Bright Path Counseling Center

"Bright Path is the Right Path"

Professional • Heartfelt • Confidential

ADULT INTAKE FORMS

Name of Therapist_____ Date _____

Client Name _____

Maiden/Birth Name _____ Date of Birth _____

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.

_____ _____

Client's Signature Date

7266 Buckley Road • N. Syracuse, NY 13212 • (315) 458-0919 • Fax: (315) 458-0954 • www.brightpathcenter.com

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 **forty-eight (48) hours** or more in advance. For instance, Monday appointments must be canceled on Thursday. Our business hours are Monday – Friday, Saturday/Sunday are not counted as business days. 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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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 48-hour notice of cancellation. Please refer to our cancellation/no show policy and our financial policy for details

_____ _____

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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 48-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 **forty-eight (48) hours** or more in advance. For instance, Monday appointments must be canceled on Thursday. Our business hours are Monday – Friday, Saturday/Sunday are not counted as business days.

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.

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NO SHOW & LATE CANCEL CONTRACT

Bright Path schedules your counselor for one hour of time basedon 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 48 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.

Client Name (Please Print): _____

_____ _____

Client's Signature Date

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INFORMED CONSENT FOR TREATMENT

I give consent for evaluation and treatment to be provided for myself/my child by any counselor associated with Bright Path Counseling Center.

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 withtreatment 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 opportunityto 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.

Client Name (Please Print): _____

_____ _____

Client's Signature Date

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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.

Today's Date: _____

Client Name: _____ Date of Birth: _____

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_____** Who is the **Victim**: **Abuser**:	**Violence in Family/Physical Abuse: Past** **Actual_____** *or* **Threatened_____** 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

Name of Primary Care Physician:_____OK to contact? Y___ or N___

Contact Info for PCP: _____

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

1. Chronic medical conditions / Serious illnesses (check all that apply):

	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

Other: _____

Any Allergies or drug sensitivities?_____

2. Previous hospitalizations / surgeries

Date	Reason

3. List any previous suicide attempts

When	What method

4. Current prescriptions / medications: _____

_____

5. Physical Exam in last year? _____No _____Yes Date:_____

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MEDICAL HISTORY: ***FAMILY***

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

Chronic medical conditions / Serious illnesses:

	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, please leave blank):

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

Using the following scale to determine how well you are coping with things at the present time.
100% means you are coping the best you ever have.

Please indicate what number represents your current coping ability: _____

_____

0 10 20 30 40 50 60 70 80 90 **100**

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

If you believe you will need more than listed above, please specify how many: _____

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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 (Clients Name): _____ 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

_____ _____
Client's Signature or Parent/Guardian Date

_____ _____
Printed Name of Parent/Guardian (if applicable) Relationship to Client (if applicable)

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.

Clients Name _____ Clients 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.

_____ _____

Client's Signature Date

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's Signature Date

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HIPAA POLICY

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 **Practice Manager**. Please address all complaints and/orrequests for amendments to your PHI, and/or requests for copies of your PHI, to Practice Manager.

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 employee's 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: Bright Path Counseling Center
7266 Buckley Road
North Syracuse NY 13212
Phone: 315-458-0919 Fax: 315-458-0954

Client Name (Please Print): _____

_____ _____

Client's Signature Date