ASPIRE GROWTH COUNSELING
PERSONAL INFORMATION FORM

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

E-Mail address_____ Social Security#:_____

Phone (home): _____ (work) _____ (cell) _____

Where may we call you? __ Home __ Work __ Cell Leave message? __ Home __ Work __ Cell

Primary Health Insurance Plan _____ Policy Holder's Name: _____

Health Plan ID #:_____ Group ID #: _____

Policy Holder's Social Security # _____ Policy Holder's DOB: _____

EAP Authorization #_____ Visits Authorized: _____

Emergency contact & phone: _____

Racial Background:

__ African-American __ Asian-American __ Caucasian __ Hispanic

__ Native American __ Other _____

Religious Affiliation: _____ Currently active? _____

Education (years completed or highest degree): _____

Marital Status: __ Never Married __ Divorced __ Widowed __ Married (date: _____)

Employer: _____

Current Occupation: _____

Spouse/ Partners Name: _____

Spouse/Partners Occupation: _____

How did you hear about us?

_____

Signature: _____ Date: _____

ASPIRE GROWTH COUNSELING

FINANCIAL POLICY

Aspire Growth Counseling accepts clients with insurance coverage as well as private pay clients. It is important that you understand that your insurance coverage is a contract between you and the insurance carrier. Aspire Growth Counseling will gladly file your insurance claims. Aspire Growth Counseling will wait a reasonable amount of time for your insurance company to pay the claim. If a claim remains unpaid by your insurance company for more than 90 days, Aspire Growth Counseling will look to you for payment of the claim. **Aspire Growth Counseling highly recommends that you become very familiar with your insurance policy and what your benefits are under your policy. The policies can be somewhat confusing, so it may be necessary for you to call your insurance carrier directly in order to gain some clarification in regards to your benefits**. In most cases, you will have a co-pay or a deductible which will be paid to our office prior to your appointments with your Therapist. When an insurance company pays Aspire Growth Counseling, we will then bill you or collect from you at your next appointment any remaining co-pay, deductible, or coinsurance that is not paid at the time of service. Billed balances are due and payable within 30 days. Aspire Growth Counseling does exercise the right to share your billing information to a collection agency if you have a balance that has been left unpaid in excess of 90 days. Payment plans for unpaid balances may be an option and would need to be discussed with the Business Manager.

Aspire Growth Counseling does have a cancellation policy which requires you to cancel your session within 24 hours prior to the session to avoid being charged. The charge for late cancellations and appointments in which there is no cancellation, and no attendance is the equal to the session hour fee payable to Aspire Growth Counseling. Aspire Growth Counseling does understand at times there may be extenuating circumstances which prevent you from canceling or coming to your appointment. Aspire Growth Counseling will consider these situations on a case by case basis. A successful outcome in therapy will be fostered by your commitment to the process.

If you are currently applying for disability, or apply at any point in your therapeutic experience, please notify your therapist so that you can be appropriately referred to a provider who can continue your behavioral health intervention during this process.

Below are the rates for **private pay** clients and for **some services that are not covered by most insurance policies**:

Initial Intake (1hour) $150.00

Individual Therapy Session (50 minutes) $130.00

Individual Therapy Session (80 Minutes) $150.00

Family, Marriage, or Couples Therapy Session (50 minutes) $150.00

Family, Marriage, or Couples Therapy Session (80 Minutes) $170.00

Group Therapy- Prices vary depending on group. Please ask group facilitator for prices.

Telephonic Counseling (self-pay per 15 minutes) $44.00 (there is no charge for brief phone conversations with your therapist, however telephonic therapeutic sessions will be charged).

Photocopies of Medical Records $0.15 per page and a $50.00 administrative charge

Paperwork completed during a session- no charge

Paperwork outside of a regular session $44.00 per 15 minutes

Late Cancellation (Less than 24 hours' notice)/No shows are equal to your normal session rate.

Court Appearances (includes travel and wait time) $300.00 per hour.

Return Check Fee $25.00

ALL PAYMENTS (INCLUDING COPAYS AND DEDUCTIBLES) ARE DUE AT THE TIME OF SERVICE.

ALL DENIED CLAIMS BY THE INSURANCE COMPANY ARE ULTIMATELY THE RESPONSIBILITY OF THE CLIENT.

I have read and understand this policy and will honor the guidelines of this policy.

_____ _____

Signature Date

Credit Card Pre-Authorization Form

Patient Name:_____ Date:_____

Patient D.O.B.:_____

Patient Address:_____

The undersigned Patient/Cardholder hereby authorizes Sondra Wilkinson, LPC to obtain payment of fees for services from the Patient/Cardholder's credit card account identified below. Sondra Wilkinson, LPC may charge the account for missed appointments (minimum 24 hours notice cancellation notice is required), without requirement of the Patient/Cardholder's signature for each payment. A receipt of the transaction with be mailed to the address provided by the Patient/Cardholder above.

By signing this form, the client/cardholder acknowledges and agrees as follows:

*This signed form is confidential and will be kept on file at Aspire Growth Counseling.
*The Patient/Cardholder authorizes Aspire Growth Counseling to automatically charge the below referenced credit card any remaining balance on the above named patient's account (including co-pays, co-insurances, deductibles, or missed appointment fees).
*The Patient/Cardholder certifies, warrants, and represents that the cardholder named above agrees to pay the credit charge(s) in accordance with agreement described above.
*Credit card payments will appear on your statement as Sondra Wilkinson, LPC or Aspire Growth Counseling.
*If the Patient/Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder agrees the charges are valid and agrees not to dispute said charges.
*This authorization will remain valid for 12 months and will automatically renew on an annual basis, unless revoked in writing with 30-day notice of revocation.
*This authorization serves as an agreement for receipts to be noted "signature on file" when charged.

PLEASE CIRCLE ONE: Visa MasterCard Discover

Printed name on card:_____

Credit Card Number:_____

CVV Number:_____

Expiration Date (Month/Year):_____

Patient/Cardholder Authorized Signature:_____

ASPIRE GROWTH COUNSELING

CONFIDENTIALITY AGREEMENT

The law protects the confidentiality of communication between clients and mental health professionals. Information can normally only be released about you to others with your written permission, though there are some exceptions you should be aware of

- When there is a suspected abuse of a child, elderly person, or disabled person.

- When it is your Therapists professional opinion that you are in danger of harming yourself, another person, or are unable to care for yourself.

- If you report to your Therapist that you have intentions of physically harming someone, your Therapist is required to inform that person of your intentions and notify the proper authorities.

- When the information is required by your insurance carrier in order for Aspire Growth Counseling to be reimbursed for services provided or for quality management services.

Appropriate assessment and treatment records are required to be kept by law and professional standards. Due to these being professional records, and sometimes written in technical jargon, it is possible for them to be misinterpreted by someone who is not familiar with mental health records. You do have the right to view your records, however it is not our practice for clients to review them directly without professional interpretation.

I have read and agree to the above terms:

Client Name (Print) _____

Client Signature _____Date_____

ASPIRE GROWTH COUNSELING

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law, HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with a notification of their privacy rights as it relates to their health care records. If you would like to see a detailed list of these rules, please feel free to ask for a personal copy. If you would like to read more about these rules before participating in our therapy sessions, please visit HHS.gov.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. If you have any questions at all about your privacy rights, please don't hesitate to ask me and we will discuss them in detail. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find I will do all I can to protect the privacy of your mental health records.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

I,_____, understand and have been provided a copy of Aspire Growth Counseling's Patient Notification of Privacy Rights document, which provides information and resources about detailed descriptions of potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____Date

_____Patient Signature/Parent Signature if minor

ASPIRE GROWTH COUNSELING

INFORMED CONSENT

I, the undersigned, voluntarily consent to participate in psychotherapeutic services provided by Sondra Wilkinson, LPC-MHSP at Aspire Growth Counseling. I understand that I may withdraw from therapy services at any time. I understand that I have the right to have any complaints heard and resolved in a timely manner. If you have a complaint about your treatment, therapist, or any office policy, please inform us immediately so we can resolve the issue. We look forward to providing the best services possible to you and we value you as an individual with choices. With that said, we are pleased you have chosen Aspire Growth Counseling to assist you in your journey to happiness.

_____

Name (please print)

_____

Signature of client or legal guardian Date

_____

Therapist signature Date

ADULT HISTORY:

Immediate family members and unrelated individuals living with you

Name	Age	Relationship: (Spouse, Son, Daughter)	Living with you (Y/N)
1			
2			
3			
4			
5			
6			

No. of previous marriages:_____

LIST/DESCRIBE WHAT CHANGES YOU WANT TO MAKE WHILE IN COUNSELING:

_____

_____

_____

_____

_____

What causes the problem(s)? _____

_____

When did it start?_____

_____

FAMILY HISTORY:

	Yes	No	Relationship: Mother	Father	Brother	Sister	Grand parent
Drugs/ Alcohol:	☐	☐	☐	☐	☐	☐	☐
ADHD:	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐

Other (Diabetes, Thyroid, Tourette's, Seizures, Hypertension) _____

_____

_____

_____

MEDICAL HISTORY

Are you currently under the care of a physician? _____ Yes _____ No Reason? _____

When was your last checkup? _____

Please list any prescription or over the counter medications you are currently taking: _____

_____

_____

_____

Doctor's name _____ Phone number: _____

Current medical issues _____

_____

Past medical issue; include hospital stays, head injuries, etc., and dates it happened:_____

_____

_____

TREATMENT HISTORY:

Have you ever received counseling for any reason? (If yes, please list when and why) _____

_____

Have you ever been hospitalized for a psychiatric reason? (If yes, please list when and why) _____

_____

Have you ever received treatment for drugs or alcohol? (If yes, please list when and why)_____

_____

Have you ever attended any self- help groups such as AA, CODA, etc.?_____

_____

WEIGHT: □ Unchanged □ Weight gained (Last 6 mo) _____ □ Wt. Loss (6 mo) _____

□ Purging (Freq) _____/_____ □ Binging (Freq) _____/_____

□ Laxative Use □ Diuretic use □ Diet Pills □Menstrual Problems (Explain) _____

_____

_____

SLEEP: □ Unchanged □ Can't fall asleep □ Sleep constantly □ Awaken early □ Nightmares

□ Can't wake up □ I sleep but I don't feel rested

COMMENTS: _____

_____

_____

SUBSTANCE /ALCOHOL USE

Do you or have you ever had a substance abuse problem? □ No □ Yes □ Now □ In the past

Have other people thought you might have a substance abuse problem? □ No □ Yes □ Not currently

Do you believe someone in your family might have a substance abuse problem? □ No □ Yes Who? _____

Method/ Frequency/ Date of last use/ Type of drug: □ IV □ Snorted □ Swallowed □ Smoked

_____

Do you use tobacco? □ No □ Yes If so, how much daily?_____

Alcohol Use:

Frequency: _____ Usual drinks/ sitting _____ Intoxication: _____

Other Substance use (in the last six months)

Substance: _____ Freq. _____ Amount _____ Duration _____

Substance: _____ Freq. _____ Amount _____ Duration _____

TRAUMA HISTORY:

(Please identify sexual abuse, physical abuse, or other abuse.)_____

_____

_____

_____

SUICIDAL THOUGHTS: □ Yes, current □ Yes, in the past □ No

SUICIDAL PLAN OR INTENT: □ Yes, current □ Yes, In the past □ No

If you feel like hurting yourself now, do you have a plan? (If so, please explain)

_____

_____

_____

Past attempts: □No □ Yes # of attempts _____ □ Self- mutilation _____

Date of last attempt: _____ Method: _____

HOMICIDAL THOUGHTS: □ Yes □ Yes, In the past □ No

HOMICIDAL PLAN OR INTENT: □ Yes, current □ Yes, In the past □ No

If you feel like hurting someone now, do you have a plan? (If so, please explain)

_____

_____

_____

Have you ever been violent or hurt someone? □No □ Yes (If so, please explain using dates)

_____

_____

Is there anything else you think we should know in order to be helpful?

_____

ASPIRE GROWTH COUNSELING
141 N. Martinwood Rd., Suite 103-20
Knoxville, TN 37923-5137
865-236-1442

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

This authorizes Sondra Wilkinson, LPC-MHSP at Aspire Growth Counseling to disclose information concerning

me, _____

to and from _____

The purpose of this disclosure is related to my therapeutic work including: (initial all that apply)

_____ medical records
_____ diagnostic impressions
_____ treatment process & response to treatment
_____ psychosocial history
_____ progress
_____ telephone consultation
_____ other (specify) _____
_____

I authorize the disclosure of my protected health information (*). I understand that this authorization is voluntary. I understand that if the person(s) that I authorize to send/receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organizations may not be protected by those laws. This release shall remain in effect for one (1) year after the signing date of this release or until canceled by me in writing at any time or on the following date_____.

Signature _____ Date _____

Witness _____

*Protected health information (PHI) is health information that is created or received by a health care clearing house which relates to 1.) the past, present, or future physical or mental health of an individual; 2.) the provision of health care to an individual; or 3.) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R