WELLSPRING
THERAPY CENTER

4301 W 57th St Suite 100
Sioux Falls, SD 57108
605 335-1516
FAX 605 731-0896

WELLSPRING USE ONLY
ACCT #: _____
Diag: _____ _____ _____
First Session ___/_____/_____
CK GK KM WJ

ADMINISTRATIVE INFORMATION

CLIENT

Legal Name _____ Date _____

Address _____

_____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Email _____

Date of Birth _____ ❑ Male ❑ Female

Civil Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
Student: ❑ Full time ❑ Part time

SPOUSE/ PARENT *(if client is a minor child)*

Name _____

Address *(if different than client)* _____

_____ Zip Code _____

EMPLOYMENT OF CLIENT

Employer _____ Occupation _____

BILLING NAME/ RESPONSIBILITY *(If other than client)*

Name _____ Relation to client _____

Address _____ Phone ( ) _____

Please call the 800 number on your insurance card to make sure that Mental Health is covered by your Medical Insurance. If it is covered by a different company please notify our office.

Please supply insurance card for copying

INSURANCE INFORMATION *Complete if policy holder is not client*

Employer of policy holder _____

Policy Holder _____ Relationship to client _____

Date of Birth of policy holder _____

INSURANCE AUTHORIZATION

I hereby authorize WellSpring Therapy Center to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process my claims. I hereby authorize direct payment to WellSpring Therapy Center from insurance carriers for services rendered if my account is not paid in full. I permit a copy of this authorization to be used in place of the original.

★ **Signature of Client or Guardian** _____ **Date** _____

(OVER)

HEALTH INFORMATION

My present health is ❑ Excellent ❑ Good ❑ Fair ❑ Poor

List any significant health concerns _____

_____

Are you currently under the care of a physician? ❑ Yes ❑ No
If 'yes', for what? _____

Are you taking medications at this time? ❑ Yes ❑ No
If 'yes', list drugs, dosage, schedule

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Do you smoke? ❑ Yes ❑ No Packs per day? _____ How long? _____ years

Do you use alcoholic beverages? ❑ Yes ❑ No

If 'yes', how often? _____

Have you ever received or are you now receiving Family Therapy, Psychological, or Psychiatric counseling? ❑ Yes ❑ No

Referred by _____ Family Doctor _____

PHYSICIAN AUTHORIZATION

If your physician referred you, it is helpful for your therapist at WellSpring to be able to confer with your personal physician regarding your diagnosis and treatment.

I give my permission for my therapist at WellSpring Therapy Center to release records and/or information about my treatment to my physician for the purpose of treatment, planning, and coordinating psychotherapy with my physical health care needs. I may withdraw this consent at any time in writing or verbally by advising WellSpring.

❑ Yes I AUTHORIZE this release. ❑ No, I DO NOT.

Client Signature _____ Date _____

Physician _____
If different than above

Consent withdrawn on _____