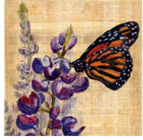


SHEILA SIMPSON-CREPS MA, LMHC, MFA
360-293-3489 Office: 1004 7th St. Anacortes, WA 98221
info@artwellspring.com www.artwellspring.com
Mail address: P.O. Box 83 Lopez Island, WA 98261

Intake Information

Please circle phone numbers where it's okay for me to leave confidential messages.

Date____________________ Referral Source__________________________________

Client Name ____ DOB _________________

Address ____

City, State, Zip _________________________________ Home phone ______________________

Occupation ___________________________________ Work phone _______________________

Employer _____________________________________ Cell phone ________________________

Email ____ Social Security # ___________________

Marital Status **[ ]** married/years______ **[ ]** divorced/years_____ **[ ]** unmarried Age____________

Ethnicity and Race: ____

****

Check one: [ ] partner [ ] spouse [ ] parent [ ] child

Parent or Guardian Name ____ DOB _____________

Address ____

City, State, Zip ____________________________________ Hm. phone _____________________

Occupation ______________________________________ Wk. phone _______________________

Employer ____ Cell phone _______________________

Marital Status **[ ]** married/years______ **[ ]** divorced/years_____ **[ ]** unmarried Age____

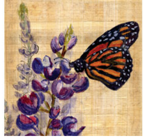
Emergency contact: Name ______________________________Phone __________________________

Please briefly describe your main reasons for seeking psychotherapy at this time. Please Include, previous and current therapy experiences (use back side of page if needed).

Please list current medications and dosages:

If you are planning to use insurance benefits, please provide your most current insurance card for photocopying. I am a **preferred provider** for CIGNA, First Choice, Lifewise, Premera, and Regence, Group Health PPO, and Tricare insurance plans. Please plan to pay the fee for services at the time of your sessions. For other insurance plans I can provide you with a bill so that you can send it into your insurance company for reimbursement. ***Insurance companies may not reimburse you for the full amount charged.***

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.



SHEILA SIMPSON-CREPS MA, LMHC, MFA
360-293-3489 Office: 1004 7th St. Anacortes, WA 98221
info@artwellspring.com www.artwellspring.com
Mail address: P.O. Box 83 Lopez Island, WA 98261

INSURANCE BILLING INFORMATION

The following information is required by your insurance company and will be used only for billing purposes.

Please attach a photocopy of both sides of your insurance card(s), or bring the card to your first session.

Insured's Name: _______________________________Insured's Birth Date: ____________________

Your relationship to insured (circle one): Self | Spouse | Child | Parent | Partner |other: ____________________

Insured's Address *if different from above:*

____

City: _______________________________________ State:_________ Zip code: ________________

Primary Insurance Carrier: _____________________________Plan Name: __________________ Policy or ID Number: ______________________ Insured's Group Number: ____________________ Insured's Employer: ____________________________ City: _______________________ State: ____ Insurance Company Address: ____ City: ___________________________ State:_____ Zip code: __________ Phone: _______________ Deductible: __________ Copay/Co-Insurance Amount: ____________ Effective Date _____________

Secondary Insurance Carrier: ____________________________Plan Name: _________________ Policy or ID Number: _________________________ Insured's Group Number: __________________ Insured's Employer: ____________________________ City: ______________________ State: _____ Insurance Company Address:____ City: ___________________________ State:_____ Zip code: __________ Phone: _______________ Deductible: __________ Copay/Co-Insurance Amount: ____________ Effective Date _____________

GUARANTOR

This refers to the person ultimately responsible for payment if outstanding charges are due, including any fees related to late payment or missed sessions.

Guarantor's Full Name ____ Circle One: Male | Female

Your relationship to client (circle one): Self | Spouse | Child | Parent | Other __________________

Guarantor's address (if different than insured's):

____

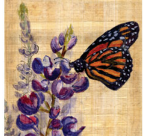
City: ______________________________ State:____ Zip code: ___________Phone: ____________

Date of Birth: __________________ SSN ____________________ Marital Status ____________

Employer _________________________________ Phone ____________________

Employer Address ____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.



SHEILA SIMPSON-CREPS MA, LMHC, MFA
360-293-3489 Office: 1004 7th St. Anacortes, WA 98221
info@artwellspring.com www.artwellspring.com
Mail address: P.O. Box 83 Lopez Island, WA 98261

Mutual Consent: Contract For Using Client Art and Sandplay Images

If you should choose to participate in Art activities, or Sandplay, (**neither is required for counseling**), as a matter of course, Sheila Simpson-Creps keeps a photocopy of art and Sandplay images in the client's file, and generally keeps client's artwork in a separate file, unless, on occasion the artwork goes home with the client as in Parent/Child Attachment Enhancement processes. Either you, or the parent of a child under age 13, in this document, must agree to any other use.

This contract is between Sheila Simpson-Creps, MA, LMHC, and:

____

(Enter your full name above)

I, ____(enter your name) grant my permission to Sheila Simpson-Creps (M.A. LMHC, MFA, license LH60389084) to use and/or display and/or photograph my or ___________________________'s art, or Sandplay products from therapy sessions for the following purpose(s):

Check all that apply:

- ☐ Artwellspring Website (Sheila's counseling website)
- ☐ Exhibition Publication in a professional journal
- ☐ Presentation at professional conferences
- ☐ Educational purposes
- ☐ Filming, sound recording, photography

I understand that there are times when my work with Sheila, in art therapy and Sandplay, will be discussed in consultation with other mental health professionals. All efforts will be made to keep your identity anonymous and confidential.

Client or Parent/Guardian Signature: ____ Date: ____________

- I, Sheila Simpson-Creps of Artwellspring Counseling, agree to the following conditions listed above in connection with my use of your artwork and Sandplay images. I agree to safeguard your expressive images to the best of my ability and to notify you immediately of any loss or damage while your artwork is in my possession. I agree to provide an appropriate format for presentation if I exhibit your artwork, and to bear other costs related to exhibition. I agree to return your artwork immediately if you decide to withdraw your consent. I agree to safeguard your confidentiality. Confidentiality of the client's name and identifying information will be maintained, unless otherwise agreed upon in writing.

____ Date: ______________________

Sheila Simpson-Creps, MA, LMHC, AT

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.