Therapist: ______________________________

Supervising Therapist: ______________________

Client Information and Billing Consent

Client Name: ____ Birth Date: ____/____/____

Address: ____ Sex: Male Female Transgender

City, state, zip: ____ Martial Status: ____________________

(H) Phone: ____________________ (W) Phone: ______________________ (C) Phone: ______________________

If we need to leave you a message, which number should we use? ______________________________

Employer: ____________________________ Personal Email: __________________________________

Emergency Contact: __________________________ Phone: __________________________________

Referral Source: ____________________________ **Agreed Fee/copay**: ________________________

<u>For Minors Only</u>:

Parent/Guardian Names: ____

Who has legal custody? __________________________ Physical Custody? _______________________

Student: Y N Full-time Part-time School: ______________________________ Grade: __________

Primary Insurance	**Secondary Insurance**
Primary Insured Name: ____________________	____________________
Insured DOB: ____________________	____________________
Relationship to Insured: ____________________	____________________
Insurance Co: ____________________	____________________
Policy/ID#: ____________________	____________________
Group#: ____________________	____________________
Effective Date of Coverage: ____________________	____________________
Deductible: ____________________	____________________

I hereby certify that the above statements are correct. I authorize the release of any medical information necessary to process this claim. I also authorize benefits under this claim paid directly to the therapist for services described. I further understand that it is my responsibility to notify the therapist/staff of any changes in my insurance coverage.

Signed: ____ **Date** ______________

Office Use Only

Axis I Diagnosis ________________ Axis II Diagnosis __________________

Axis III: ____________________ GAF: ________ Prior Authorization #: ____________

Notes: ____

Consent for Treatment, Information Use and Disclosure

Consent to use Disclosure of Healthcare Information for Treatment, Payment and Healthcare Operations

By signing this statement, I understand that as a part of my health care, Beacon Therapy Associates, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning my care and treatment
- A means of communication among authorized health professionals who contribute to my care
- A source for applying my diagnosis information when filing a claim to my insurance
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Informed Consent for Confidentiality

1. If anyone requests information about me, my therapist will not give it unless and until I have signed a separate written authorization for her/him to do so. My therapist will not discuss anything about me with anyone without my written permission, except as noted here:

   A. If I use insurance benefits, my therapist and Beacon Therapy Associates cannot guarantee confidentiality from the insurance company.
   B. If my therapist learns that I have abused a child, a spouse, or vulnerable adult (or if I am a child, spouse, or vulnerable adult and report having been recently abused), she/he must report it to the proper authority.
   C. If my therapist has good reason to believe that I intend to physically harm myself or someone else, she/he will discuss it with me and may be required to warn that person or persons (the Tarasoff duty), or to take steps to prevent such harm by notifying the authorities.
   D. If my therapist has good reason to believe that I may be a danger to myself, she/he will contact at least one concerned person and/or take steps to prevent such harm by notifying the authorities.
   E. If I give permission to release my records to a legal representative of my choice, these records could become discoverable by other legal representatives. If subpoenaed by the courts to release your records, we may have to do so.
   F. My therapist may discuss my case with Beacon Therapy Assc.'s clinicians and/or other outside professional case consultation groups. Identifying information (such as full name) will not be shared without written permission.
   G. I give my permission to disclose case information to referring clinicians within the Beacon Therapy Network.
   H. Beacon Therapy Associates, PC is in compliance with the State Department of Human Services which has the right to review all cases. DHS must abide by all rules of confidentiality.

2. All non-emancipated minor clients under the age of 18 years old must have the consent (of at least one) of their parent(s)/guardian following an initial intake session to receive further treatment services. Exceptions to this rule are when a minor is seeking services related to pregnancy, venereal disease or substance abuse.

Acknowledgement of Informed Consent & Agreement for Therapy Services

I acknowledge that it is my choice to participate in on-going therapy (or have my child participate). I will take responsibility for my therapy participation. I understand that I can not attend therapy under the influence of drugs or alcohol. I further understand that I may be charged a fee for any missed appointments or late cancelations. I will discuss early termination prior to ending therapy.

Payment Agreement

- I understand that I am ultimately responsible the payment of services received.
- If using insurance, I am responsible for payment of my co-pay at the time of services.
- I further understand that I am to give a 24 hour notice when canceling appointments. In the case of missed appointments or cancellations shorter than 24 hours, a $60 fee may apply. Late arrivals will be charged the full fee.

I fully understand and accept the terms listed above.

______________________________ / ______________________________ __________

Client's Signature | Legal Guardian /Relation to Client | Date

PERSONAL HISTORY FORM

Client name: ____ D.O.B. __________ Gender: M F T

Primary concern(s): ____ Depression ____ Anxiety ____ Alcohol/drugs _____ Anger Issues
____ Coping ____ Fear/phobias ____ Behavior problems _____ Martial issues

Other ____

Please circle behaviors and symptoms that are problematic:

Anxiety
Irritability
Panic attacks
Worrying
Fears/Phobias
Recurring Thoughts
Hallucinations
Impulsivity
Attention Problems
Heart Palpitations
Trouble concentrating
Depression
Fatigue
Suicidal thoughts
Loneliness
People avoidant
Hopelessness
Eating issues Sick often
Self injury
Sleep disturbance
Mood swings
Anger
Aggression
Addictive Behaviors
Alcohol/drug problems
Gambling

Briefly describe how the symptoms impact your daily living: ______________________________________

____

Is there any additional information that would assist me in understanding your concerns and problems? ________________

____

Do you feel suicidal at this time? Yes or No
Have you ever attempted suicide? Yes or No
Do you have a plan for suicide? Yes or No
When? __________________________________

Have you recently experienced any that follow?

- Recent death/birth
- Accident, fire, disaster
- Separation or divorce
- Job loss or change
- Arrest or legal matter
- DUI
- Major Financial problems
- Change in living situation
- Physical/emotional abuse
- Sexual abuse or assault
- Thoughts/acts of violence
- Thoughts/acts of hurting self
- Custody issues
- Pregnancy
- Miscarriage
- Abortion
- Diagnosis of major illness
- Relationship discord

Marital status (circle):

- Single
- Married
- Divorced/Separated
- Widowed

Sexual orientation: ____

Developmental history:

Has there been a history of child abuse? Yes or No If yes, which type: ___ Sexual ___ Physical ___Verbal
Other childhood issues: ___Neglect _____Exposure to trauma _____Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain ____

Social Relationships: Circle how you generally get along with other people:

Affectionate Aggressive Avoidant fight/argue often Follower
Friendly Leader Outgoing Shy/withdrawn Submissive

Spiritual/Religious:

Are you connected with a spiritual or religious group? Please explain____
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal:

Are you involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges ____
Are you currently on probation or parole? Yes or No
Have you been accusations of any sexual crimes? Yes or No

Education, Employment, Military:

Education:	Currently enrolled in school	High school grad/GED	Vocational school
	Some College	College Graduate	Masters or Doctorate

Any learning disabilities: Yes or No If yes, please explain ____

Employment: Current employer ____

Fulltime	Part time	Temp	Laid-off	Disabled	Retired	Social Security
Job satisfaction:		poor	good	fair	great	

Military experience? Yes or No Combat experience? Yes or No Where: ____________________________

Branch: ________________________ Type of discharge __________________________ Service length __________

Leisure/Recreational:

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling sports, etc.)

____

____

Medical/Physical Health:

Primary Doctor ________________________ Do you consent for them to be notified of your treatment? _____________

List any current health conditions you have and any recent health changes: ______________________________________

Current prescribed medications: ____

Chemical use History:

____

____

How does your use affect your life? ____

Has anyone expressed concern about your use? Yes or No Are you concerned about your use? Yes or No

Are there presently or past history of a family member having problems with drugs or alcohol? Yes or No

Consequences experienced because of your use? Legal, relational, physical, mental, job, financial

Please explain: ____

____

Counseling/treatment History: **When:** **Where:**

	When:	Where:
Counseling/Psychiatric Care	______________	____
Drug/alcohol treatment	______________	____
Psychiatric hospitalizations	______________	____

- Is there a family history of mental illness or substance abuse? Yes No Not sure
  If yes, please explain: ____

- Have you ever been given a mental health or substance related diagnosis? Yes No Not sure

If yes, what was that diagnosis? ____

Please list your desired outcome for therapy:

____

____

____

____

____

____

Is there anything else that you think that I should know that would help as we work toward your goals? Yes No

____

____

____

____

____

For clinician use only:

Genogram