MY PERSONAL STRENGTHS

By Bob Stahn

NAME:_____ DATE:_____

Each of us have personal strengths and positive characteristics. In the list of attributes below rate each one on how well it describes you—
1 = very little, 3 = moderately 5 = very much.

	1	2	3	4	5
Accommodating/ Adaptive/ Flexible					
Adventuresome/ Curious/ Inquisitive					
Assertive/ Bold					
Believing/ Faithful/ Spiritual					
Calm/ Peaceful/ Relaxed					
Careful/ Cautious					
Caring/ Nurturing/ Compassionate					
Committed/ Dedicated					
Competent/ Adequate					
Confident/ Possessing Self Esteem					
Consistent					
Cooperative					
Courageous					
Creative/ Imaginative/ Inventive					
Decisive (makes decisions easily)					
Determined/ Strong-willed/ Driven					
Diligent/ Valiant/ Hard-working					
Encouraging/ Inspiring					
Energetic/ Vigorous/ Enthusiastic					
Expressive					
Forgiving					
Friendly/ Personable/ Warm					
Fun-loving/ Playful					
Generous/ Selfless/ Liberal					
Genuine/ Sincere/ Open					
Goal-oriented/ Purposeful					
Grateful/ Appreciative/ Thankful					
Handy/ Industrious/ Resourceful/ Capable					
Happy/ Joyful/ Cheerful/ Jolly					
Helpful					
Honest					

(OVER PLEASE)

MY PERSONAL STRENGTHS (cont.)

	1	2	3	4	5
Humble/ Meek					
Humorous/ Witty/ Funny					
Independent/ Autonomous					
Insightful/ Self-Aware					
Integrity Possessing					
Loving					
Loyal/ True					
Mature/ Sensible/ Wise/ Practical					
Motivated/ Self-Starting					
Neat/ Tidy/ Clean					
Obedient/ Compliant/ Dutiful					
Optimistic/ Positive					
Organized/ Structured					
Passionate/ Zealous					
Peacemaking/ Calming					
Perceptive/ Observant/ Being Aware					
Persistent/ Tenacious/ Persevering					
Productive					
Punctual					
Resilient (easily bounce back)					
Respectful					
Responsible					
Reverent					
Self-controlled/ Self-disciplined					
Smart/ Clever/ Intelligent/ Ingenious					
Strong/ Solid					
Thrifty/ Conservative					
Thoughtful/ Considerate/ Kind					
Thorough/ Complete					
Tolerant/ Accepting					
Trusting					
Trustworthy/ Dependable/ Reliable					
Understanding/ Empathetic					
Uninhibited/ Spontaneous					
Unique					

Well Spring Counseling, LLC
Client Information

Bob Stahn, Ed. M., LCPC, ICADC

Client's Name:_____ Age:_____ Birth Date:_____ Sex: M F Marital Status:_____

Address:_____ Zip:_____ Social Security No:___-___-____

Home Phone:_____ Cell:_____ Place of Employment & Phone:_____

Your Physician & Phone:_____ List Medications:_____

List Physical Complaints, Illnesses, Surgeries, etc.:_____

Spouse/Guardian's Name:_____ Spouse/Guardian's Employer:_____

Spouse/Guardian's Social Security No:___-___-____ Spouse/Guardian Phone:_____

Did anyone refer you? If yes, who?_____ Previous Counseling/Treatment? Yes No When?_____

Where?_____ With Whom?_____

Please List Immediate Family Members and Ages:_____

_____

MOST MAJOR INSURANCE COMPANIES ACCEPTED

PRIMARY INSURANCE

Insurance Company:_____
Insured's Name:_____
Insured's Birth Date:_____
Insured's Relationship to Client:_____
Insured's Employer_____
Insured's ID Number:_____
Insurance Phone:_____
Group Number:_____
Policy Number:_____

SECONDARY INSURANCE

Insurance Company:_____
Insured's Name:_____
Insured's Birth Date:_____
Insured's Relationship to Client:_____
Insured's Employer_____
Insured's ID Number:_____
Insurance Phone:_____
Group Number:_____
Policy Number:_____

RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I authorize Bob Stahn to disclose portions of the clinical record of the client names above to the Insurance Company and/or its contracted review agent for the purpose of reimbursement of counseling services. I hereby release Bob Stahn and my clinician associated with my case from all liability that may arise as a result of disclosure of information to the Insurance Company.

Also, I hereby authorize payment directly to Bob Stahn of all professional expense benefits payable to me, but not to exceed the regular charges or fees for services provided. I do understand that I am financially responsible for my amounts that are not paid by my insurance company.

I further understand that if my insurance company requires a pre-authorization in order to pay for a session, I am responsible to obtain any pre-authorization. Not acquiring a pre-authorization does not eliminate my responsibility to pay for a session. If I am accessing Employee Assistance Program (EAP) benefits, any appointment scheduled but not attended (or cancelled within 24 hours) will be charged one EAP visit.

Signature of Primary Insured:_____ Date:_____

Signature of Secondary Insured:_____ Date:_____

NOTE: All appointments must be attended. If not attended or cancelled 24 hours prior to the appointment, you will be billed the session fee for them. Arrangements can be made in case of emergencies or other circumstances.

(OVER PLEASE)

Well Spring Counseling, LLC

611 Hoopes Ave
Idaho Falls, ID 83401

Office Policies

Please read and sign this office policy statement. By signing below, you acknowledge and agree to the terms listed below. If you have any questions, the therapist or office manager will be glad to help you.

Thank you for coming to Well Spring Counseling, LLC. We would like to take this opportunity to explain our office policies and billing procedures. Your insurance information is obtained on your first visit and we then can file your insurance for you. We would like to have your portion paid at the time of your visits. If you do not have insurance, we would like full payment at the time of services unless other arrangements have been made previously.

At Well Spring Counseling, we see you as the expert on you and we see ourselves as assistants to the expert. You direct the focus of the counseling, the duration of the counseling term and the frequency of visits. You drive the counseling 'bus' and we get to navigate. Together, we can quickly get you to where you want to go. While many people benefit from counseling, there is no guarantee of a positive therapeutic outcome.

When full payment for the session is made at the time of counseling, you will receive a $10/hour discount. If you would like, Well Spring Counseling can provide a statement for YOU to submit to your insurance provider. If you choose to have Well Spring Counseling submit the claim to your insurance provider, the same-day discount will not apply.

Our therapists' counseling sessions are usually fifty to sixty minutes in duration and are charged at a rate of $110.00 per session ($70 per 30-minute session) unless other arrangements are made with the therapist. **Unattended appointments will be assessed your full session's charge without 24 hours prior notice at the therapist's discretion.** Insurance providers will not pay for missed appointments or late cancellations.

Insurance providers have different authorization requirements. Due to the number of clients we work with, our office cannot perform this service; this is ultimately your responsibility. Please call your insurance provider if you have questions.

In order to submit claims to your insurance provider, it will be necessary to provide certain *psychological/medical* information to your insurance provider.

All overdue accounts will accrue interest at the rate of 1.75% per month (21% per year) with a $5 minimum. Accounts with no payment in a 60-day period may be turned over to collections.

CONFIDENTIALITY: All information revealed in counseling is confidential with the following exceptions: 1. Intent to commit serious crime; 2. Intent to harm self or others; 3. Prior abuse or neglect of a minor, or intent to abuse or neglect a minor and/or vulnerable adult; 4. Unethical behavior by a previous conselor; 5. Responding to a subpoena or court order. If the information is legally confidential, therapists and staff at Well Spring Counseling cannot be compelled to disclose the information without the client's (or guardian's) consent, subpoena or court order. You may direct your therapist to share information by completing a Release of Information form. As a matter of policy, Well Spring Counselors will not give testimony in court. By signing below, you accept and understand Well Spring Coundeling's Notice of Privacy Practices and limits of confidentiality.

RECORDS: I acknowledge that my clinical and administrative records are the property of Well Spring Counseling. I have the right to view and receive copies of the records upon request. I acknowledge that my files or information may be shared, without identifying information, with Well Spring collegues in case consultation. In the event of death or incapacitation of the therapist, I give permission for my records to be transferred to my new therapist.

RIGHT TO CHOOSE: You have the right to select a counselor, seek a second opinion or stop counseling at any time.

LICENSING: The Idaho Division of Occupational and Professional Licenses has the general responsibility of regulating the practice of licensed professional therapists. The license of any individual under the licensing laws of Idaho does not imply or constitute an endorsement of that therapist nor guarantee effectiveness of treatment. The Idaho Division of Occupational Licenses, 11351 W. Chinden Blvd., Bldg. #6, Boise, ID 83714.

ETHICS: Licensed therapists are required to adhere to the professional code of ethics adopted by the American Counselors Association.

TRAUMA TREATMENT: BIRRT (Brief Imagery Rescripting, Reprocessing Therapy) is an effective, brief and economically beneficial modality that has been sucessfully used for years and is a non-empirical method of decreasing trauma symptoms.

FOCUS: I UNDERSTAND MY COUNSELING FOCUS WILL BE (Please check one): ☐ INDIVIDUAL ☐ RELATIONSHIP ☐ FAMILY

I have read the above as well as the HIPAA Policy and agree to the terms described.

Signature of Client (or Guardian, if client is a minor)	Printed Name	Date
Signature of Client (or Guardian, if client is a minor)	Printed Name	Date

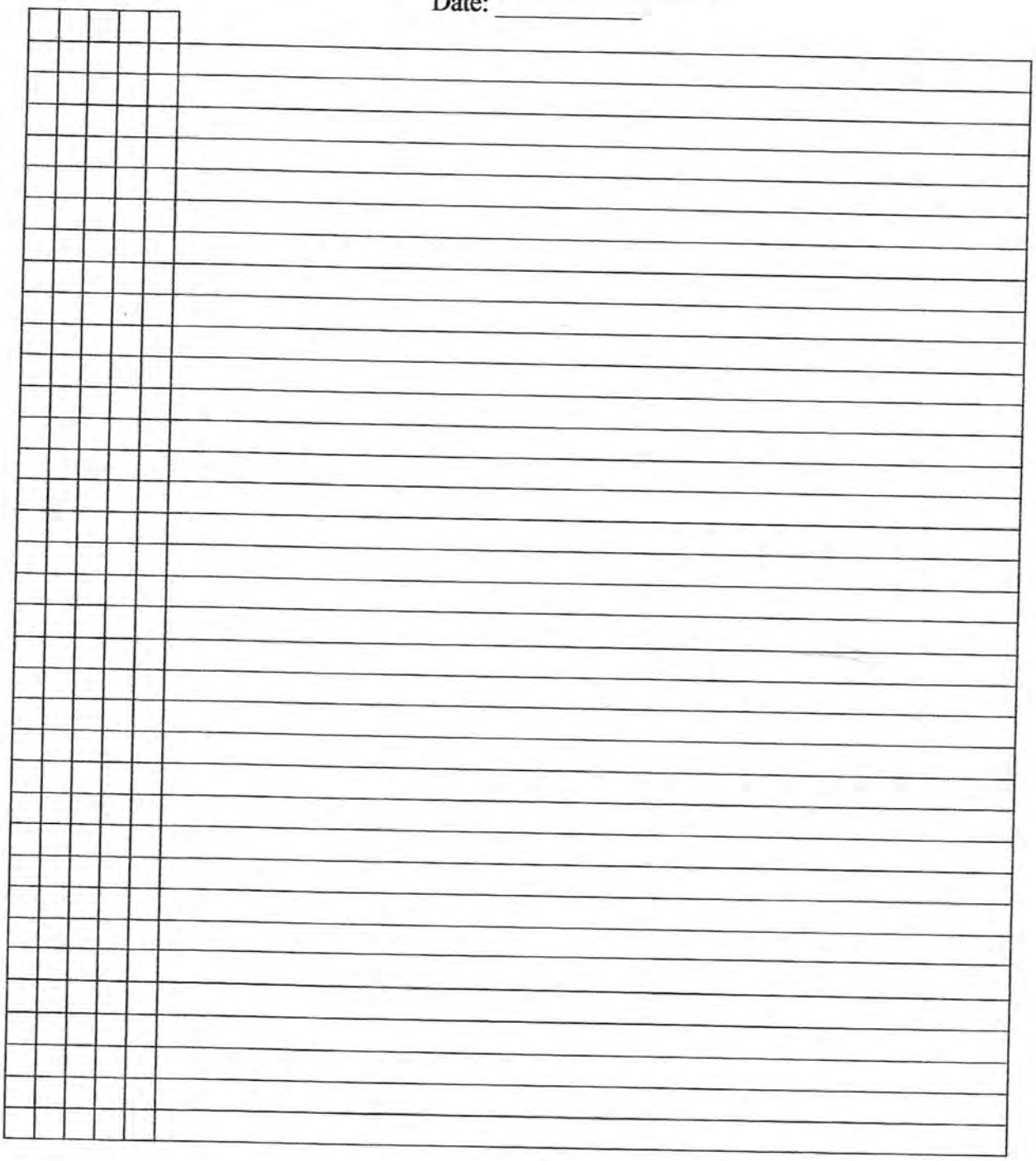
Well Spring Counseling

Bob Stahn, Ed.M., LCPC, MAC, ICADC

Miracle List of

_____

Date: _____



Want " "; Confidence " "; Willingness " "; Today " " because _____

_____

_____

Date: _____

Well Spring Counseling

How Did You Hear About Us? Please check ONE of the following:

( ) A family member – (name) _____

( ) A friend – (name) _____

( ) Internet
- ( ) Facebook
- ( ) Search Engine

( ) Road Signage

( ) Phone Book
- ( ) Yellow Pages
- ( ) Local Pages

( ) Attended a presentation

( ) Radio

Any additional comments you would like to give us?

_____

_____

_____

Thank You

Well Spring Counseling, LLC
611 Hoopes Ave,
Idaho Falls, Idaho 83401
(208) 557-7500 or 557-9724

Bob Stahn, Ed.M., LCPC, MAC, ICADC

Release of Information

Clinical Records

I (We) Name:_____ Client ID #:_____
Address:_____ City/State/Zip:_____
Home Ph:_____ Work Phone:_____

Do hereby authorize Well Spring Counseling, LLC staff to use and disclose the following Protected Health Information (PHI):

To mutually exchange any and all information on (my/our) social, emotional, educational, religious, psychological, mental health/counseling and medical histories, including assessments, background, opinions on any other relevant data necessary to assist in providing continuing service to (me/us). I (We) understand that this consent will remain in effect indefinitely or until (I/we) cancel it by written notice to the agency.

_____

_____

If this consent is for publicizing my comments, by initialing this paragraph I acknowledge that I have not been coerced into making those statements nor have they been solicited, but I have willingly volunteered them. I also understand that my comments will be identified by my first name or initials in such a way as to protect my confidentiality. ____

If this consent is for allowing recording (either audio or visual) of me, I acknowledge that it is for training purposes only at Well Spring Counseling, LLC, and that the recording will be erased after the training has been completed. ____

The above-prescribed PHI will be released to the following entities:

Name:_____ Name:_____
Address/Ph:_____ Address/Ph:_____

Note: This information has been disclosed to you from records whose confidentiality may be protected by Federal Law (42 CFR, Part 2) prohibits you from making any further disclosure of it without the consent of the person to 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. The Federal rules restrict any use of the information to criminally investigate or prosecute the client.

For up to one (1) year from the date of the signature below the above-stated entities may use the PHI for the following purposes:

_____

_____

I (we) agree to indemnify and hold harmless all persons and groups named above from any and all liability for claims, actions, damages or suits arising from or relating to the release or exchange of information made pursuant to this authorization for release of confidential information.

This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.

Signature:_____ Date:_____

Signature:_____ Date:_____

If under 18 years of age, signature of parent or guardian is required.

Adverse Childhood Experience (ACE) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No

6. Were your parents **ever** separated or divorced?
   Yes No

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No

10. Did a household member go to prison?
    Yes No

COUNSELING SESSION NOTE

WELL SPRING COUNSELING, LLC
BOB STAHN, ED.M, LCPC, MAC, ICADC

CLIENT NAME:_____

Date:

S._____

O&A._____

P. HW:_____

Date:

S._____

O&A._____

P. HW:_____

Date:

S._____

O&A._____

P. HW:_____