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**: _____

For Minors Only:

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 & RELATIONSHIP HISTORY FORM

Partner A: _____ D.O.B. _____ Gender: M F T

Partner B: _____ 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 for either partner:

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

Briefly describe how the symptoms above or other concerns impact daily living and the relationship: _____

_____

Either Partner:

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

Have either of 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: ___ living together ___ living apart
- Married: Years married: _____
- Previous marriages for each partner: A: ___ B:__
- Has either partner been widowed? _____
- Currently Separated: _____

Sexual orientation: _____

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

Partner A:

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Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

Partner B:

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Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

Partner A:

Spiritual/Religious:

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

Developmental history:

Has there been a history of child abuse? Yes / 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 either partner's upbringing? Yes / No
Please explain _____

Legal:

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

Education: Currently enrolled in school High school grad/GED Vocational school
Some College College Graduate Masters or Doctorate
Any learning disabilities: Yes / No If yes, please explain _____

Employment:

Current employer _____

Fulltime Part time Temp Laid-off Disabled Retired Social Security

Military experience for either partner? Yes / No Combat experience? Yes / 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, walking, exercising, diet/health, hunting, fishing, bowling, traveling sports): _____

Medical/Physical Health: Primary Doctor _____ Do you consent for them to be notified of your treatment? _____

Current health conditions/recent health changes: _____

Current prescribed medications: _____

Chemical Use History:_____

_____

How does your use affect your life? _____

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

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

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

Counseling/Treatment History:	**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? _____

- Have you ever had couples/marriage counseling for this relationship? Yes / No

  If yes: when & where: _____

  What was the outcome? _____

  What did you find helpful? _____

Please answer the following questions about your relationship by filling in the blank with the corresponding number that best describes your relationship in the recent months. These questions will help me better understand your relationship dynamics and opinions.

All of the time	Almost Always/Frequently	Occasionally	Rarely	Never
5	4	3	2	1

1. _____ How often do you calmly discuss important topics (i.e., finances, religious matter, goals, parenting, etc.)?
2. _____ How often do you discuss or consider separation or divorce?
3. _____ How often do you confide in your spouse?
4. _____ How often do you quarrel?
5. _____ How often do you kiss your partner?
6. _____ How often you disagree about major life/household/career decisions?
7. _____ How often do you laugh together?
8. _____ On a scale from 1-10 (10 being the highest), how satisfied are you concerning sex relations with your partner?
9. _____ On a scale from 1-10, how happy are you in your relationship?
10. _____ On a scale from 1-10, how confident are you in the future of your relationship?

Is there any additional information that would help me better understand you, your relationship, or your goals for therapy?

_____

_____

_____

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_____

_____

_____

Partner B:

Spiritual/Religious:

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

Developmental history:

Has there been a history of child abuse? Yes / 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 either partner's upbringing? Yes / No
Please explain _____

Legal:

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

Education: Currently enrolled in school High school grad/GED Vocational school
Some College College Graduate Masters or Doctorate
Any learning disabilities: Yes / No If yes, please explain _____

Employment:

Current employer _____

Fulltime Part time Temp Laid-off Disabled Retired Social Security

Military experience for either partner? Yes / No Combat experience? Yes / 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, walking, exercising, diet/health, hunting, fishing, bowling, traveling sports): _____

Medical/Physical Health: Primary Doctor _____ Do you consent for them to be notified of your treatment? _____

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Chemical Use History:_____

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

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

Counseling/Treatment History:	**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? _____

- Have you ever had couples/marriage counseling for this relationship? Yes / No

  If yes: when & where: _____

  What was the outcome? _____

  What did you find helpful? _____

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All of the time	Almost Always/Frequently	Occasionally	Rarely	Never
5	4	3	2	1

11. _____ How often do you calmly discuss important topics (i.e., finances, religious matter, goals, parenting, etc.)?
12. _____ How often do you discuss or consider separation or divorce?
13. _____ How often do you confide in your spouse?
14. _____ How often do you quarrel?
15. _____ How often do you kiss your partner?
16. _____ How often you disagree about major life/household/career decisions?
17. _____ How often do you laugh together?
18. _____ On a scale from 1-10 (10 being the highest), how satisfied are you concerning sex relations with your partner?
19. _____ On a scale from 1-10, how happy are you in your relationship?
20. _____ On a scale from 1-10, how confident are you in the future of your relationship?

Is there any additional information that would help me better understand you, your relationship, or your goals for therapy?

_____

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