Client Information band Billing Consent

Therapist _____

Client Name_____Birth Date_____
Home Address_____
City, state, zip _____
(H) Phone_____(W) Phone_____(C) Phone _____
Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Sex: ☐Male ☐ Female ☐Other

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 an encryption service unless a request is made by the client to not do so. Please initial stating understanding of limited confidentiality while using electronic communications: _____

If we need to leave a message, which number is preferred? ☐ Home ☐ Work ☐ Cell
Emergency Contact_____ Phone_____
Referral by_____ Agreed Fee/co-pay: $ _____

For Minors Only:
Mother's Name_____Father's Name_____
Who has legal custody? ☐ Both Parents ☐ Mother ☐Father ☐Other _____
Who has physical custody? ☐Both Parents ☐ Mother ☐Father ☐Other_____
☐Full-time student ☐Part-time student ☐ Not attending school
Name of School:_____Grade: _____

Primary Insurance
Insured Birth Date_____
Primary Insured Name_____
Relationship to Insured_____
Insurance Company_____
Policy/ID# _____
Group#_____
Effective Date:_____Deductible:$ _____

Secondary Insurance
_____
_____
_____
_____
Group#_____
Effective Date:_____Deductible:$ _____

I hereby certify that the above statements are correct. I authorize Beacon Therapy Associates, PC to process claims made by services rendered. I authorize the release of any medical information necessary to process all claims. I also authorize benefits under claims submitted be 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.

Signed:_____ Date _____

All balances are due in full at the time of your appointment

Policies with a CO-PAY, DEDUCTIBLE or FEE FOR SERVICE require a credit card on file to use for fees not covered by insurance provider.
Card Holder Name_____Credit Card Number_____
Exp Date /_____CVV Code_____
I hereby give consent to charge my debit card or credit card listed above for any outstanding balance such as copays, deductibles, or fees my carrier determines payable by me. Charges will be made at the date of service for copays and monthly, after insurance processing for all other fees.
Signature_____Date_____

Office Use Only

Diagnosis_____Prior Authorization #_____#of allowed visits _____

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 notedhere:
   A. If I use insurance benefits, my therapist and Beacon Therapy Associates cannot guarantee confidentialityfrom the insurance company.
   B. If mytherapist 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 mytherapist 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 theauthorities.
   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 TherapyAssociation's clinicians in case consultation.
   G. I give mypermission 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 substanceabuse.

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 thetherapist 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_____ Client Birth Date_____

Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Gender: ☐Male ☐Female ☐Other Partner/Spouse's name _____

Children's name & ages_____

Employer: _____

Work Status ☐FT ☐PT ☐Retired ☐Unemployed ☐Student

Position_____ # of years at current employer: _____

Primary concern(s) that is pertaining to today's appointment (check all that apply)

☐Depression
☐Anxiety/Panic attacks
☐Addiction issues
☐Anger issues
☐Life transition issues
☐Behavior problems
☐Marital/Relationship issues
☐Avoidant behavior
☐Coping with chronic pain or health condition
☐Relationship discord
☐Low self-esteem
☐Emotional/Physical abuse
☐Coping/Grief
☐Other: _____

Symptoms/Impairments	No	Current Problem	Past Problem	Age at start
Addictive Behaviors				
Aggression				
Alcohol/drug addiction				
Anger				
Anxiety/Worry				
Attention Problems				
Bipolar Depression				
Depression				
Eating too much/little				
Emotional/Physical abuse				
Excessive worry				
Fatigue				
Fears/Phobias				
Hallucinations/Delusions				
Heart Palpitations				
Hopelessness				
Impulsivity				
Irritability				
Loneliness				
Low self-esteem				
Memory lapses				
Mood swings				
Obsessive/Compulsive behavior				
Panic attacks				
Paranoia				
People/Place avoidant				
Recurring thoughts				
Ruminating thought				
Self-harming				
Sexual dysfunction				
Sick/Injured often				
Sleep disturbance				
Stress issues				
Suicidal thoughts				
Trouble concentrating				
Underachievement				

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

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 Date of attempt_____

Check 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/still born
☐Diagnosis of major illness
☐Relationship discord
☐Relocation home/work
☐Witness to a crime/abuse/disaster
☐War time participation

Other traumas _____

If you have military experience: Military branch_____Years _____

Leisure/Recreational
Describe special areas of interest or hobbies: _____

How much time do you dedicated to special interests: ☐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:		Level of consumption:	Age at first use:
Alcohol:	☐ Yes ☐ No	_____	_____
*Street drugs	☐ Yes ☐ No	_____	_____ __
Nicotine:	☐ Yes ☐ No	_____	_____
Caffeine:	☐ Yes ☐ No	_____	_____

*If stated yes, please list which street drugs used: _____

_____

How does your use affect your life? _____

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 ☐ Notsure

If yes, please explain:

_____
_____
_____
_____

If you ever been given a mental health or substance related diagnosis, what was that diagnosis?

_____

Please tell us anything else that you feel we should know to better assist you in your therapy:

_____
_____
_____
_____
_____
_____

What is your desired outcome for therapy:

_____
_____
_____
_____
_____

Genogram

Mental Health Screeners (put X for the most appropriate response)

Mood	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**	
Little interest or pleasure in doing things					
Feeling down, depressed, or hopeless					
Trouble falling or staying asleep, or sleeping too much					
Feeling tired or having little energy					
Feeling bad about yourself, or that you are a failure or have let yourself or your family down					
Trouble concentrating on things, such as reading the newspaper or watching television					
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					
Thoughts that you would be better off dead or hurting					
OFFICE USE ONLY - TOTAL PHQ:					

Anxiety	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**	
Feeling nervous, anxious or on edge					
Not being able to stop or control worrying					
Worrying too much about different things					
Trouble relaxing					
Becoming easily annoyed or irritable Being so restless that it is hard to sit still					
Feeling afraid as if something awful might happen					
OFFICE USE ONLY - TOTAL GAD:					

Chemical Use	**No**	**Yes**	
Have you ever felt you should cut down on your drinking?			
Have people annoyed you by criticizing your drinking?			
Have you ever felt bad or guilty about your drinking?			
Have you ever felt you should cut down on your drinking?			
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener?)			
OFFICE USE ONLY - TOTAL CAGE:			

Functional Impairment	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Extreme difficulty**	
Standing for long periods such as 30 minutes?						
Taking care of your household responsibilities?						
Learning a new task, for example, learning how to get to a new place?						
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?						
How much have you been emotionally by your health problems?						
Concentrating on doing something for 10 minutes?						
Walking a long distance such as a kilometer (or equivalent)?						
Washing your whole body?						
Getting dressed?						
Dealing with people you do not know?						
Maintaining a friendship?						
Completing your day-to-day work?						
OFFICE USE ONLY - TOTAL:						