PATIENT INFORMATION SHEET

Patient Information

PATIENT NAME _____ DATE OF BIRTH ___ ___
First Middle Last

SEX M☐ F☐ (Check One) MARITAL STATUS M☐ S☐ D☐ W☐ (Check One) SOCIAL SECURITY # _____

ADDRESS _____
Street City State Zip

HOME TELEPHONE ( ) _____ WORK TELEPHONE ( ) _____ CELL PHONE: ( ) _____

PLACE OF EMPLOYMENT _____

EMERGENCY CONTACT INFORMATION _____
NAME PHONE # CELL PHONE # RELATIONSHIP

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN _____
PHONE # _____ PHONE # _____

Primary Coverage *Insurance Information*

PRIMARY INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ DOB: _____

SUBSCRIBER'S PLACE OF EMPLOYMENT _____ SUBSCRIBER'S SS# _____

INSURANCE ID NUMBER _____ EFFECTIVE DATE

GROUP NUMBER _____ _____

INSURANCE ADDRESS _____
Street City State Zip

TELEPHONE NUMBER ( ) _____ RELATIONSHIP TO PATIENT (Check One) Self☐ Spouse☐ Parent☐ Step-Child☐ Other☐

Secondary Coverage *Insurance Information*

SECONDARY INSURANCE COMPANY _____

SUBSCRIBER'S NAME _____ DOB: _____

SUBSCRIBER'S PLACE OF EMPLOYMENT _____ SUBSCRIBER'S SS# _____

INSURANCE ID NUMBER _____ EFFECTIVE DATE

GROUP NUMBER _____ _____ /

INSURANCE ADDRESS _____
Street City State Zip

TELEPHONE NUMBER ( ) _____ RELATIONSHIP TO PATIENT (Check One) Self☐ Spouse☐ Parent☐ Step-Child☐ Other☐

****

GUARANTOR NAME _____ PATIENT Y☐ N☐ (Check One)
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT)

ADDRESS _____
Street City State Zip

TELEPHONE NUMBER ( ) _____ RELATIONSHIP TO PATIENT Self☐ Spouse☐ Parent☐
CELL PHONE NUMBER ( ) _____ (Check One) Step-Child☐ Other☐

1. I hereby authorize payment of healthcare/medical benefits to the provider of service. I understand that I am financially responsible to the provider for any charges not covered by my health care/medical plan.
2. I hereby authorize the release of any medical information necessary to process health care/medical claims.

SIGNED: _____ DATE: _____

Name _____Date_____

What brings you to therapy?

_____

_____

_____

_____

When do you believe your concerns began? _____

Have you ever engaged in therapy prior (If so, when/where)?

_____

_____

What have you done to solve your present concerns?

_____

_____

What are your strengths?

_____

_____

What are your goals for improvement?

_____

_____

Where do you get support?

_____

_____

Describe your drinking of alcohol? (# days a week & how many per occasion)

_____

_____

Describe any other drug use?

_____

_____

Have you ever been treated for an inpatient stay at a hospital for mental health or alcohol/other drug use? If so, when and where?

_____

_____

_____

_____

Do you have any knowledge of family history of mental health concerns or alcohol/drug use?

_____

_____

_____

Health Information Psychological factors can affect health directly. To help me understand you and your concerns, I ask you to provide the information below. How would you rate your present health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician Name _____

Address _____

Physician Phone # _____

Date of last visit? _____

What current physical symptoms/ concerns are you experiencing? _____

How would you describe your diet?

How are you sleeping?

Are you a smoker, if yes, daily amount?

Do you exercise, if yes, please describe?

Have you ever had thoughts of hurting yourself or an attempt?

Please check if you or a family member has any of the following:

	You	Family
Alcoholism	☐	☐
Blood Problems	☐	☐
Arthritis	☐	☐
Anorexia/Bulimia	☐	☐
Cancer	☐	☐
Sexual Abuse	☐	☐
Cirrhosis	☐	☐
Physical Abuse	☐	☐
Diabetes	☐	☐
Physical Disability	☐	☐
Allergies	☐	☐
Developmental Disability	☐	☐
Asthma	☐	☐
Multiple Sclerosis	☐	☐
Seizures	☐	☐
Blood Pressure	☐	☐
Heart Issues	☐	☐

If there are other self/family health concerns not mentioned above please share:

_____

_____

_____

Please list medications you are on presently:

Med: _____ Dosage: _____
Med: _____ Dosage: _____
Med: _____ Dosage: _____
Med: _____ Dosage: _____
Med: _____ Dosage: _____
Med: _____ Dosage: _____
Med: _____ Dosage: _____

How did you learn about WellSpace Therapeutics?_____

Signature _____ Date_____

WellSpace Therapeutics, LLC

1130 Wapakoneta Avenue
Sidney, OH 45365

Consent To Use Unencrypted EMail or Text

It is very important that you are aware that computer e-mail, texts, and e-fax communication, can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them.

Generally, e-mails, text messages,and e-faxes are not encrypted in transit over the Internet. It is always a possibility that emails, texts, and e-faxes can be erroneously sent to the wrong address and computers. Unencrypted email or texts provide as much privacy as a postcard.

You should not communicate any information to your health care provider that you would not want to be included on a postcard that is sent through the Post Office. E-mail messages on your computer, your laptop, tablet, phone or other devices have inherent privacy risks especially when your e-mail access is provided through your employer or school or when access to your e-mail messages is not well protected. Please, note that e-mails, faxes, and texts are all part of your clinical records.

Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phone calls, phone messages, or e-faxes. If you communicate confidential or private information via encrypted email, texts or e-fax or via phone messages, it will be assumed that you have evaluated the risks and made an informed decision. Your therapist will view it as your agreement to take that risk that such communication may be intercepted, and your desire to communicate on such matters will be honored. Please do not use email, texts, voice mail, or e-faxes for emergencies.

Client's Name _____

(if client is a minor, please use responsible party's information)

Client's Phone # _____

Client's E-Mail_____

Client's Signature _____

Date _____

New Client
Credit Card on File

A credit card must be on file in order to charge for fees and services not covered by insurance. Your card will be billed as soon as the services are rendered or as soon as a no show or late cancellation occurs.

Name on card_____

Credit Card or HSA Card Number:_____

Type of Card:_____

ZIp Code:_____

Expiration Date:_____ 3 digit security code:_____

Signature:_____

Wellspace Therapeutics

1130 Wapakoneta Avenue
Sidney, Ohio

Office Policies

Modalities:

WellSpace therapists use a variety of treatment options with clients. Some treatment modalities include but are not limited to Cognitive Behavior Therapy, EMDR, Gestalt Therapy, Play Therapy.

Payment:

Payment for the session is due at the time services are rendered. Clients are responsible for all balances and any fees associated with collecting outstanding balances.
Insurance claims will be filed for you, but you are ultimately responsible for resolving issues as well as any balance that your insurance company does not pay.
If during treatment you require a written report or telephone consultation, this will be billed to the client, not the insurance, $20.00 per 15 minute increments.

Cancellation Policy:

Clients will be charged a fee of $60.00 if your session is not canceled within a 24-hour notice period. If you simply do not show, a $60.00 fee will be assessed as insurance companies do not pay for no-shows.

Returned Check Fee:

A $30.00 fee will be assessed for any returned checks.

Confidentiality:

You may be assured that all information that you reveal in each session will be confidential unless you sign a written release to another party. However, there are exceptions; by law, if you are suicidal, homicidal, are suspected of child or elder abuse, this will be reported to the proper authorities.

Crisis:

In the event you are in crisis and unable to reach the therapist, please call the 24-hour Tri-County Crisis Line at 800-351-7347 or if you cannot call, text 4hope to 741 741

By signing below, you are indicating that you have read and understand the above policy and consent to receive treatment.

Signed:_____
Date:_____

By signing below, you are indicating that you authorize the release of medical information necessary to process insurance claims.

Signed:_____
Date:_____