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Welcome to Sphaira Wellness, LLC

Thank you for choosing Sphaira Wellness, LLC as your mental health provider. This practice is committed to your successful treatment. Anytime you have questions regarding your treatment or service fees, please discuss them with me promptly and frankly; I will make every effort to avoid a misunderstanding.

CONFIDENTIALITY:
What is revealed in this setting is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to suspected child abuse, elder abuse, threatened homicide or suicide.

FEES AND PAYMENT:
Fees for therapy are $180 for an initial assessment/intake and for couple/family therapy. Individual counseling is $150 per 50 minute session and group therapy is $165 per 60 minute session. For telephone consultation and requested letter writing, the charge is $100 and is not billable to insurance. In the situation a letter would result in a charge you would be informed prior to completion of letter. *Because of the small size of the practice, I do not handle court work/custody cases.

CANCELLATIONS:
Cancellations must be made at least **24 hours** in advance. If an appointment is canceled or missed without 24 hours of advanced notice, you may be charged a no-show fee of $70, which is not billable to insurance.

REGARDING INSURANCE:
Fees for services are your responsibility. As a courtesy to you, your insurance carrier will be billed by my contracted biller. It is your responsibility to verify your coverage and to obtain prior authorization, if necessary. Any amount not covered under your insurance is your responsibility. If your insurance carrier fails to pay your claim within 45 days from the date of service, a second notice may be sent to your carrier; however, the balance will become your responsibility. Also, it is your responsibility to contact your carrier regarding any unpaid claims. You are responsible for any unpaid balances that accrue, which may include co-pay and coinsurance balances.

Payment or co-pays are expected at the time of service. Cash/check or credit cards are accepted.

Outstanding accounts may be submitted to small claims court if prior financial arrangements have not been made or if you fail to make you're agreed upon monthly payment.

There is a return check fee of $35.

CONTACTING YOUR THERAPIST:
During regular business hours, you may use the phone number above to contact me for scheduling or business and administrative purposes. In non-emergency situations, please make note of your concerns to share during our next meeting**. In the event of a crisis, you should contact the Crisis Center 24 hours a day, 7 days per week at 920-832-4646. For medical emergencies, call either your primary care physician or 911.**

Date: ____________________________ Signature of Client: ____

Date: ____________________________ If Minor, client's guardian Signature _______________________________

PATIENT REGISTRATION FORM

Patient Information

Last Name:________________ First: ________________ M.I. ___ Gender: M F Date of Birth: _______

Address: ______________________________ City: ___________________ State:____ Zip: __________

Phone # (Home): __________________ (Cell):____________________ (Work): _____________________

May we leave a message? Y N SS# (needed for insurance) _________________________________

Custodial Parent/Guardian:____________________________ Relationship:_________________________

Insurance Information

Primary Insurance: ________________________ Secondary Insurance: __________________________

Policy #______________Group #_____________ Policy #________________Group #_______________

Subscriber Name: ________________________ Subscriber Name: _____________________________

Subscriber SS #: _________________________ Subscriber SS #: ______________________________

Subscriber Birth Date: _____________________ Subscriber Birth Date: __________________________

Relationship to Patient: ___________________ Relationship to Patient: ________________________

Employer: ______________________________ Employer: ___________________________________

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to all insurance benefits, if any, otherwise payable to me, for services rendered.

I understand and agree that I am financially responsible for all charges, legal or clinical, whether or not paid by insurance. I hereby authorize the provider and all employees to release any and all information necessary, printed or verbal to secure the payment of benefits. I authorize the use of this signature on all claims (manual or electronic).

___________________________________ ______________________

Signature Date

____

Print Name

Sphaira WELLNESS LLC
Your link to emotional and physical healing

Intake Information

Rate the following on a scale of 1-5 (1- poor 5 – no concerns). Add details if you prefer.

Sleep ____

Appetite____

Exercise ____

Physical Health____

Support from Friends and/or Family____

Employment/Academic____

Spiritual____

Financial____

Do you use alcohol or other mood altering substances? Yes ____ No______

If yes please list substances (non- prescribed unless taken other than prescribed), average occasions and amounts per month. ____

____

If yes to substance use, have you ever had relationship, financial, legal, occupational or other consequences due to use of the substance (s)? Yes _____ No________.

Please list any family members that have or had any mental health or substance abuse issues.

____

____

____

Use remaining space to share any issues, concerns, symptoms you would like to be viewed as priority in first few sessions.

____

____

____

Please note if you have present or past situations of trauma/abuse that you have witnessed or experienced it could be impacting current symptoms. Sharing this information is your choice to make at any time you are comfortable sharing.

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WELLNESS
LLC
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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

PATIENT NAME (print): ______________________________________ Date Of Birth: ________________

I authorize Amy M. Fifield, LPC and Sphaira Wellness, LLC to exchange information with the following party or parties:

____

(Name of person or organization)

Purpose of Exchange of Information

By signing this release, I give my consent to the above provider to exchange information, either verbal or written, via mail or electronic media to the party or parties listed above. I understand that this may include the release of information pertaining to psychiatric evaluations, progress and session notes, consultations, and any other information related to my ongoing treatment. I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal standards and my health information may be re-disclosed without my authorization.

I understand that I have the right to inspect and receive a copy of the disclosed material and a copy of this consent form as established in this agency's policies and procedures. This authorization to release information may be revoked by me at any time, in writing, except to the extent that action has been taken in reliance therein. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not reproduced by federal privacy standards.

This authorization will remain in effect until revoked or until the following date:____________________

____ ______________________

Signature of Patient Date

____ ______________________

Signature of Parent/Guardian Date

____ ______________________

Signature of Witness Date

NOTE TO CLIENT AND RECIPIENT OF INFORMATION:
This information has been disclosed to the above named person/organization from records whose confidentiality is protected by WI Statute 51.30, HFS 75.13 and/or Federal Regulation 42 CFR, Part II. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

EMERGENCY CONTACT

In the event of an emergency, please provide the name and contact information of the nearest relative not living with you:

Full Name (first and last):____

Address: ____

City: ____ State:______ Zip: _____________

Phone Number: _________________________ Relationship: __________________________

PRIMARY PHYSICIAN

Please provide the name and contact information of your primary/personal physician:

Primary / Personal Physician:____

Clinic: ____

Address: ____

City: ____ State:______ Zip: _____________

Phone Number: __________________________________

Hospital Preference: ____

DEBIT/CREDIT CARD PAYMENT AUTHORIZATION

*Please bring your card to your first session

All clients are required to keep a valid credit card number on file. This credit card will be used in case of: co-pays /coinsurance fees of any account balances that incur that are outstanding with no payment plan set up that are post 90 days. In addition, this card may also be used in the case of a no-show fee (or cancellations with less than 24 hours advanced notice). If you choose you can have a card on file and request it be run for co-pays/anticipated member responsibility after attendance at each appointment.

All CC information will be kept in a confidential and secure location.

Debit/Credit Card Information (please circle card type)

Visa Mastercard Discover

Client Name: _____________________

Name on card: ______________________

CC Number: _________________________ Exp. date: _____

3- digit CVV/CSC Code (back of card): ______

Zip Code where card is authorized: ________

I ______________________________ (print name) have read and understand the terms of providing my credit card information to Amy M. Fifield, LPC and Sphaira Wellness, LLC. I understand that my credit card may be charged if I am delinquent in payment for services provided or if I incur a no-show fee.

Signature _______________________________ Date_____________

SYMPTOM	Never	Prior to last 12 months	In last 6 months	SYMPTOM	Never	Prior to last 12 months	In last 6 months
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			

Bingeing				Blackouts			
Food preoccupation				Stomach problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			

Please check to what extent the symptoms in last 6 months have impacted your ability to function the way you would like to or need to be functioning. Not at all _______ Minimal _______ Challenging_______ Unmanageable ______

Additional comments:

____
____
____
____

Medications or other medical issues (allergies, thyroid, diabetes, etc.) we should know about:

____
____
____
____

Family History of individuals who have had or you suspect may have had symptoms of mental health (anxiety, depression, attention issues, ect)

____
____
____
____