Bright Path
Counseling Center

"Bright Path is the Right Path"

Professional • Heartfelt • Confidential

(*Office Use*) DX:_____

APPLICATION

Name of Therapist _____ Date _____

Your Name _____ SS # _____

Maiden/Birth Name _____ Date of Birth _____ Age _____

Address _____ Zip _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

E-mail: _____ Marital Status (M/S) _____ Highest Grade Completed _____

Place of Employment: _____ Occupation: _____

Referred by: _____ Previous Counseling (Yes/No): _____

Responsible Party (must be completed if client is a minor)

Name: _____ Social Security Number: _____ - ____ - _____

Relationship to Patient: (please check): ( )parent, or ( )legal guardian Date of Birth: _____

Street Address: _____ Home Number: _____

State and Zip Code _____ Cell Number: _____

PRIMARY INSURANCE INFORMATION: Plan Name: _____

Insured I.D. Number: _____ Group Number: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder ID Number: _____ Policy Holder Date of Birth: _____

SECONDARY INSURANCE INFORMATION: Plan Name: _____

Insured I.D. Number: _____ Group Number: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder ID Number: _____ Policy Holder Date of Birth: _____

I understand that I will be responsible for any deductible or remaining balance not payable by my insurance company at the time service was rendered. Further, I hereby give permission to Bright Path Counseling Center to verify my insurance coverage and to provide my insurance company with any information requested by them for the purpose of determining benefits.

Responsible Party Signature: _____ Date: _____

Witness: _____

Please Note: A No Show or Late Cancellation fee will be imposed if we are not notified of cancellations within 24 hours prior to any scheduled appointment!

___ ***Check here if you have been given copies of the program rules, regulations and you understand them.***

___ ***Please initial here that you have reviewed our HIPAA Policies***

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Financial Policy - *Please Read and Sign*

Welcome to Bright Path. We are committed to providing you with outstanding care and service during your treatment. We make every effort to assist with predetermining your insurance benefits prior to starting treatment. *However, please understand that payment for services is considered a necessary part of your treatment program.*

1. **PAYMENT: You are responsible for all fees at the time professional services are rendered to you.** We accept checks, cash, Visa, Master Card, and Discover cards. **You will be responsible for any deductible(s) and/or co-payments that are due. A finance fee of $15.00 will be charged to any balance over 30 days old. Thereafter, an additional $15 fee will be charged at 60 days and again at 90 days for a total of $45 in service fees. After 90 days, your account will be turned over to collection.** If your account is delinquent, counseling services will be interrupted until payment is received.

2. **URINE SCREENS**: For clients participating in our Alcohol/Substance Abuse Program, the lab we use for random urine screens is Medlab, Inc. **You will be required to pay a $20 fee to Bright Path to cover this service. We do not submit claims to insurance companies for urine screens.** If you would like to submit your own claim with your insurance for reimbursement, we can provide the necessary documentation.

3. **OUT-OF-NETWORK INSURANCE**: We do not file insurance claims for you if our office does not participate with your insurance carrier(s). However, our receipts are adequately itemized and coded for ease in filing for reimbursement with your carrier.

4. **DENIED CLAIMS**: We will submit insurance claims to our participating insurance companies. However, if your insurance company denies claims, **payment for services rendered is your financial responsibility.**

5. **PRE-AUTHORIZATION AND DEDUCTIBLES**: It is your responsibility to check with your insurance company before coming to our office to determine if you have a deductible and whether prior authorization is required for your insurance. **You are responsible for deductibles as well as insurance denials occasioned by failure to obtain preauthorization.**

6. **PAPERWORK RELEASE**: No paperwork can be released to outside parties without written consent unless your account is paid in full.

7. **LATE CANCELLATION AND NO-SHOW FEES**: It is our policy to charge a fee for unexcused cancellations or failure to show up to your appointment unless the appointment was canceled twenty-four (24) hours or more in advance. **These fees are posted in our front office.** Your insurance company **is not** responsible for such charges.

8. **RETURNED CHECK FEE**: There is a **$45.00** fee for checks that are returned due to insufficient funds.

9. **ATTORNEY FEES**: If we are required to engage the services of an attorney in order to collect any amount you owe us, you will be responsible for the reasonable attorney's fees and other collection expenses incurred.

If you have a balance due on your account from previous visits, please remit this balance in full before your appointment with your therapist.

Please sign below to indicate your acceptance of these terms.

Client's Signature _____ Date _____

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PATIENT RIGHTS

1. Each client has a right to an individually designed plan of service based on his or her individual needs in which the client has participated in developing, and which includes goals that the client has agreed to work towards.

2. Each client shall be free of any personal involvement with any facility staff member.

3. Each client has the right to considerate and respectful care.

4. Each client has the right to receive services from staff that is competent, caring, and of sufficient number to provide service absolutely.

5. Each client has the right to be treated in a way that recognizes and responds to his or her cultural identity and/or sexual orientation.

6. Each client has the right to know the client services coordinator responsible for coordinating his or her care and the name of any other person providing care to him or her.

7. No client shall be treated by a staff member known to be under the influence of alcohol or illicit drugs.

8. Each client has the right to obtain from his or her service coordinator, current information concerning his/her diagnosis and treatment in terms that he or she can understand.

9. Each client has the right to receive services in a physical environment that is safe, sanitary, reflective of human dignity, conducive to effective treatment, and which appropriately safeguards the privacy and confidentiality of client-staff interaction.

10. No treatment requiring the order of a physician shall be rendered to client except upon the prior written order of a physician, based upon a personal examination.

11. Each client has a right to examine and receive an explanation of his/her bill, regardless of the source of payment.

12. Each client may object to conditions at the facility, and has a right to reasonable, prompt response from the Clinical Director. Each client also has the right to complain to the Clinical Director, and obtain from the facility staff information about how such a complaint may be filed.

13. All treatment is voluntary. There may be legal, family, or employment consequences if treatment is refused or terminated early.

14. It is our policy to charge a client for any appointment scheduled, unless we have received 24-hour notice of cancellation. Please refer to our cancellation/no show policy and our financial policy for details. Thank You.

Signature: _____ Date: _____

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CANCELING APPOINTMENTS OR

NOT SHOWING UP FOR YOUR SCHEDULED APPOINTMENTS

Bright Path Counseling Center was created as a place to meet your counseling needs in a setting filled with respect, comfort, confidentiality, professionalism and personal caring. The main ingredient that makes this possible is the outstanding professional counselors and administrative staff that we have assembled for your needs.

With great respect, we honor your journey to healing by providing quality care in a timely fashion. We also have limited space and time. Therefore, every appointment set up for you is at a premium. We therefore appreciate your return of this respect by committing to meet your appointment time. We know that you will understand the need for us to uphold the following policies:

1. **Be On Time:** Try to arrive a few minutes before your appointment so that you have the full time for your session. Therapists need to conclude your session at the appropriate time so they can complete your paperwork and be ready for the next client for their scheduled time.

2. **Not Showing Up:** If you fail to be here for your appointment without notice, please remember that this time has already been committed to you and you will be **charged a No-Show Fee.**

3. **Cancellations Without 24-Hour Notice:** Appointment times cannot be filled with someone else without sufficient notice. Therefore, you are still responsible for that time slot and will be **charged a Late Cancellation Fee.**

4. **Recurring Missed Appointments: If you are an *established client* and you have two unexcused *appointments in a row or within a month*; this indicates that you are not committed to your counseling and therefore will be discharged from Bright Path Counseling Center.** At the discretion of the multi-disciplinary team, you will be eligible to "re-enter" counseling thirty days from the discharge date, as long as your account balance has been paid in full.

5. **Emergency Cancellations:** With a doctor's written report, a car mechanic's receipt, or other **proper documentation**, we will reschedule your appointment for the next available time that your therapist can offer and waive the Late Cancellation Fee. Excused cancellations will not affect your ability to remain in counseling.

6. **Severe Weather:** Severe weather warnings must be announced on public broadcasting systems or the Internet, in order for "weather" to be a valid reason for not showing up for your appointment or canceling in less than 24 hours from the scheduled time. **You must still call to cancel the appointment in order to avoid the missed appointment Fee.**

_____ Reviewed With Client

_____ Therapist Initials

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Background Information — Adult Format

Please provide the following information about yourself (if you are bringing your child to counseling, you will be given another form to fill out about your child). This information will help us better understand the situations you are experiencing. The information is confidential and will not be released without your written permission.

Name _____ **Today's Date** _____

SITUATIONS YOU ARE HAVING

Please use a checkmark (√) to indicate which of the following situations apply to you:

Depression	Parent-child conflict (self)
Suicidal thoughts	Parent-child conflict (spouse)
Suicidal actions	Marital – relationship issues
Anxiety / Fears / Worries	Brother / sister issues
Panic attacks	Blended family issues
Anger / Temper issues	Violence in family (actual or threatened)
Alcohol / Other drug abuse (self)	Communication issues
Alcohol / Other drug abuse (family)	Sexual dysfunction
Job / School situations / unemployed	Sexual abuse when younger
Legal issues	Physical abuse when younger
Death of a loved one	Compulsive gambling
Major losses / difficult changes	Eating disorder

ANY DIFFICULTIES WITH COPING?

Please use a checkmark (√) to indicate which of the following situations apply to you:

____ Sleep issues __ difficulty falling asleep __ waking up in the middle of the night __ waking up too early __ sleeping too much __ nightmares	____ Change in appetite __ gaining weight (____ pounds) __ losing weight (____ pounds) __ not hungry __ throwing up after eating __ feeling sick to my stomach
Moody or crying more than usual	Constipation or diarrhea
Feeling guilty, worthless, or hopeless	Difficulties concentrating
Fatigue / low energy	Difficulty remembering things
Hyper / too much energy	Withdrawing from others
Loss of interest in things	Repeated actions I can't stop
Disturbing thoughts I can't stop	Can't stop washing hands/body
People are out to get me	People are picking on me
Can't stop counting or checking things	**Other** (please specify below)

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MEDICAL HISTORY

*Please **circle** any of the following medical conditions that you have now or have had in the past:*

1. Chronic medical conditions / Serious illnesses (if none apply, circle **None**):

Asthma Diabetes Ulcers Migraines Epilepsy Seizures
Lupus Stroke Cancer Heart Condition Multiple Sclerosis
Headaches Previous head injury Thyroid Condition Gynecological Conditions

None **Other** _____

Any allergies or drug sensitivities? _____

2. Previous hospitalizations / surgeries

Date	Reason

3. List any previous suicide attempts (If none, write **None)**

When	What method

4. Current prescriptions / medications: _____

_____

5. Family history – any major health issues or drug and/or alcohol use:

_____

_____

PREVIOUS COUNSELING

Name of therapist or agency	Date and focus of sessions

In your family, has anyone ever been diagnosed and/or treated for the following:

__ Schizophrenia _____ __ Manic-Depressive Disorder _____

__ Major depression _____ __ Alcoholism _____

LIFESTYLE CHOICES

1. Smoking (how much?) _____
2. Alcohol use (how much, how often?) _____
3. Other drug use (which, how much?) _____
4. How much coffee/tea/Coke/Pepsi? _____
5. Have you had any legal charges? If so, complete form below (If none, write **None**):

Date	What charges?

6. Have you had any previous (or current) CPS involvement? Yes ___ No ___

7. What is the highest level of schooling you have completed? _____

8. Are there any guns or weapons in your house? _____

RELATIONSHIPS

Please use a checkmark (√) to indicate which of the following situations apply to you:

Too few friends	Enough friends
I talk to my friends about my problems	I don't talk to my friends about my problems
I am overly shy	I find it very difficult to open up to others
I make friends easily	I find it hard to keep friends
Others seem to be picking on me	No one really seems to understand me

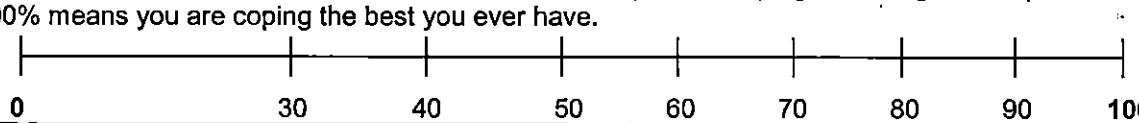
SOURCES OF STRESS

Please list the things/events/situations that are creating stress in your life at the present time (please include significant losses and changes in your life):

1.	4.
2.	5.
3.	6.

CURRENT FUNCTIONING

Place an "X" on the following scale to indicate how well you are coping with things at the present time. 100% means you are coping the best you ever have.



YOUR GOALS IN COUNSELING

Please list the goals you hope to achieve in counseling. (Be as specific as you can.)

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

HOW MANY SESSIONS DO YOU THINK YOU WILL NEED?

Please place a checkmark (√) in the answer that best describes your expectations:

__ 1-3 sessions __ 4-6 sessions __ 7-9 sessions __ 8-12 sessions

__ _____ (Please specify how many.)

WHAT DO YOU THINK OF THIS FORM?

__ Shouldn't be used __Okay __ Questions were too personal

__ Didn't really understand the questions __ Good way to gather needed information

EMERGENCY CONTACT RELEASE FORM

Please sign consent for a person you would like notified in the event of an emergency.

Your Name _____ Your Date of Birth _____

Permission is hereby given to **Bright Path Counseling Center** and its employees to obtain information from and/or release information to:

Name of Person to Contact: _____

For the purpose of:
( ) Emergency Contact Person's Phone Number :_____

Extent or nature of information to be disclosed:

*The only information that can be released is information relating to accident or injury.

PROHIBITION ON DISCLOSURE OF INFORMATION CONCERNING ALCOHOLISM CLIENT

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulation (42-CRD, part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as other wise permitted by such regulations, as well as Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. pts. 160 & 164. The general authorization for the release of medical or other information is NOT sufficient for this purpose. I understand that I may revoke this consent at any time by notifying the agency in writing, except to the extent that action has been taken in reliance on my consent. (Note: This pertains only to alcoholism clients.)

Bright Path Counseling Center is released from all legal responsibility that may arise from this fact.

I, the undersigned, have read the above and authorize the staff of the facility to disclose such information as herein contained.

Date _____

Signature _____ Witness_____

This authorization expires one year from its signing. A copy is as valid as the original document.

Note: Any information released through this form will be accompanied by Form A-400:
Prohibition on Redisclosure of Information Concerning Alcoholism Patient.

BACKGROUND
On May 5, 2007, the Governor signed a new law, known as "Jonathan's Law" (Chapter 24 of the Laws of 2007), which became effective immediately. This new law, stimulated by the tragic death of a 13-year old Jonathan Carey, while in residential care makes changes in the way in which certain notifications are made and information is shared, regarding incidents involving the health and safety of patients.

You have the right to refuse this request. If you choose not to identify an emergency contact please sign below.

I understand by signing below I am refusing to name and give consent for a person to be notified in the event of accident or injury.

_____ _____
Client Date

_____ _____
Witness Date

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HIPAA

We at **Bright Path Counseling Center** are committed to safeguarding your **personal health information** (PHI). PHI is any information that can identify you as an individual **and** your past, present, or future medical and/or mental health condition.

This notice, in addition to telling you about the ways that we may use and disclose your medical information, also describes your rights, and the obligations that we have regarding the use and disclosure of medical information. Federal and state law require us to:

1) Make sure your PHI is kept private;
2) Give you notice of our legal duties and privacy practices with respect to your PHI; and
3) Follow the terms of the notice that is currently in effect.

Therefore, we will release your PHI only under the following circumstances:

1) When you give us written consent to do so.
2) When we are required by a specific court order to do so.

We will make changes in our privacy policy only as required by law. We will notify you in advance of those changes, in writing.

Privacy Compliance Officer:

The privacy compliance officer at **Bright Path** is **Bonnie Merkel**. Please address all complaints and/or requests for amendments to your PHI, and/or requests for copies of your PHI, to Bonnie Merkel.

Nonpublic Personal Information:

Nonpublic Personal Information is the information you give your insurance company when you sign up for benefits, such as name, address, Social Security number, date of birth, etc. We will only provide that information to your insurance company (or companies) in order to verify benefits and obtain payment for services rendered. We will not disclose that information to any other entity unless 1) required to do so by court order; or 2) you give us written consent to do so.

Psychotherapy notes:

Psychotherapy notes have special protection under the new HIPAA regulations:

1) They can only be released under a court order that shows the necessity of their release.
2) Barring a court order, they can only be released **when the therapist determines the release to be in your best interest.**
3) Psychotherapy notes will never be released without your consent, but they may not be released to an entity you authorize, if your therapist deems it to be detrimental to your treatment.
4) Your insurance company may no longer pre-condition payment of benefits on the release of psychotherapy notes.

Please note the following restrictions, and please do not ask us to violate them:

1) We cannot acknowledge your presence and/or treatment at Bright Path Counseling Center without your written consent, or a court order. We cannot do so for family members, friends, employers, lawyers, government agencies, etc. If you want any of the above to act on your behalf, including the setting or changing of appointments, you must sign a written authorization.

2) We cannot complete any paperwork for any local, state or federal agency, for any purpose, without your consent. We cannot provide any PHI to any insurance agency other than the one(s) reimbursing us for authorized care without your specific written authorization.

Individual Rights:

1) You have the right to inspect and/or copy your PHI, when your therapist determines that such an inspection and/or copying would not be detrimental to your physical health or personal safety, and would not cause harm to another individual. **This right does not extend to psychotherapy notes, as noted above.**
2) You have a right, under law, to request an accounting of the instances in which we disclosed your PHI, other than disclosures made for the purpose of treatment, payment, and disclosures made with your authorization. However, at **Bright Path Counseling Center**, we do not make any disclosures outside of those parameters.
3) You have the right to request additional restrictions on our use and disclosure of your PHI. However, the law will not permit us to honor those additional restrictions if they keep us from receiving payment for services rendered.

Amendment:

You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We will deny your request if we did not create the information you want amended, or if we determine the current information is accurate. If we accept your request, we will make a reasonable effort to notify others, including people or organizations you name in your written request, and will include the changes in all future disclosures of your PHI. If we deny your request, we will provide a written explanation. You may then respond with a written statement of disagreement that will be attached to the information you want amended. You may contact Bonnie Merkel for a form to complete and return to us.

Safeguards:

We employ the following safeguards to insure the privacy of your PHI:

- All of our employees sign an agreement to follow our Confidentiality guidelines.
- All of our employees complete privacy training.
- We have implemented sanctions for the violation of privacy practices, up to and including loss of employment.
- We have a privacy coordinator who detects and prevents security breaches.
- All computer systems that contain personal information have security protection.
- All physical files are kept in a double-locked storage container.
- All of our therapy offices conform to state and federal privacy regulations with regards to construction and use.

Questions and Complaints:

If you want more information about our privacy practices, or feel that your privacy rights have been violated, please contact our privacy officer. You may also submit a written complaint to the Department of Health and Human Services. We will provide you with the address to file your complaint with HHS upon request.

Please contact: Bonnie Merkel
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Phone: 315-458-0919 Fax: 315-458-0954