

**BRIGHTER TOMORROWS CONSULTING, LLC**  
**SHANNON M. ELLER, LPC, LMFT, RPT, CPCS**  
1815 North Expressway, Suite B  
Griffin, Ga. 30223  
Phone: 770-468-7424 / Fax: 770-412-1087

**CLIENT INFORMATION**

Date: \_\_\_\_\_

Client Name: \_\_\_\_\_  
(Last) (First) (Middle)

Legal Guardian Name (if applicable): \_\_\_\_\_

Client Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ S.S.N.: \_\_\_\_\_

Employed [Y/N]: \_\_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact (person not living w/ you): \_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship w/ you or client) (Contact Number)

Medical/Physical Problems: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Known allergies to medications: \_\_\_\_\_

How did you find out about us (Brighter Tomorrows Consulting, LLC)? \_\_\_\_\_

Who is responsible for fee payment (co-payment) for today's visit us? \_\_\_\_\_

**I understand that when I schedule an appointment, I am reserving 45 minutes of the therapist's time. If I do not show for my scheduled appointment or give less than a 24 hour notice to cancel my appointment, there will be a \$25.00 administrative fee for the appointment time. This \$25.00 administrative fee will be required in order to cover the reserved appointment time, staff, office time, and other costs that are not reimbursable.**

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**Mental Health/ Substance Abuse Family History:** \_\_\_\_\_

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**Prior Mental Health/Substance Abuse Treatment (use the space below as needed)**

<b>Month/Year:</b>	<b>Provider:</b>	<b>Outcome:</b>

**Who referred you to your provider?** \_\_\_\_\_

**If your referral source is another health care professional, may we contact him/her to coordinate your cost? Yes / No**

**May we contact your primary care physician (PCP) to coordinate your care? Yes / No**

**PCP Name:** \_\_\_\_\_

**Therapist Name:** \_\_\_\_\_

**First Appointment Date:** \_\_\_\_\_

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**CLIENT/PATIENT INSURANCE INFORMATION SHEET**

**Client Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Phone: (Home)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_ **(Work)** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Marital Status:** Married \_\_\_\_ Single \_\_\_\_ Divorced \_\_\_\_ **Gender:** Male \_\_\_\_ Female \_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_

**Insured's Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Client's Relationship to Insured:** Self \_\_\_\_ Spouse \_\_\_\_ Child \_\_\_\_ Other \_\_\_\_

**Insured's Date of Birth:** \_\_\_\_\_ **Insured's Social Security #:** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Insurance Carrier:** \_\_\_\_\_

**Insurance Phone #:** \_\_\_\_\_

**Insurance ID#:** \_\_\_\_\_

**AUTHORIZATION INFORMATION: (Please enclose a copy of authorization letter if available)**

**1. Number of Sessions:** \_\_\_\_\_

**2. Start and End Dates:** \_\_\_\_\_

**3. Authorization #:** \_\_\_\_\_

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**INFORMED CONSENT TO TREATMENT**

**Payment, Fees, and Expectations:**

I hereby consent to my provider at Brighter Tomorrows Consulting, LLC (hereinafter referred to as BTC) to treat me for counseling and psychotherapy. The initial session fee is \$150.00 and \$125.00 for subsequent appointments. In addition to appointments, I may be charged for other professional services that I require such as report writing, filling out forms, telephone conversations longer than 10 minutes, summaries, and any other services that I may require. Psychotherapy sessions are generally 45 minutes in length and may be scheduled at varying time intervals including weekly, bi-weekly, or monthly. If I cannot make my appointment, I agree to notify BTC at least 24 hours in advance, or as early as feasible, prior to the scheduled appointment time. In order to avoid late charges for missed appointments, appointments must be canceled at least 24 hours in advance. There will be a \$25.00 administrative fee for all appointments not cancelled within the 24 hour notice in order to cover staff and administrative costs. Fees must be paid by the next scheduled appointment. My insurance plan will not cover these charges. I understand that if I have three late cancellations and/or 2 no shows, therapy may be terminated. If I become involved in litigation, in which BTC's participation is required, I will be expected to pay for the professional time required. Due to the complexity and difficulty of legal involvement, fees for preparation and attendance at any legal proceeding are \$150.00 an hour. By initialing this paragraph, I am indicating my understanding of these payment policies, fees, and expectations.

\_\_\_\_\_  
Client Initials (above)

**Confidentiality:**

I understand that information obtained during the course of treatment will not be released without consent, except in the case of emergency or as required by law. I understand that confidentiality is waived in the following circumstances: (1) If a client becomes a danger to self or others, (2) if session records are subpoenaed by court of law, (3) in case of physical or sexual abuse of minors, the elderly, disabled, or incompetent others. I also authorize BTC to release any and all information regarding diagnosis, treatment, and prognosis with respect to any mental condition and / or treatment to my insurance company (s) or its legal representative as indicated. Any such disclosure shall be limited to information that is reasonably necessary for the discharge of legal and contractual obligation of the insurance company (s). I understand the information obtained by use of this authorization will be used by the insurance company (s) to determine eligibility benefits under existing policy. In the event that BTC experiences a breach in security, we will contact clients and law enforcement.



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**Notice and Agreement of Legal Issues,  
c/o Brighter Tomorrows Consulting, LLC**

Legal issues in the clinical relationship can include, but are not limited to, the following:  
*Court room procedures, depositions, testimonies, clinical summaries, and court appearances*

**Disclaimer:** Brighter Tomorrows Consulting, LLC, hereinafter referred to as BTC, understands that there are certain situations that require clients to become involved in legal proceedings. Such legal proceedings can include, but are not limited to: criminal hearings/trials, drug court, mental health court, custody issues, divorce, visitation rights, and DFCS referrals. BTC is willing to cooperate with the client and other parties upon the following stipulations:

1. \_\_\_\_\_ BTC is willing to provide a comprehensive, clinical summary detailing assessments, diagnoses, session notes, treatment plans, and clinical progress. An adequate and reliable summary requires a *minimum* of six (6) sessions, at standard industry duration and at standard rate, in order to complete a comprehensive, clinical summary. The fee for the clinical summary, which does not include the fee for the minimum six (6) sessions, is one hundred fifty and <sup>00</sup>/<sub>100</sub> (\$150.00) dollars per clinical summary.
2. \_\_\_\_\_ BTC is willing to appear in court as a witness on behalf of the client upon the following stipulations:
  - BTC is *requested* to appear in court *without being* subpoenaed.
  - Receiving a subpoena to appear in court will be understood as a change of relationship between the client and the counselor. The relationship will change from a *clinical* relationship to a *legal* relationship. This change may result in termination of the client from the practice of BTC due to the broken clinical relationship.
3. \_\_\_\_\_ If BTC agrees to testify as a witness, expert or otherwise, on the client's behalf, BTC would request to be allowed to stay on site at the practice *and* be given a one-hour notice (or other reasonable time necessary to appear depending on location of the courthouse) prior to being called as a witness in court or any other legal proceedings. The client understands that there is a fee of one hundred fifty and <sup>00</sup>/<sub>100</sub> (\$150.00) dollars charged, per hour, in order to reimburse BTC for loss of clinical time during court or any other legal proceedings. This fee is *not reimbursable* by insurance and will be paid by the client *prior* to appearing in court or any other involvement of legal proceedings.

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**FINANCIAL POLICY**

Thank you for choosing Brighter Tomorrows Consulting, LLC, hereinafter referred to as BTC. We are committed to providing you with the best available counseling and psychotherapeutic care. In our ongoing process to make sure all your needs are met, our counseling staff will be available to discuss our fees and this policy with you. The services you have elected to participate in imply a financial responsibility on your part.

Payments for all services will be due at the time services are rendered. In order to better serve you, we accept cash, check, Visa, and MasterCard. As a courtesy to you, we will verify your coverage and bill your insurance carrier on your behalf; however, you are ultimately responsible for the entire bill. As the responsible party, please understand:

**(PLEASE INITIAL THE FOLLOWING)**

\_\_\_\_\_ Your insurance policy is a contract between you, your employer (if applicable), and your insurance provider. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and “usual” and “customary” charges. As your medical provider, we will only supply factual information to facilitate claims processing.

\_\_\_\_\_ I understand that I may have an insurance plan that restricts my therapy, either by units or by payable dollar amount, and that it is my financial responsibility for the differences between services covered by my policy and the actual services provided.

\_\_\_\_\_ I understand that BTC does not participate with or file claims to Medicare. However, we **DO ACCEPT Medicaid CMOS: Cenpatico, Amerigroup, and WellCare.**

\_\_\_\_\_ I understand that if I should incur a balance that I am unable to pay within one billing cycle, that I am required to contact Shannon M. Eller at Brighter Tomorrows Consulting, LLC to set up a payment plan.

\_\_\_\_\_ Returned checks and unpaid balances may be subject to collection placement and collection fees. I will be responsible for all costs of collecting monies owed including processing fees.

We understand financial problems may affect timely payment. We encourage you to communicate any such problems so that we may assist you in keeping your account in good standing.

\_\_\_\_\_  
Client's Name (Print):

\_\_\_\_\_  
Client's Parent/Guardian Signature:

\_\_\_\_\_  
Relationship to Client:

\_\_\_\_\_  
Date:

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**HIPAA NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.**

**Summary:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. As a client, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communication.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this Notice.
7. The right to file a complaint if you feel your privacy has been violated.

We want to assure you that your medical/protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of Brighter Tomorrows Consulting, LLC's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person named as the Privacy Officer. I further understand Brighter Tomorrows Consulting, LLC will offer updates to me regarding this NOTICE OF PRIVACY PRACTICES, should it be amended, modified, or changed in anyway.

\_\_\_\_\_  
Patient or Representative Name: (Please Print)

\_\_\_\_\_  
Patient or Representative Signature: (Please Print)

\_\_\_\_\_  
Date:

\_\_\_\_\_ Patient Refused to Sign \_\_\_\_\_ Patient was unable to sign because: \_\_\_\_\_

Documented By: \_\_\_\_\_



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**AUTHORIZED PATIENT NOTIFICATION LIST**

**(Required of HIPAA) Health Insurance Portability and Accountability Act**

**I authorize all Brighter Tomorrows Consulting, LLC employees and / or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my care. This can include appointments and any other pertinent information pertaining to my care with the following designated people:**

_____	_____
_____	_____
_____	_____
_____	_____

**This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with written notification. You will need to state who you would like to have removed and/or added to the Authorized Notification List.**

\_\_\_\_\_  
**Client/Other Person Authorized To Sign:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Relation to Above Signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Witness:**

\_\_\_\_\_  
**Date:**

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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Please complete this authorization by printing legibly. Please sign and date.

I authorize and request the disclosure of protected information from:

\_\_\_\_\_

Name of Healthcare Facility to release medical information:

Street Address:

City, State, and Zip Code:

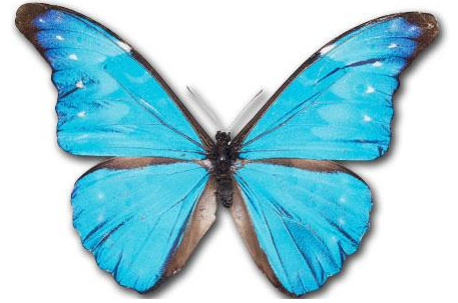
To release health information about the following patient:

Print Client's Name:

Date of Birth:

City, State, Zip Code:

Telephone Number:



I expressly request that the information in the designated record set be disclosed for date(s) of service: \_\_\_\_\_ to include the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> History & Physical          | <input type="checkbox"/> Lab Reports          | <input type="checkbox"/> Physician's Orders    |
| <input type="checkbox"/> Discharge Summary           | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Cardiovascular        |
| <input type="checkbox"/> Consultations               | <input type="checkbox"/> EKG                  | <input type="checkbox"/> Diagnostic Reports    |
| <input type="checkbox"/> Operative Reports           | <input type="checkbox"/> Emergency Center     | <input type="checkbox"/> Urgent Care Records   |
| <input type="checkbox"/> Progress Notes              | <input type="checkbox"/> Pathology Reports    | <input type="checkbox"/> Hospice Records       |
| <input type="checkbox"/> Outpatient Rehab<br>Records | <input type="checkbox"/> Health Center/Clinic | <input type="checkbox"/> Other (specify) _____ |

This protected health information is disclosed for the following purpose(s):

- |   |  |                                |
|---|--|--------------------------------|
| <input type="checkbox"/> Insurance                                    | <input type="checkbox"/> Continued Treatment   | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Client's / Client's Representative's Request | <input type="checkbox"/> Other (specify) _____ |                                |

You are authorized to release the above records to the following:

Client/Other Person Authorized To Sign:

Date:

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S.S. #: \_\_\_\_\_ Client: \_\_\_\_\_  
D.OB.: \_\_\_\_\_ Address: \_\_\_\_\_

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**RELEASE OF INFORMATION AUTHORIZATION**

I hereby request and authorize: **Brighter Tomorrows Consulting (Shannon M. Eller, LPC)**  
(Name of Persons or Agency Requesting / Receiving Information)

**1815 North Expressway, Ste B, Griffin, GA 30223**

(Address)

*And*

---

(Name of Persons or Agency Sending / Receiving Information)

---

(Address)

To obtain from each other the following type (s) of information from my records (and any specific portion thereof):

\_\_\_\_\_  
\_\_\_\_\_

For the purpose of: \_\_\_\_\_

\_\_\_\_\_

---

\_\_\_\_\_ This authorization shall remain in effect for one year from the date of the signature below.

\_\_\_\_\_ The consent can be withdrawn upon notification.

\_\_\_\_\_  
Client Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature of Parent or Authorized Representative, or relationship to  
client, where applicable:

\_\_\_\_\_  
Signature of Witness/Title:

\_\_\_\_\_  
Date:

**Clinical History**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**SI (Suicidal)/HI (Homicidal) History:** \_\_\_\_\_

**Self-Injurious Behaviors:** \_\_\_\_\_

**Family History (Substance Abuse or Mental Health Issues):** \_\_\_\_\_

**Previous Substance Abuse/Mental Health History Treatment:** \_\_\_\_\_

**Alcohol/Substance Use History:** \_\_\_\_\_

**Hospitalizations/Detox:** \_\_\_\_\_

**Medical Conditions/ Issues:** \_\_\_\_\_

**Current Symptoms:** \_\_\_\_\_

**Legal History:** \_\_\_\_\_

**Goals and Expectations of the Counseling Process:** \_\_\_\_\_

\_\_\_\_\_  
**Client Signature:**

\_\_\_\_\_  
**Date:**

\_\_\_\_\_  
**Counselor's Signature:**

\_\_\_\_\_  
**Date:**

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**Confidentiality Policy**

What is confidentiality?

Due to the sensitive and personal nature of counseling, questions regarding confidentiality are understandable. You should feel free to direct any questions about confidentiality to your therapist at Brighter Tomorrows Consulting, LLC, hereinafter referred to as BTC, at any time.

All therapeutic services at BTC are strictly confidential. This means that nothing you share with your therapist is revealed to anyone outside of BTC without your permission. More specifically, we do not disclose your name or identifying information to anyone outside of BTC including other students, your family, professors, and university deans.

In order to provide you with the highest quality of care, your therapist may consult with other counseling staff members. Other than these internal consultations, it is completely your decision whether to tell anyone that you are in counseling. If, for example, you would like us to speak with someone (e.g. your parents or an outside doctor) about some aspect of your mental health care, we can do that but, only with your permission.

Are there limits to confidentiality?

Yes, there are situations in which we are required by law and/or professional ethics to release information. These include:

1. Our assessment that you may be a danger to yourself or others.
2. Our assessment that a child or elder is being abused, neglected, or exploited.
3. If we are required to present records or information as a part of a legal proceeding.

By signing this agreement, I understand this confidentiality policy of Brighter Tomorrows Consulting, LLC.

**Client Signature:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_

**Counselor's Signature:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_

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**Notice of Privacy**

**How We May Use and Disclose Information About You:**

The following categories describe different ways that we use and disclose information about you. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the following categories.

**For Payment:** We may use and disclose information about you to provide the treatment and services you receive from Brighter Tomorrows Consulting, LLC, hereinafter referred to as BTC. You may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may disclose your record to an insurance company, so that we can get paid for treating you.

**For Treatment:** We may use information about you to provide you with treatment or services. We may disclose information about you to personnel who are involved in taking care of you at BTC or a hospital. For example, we may disclose information about you to people outside of the practice who may be involved in your care, such as family members, clergy or other persons, if a consent form is signed.

**For Health Care Operation:** We may use and disclose information about you for health-care operations. These uses and disclosures are necessary to run the practice and ensure that all of our clients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts, if a consent form is signed.

**Who Will Follow This Notice?**

This notice describes BTC policies and procedures and that of any health care professional authorized to enter information in to your chart, which we allow in order to help you, as well as staff and other practice personnel.

**Policy Regarding the Protection of Personal Information:**

We create a record of the care and services you receive at BTC. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by BTC, whether made by BTC personnel or by your personal doctor. The law requires us to: Insure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy practice with respect to information about you, and to follow the terms of notice that is currently in effect. Other ways we may use your benefits and services: Providing your information to individuals involved in your care or payment for you care; research: to advert a serious threat to health safety and for treatment alternatives. Other uses and disclosures of your personal information can include, but is not limited to: Disclosure to or for coroners, medical examiners and funeral directors, health oversight activities, organs and tissue donation, protective services for president and others, public health risk, and worker's compensation. In order for this information to be disclosed, it would require a written consent form to be signed. Exceptions to this are: 1) Suspicions of child or elderly abuse, 2) A threat to self or others, 3) A court order.

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**NOTICE OF INDIVIDUAL RIGHTS**

**You have the following rights regarding clinical information we maintain about you:**

**Right to and Accounting of Disclosure:**

You have the right to request an “accounting of disclosure” list. This is a list of disclosures that we have made about you. To request this list, you must submit your request in writing to Brighter Tomorrows Consulting, LLC, hereinafter referred to as BTC. Your request must state a time period, which may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example: on paper; electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you a fee of providing the list. We will notify you of the fee involved and you may choose to withdraw or modify your request at that time before any fees are incurred.

**Right to Amend:**

If you feel that information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for BTC. To request an amendment, your request must be made in writing and submitted to BTC and you must provide a reason that supports your request. We may deny your request for an amendment.

**Right to Inspect and Copy:**

You have the right to inspect and copy information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain, very limited circumstances.

**Right to a Paper Copy of this Notice:**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

**Right to Request Confidential Communications:**

You have the right to request a restriction or limitations on the information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to BTC.

**Change to this notice:**

We reserve the right to change this notice. We will post a copy of the current notice in the office of BTC.

**Complaints:**

If you believe your privacy rights have been violated, you may file a complaint with BTC or with the Secretary of the Department of Health and Human Services. To file a complaint with BTC, contact Shannon M. Eller at 770-468-7424. All Complaints must be submitted in writing. You will not be penalized for filing a complaint.

**Other Uses of Clinical Information:**

Other uses or disclosure of clinical information not covered by this notice or by the laws that apply to use it, will be made with your written authorization. If you provide us permission to use or disclose clinical information about you, you may revoke that permission in writing at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact Shannon M. Eller. I acknowledge by signing below that I have received the **Notice of Privacy Practices and Notice of individual rights.**

**Client or Client’s Personal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**INITIAL BIOPSYCHOSOCIAL ASSESSMENT 1**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is client's primary language?  English  Spanish  other: \_\_\_\_\_

Chief Complaint: (In client's own words)

Why are you here today? \_\_\_\_\_

Precipitating Event: (Events which occurred in previous 24-72 hours which prompted your appointment.)

\_\_\_\_\_

Previous Psychiatric/Substance Abuse Treatment:  Denies  Unknown

<u>TX Provider/Facility Name</u>	<u>Date</u>	<u>Reason for Treatment</u>	<u>Inpatient</u>	<u>Partial</u>	<u>Residential</u>	<u>Outpatient</u>
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_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

What are your Hopes and Dreams for Recovery?

\_\_\_\_\_

Initial Health Screening History of hospitalization(s) for medical/ physical problem(s)?

<u>Medical/Physical Problem:</u>	<u>Treatment Received:</u>	<u>Date:</u>
----------------------------------	----------------------------	--------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medical History:**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bowels	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Encephalitis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Seizures
<input type="checkbox"/> Other _____	<input type="checkbox"/> Ulcers	

<input type="checkbox"/> Gonorrhea		<input type="checkbox"/> Syphilis
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Arthritis
<input type="checkbox"/> Gynecological		<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Neurological Exam		

<input type="checkbox"/> Hepatitis (type) _____	Have you ever been or are now
<input type="checkbox"/> Herpes	concerned about HIV/AIDS?
<input type="checkbox"/> Meningitis	<input type="checkbox"/> yes <input type="checkbox"/> no



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**INITIAL BIOPSYCHOSOCIAL ASSESSMENT 2**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS: (MEDICAL/PSYCHIATRIC)**

Medications	Dosage	Frequency:	Prescribed By:	Last Use:	Is medication being taken as prescribed:		Check if it is currently effective:
					Yes	No	
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

List psychiatric medications that were effective in the past: \_\_\_\_\_

List all allergies (including allergies to medications, foods, insects, substances and any others):  
 \_\_\_\_\_

**PAIN SCREENING:**

Do you have pain now? \_\_\_ No \_\_\_ Yes    Have you had pain in the last several weeks? \_\_\_ No \_\_\_ Yes

If yes, where is your pain? \_\_\_\_\_ Describe your pain: \_\_\_\_\_

What makes your pain better? \_\_\_\_\_ What makes your pain worse? \_\_\_\_\_

How has pain interfered with your life? \_\_\_\_\_

What treatment or medications have you received for your pain? \_\_\_\_\_

If any, who prescribed this for you? \_\_\_\_\_

Rate how well your pain is managed: (Circle One)

Complete relief: 0 1 2 3 4 5 6 7 8 9 10 No relief:

Please list all healthcare providers treating you at this time: \_\_\_\_\_

Date last treated by a physician: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_

Have you submitted any lab specimen in the past 30 days? \_\_\_ No \_\_\_ Yes (Need to obtain a copy)

Date of last dental exam: \_\_\_\_\_ Are you in need of dental care? \_\_\_ No \_\_\_ Yes

Do you wear dentures or bridges? \_\_\_ No \_\_\_ Yes (If yes, do they interfere with eating?) \_\_\_ No \_\_\_ Yes

**NUTRITION SCREEING:**    Weight: \_\_\_\_\_    Height: \_\_\_\_\_' \_\_\_\_\_"    Usual Weight: \_\_\_\_\_ lbs.

Any recent unplanned weight loss? \_\_\_ No \_\_\_ Yes    How much: \_\_\_\_\_ lbs.    In what amount of time? \_\_\_\_\_

Are you under a dietician's or Nutritionist's care? \_\_\_ No \_\_\_ Yes    For what reason? \_\_\_\_\_

Current Diet: \_\_\_ Regular \_\_\_ Diabetic \_\_\_ Renal \_\_\_ Low Sodium \_\_\_ Low Fat/Cholesterol  
 \_\_\_ Bland \_\_\_ Other: \_\_\_\_\_

Are you currently pregnant? \_\_\_ No \_\_\_ Yes    Which trimester? \_\_\_ Lactating (Breast Feeding) \_\_\_ No \_\_\_ Yes

Do you have a history of: \_\_\_ Diabetes \_\_\_ Hypertension \_\_\_ Constipation \_\_\_ Nausea/Vomiting  
 \_\_\_ Renal Failure \_\_\_ Cardiac Disease

Check all that apply to you, now or in the past: \_\_\_ Bingeing \_\_\_ Compulsive overeating

\_\_\_ Excessive Exercising \_\_\_ Purging \_\_\_ Absence of Menses

How many meals do you eat a day? \_\_\_\_\_ Where do you typically eat? (home, restaurant, other): \_\_\_\_\_

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**INITIAL BIOPSYCHOSOCIAL ASSESSMENT 3**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**ALCOHOL/DRUG HISTORY:**    \_\_\_ Yes    \_\_\_ No    (if no, go to Family History Section)

- |   |                               |                    |                                  |
|---|-------------------------------|--------------------|----------------------------------|
| ___ Alcohol                                 | ___ Marijuana                 | ___ Stimulants     | ___ Barbiturates                 |
| ___ Cocaine                                 | ___ Hallucinogens (Acid, LSD) | ___ Methadone      | ___ Pain Medications             |
| ___ Crack                                   | ___ Opiates                   | ___ Tranquillizers | ___ Over-the-Counter Medications |
| ___ Tobacco                                 | ___ Heroin                    | ___ Sedatives      | ___ Caffeine                     |
| ___ Methamphetamine (crystal meth, ecstasy) | ___ Inhalants                 |                    |                                  |
| ___ Other (specify) _____                   |                               |                    |                                  |

**COMPLETE THE FOLLOWING FOR THE ITEMS CHECKED ABOVE:**

Substance Checked:    Amt/ Frequency:    Duration of time:    First Use:    Last Use:    Amt used in the last 24hrs:

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Withdrawal symptoms/behaviors from alcohol/drug use (Check all that apply)

- |                           |                              |                     |                      |
|---------------------------|------------------------------|---------------------|----------------------|
| ___ Aggression/Assaultive | ___ Cramps                   | ___ Agitation       | ___ Weakness         |
| ___ Profuse Sweating      | ___ Change in Blood Pressure | ___ Tingling        | ___ Rapid Heart Beat |
| ___ Diarrhea              | ___ Fever/Chills             | ___ Nausea/Vomiting | ___ Tremors          |
| ___ Irritability          | ___ Delirium                 | ___ Anorexia        | ___ None             |

Do you have a history of withdrawal, DT's, blackouts (loss of time), seizures, etc.? \_\_\_\_\_

What is the longest period of sobriety? \_\_\_\_\_

**FAMILY HISTORY:**

Yes    No    Describe:

- |  |     |     |       |
|--|-----|-----|-------|
| Is there a family history of drug or alcohol problems?                     | ___ | ___ | _____ |
| Has anyone in your family received treatment for drug or alcohol problems? | ___ | ___ | _____ |
| Is there a family history of mental illness?                               | ___ | ___ | _____ |
| Has anyone in your immediate family received treatment for mental illness? | ___ | ___ | _____ |

**PSYCHOSOCIAL HISTORY:**

Do you have any conflicting problems with your sexual history/orientation? \_\_\_\_\_ if so, please describe:

Describe your leisure and recreational activities: \_\_\_\_\_

Describe your social activities: \_\_\_\_\_

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**INITIAL BIOPSYCHOSOCIAL ASSESSMENT 4**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SPIRITUAL ASSESSMENT:**

How do you address bereavement (the death of a family member or friend)?

\_\_\_\_\_

Were you raised in a particular religion? \_\_\_ Yes \_\_\_ No If yes, what religion? \_\_\_\_\_

Do you consider yourself spiritual or religious? \_\_\_\_\_

What specific practices do you carry out as a part of your spiritual/religious beliefs? (Check all that apply)

\_\_\_ Meditation \_\_\_ Prayer \_\_\_ Church \_\_\_ Other \_\_\_\_\_

Have you ever called upon God or a higher power to help you? \_\_\_ Yes \_\_\_ No

Who or what provides you with strength and hope?

\_\_\_\_\_

What things do you believe in that gives purpose and meaning to your life? \_\_\_\_\_

Are there any beliefs or customs from your upbringing that are causing you problems or concerns? If so, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you ever been a victim of physical or sexual abuse? \_\_\_ Yes \_\_\_ No

Have you been sexually active? \_\_\_ Yes \_\_\_ No

Do you have any conflict or problems stemming from your childhood? \_\_\_ Yes \_\_\_ No

If so, please describe: \_\_\_\_\_

Do you have financial problems? (Debt, income, spending patterns): \_\_\_\_\_

Military History: \_\_\_ Yes \_\_\_ No \_\_\_ Air Force \_\_\_ Army \_\_\_ Navy \_\_\_ Marines \_\_\_ Coast Guard

Date Inducted: \_\_\_\_\_ Type of Discharge: \_\_\_\_\_

**SUPPORT SYSTEMS:** (Availability of family/friends to participate in treatment, special family concerns)

Describe your current household (marital status, quality of relationships with significant others/children): \_\_\_\_\_

\_\_\_\_\_

**LIST ALL PEOPLE LIVING IN YOUR HOME, NOT INCLUDING YOURSELF:**

Name: \_\_\_\_\_ Relation to You: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Occupation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you want your significant other or anyone in your family to participate in your treatment? \_\_\_ Yes \_\_\_ No

If so, who: \_\_\_\_\_

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**INITIAL BIOPSYCHOSOCIAL ASSESSMENT 4 (continued)**

**REVIEW COMMUNITY RESOURCES:** (Check all that apply now or that you have used in the past):

Health Department     Church     Medical Clinics     Vocational Rehab     SSI/Medicaid  
 Adult Education     Housing     Schools     Food Stamps     Insurance     SSI/Medicare  
 Child Support     Volunteer Program     Other Community Resources (please specify): \_\_\_\_\_  
 DFACS (Name and Number of current caseworker): \_\_\_\_\_

**LEGAL STATUS ASSESSMENT:**

Are there any current/pending legal problems?     Yes     No  
Are you on probation/parole?     Yes     No    (If yes, P.O.'s Name): \_\_\_\_\_  
Do you have any previous legal history?     Yes     No

**EDUCATIONAL ASSESSMENT:**

Highest completed level of education:  
\_\_\_\_\_

Check any of the following areas interfering with your learning:

Language     Physical/Medical     Memory     Impaired Vision  
 Religious  
 Hard of Hearing     Cultural     Reading     Attention     Age Related  
Easiest method of learning:     Written     Verbal     Demonstration  
 Other \_\_\_\_\_

Do you have goals to further your education?     Yes     No    if yes, Specify:  
\_\_\_\_\_

What areas of study interest you?  
\_\_\_\_\_

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**CLINICAL ASSESSMENT**

**GENERAL HISTORY:**

Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Education (Highest Grade Completed) \_\_\_\_\_

What are your living arrangements – do you live alone or with family? \_\_\_\_\_

How do you make your living –current employment –disability? \_\_\_\_\_

What brings you here today? \_\_\_\_\_

What would you like to happen while you are here – What can I do to help you achieve your goal (s)? \_\_\_\_\_

What things have been causing you to feel more stress lately? (Please describe in the space provided)

Relationships: \_\_\_\_\_

Job Stress: \_\_\_\_\_

Financial Stress: \_\_\_\_\_

Recent Loss: \_\_\_\_\_

Health Problems: \_\_\_\_\_

What have you done in the past to be able to cope more effectively with stress? \_\_\_\_\_

Does your spirituality or faith play a role in your ability to cope with stress? \_\_\_\_\_

If so, what things have you tried that have been effective with dealing with problems and loss? \_\_\_\_\_

Is there some way that I can assist you in meeting your spiritual needs? \_\_\_\_\_

Are there any cultural practices that I need to know about in order to take better care of you? \_\_\_\_\_

Have there been any recent changes in your family or social life? \_\_\_\_\_

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**CLINICAL ASSESSMENT (continued)**

**GENERAL HISTORY (continued):**

Have there been any major family changes (such as divorce- or children moving in or out; worries about health or another family member) within the last year or so? \_\_\_\_\_

Have there been any deaths or losses that were significant within the last 3-5 years? \_\_\_\_\_

How do you feel you have handled these changes and losses? \_\_\_\_\_

Are you here to work on some of these areas? \_\_\_\_\_ If so, what would you like to see happen as a result of your treatment here? \_\_\_\_\_

Have you been having problems with anxiety? \_\_\_\_\_ Describe your symptoms: \_\_\_\_\_

What helps you deal with anxiety? \_\_\_\_\_

Have you been thinking about suicide or your own death? \_\_\_\_\_

Have you had any plans to kill yourself? \_\_\_\_\_ If so, what was the plan? \_\_\_\_\_

What physical illnesses, mental illnesses, or other conditions make it harder for you to cope? \_\_\_\_\_

Have you been feeling depressed lately? \_\_\_\_\_

**Describe your symptoms (circle):** insomnia, poor appetite, overeating, social withdrawal, anhedonia (not caring about anything –no fun in life) indecisiveness, problems with concentration, apathy, somatic focus (excessive worrying about physical illness) helplessness and hopelessness, behavioral choices, decreased ability to do self-care.

Have you had any previous suicidal attempts? \_\_\_\_\_ Method? \_\_\_\_\_

How many attempts? \_\_\_\_\_ How recent? \_\_\_\_\_

Who do you turn to when you need help? \_\_\_\_\_

Will you be able to depend on these people while you work on personal issues? \_\_\_\_\_

Significant losses: \_\_\_\_\_

Have you been using drugs or alcohol to deal with your pain and loss? \_\_\_\_\_

\_\_\_\_\_ Alcohol    What do you drink? \_\_\_\_\_ How much do you drink in a week? \_\_\_\_\_

\_\_\_\_\_ Drugs    What drugs do you use (prescription or street drugs)? \_\_\_\_\_

Daily usage: \_\_\_\_\_ Weekly usage: \_\_\_\_\_

What stopped you from killing yourself? \_\_\_\_\_

Have you had thoughts of killing or harming others? \_\_\_\_\_ Who? \_\_\_\_\_

Why? \_\_\_\_\_

Have you ever experienced any physical abuse in the past? \_\_\_\_\_

Have you ever experienced any emotional abuse in the past? \_\_\_\_\_

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**CLINICAL ASSESSMENT (continued)**

**GENERAL HISTORY (continued):**

Have you ever experienced any sexual abuse in the past? \_\_\_\_\_

Have you had therapy to deal with these issues in the past? \_\_\_\_\_

Do you feel that you need further therapy to cope with these issues? \_\_\_\_\_

Have you been seeing a mental health professional? \_\_\_\_\_ Who? \_\_\_\_\_

Have you been taking your medications as prescribed? \_\_\_\_\_

If not, why? \_\_\_\_\_

Have you been seeing or hearing things? \_\_\_\_\_

Have you been suspicious of others lately? \_\_\_\_\_

Have you been hearing voices? \_\_\_\_\_ What do they say? \_\_\_\_\_

When did you start having concerns about your behavior, thoughts, or condition? \_\_\_\_\_

Describe what it has been like since then: \_\_\_\_\_

Are you currently involved in any legal actions? \_\_\_\_\_

Are you on probation or parole? \_\_\_\_\_ Probation Officer Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ (Client needs to sign a release of information)

Are there any legal charges pending against you? \_\_\_\_\_

\_\_\_\_\_  
Client name (Print):

\_\_\_\_\_  
Client Signature:

\_\_\_\_\_  
Street Address (Include Apt. #):

\_\_\_\_\_  
Date:

\_\_\_\_\_  
City, State, Zip Code:

\_\_\_\_\_  
Telephone #:

