The Office of
James G. Wellborn, Ph.D.
Child, Adolescent & Family Psychologist

Psychological Services Consent Form

Client Information
Client's Name: _____ Today's Date: _____
SS#: _____-____-_____ Date of Birth: _____ Living with: _____

Primary Responsible Party (Person responsible for any charges or fees not covered by insurance)
Responsible Party: _____ Relationship to Client: _____
Address: _____ City, State, Zip: _____
Responsible Party SS#: _____-____-_____ Responsible Party Date of Birth: _____
Responsible Party Employer: _____ Work Telephone: (___)_____
Responsible Party Home Telephone: (___)_____ Cell: _____
Email address:_____

Insured Party (Person carrying the insurance that covers the client. Please indicate if same as above)
Insured Party: _____ Relationship to Client: _____
Address: _____ City, State, Zip: _____
Insured Party SS#: _____-____-_____ Insured Party Date of Birth: _____
Insured Party Employer: _____ Work Telephone: (___)_____
Insured Party Home Telephone: (___)_____ Cell: _____

Referral Source (Person or agency who recommended Dr. Wellborn to you)
Name: _____ Telephone: _____
Address: _____ Relationship to Client: _____
I hereby authorize Dr. Wellborn or his designated staff to notify the above named referral source of my having made this appointment. The scheduled appointment is the only information that will be disclosed to the referring professional and is done as a professional courtesy.

Initial: _____

Informed Consent For Psychological Services
Please place your initials in the designated spaces to indicate that you have read and understood each of these conditions for treatment. Your signature is also required at the end of this form. Clients aged 16 and older must also read, initial and sign this form.

I hereby authorize Dr. Wellborn or his designated staff to release to any appropriate insurance-related entity or collection agency the information needed to process claims in reference to this treatment.

Initial: _____

(For clients 16 and older) I hereby authorize Dr. Wellborn or his designated staff to obtain and/or disclose information pertaining to billing, charges and payments as well as treatment progress summaries to my parents, legal guardians and/or the individual(s) responsible for charges associated with my account.

Initial: _____

I understand that payment is due in full at the time of service. Should my account become delinquent and be referred to any third party for collection effort, I agree to pay all reasonable attorney fees, court costs, and a collection expense of not more than 30 percent of any referred balance.

Initial: _____

I understand that clients are seen by appointment only and that any appointment cancellation made less than one business day in advance of the scheduled time will incur a cancellation fee equal to Dr. Wellborn's regular session fee.

Initial: _____

I understand that information shared with Dr. Wellborn is completely confidential with the following exceptions:

1. If any person being treated threatens serious bodily harm or death to him/herself or to another person, Dr. Wellborn or his designated staff will contact the appropriate people or agencies in an attempt to insure the safety of all concerned parties.
2. Dr. Wellborn is bound by law to report any suspicions of child or dependent adult abuse to the appropriate authorities.
3. Dr. Wellborn will comply with any and all valid court orders including those to release confidential information.
4. Dr. Wellborn regularly consults with other therapists during which he discusses specific aspects of psychotherapy sessions in order to insure quality treatment. Nevertheless, the consulting therapist is bound by the same confidentiality as Dr. Wellborn.
5. Dr. Wellborn is required by law to disclose a client's health information to authorized federal officials conducting national security and intelligence activities or providing protective services to the President or other important officials. It is unlawful for Dr. Wellborn to reveal that this information has been disclosed.

Information of any kind about your treatment or appointments will not be released without your prior, written permission except as outlined above or as otherwise required by law. I have reviewed and understand my rights to confidentiality and privacy as stated here and as provided by the Health Information Portability and Accountability Act.

Initial: _____

Dr. Wellborn will work with you to determine the most appropriate treatment for the difficulties you are experiencing. This includes developing a treatment plan, providing psychotherapy, consultations, or referring you to another professional with the appropriate expertise. You have the right to competent, quality treatment that is consistent with professional standards established in practice and supported by research. Dr. Wellborn is committed to using his skill and knowledge to help resolve any difficulties that arise. However, psychotherapy is not an exact science. While therapy most often improves or alleviates problems, I understand there is still the possibility that I may experience negative effects from therapy despite my best efforts and those of Dr. Wellborn. Negative effects could include the worsening of problems, strained or damaged relationships with others during treatment, and the uncovering of unexpected, disturbing issues.

Initial: _____

I voluntarily consent to participation in the assessment and treatment that may be performed during this (series of) visit(s) with Dr. Wellborn.

Initial: _____

I understand that I will be responsible for compensating Dr. Wellborn at the rate of $400/hour for court related services, including travel, if he must prepare for and/or appear in court on behalf of the client or client family.

Initial: _____

I understand that Dr. Wellborn is not available by email or the internet for psychotherapy, professional consultation, or for emergencies. I understand that information available on the internet by way of any websites or social media accounts associated with Dr. Wellborn does not constitute advice, diagnosis, or treatment by Dr. Wellborn.

Initial: _____

Confidentiality may be compromised by contact with Dr. Wellborn using electronic forms of communication such as unencrypted email, internet transmissions or cellular phone calls and text messaging. I understand that Dr. Wellborn cannot guarantee confidentiality when communicating with him through these media.

Initial: _____

Dr. Wellborn will send appointment reminders to your primary contact email. The appointment reminder will contain only the date and time of your appointment along with Dr. Wellborn's name. This message will not be encrypted. Healthcare information sent by regular e-mail can be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. Your signature indicates that you understand and accept responsibility for these risks and would nevertheless like to receive a reminder by email.

Initial: _____

Clients who have not had a session in over 30 days (or within a mutually agreed upon time) will be considered inactive (though it is always preferable to have a final session before ending therapy in order to review and evaluate the sessions and assess overall progress). Nevertheless, anyone wishing to return to active therapy can do so by contacting Dr. Wellborn to make arrangements to resume the therapeutic relationship.

Initial: _____

Emergencies

In case of emergencies, you may contact your nearest hospital emergency room. There is also a list of emergency and crisis resources provided on the emergencies page on Dr. Wellborn's web site (www.drjameswellborn.com). Instructions for contacting Dr. Wellborn through his cell phone can also be found on the emergencies page of his website. **Dr. Wellborn is not available by email or the internet for emergencies.**

Initial: _____

Please sign below and indicate the date that you read and agreed to the conditions outlined above concerning psychological services provided by Dr. Wellborn. You may request a copy for your records.

_____

Client Signature **Date**

_____ _____

Signature of the Responsible Party **Date** **(Relation to Client)**

Please note: Dr. Wellborn shares a common waiting room and office building with other independent mental health professionals. The office building belongs to the Brentwood United Methodist Church (BUMC). Nevertheless, Dr. Wellborn is completely independent from these mental health professionals and from BUMC in providing you with clinical services. He alone is solely responsible for those services. Dr. Wellborn's professional records are separately maintained and no one can have access to them without your specific, written permission.