Therapist: _____

Supervising Therapist: _____

Client Information and Billing Consent

Client Name: _____ Birth Date: _____/_____/_____

Address: _____ Sex: Male Female Other

City, state, zip: _____ Marital Status: _____

(H) Phone: _____ (W) Phone: _____ (C) Phone: _____

I give my permission to be called at: Home: Yes No Cell: Yes No Work: Yes No I give my permission to be emailed: Yes No Special instructions_____.

I understand that caller ID may disclose the therapist's name to others and that email may not be confidential unless encrypted. Therapist will send emails through and encryption services. Please initial:_____

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

Emergency Contact: _____ Phone: _____

Referral Source: _____ Agreed Fee/co-pay:_____

For Minors Only: Parent/Guardian Names: _____

Who has legal custody? _____ Physical Custody? _____

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 Beacon Therapy Associates, PC to process this claim. I authorize the release of any medical information necessary to process this claim. I also authorize benefits under this claim paid directly to Beacon Therapy Associates for services described. I further understand that it is my responsibility to notify the therapist/staff of any changes in my insurance coverage and/or address. 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

Signed: _____ **Date** _____

Office Use Only

Diagnosis _____

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 am consenting to treatment and 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, sessions, diagnoses, treatment, and 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 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 ordered by the courts to release records, we may have to do so.
   F. My therapist may discuss my case with Beacon Therapy Association's clinicians in case consultation.
   G. I give my permission to disclose case information to referring clinicians within Beacon Therapy Associates.
   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 minor clients 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) and take responsibility for my therapy participation. I understand that I cannot attend therapy under the influence of drugs or alcohol. I understand that therapy sessions may not be recorded. I understand that contact with my therapist through email, fax or cell phone may not be in total confidence and vulnerable to hacking by outside parties. I further understand that I may be charged a fee for any missed appointments or late cancelations. Failure to keep two appointments as scheduled may result in suspension or termination of services. Should I decide to terminate therapy before goals are met, I will discuss the early termination with my therapist prior to ending therapy.

Confidentiality in Family and Couples Therapy

Therapists at BTA adopt a "no secrets" policy when working with families and couples in therapy. This means that if you or your partner participate in individual sessions as part of couple/family therapy or communicate independently with the therapist, any information disclosed will be considered to be a part of therapy and may be discussed in joint sessions. Secrets between partners is not encouraged. However, please do not disclose any information to the therapist that you wish to keep from your partner. When entering marriage counseling, you agree at the start of treatment that if you eventually decide to divorce, neither party will request testimony from the therapist. Initial: _____

I fully understand, agree and accept the terms listed above.

_____/_____ _____

Client Signature | Legal Guardian /Relation to Client | Date

ADULT PERSONAL HISTORY FORM

Client name: _____ **Date of birth:** _____

Marital status (circle): Single Married Divorced Separated Widowed **Gender:** M F T

Children's name & age: _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Employer: _____ **Status (circle):** FT PT Retired Unemployed Student

Primary concern(s) that is pertaining to today's appointment:

_____ Depression _____ Anxiety/Panic attacks _____ Alcohol/drugs _____ Anger Issues

_____ Fear/phobias _____ Behavior problems _____ Marital issues _____ Avoidant behavior

_____ Chronic Pain _____ Relationship discord _____ Low self-esteem _____ Coping/Grief

_____ Other: _____

Symptoms/Impairments (circle): **Amount of time symptoms have been problematic?:** _____

Addictive Behaviors	Hallucinations	People avoidant
Aggression	Heart Palpitations	Recurring Thoughts
Alcohol/drug problems	Hopelessness	Self injury
Anger	Impulsivity	Sexual dysfunction
Anxiety	Irritability	Sick often
Attention Problems	Loneliness	Sleep disturbance
Depression	Low self-esteem	Stress
Eating issues	Mania	Suicidal thoughts
Fatigue	Memory lapses	Trouble concentrating
Fears/Phobias	Mood swings	Underachievement
	Panic attacks	Worrying

Briefly describe how the symptoms impact you at home, work, school or socially: _____

_____

In the past 30 days, how many days were these difficulties present?: # of days____ How many days did you miss work or school because of these difficulties?: # of days _____

Do you feel suicidal at this time? Yes No Do you have a plan for suicide? Yes No Plan: _____

Have you ever attempted suicide? Yes No When? _____ _____

Briefly list major traumas or life events:

- Recent death/birth
- Accident, fire, disaster
- Separation or divorce
- Arrest or legal matter
- Physical/emotional abuse
- Sexual abuse or assault
- Thoughts/acts of violence
- Thoughts/acts of hurting self
- Miscarriage
- Diagnosis of major illness
- Relationship discord
- Relocation home/work

Other traumas: _____

_____

Military experience? Yes No **Combat experience?** Yes or No Where: _____

Leisure/Recreational:

Describe special areas of interest or hobbies:_____

How much time do you dedicated to special interests(circle)?: None Little Some Fair amount

Strengths/Weaknesses:

Strengths you feel you have: _____

Weaknesses you feel you have: _____

Medical/Physical Health:

Primary Care Physician/Clinic: _____ Phone: _____

Do you give consent for your therapist to notify your PCP of your treatment (circle)?: Yes No Initials: ____

Current health conditions: _____

_____

Recent health changes: _____

Current prescribed medications/dosages: _____

_____

Chemical use History:

Alcohol: Yes No Level of consumption: _____ Age at first use: _____
Street drugs: Yes No Level of consumption: _____ Age at first use: _____
Nicotine: Yes No Level of consumption: _____ Age at first use: _____
Caffeine: Yes No Level of consumption: _____ Age at first use: _____
How does your use affect your life? _____

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

Do wish to add smoking cessation as a part of your therapy? Yes No

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? _____

Please list your desired outcome for therapy:

_____

_____

_____

Mental Health Screeners

		Not at all	Several Days	More than half the days	Nearly every day	
	Mood:					
1	Little interest or pleasure in doing things	0	1	2	3	
2	Feeling down, depressed, or hopeless	0	1	2	3	
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3	
4	Feeling tired or having little energy	0	1	2	3	
5	Poor appetite or overeating	0	1	2	3	
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3	
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	
9	Thoughts that you would be better off dead or of hurting	0	1	2	3	
	Total PHQ:					
	Anxiety:					
10	Feeling nervous, anxious or on edge	0	1	2	3	
11	Not being able to stop or control worrying	0	1	2	3	
12	Worrying too much about different things	0	1	2	3	
13	Trouble relaxing	0	1	2	3	
14	Being so restless that it is hard to sit still	0	1	2	3	
15	Becoming easily annoyed or irritable	0	1	2	3	
16	Feeling afraid as if something awful might happen	0	1	2	3	
	Total GAD:					
	Chemical Use:					
17	Have you ever felt you should Cut down on your drinking?	No	Yes			
18	Have people Annoyed you by criticizing your drinking?	No	Yes			
19	Have you ever felt bad or Guilty about your drinking?	No	Yes			
20	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?	No	Yes			
	Total CAGE:					

	Functional Impairment:	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**
21	Standing for long periods such as 30 minutes?	0	1	2	3	4
22	Taking care of your household responsibilities?	0	1	2	3	4
23	Learning a new task, for example, learning how to get to a new place?	0	1	2	3	4
24	How much of a problem did you have joining in community activities (festivities, religious or other activities) in the same way as anyone else can?	0	1	2	3	4
25	How much have you been emotionally affected by your health problems?	0	1	2	3	4
26	Concentrating on doing something for 10 minutes?	0	1	2	3	4
27	Walking a long distance such as a kilometer [or equivalent]?	0	1	2	3	4
28	Washing your whole body?	0	1	2	3	4
29	Getting dressed?	0	1	2	3	4
30	Dealing with people you do not know?	0	1	2	3	4
31	Maintaining a friendship?	0	1	2	3	4
32	Completing your day-to-day work?	0	1	2	3	4

Total WHODAS (1, 2, 3, 4 or 5):