Client Information and Billing Consent

Therapist: _____

Client Name: _____ Birth Date: / /
Address: _____ Gender: _____
City, state, zip: _____ Marital Status: _____
(H) Phone: _____ (W) Phone: _____ (C) Phone: _____

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 should we use? _____
Emergency Contact: _____ Phone: _____
Referral by: _____ Agreed Fee/co-pay: _____

For Minors Only: Parent/Guardian Names: _____
Who has legal custody? _____ Physical Custody? _____

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

Consent for Services to Minor Child

By law, on-going counseling services may not be provided to minors without the informed consent of parents or legal guardians. Parents and legal guardians have the right to be kept informed as to what takes place in therapy. *

I/We_____D.O.B. _____

_____ D.O.B. _____

the parent/guardian(s) of_____D.O.B. _____

authorize therapist (s),_____to provide counseling services to

minor child (named above) beginning on the_____day of_____,_____for the

purpose of individual therapy concerning:_____.

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of parent/legal guardian Date

_____ _____
Signature of client Signature of Counselor

*

- These rights may be waived when a minor's life or health is believed to be at risk; the minor is emancipated, married or has borne a child; or when in need of services relating to pregnancy, VD or substance abuse.
- A child is considered a minor in the state of Minnesota until they have both reached the age of 18 and graduated high school/GED, but no later than the age of 20.
- If parents are legally married or have joint legal custody, then only one parent needs to sign the consent.

MINOR PERSONAL HISTORY FORM

Client name:_____ Date of birth: _____

Gender:_____ School: _____Grade: _____

Parents:_____and _____

Are parents still married?_____If no, who has legal custody: _____

If no, describe the physical custody arrangement: _____

Employer:_____Position at employer: _____

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

Addiction issues		Behavior problems		Family issues		Problems with food	
Anger issues		Coping/Grief		Life transition issues		Relationship discord	
Anxiety/Panic attacks		Depression		Low self-esteem		Sexual/Gender issues	
Avoidance Behavior		Emotional/Physical abuse		OCD		Work/School issues	

Symptoms/Impairments	No	Current Problem	Past Problem	Age at start	Briefly describe how the symptoms identified impact you at home, work, school or socially:
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					

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 that you have experienced:

Abortion	
Accident, fire, disaster	
Adoption	
Arrest or legal matter	
Diagnosis of major illness	
Miscarriage/still born	
Physical/emotional abuse	
Recent death/birth	
Relationship discord	
Relocation home/work	
Separation or divorce	
Sexual abuse or assault	
Thoughts/acts of hurting self	
Thoughts/acts of violence	
War time participation	
Witness to crime/abuse/disaster	

Other traumas _____

Leisure/Recreational:
Describe special areas of interest or hobbies:
_____
How much time do you dedicated to special interests?
_____

Strengths/Weaknesses:
Strengths you feel you have:
_____
Weaknesses you feel you have:
_____

Medical/Physical Health:
Primary Care Physician/Clinic: _____ Phone: _____

	Yes	No	Guardian initials:
Do you give consent for your therapist to contact your doctor regarding your treatment here?			

Current health conditions:
_____

Recent health changes:
_____
Current prescribed medications/dosages:
_____

Chemical Use History:	Level of consumption:	Age at first use:
Alcohol:		
*Street drugs:		
*please list which street drugs used:		
Caffeine:		
Nicotine:		

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

Counseling/treatment History:	Date	Location
Outpatient Counseling/Psychiatric Care:		
Drug/alcohol treatment:		
Psychiatric hospitalizations:		

Is there a family history of mental illness or substance abuse?		No		Yes

If yes, please explain:

_____

Have you ever been given a mental health diagnosis?		No		Yes

If yes, what was 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 ("x" box with 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:						