Bright Path
Counseling Center

"Bright Path is the Right Path"

Professional • Heartfelt • Confidential

ADULT APPLICATION

APPLICATION

Name of Therapist _____ Date _____

Your Name _____ SS # _____

Maiden/Birth Name _____ Date of Birth _____ Age _____

Address _____ Zip _____

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

Marital Status _____ Highest Grade Completed _____

Place of Employment: _____ Occupation: _____

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

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.

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 on the previous business day or more in advance. For instance, Monday appointments must be canceled on Friday!

_____ Please initial here that you have reviewed our HIPAA Policies

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Financial Policy

Welcome to our office. We are committed to providing you with quality health care and treatment.
Please understand that payment of your bill is considered an integral part of your health care and treatment.
The following is a statement of our **Financial Policy**.

1. Before you see a therapist, our office manager must receive all the required administrative forms completely filled in and signed.

2. **You are responsible for all fees at the time professional services are rendered to you.** We accept check, cash, money orders, Visa, Master Card, and Discover card. A **finance fee of $5.00 will be charged to any balance over 30 days old.** If your account is delinquent, counseling services will be interrupted until payment is received.

3. If our counselor chooses to perform urine screens, the lab we use for urine screens is Med Lab, Inc. **You will be required to pay a $20 fee to Bright Path for this service unless covered by Medicaid**. We do not submit claims to other insurance companies for urine screens. If you would like to submit your own claim, we will be happy to give you the necessary documentation to do so.

4. In the event that we are unable to file your insurance claim for any reason, our receipts are adequately itemized and coded for ease in filing for reimbursement with your carrier by yourself.

5. We will submit all claims to participating insurance companies. You will be responsible for any deductible(s) and/or co-payments that are due at the time of service. **If for any reason claims are denied by your insurance company, payment for services rendered are still your responsibility.**

6. Although we do everything we can to predetermine your insurance benefits and obtain prior authorizations where necessary, it is still your responsibility to check with your insurance company to ascertain your insurance coverage and to get any necessary prior authorization or physician referral. **You are responsible for any denial occasioned by failure to do so.**

7. No paperwork will be released to anyone unless your account is paid in full.

8. It is our policy to charge a **fee for cancellations or failure to keep your appointment** unless appointments are canceled **twenty-four (24) hours** of the previous business day or more in advance. For instance, Monday appointments must be canceled on Friday. Your insurance company **is not** responsible for such charges.

9. There is a **$35.00 fee for checks that are returned** for insufficient funds.

10. 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 today from previous visits, please remit this balance in full before you see the therapist today.

Please sign below to indicate your acceptance of these terms.

_____ _____

Client's Signature Date

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Patient/Client 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 which are competent and caring.

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

6. Each client has the right to know the counselor 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 who is known to be under the influence of alcohol or illicit drugs.

8. Each client has the right to obtain from his or her counselor 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. Each client has a right to examine and receive an explanation of his/her bill, regardless of the source of payment.

11. Each client may object to conditions at the facility and has a right to reasonable, prompt response from either the Practice Manager or 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.

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

13. It is our policy to charge a client for any unused service scheduled unless we have received 24-hour notice of cancellation. Please refer to our cancellation/no show policy and our financial policy for details

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 superior counseling 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 have limited space and time, therefore, every appointment time set for you is at a premium.
We appreciate your returning this respect by committing to be here at your appointment time.
We know you will understand the need for us to uphold the following policies:

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 proper closure to your session.

Not Showing Up: If you fail to be here for your appointment, please remember that **this time has already been committed to you** so you will be responsible to pay a **No-Show Fee, regardless of your insurance carrier**.

Cancellations Without 24-Hour Notice: Your appointment times cannot be filled with another client without sufficient notice. Therefore, you are still responsible for that time slot and will be charged a **Late Cancellation Fee regardless of your insurance carrier**. Appointments must be canceled **twenty-four (24) hours** of the previous business day or more in advance. For instance, Monday appointments must be canceled on Friday.

Recurring Missed Appointments: If you are an *established client* and you miss two appointments in a row, it shows that you are probably not committed to your counseling. Therefore, you may be discharged or placed on a clinical pause. At the discretion of the multi-disciplinary team, you will be eligible to "re-enter" the program thirty days from the discharge or pause date provided your account balance has been paid in full.

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 a missed appointment Fee.

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 less than 24 hours in advance. You must still call to cancel the appointment in order to avoid the missed appointment Fee. Please take advantage of our telehealth video and phone sessions during inclement weather!

_____
Reviewed With Client - Therapist Initials

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NO SHOW & LATE CANCEL CONTRACT

Bright Path schedules your counselor for one hour of time based on the appointment you have made. That is a commitment!

Bright Path charges a fee for appointments when the client either fails to show up to their appointment (No Show) or cancels their appointment less than 24 hours of the scheduled time (Late Cancel).

These fees are *not reimbursed by insurance companies* and are therefore accepted as part of this contract as a *Non-covered Service.*

These fees cover reservation of your counselor's contracted time for counseling services that could not be rendered due to your failure to show and the resulting inability to otherwise provide services to other clients during that scheduled time due to lack of adequate notification.

Bright Path's Fees are as follows:

No Show Fee: $45.00

Late Cancel Fee: $25.00

Further, Bright Path reserves the right to:

1. Pause any additional appointments for clients who have failed to show for their appointments (No Show).

2. Pause any additional appointments for clients who have either No-Showed or who have Late Canceled twice within a 30-day window.

3. Pause any additional appointments for failure to pay fees associated with this contract.

It is at the discretion of Bright Path Counseling Center when and if additional appointments can be made at our facility based on the poor attendance record or inappropriate behavior of the client at Bright Path.

Bright Path does accept Emergency Cancellations and Severe Weather as waivers for these fees as outlined in our application. Written documentation for Emergency Cancellations is expected.

Client Name (Please Print): _____

Parent/Legal Guardian Name (Please Print):_____

Client signature or Parent/Legal Guardian: _____

Date: _____

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Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by

_____.

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____
Signature of Patient or Parent/Guardian Date

_____
Printed Name

_____
Relationship to Patient (if applicable)

_____ _____
Witness Signature Date

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ADULT CLIENT 6/2020

Background Information

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.

(Please Print)

Name _____ **DOB** _____

Today's Date _____

SITUATIONS YOU ARE HAVING

√	Check all that apply	√	Check all that apply
	Depression		Parent-child conflict (self)
	Suicidal thoughts		Parent-child conflict (spouse)
	Suicidal actions		Marital – relationship issues
	Anxiety / Fears / Worries/ Moody		Brother / sister issues
	Panic attacks		Blended family issues
	Communication issues		Nicotine abuse by family member
	Anger/ Temper Issues		Eating disorder
	Sexual dysfunction		Compulsive gambling
	Alcohol / Other drug abuse (family)		Job / School situations / unemployed
	Alcohol / Other drug abuse (self)		Legal issues
			Death of a loved one

TRAUMA HISTORY

	Violence in Family/Physical Abuse: Current **Actual** *or* **Threatened** - *Circle one* Who is the **Victim**:_____**Abuser**:_____		**Violence in Family/Physical Abuse: Past** **Actual** *or* **Threatened** - *Circle one* Who is the **Victim**:_____**Abuser**:_____
	Current Sexual abuse: **Victim**:_____**Abuser**:_____		**Past Sexual abuse**: Age: **Victim**:_____**Abuser**:_____
	Other Current Abuse - Describe:		**Other Past Abuse - Describe:**
	Major losses: Please List		**Difficult changes: Please List**

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DIFFICULTIES WITH COPING

√	Check all that apply	√	Check all that apply
	____ 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)

MEDICAL HISTORY: ***SELF***

Name of Primary Care Physician :_____ OK to contact? Y or N (circle)

Contact Info for PCP: _____

*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	Liver Damage	Kidney
Lupus	Stroke	Cancer	Epilepsy/Seizures	Heart
Headaches	Head Injury	Thyroid	Dementia	Addiction
Hepatitis	Hypertension	Chronic Fatigue	Multiple Sclerosis	Depression
Ulcers	Cancer	Migraines	OB-GYN	Anxiety

None Other _____

Any allergies or drug sensitivities? _____

2. Previous hospitalizations / surgeries

Date	Reason

3. List any previous suicide attempts If none, circle ⇒ None

When	What method

4. **Current prescriptions / medications:** _____

_____

5. **Physical Exam in last year? ___Yes ___No Recommended? ___Yes ___No**

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MEDICAL HISTORY: *FAMILY*

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

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

Asthma	Diabetes	Ulcers	Liver Damage	Kidney
Lupus	Stroke	Cancer	Epilepsy/Seizures	Heart
Headaches	Head Injury	Thyroid	Dementia	Addiction
Hepatitis	Hypertension	Chronic Fatigue	Multiple Sclerosis	Depression
Ulcers	Cancer	Migraines	OB-GYN	Anxiety

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

__ Schizophrenia _____ __ Manic-Depressive Disorder _____

__ Major depression _____ __ Alcoholism _____

__Drug Abuse_____

Other medical: _____

PREVIOUS COUNSELING FOR SELF

Name of therapist or agency	Date and focus of sessions

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. Spiritual Identification _____
6. Cultural Concerns _____
7. Have you had any legal charges? If so, complete form below (If none, write **None**):

Date	What charges?

8. Have you had any previous (or current) CPS involvement? Yes ___ No ___
9. What is the highest level of schooling you have completed? _____
10. Are there any guns or weapons in your house? _____

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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

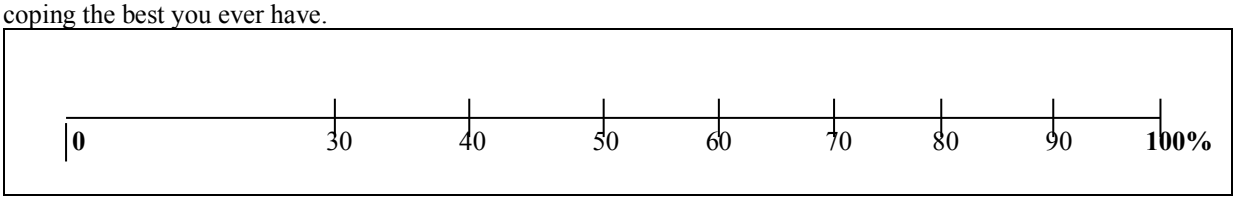
SOURCES OF STRESS

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.)

Therapist Review: _____(Initials) _____(Date)

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AUTHORIZATION

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

_____

(Name of organization or individual)

Regarding: _____ Date of Birth: _____

For the purpose of:

( ) Coordination of treatment
( ) Insurance reimbursement
( ) Legal concerns
( ) Collateral contact
( ) Referral out
( ) Probation requirements
( ) Contact referral source
( ) Other: _____

Extent or nature of information to be disclosed:

Yes	No		Yes	No	
( )	( )	Psychosocial evaluation	( )	( )	Urine drug Screen
( )	( )	Alcohol/drug evaluation	( )	( )	Breathalyzer results
( )	( )	Participation in treatment	( )	( )	Psychological testing
( )	( )	Progress in treatment	( )	( )	Discharge Summary
( )	( )	Recommendations	( )	( )	Other: _____

_____

I understand that I may revoke this consent at any time by notifying the agency in writing, except to the extent that action has already been taken in reliance on my consent. 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.

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EMERGENCY CONTACT RELEASE FORM

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

(Please print)

Your Full 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: _____

Emergency Contact Person's Phone Number: _____

For the purpose of releasing information relating to an accident, injury or medical emergency.

Note that in an event of an emergency no information protected under Health Insurance Portability and Accountability Act of 1996 ("HIPPA") 45 C.F.R. pts. 160 & 164 will be disclosed to your emergency contact. I understand that I may revoke this consent at any time by notifying the agency in writing, except to the extent that action has already been taken in reliance on my consent. 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.

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 also 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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