____

First Middle Last

SSN#: _____ DOB: _____ Driver's License#: _____

Address:

_____

Street number City state zip code

Home Phone number: _____ Cell: _____

Work Phone number: _____ Email: _____

Note: All calls, Text messages and emails will be discreet, but please indicate any restrictions below

_____

Employer: _____ Occupation: _____

Employer Address: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____

Additional Client /Emergency Contact Information

Name: _____ DOB: _____

Phone #: _____ Address: _____

Relationship to client :_____

Please list any other additional clients:

_____

Primary Insurance Information

Primary Insurance Company Name: _____ Group #: _____ Policy #: _____

Name of Policy Holder: _____ Relationship to Client: _____ Sex: M F

SSN#: _____ DOB:_____ Driver's License #: _____

Policy holder's Address : _____ City/State:_____ Zip code:_____

Home Phone: _____ Cell:_____ Email:_____

Secondary Insurance Information (If Applicable)

Secondary Insurance Company Name: _____ Group #: _____

Policy #: _____

Name of Policy Holder: _____ Relationship to Client: _____ Sex: M F

SSN#: _____ DOB:_____ Driver's License #: _____

Policy holder's Address : _____ City/State:_____ Zip code:_____

Home Phone: _____ Cell:_____

Email:_____

Release and Authorization for Supervision

Client Name: _____

The therapy services you will be receiving are being provided by a therapist under supervision to obtain clinical licensure from the Kansas Behavioral Sciences Regulatory Board. In order to meet the state supervision requirements, your therapist requires your agreement in writing to be supervised by the following clinical supervisors.:

Supervisor Name	License number	Location
Jenny Findling, PhD, LCPC	LCPC 327	The Caring Center of Wichita 714 S Hillside St. Wichita, KS 67211 Phone: (316) 253-5448

Therapists under supervision and their supervisors are bound by the professional requirements of the National Cer Code of Ethics and the American Association for Marriage and Family (AAMFT) Code of Ethics to treat all information as strictly confidential with the exceptions as defined by Kansas State Law. Should there be a conflict between these two codes in any particular area, the code with the strictest standards will be followed. By signing this document, you are acknowledging you understand and accept the provisions noted above. Additionally, by signing this document, you are acknowledging there are exceptions to confidentially, which are:

A. Your therapist will discuss your case with the clinical supervisor(s) listed above for the purpose of obtaining guidance, instruction and approval of particular treatment practices.
B. Kansas State law requires exceptions if:
    a. There is a reason to suspect child abuse or elder abuse/neglect/exploitation.
    b. You reveal intent to harm yourself or others.
    c. Legal, cases when the therapist and/or our records are ordered into court.
    d. You sign a consent form to release information to a specific party/agency.

Printed name of legally Responsible Person	Relationship, Date:
Client Signature:	Date:
Client Signature:	Date:
Therapist Signature:	Date:

Current Symptom Checklist

Client Name: _____

Date: _____

Please rate the intensity of the symptoms and check all that apply:

None = This symptom is not present at this time **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning **Moderate** = Significant impact on quality of life and day-to-day functioning **Severe** = Profound impact on quality of life and/or day-to-day functioning **Past** = Have experienced this before but not within the past 6 months.

Symptom	None	Mild	Moderate	Severe	Past	Symptom	None	Mild	Moderate	Severe	Past
Depressed mood						Property destruction					
Appetite Increase/Decrease						Physically Aggressive					
Sleep loss/ Too much						Defiance/ Refusal					
Fatigue / low energy						School/ work problems					
Feeling slowed down						Social Awkwardness					
Lack of Enjoyment						Anxiety					
Emotionality						Panic Attacks					
Tearfulness						Phobias					
Sexual Dysfunction						Obsessions/ Compulsions					
Poor Hygiene						Frequent Headaches					
Grief						Frequent stomachaches					
Guilt						Muscle Tension					
Hopelessness						Constant Worry					
Worthlessness						Anorexia					
Social Isolation						Bingeing/ Purging					
Suicidal/ Homicidal thoughts						Laxative/ Diuretic abuse					
Self-Harm						Constipation/ Diarrhea					
Mood Swings						Hallucinations					
Elevated mood						Paranoia					
Agitation						Emotional trauma victim					
Racing thoughts						Physical trauma Vitim					
Hyperactivity						Sexual trauma victim					
Poor concentration						Substance/ Alcohol abuse					
Poor task completion						Gambling					
Impulsivity						Relationship Conflict					
Easily frustrated						Infidelity					
Learning Disability						Other:					
Developmental disability											

Please list current or/ past medical issues (including a history of head injury, past surgeries, car accidents):

_____

_____

Reason(S) for seeking therapy: _____

Are you currently taking any prescription medication:_____yes_____no If yes, please list below

Medication_____Reason_____Dose_____how Long_____

Medication_____Reason_____Dose_____how Long_____

Primary Care Physician:_____

Adress_____ Phone_____

Informed Consent and Therapy Contract

We feel it is important that, you are fully informed about therapy services you will be receiving. Your signature below indicates you have received, read, and understand the practice policies of this therapy site in helping you make an informed decision about entering therapy.

1. I understand my licensed therapist is a Licensed Marriage and Family Therapist, or a **Licensed Professional Counselor**, or a Licensed Master Social Worker.

2. I understand my therapist is bound by the Code of Ethics set forth by the American Association for marriage and Family therapy (AAMFT) and by the National Association of Social Workers (NASW) and by the American Counseling Association (ACA) and I can request a copy of those ethics at any time.

3. I understand, except under specific circumstances mandated by law, communication with my therapist will remain confidential, as will any records regarding the therapy process unless I sign a Release of Confidential Information form authorizing access to the information before any file information will be released in accordance with **K.S.A.65-6410**. If more than one family member participates in a session, each participating family member must consent prior to the release of file information. Where a minor is receiving services, the appointment of a Guardian Ad Litem may be necessary prior to the release of the minor client's information. I understand my family members are not entitled access to my information just because they are family.

4. I understand, under Kansas law, specific circumstances require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when:
   a. The therapist believes the client is a danger to themselves or others.
   b. The therapist believes that a child, elderly or disabled person may be subject to abuse, neglect, or exploitation.
   c. A court order exists that information regarding the therapy process be provided.

5. I understand, under Kansas law, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication contributing to symptoms of a mental disorder. To complete such a consultation, my therapist will request I complete a Release of Confidential Information form. I understand I may waive this consultation, in writing, and my therapist will discuss this process with me at any time if I so request.

6. I understand I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session.

7. I understand the services provided at NorthStar Therapy and my therapist, Scott Spradlin, LPC, LMAC is working as an independent practitioner, under the supervision of Jenny Findling, LCPC.

8. I understand the financial policies of the NorthStar Therapy/Scott Spradlin, LPA, LMAC and I agree to pay the clinical hourly rate for all sessions attended. I understand I am responsible for all unpaid balances

and / or denied claims by all third-party payers. I understand if I am unable to attend a session, I must call at least 24 hours in advance to cancel, otherwise the session will be billed at the regular session cost.

9. I understand there are third party billing and collection services that may be associated with information from my file in order to collect and / or make payment to my account and I give permission to share all necessary information with these services that may include, but not limited to, insurance companies, collection agencies and office staff. I give permission for these groups to contact me on behalf of my therapist regarding any outstanding monies owed. Scott Spradlin and NorthStar Therapy shall have the authority to charge and assess collection costs and expenses, including reasonable attorney's fee, and penalties and interest for the payment or nonpayment thereof.

10. I understand the Scott Spradlin and NorthStar Therapy utilize the services of Therapy Notes, an online billing, collecting and file management system for records administration. I give permission for Scott Spradlin, LPC, LMAC and NorthStar Therapy to share all necessary data in the upkeep of my file with Therapy Notes. I understand all employees of Therapy Notes must abide by the same confidentiality and ethical rules as stated above.

11. I understand and grant permission for any necessary office staff, on-call therapist, and / or any therapist of NorthStar Therapy to have access to my file for clerical and case management reasons. I understand all staff and therapists must abide by the same confidentiality and ethical rules as stated above.

12. I understand if I am involved in any court matters, legal matters and / or any other situations requiring involvement from my therapist, there may be additional costs incurred for any reports, appearances or consultations by my therapists as outlined in my therapist's fee schedule.

_____ _____

Parent/Legal Guardian Signature Date

(if client is underage of 18)

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Waiver of Medical / Psychiatric Consultation

I understand that under the provisions of KSA 65-6404 (b) my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder he or she may be observed while working with me or my minor child(ren) listed below:

Primary Client's name:

_____

If minor children will attend Family Therapy sessions with you, please list their names below.

Name of minor child:

_____

Name of minor child:

_____

Name of minor child:

_____

In the event I or my child (ren) do not have a primary care physician, I acknowledge my therapist has / will have recommended I seek a medical consultation.

By signing below, I am indicating that I waive my right to a medical consultation with my primary care physician by my therapist and I am aware this waiver will become part of my medical record.

_____ _____

Parent/Legal Guardian Signature (if client is under the age of 18) Date

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Client Rights and Responsibilities

- Receive Information: Each Member has the right to receive information about their insurance company, their policies and procedures, services, practitioners and providers, and the Members rights and responsibilities.

- Dignity and Privacy: Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

- Receive information on available treatment options: Each Member is guaranteed the right to receive information on medically necessary available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

- Free from restraint or seclusion. Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

- Copy of medical records: Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request they be amended or corrected as specified in 45 CFR part 164.

- Free exercise of right: Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the member is treated by the insurance company or the provider.

- Freedom to change provider. The insurance company shall not impose any limitation on the member's freedom to change mental health providers.

Members have the additional rights and responsibilities:

- To choose his/her provider (within the network)
- To ask for a therapist who understands his/her language and culture
- To receive needed services at convenient times and places
- To obtain access to services within the specified access standards
- To treat others with consideration and respect
- To be at appointments on time
- To call if he/she must cancel
- To be part of the treatment team by telling your doctor or therapist about symptoms and to ask questions
- To tell the doctor or therapist when/if you want to end treatment
- To take medication as prescribed and to tell the doctor if there is a problem
- To carry his/her insurance cards
- To tell the provider if they have other insurance
- To follow plans and instructions for care that they have agreed on with providers

Client Rights and Responsibilities Acknowledgement

I acknowledge that I have received a copy of my client rights and responsibilities provided by Scott Spradlin, LPC, LMAC and NorthStar Therapy.

_____ _____

Signature of Client or Responsible Party Date

_____ _____

Witness Date

Scott Spradlin, LPC, LMAC at NorthStar Therapy
560 S. Oliver, Wichita, KS 67218
316.260.1127/Fax: 316.2601137
scott@wisemindwiselife.com

Release of Confidential Information: General

Client Name:_____ Date of Birth: _____ SSN: _____

Client Address: _____ Client Phone: _____

I, _____, (Printed client name)

Hereby consent to communication between Scott Spradlin/NorthStar personnel and

_____ (Print name of agency/person)

_____ (Address/contact number)

_____ (Relationship to client)

The purpose of this disclosure is to facilitate communication between the above listed agency and Scott Spradlin/NorthStar Therapy to create a comprehensive coordination of services for the above-named client**:**

- ☐ Assessment & Treatment Recommendations Initials: _____
- ☐ Emergency Contact Initials: _____
- ☐ Attendance Confirmation Initials: _____
- ☐ Treatment Plan Initials: _____
- ☐ Treatment Progress Initials: _____
- ☐ Attorney/Court Reporting Initials: _____
- ☐ Third-party Payor/Funding Source Initials: _____
- ☐ Discharge Summary and Aftercare Recommendations Initials: _____
- ☐ Other: _____ Initials: _____

1. I understand that my mental health care and alcohol and/or drug abuse records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

   365 days after discharge date

2. I understand that generally Scott Spradlin/NorthStar Therapy may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign consent.

I HAVE RECEIVED A COPY OF THIS FORM Initials: _____

_____/_____ _____/_____

Signature of Client Date Signature of Therapist/Staff Date

_____/_____

Signature of Parent/Guardian/ (As needed)

Scott Spradlin, LPC, LMAC at NorthStar Therapy
560 S. Oliver, Wichita, KS 67218
316.260.1127/Fax: 316.2601137
scott@wisemindwiselife.com

Release of Confidential Information: EMERGENCY CONTACT

Client Name:_____ Date of Birth: _____ SSN: _____

Client Address: _____ Client Phone: _____

I, _____, (Printed client name)

Hereby consent to communication between Scott Spradlin/NorthStar personnel and

_____ (Print name of agency/person)

_____ (Address/contact number)

_____ (Relationship to client)

The purpose of this disclosure is to facilitate communication between the above listed agency and Scott Spradlin/NorthStar Therapy to create a comprehensive coordination of services for the above-named client**:**

- ☐ Assessment & Treatment Recommendations Initials: _____
- ☐ **Emergency Contact** **Initials: _____**
- ☐ Attendance Confirmation Initials: _____
- ☐ Treatment Plan Initials: _____
- ☐ Treatment Progress Initials: _____
- ☐ Attorney/Court Reporting Initials: _____
- ☐ Third-party Payor/Funding Source Initials: _____
- ☐ Discharge Summary and Aftercare Recommendations Initials: _____
- ☐ Other: _____ Initials: _____

1. I understand that my mental health care and alcohol and/or drug abuse records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

   365 days after discharge date

2. I understand that generally Scott Spradlin/NorthStar Therapy may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign consent.

I HAVE RECEIVED A COPY OF THIS FORM Initials: _____

_____/_____ _____/_____

Signature of Client Date Signature of Therapist/Staff Date

_____/_____

Signature of Parent/Guardian/ (As needed)

Scott Spradlin, LPC, LMAC at NorthStar Therapy
560 S. Oliver, Wichita, KS 67218
316.260.1127/Fax: 316.2601137
scott@wisemindwiselife.com

Release of Confidential Information: PRESCRIBING PHYSICIAN/NURSE PRACTITIONER

Client Name:_____ Date of Birth: _____ SSN: _____

Client Address: _____ Client Phone: _____

I, _____, (Printed client name)

Hereby consent to communication between Scott Spradlin/NorthStar personnel and

_____ (Print name of agency/person)

_____ (Address/contact number)

_____ (Relationship to client)

The purpose of this disclosure is to facilitate communication between the above listed agency and Scott Spradlin/NorthStar Therapy to create a comprehensive coordination of services for the above-named client**:**

- ☐ Assessment & Treatment Recommendations Initials: _____
- ☐ Emergency Contact Initials: _____
- ☐ Attendance Confirmation Initials: _____
- ☐ Treatment Plan Initials: _____
- ☐ Treatment Progress Initials: _____
- ☐ Attorney/Court Reporting Initials: _____
- ☐ Third-party Payor/Funding Source Initials: _____
- ☐ Discharge Summary and Aftercare Recommendations Initials: _____
- ☐ Other: _____ Initials: _____

1. I understand that my mental health care and alcohol and/or drug abuse records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

   365 days after discharge date

2. I understand that generally Scott Spradlin/NorthStar Therapy may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign consent.

I HAVE RECEIVED A COPY OF THIS FORM Initials: _____

_____/_____ _____/_____

Signature of Client Date Signature of Therapist/Staff Date

_____/_____

Signature of Parent/Guardian/ (As needed)

Scott Spradlin, LPC, LMAC at NorthStar Therapy
560 S. Oliver, Wichita, KS 67218
316.260.1127/Fax: 316.2601137
scott@wisemindwiselife.com

Release of Confidential Information: ATTORNEY/PROBATION (as needed)

Client Name:_____ Date of Birth: _____ SSN: _____

Client Address: _____ Client Phone: _____

I, _____, (Printed client name)

Hereby consent to communication between Scott Spradlin/NorthStar personnel and

_____ (Print name of agency/person)

_____ (Address/contact number)

_____ (Relationship to client)

The purpose of this disclosure is to facilitate communication between the above listed agency and Scott Spradlin/NorthStar Therapy to create a comprehensive coordination of services for the above-named client**:**

- ☐ Assessment & Treatment Recommendations Initials: _____
- ☐ Emergency Contact Initials: _____
- ☐ Attendance Confirmation Initials: _____
- ☐ Treatment Plan Initials: _____
- ☐ Treatment Progress Initials: _____
- ☐ Attorney/Court Reporting Initials: _____
- ☐ Third-party Payor/Funding Source Initials: _____
- ☐ Discharge Summary and Aftercare Recommendations Initials: _____
- ☐ Other: _____ Initials: _____

1. I understand that my mental health care and alcohol and/or drug abuse records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

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I HAVE RECEIVED A COPY OF THIS FORM Initials: _____

_____/_____ _____/_____

Signature of Client Date Signature of Therapist/Staff Date

_____/_____

Signature of Parent/Guardian/ (As needed)