BRIGHTER TOMORROWS CONSULTING, LLC
SHANNON M. ELLER, LPC, LMFT, RPT, CPCS
1815 North Expressway, Suite B
Griffin, Ga. 30223
Phone: (770) 468-7424/ (678) 408-4622 Fax: (678) 688-8164

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: ___________________________________

____

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

Month/Year:	Provider:	Outcome:

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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PHOTOGRAPHING, VIDEO RECORDING, AUDIO RECORDING, & OTHER IMAGING OF CLIENTS, VISITORS, AND WORKFORCE MEMBERS: *PLEASE INITIAL THE FOLLOWING*

________ **PURPOSE:** TO ESTABLISH GUIDELINES FOR SITUATIONS WHERE CLIENTS AND/ OR WORKFORCE MEMBERS MAY OR MAY NOT BE PHOTOGRAPHED, VIDEO OR AUDIO RECORDED OR OTHERWISE IMAGED WITHIN THE PRACTICE OF **BRIGHTER TOMORROWS CONSULTING, LLC**. TO FACILITATE COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PRIVACY STANDARDS), AND ANY AND ALL OTHER FEDERAL REGULATIONS AND INTERPRETIVE GUIDELINES PERTINENT TO THE ACT'S ENFORCEMENT.

________ **POLICY: BRIGHTER TOMORROWS CONSULTING, LLC** MUST TAKE REASONABLE STEPS TO PROTECT CLIENTS, VISITORS, AND WORKFORCE MEMBERS FROM UNAUTHORIZED PHOTOGRAPHY, VIDEO OR AUDIO RECORDINGS, OR OTHER IMAGES. DUE TO THE SENSITIVE NATURE OF CLIENT INFORMATION AND TO PROTECT CLIENT PRIVACY, BRIGHTER TOMORROWS CONSULTING, LLC MUST FOLLOW THE GUIDELINES AND PROCEDURES OUTLINED BELOW BEFORE ALLOWING, OR PRIOR TO, PHOTOGRAPHING, VIDEO OR AUDIO RECORDING, OR OTHERWISE IMAGING CLIENTS, VISITORS OR WORKFORCE MEMBERS.

________ **BRIGHTER TOMORROWS CONSULTING, LLC** PROHIBITS UNAUTHORIZED RECORDINGS, FILMS, OR OTHER IMAGES OF CLIENTS MADE FOR ANY USE. FOR PURPOSES OF THIS POLICY, WHEN AUTHORIZATION OR CONSENT IS REQUIRED IT MAY BE OBTAINED FROM THE CLIENT OR THE CLIENT'S LEGAL REPRESENTATIVE, AS DEFINED BY STATE LAW. IT IS NOT SUFFICIENT TO RELY ON THE PHOTOGRAPHER'S (CLIENT, WORKFORCE MEMBER, VISITOR) JUDGEMENT THAT A PARTICULAR CLIENT IS UNLIKELY TO BE IDENTIFIED FROM A PARTICULAR PHOTOGRAPH; CONSENT MUST BE OBTAINED FOR ALL PHOTOGRAPHS. IT IS SOMETIMES POSSIBLE FOR PEOPLE TO BE IDENTIFIED FROM FACELESS PHOTOGRAPHS, E.G. THOSE SHOWING A TATTOO, BIRTHMARK OR OTHER DISTINGUISHING MARK. PLEASE UNDERSTAND THAT CONSENT IS EXTREMELY UNLIKELY TO BE GIVEN. HOWEVER, IF GIVEN IT MUST BE IN WRITTEN FORM.

BY PROVIDING MY SIGNATURE BELOW, I UNDERSTAND THAT CLIENTS, FAMILY MEMBERS, AND/ OR VISITORS ARE NOT PERMITTED TO TAKE PHOTOGRAPHS OF OR AUDIO RECORD WORKFORCE MEMBERS WITHOUT CONSENT. TO THE EXTENT A WORKFORCE MEMBER IS AWARE OF ANY INAPPROPRIATE ATTEMPT TO PHOTOGRAPH AND/ OR AUDIO RECORD A WORKFORCE MEMBER THE WORKFORCE MEMBER MUST TAKE REASONABLE STEPS TO ENSURE THAT WORKFORCE MEMBERS ARE NOT PHOTOGRAPHED OR AUDIO RECORDED WITHIN THE PRACTICE BY A CLIENT OR THE CLIENT'S FAMILY MEMBERS OR VISITORS.

______________________________	______________________________	__________
Client's Name (Print):	**Client / Guardian's Signature:**	**Date:**

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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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INFORMED CONSENT TO TREATMENT (continued)

Billing and Insurance:

I promise to pay BTC for all charges rendered. I hereby authorize payment directly to BTC for all charges incurred in connection with the treatment of the below named client. I understand that I am financially responsible for all charges regardless of insurance. Some services that I require may not be covered under existing insurance policies and I agree to assume full financial responsibility for those services.

I acknowledge that I am voluntarily consenting to treatment and that this consent may be revoked at any time. By signing this form, I understand and I agree with the terms and conditions of this form.

______________________________ ________________________________ __________

Client's Name (Print): **Client / Guardian's Signature:** **Date:**

____

Witness Name (Print):

____ _____________

Witness Signature: **Date:**

I acknowledge that I have received a copy of Brighter Tomorrow Consulting, LLC's Notice of Privacy Practice for Protected Health Information. I understand that BTC has the right to change its notice of Privacy Practice for Protected Health Information.

____________________________________ ____________________

Signature **Date**

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CONSENT TO TREATMENT PLAN

I do hereby consent to take part in treatment at Brighter Tomorrows Consulting, LLC or Incorruptible Seed Ministries, Inc. I understand that implementing a treatment plan and regularly assessing progress and treatment goals are in my best interest. I agree to play an active role in this process. I have had explained to me and acknowledge understanding of the following (Please initial beside each statement):

- **________ I have the right to have my treatment explained to me.**
- **________ I have the right to refuse recommended treatment protocols.**
- **________ I understand that failure to comply with recommended treatment protocols *MAY* result in termination of treatment.**

Client's Name (Print): ____________________ **Client/ Guardian's Signature:** ____________________ **Date:** __________

____

Witness Name (Print):

____________________________________ __________

Witness Signature: **Date:**

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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 $^{00}/_{100}$ ($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 $^{00}/_{100}$ ($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's Signature:**

___________________________________ ______________________________

Relationship to Client: **Date:**

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DECRIBES 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.

____
Client or Representative Name: (Please Print)

____ ____________
Client or Representative Signature: Date:

________Client Refused to Sign ________Client was unable to sign because: _____________________

Documented By: ____

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AUTHORIZED CLIENT/ 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:**

____History & Physical	____Lab Reports	____Physician's Orders
____Discharge Summary	____Radiology Reports	____Cardiovascular
____Consultations	____EKG	____Diagnostic Reports
____ Operative Reports	____Emergency Center	____Urgent Care Records
____Progress Notes	____Pathology Reports	____Hospice Records
____Outpatient Rehab Records	____Health Center/Clinic	____Other (specify) ______________

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

____Insurance ____Continued Treatment ____Legal

____Client's / Client's Representative's Request ____ 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.O. B.: _____________________ Address: ___________________________

____

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:**

Brighter Tomorrows Consulting
Together Tomorrow will be Brighter

1815 North Expressway, Suite B * Griffin, GA 30223
678-408-4622 Office * 678-688-8164 Fax * 770-468-7424 Mobile

Appointment & No-Show Policy

Our goal is to provide the highest quality of care within a timely manner. In order to do so, we have established a cancellation/no show policy. We, at Brighter Tomorrows Consulting, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 678-408-4622

To ensure that each client is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled client to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the client to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: Our Clinicians are very busy, and their schedules fill up very fast. Whenever possible, we like to fill cancelled spaces to shorten the waiting period for clients.

2. If less than a 24-hour cancellation is given your appointment will be documented as a "No-Show."

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Brighter Tomorrows Consulting will assist you to reschedule this appointment if needed.

5. After your 2nd "No-Show/Missed" appointment, you will be assessed a $35.00 fee. This fee will be assessed after every "No-Show/Missed" appointment thereafter. All fees must be paid and up to date prior to making a returning appointment.

6. If you have 3 "No-Show/Missed" appointments within six months dismissal from the practice will be considered.

I have read and understand Brighter Tomorrows Consulting No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Brighter Tomorrows Consulting appropriately if I have difficulty keeping my scheduled appointments. I understand that my credit/debit card on file may be charged for any missed appointment or violation of this policy.

____ _______________________

Client Signature or Parent/Guardian if Minor: Date

____ _______________________

Staff Signature Date

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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's 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.

BRIGHTER TOMORROWS CONSULTING, LLC
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Griffin, Ga. 30223
Phone: (770) 468-7424/ (678) 408-4622 Fax: (678) 688-8164

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's Signature: __________________ 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

TX Provider/Facility Name	Date	Reason for Treatment	Inpatient	Partial	Residential	Outpatient
_______________________	__________	_______________	_____	____	____	_____
_______________________	__________	_______________	____	____	____	_____
_______________________	__________	_______________	____	____	____	_____

What are your Hopes and Dreams for Recovery?
____
____

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

Medical/Physical Problem:	Treatment Received:	Date:
______________________	______________________	____________
______________________	______________________	_____________
______________________	______________________	______________

Medical History:

_____ Asthma
_____ Cardiac
_____ Diabetes
_____ Sickle Cell Anemia
_____ Toxoplasmosis
_____ Tuberculosis
_____ Chicken Pox
_____ Other___________

_____ Bowels
_____ Emphysema
_____Hypertension
_____ Cirrhosis
_____ Thyroid
_____ Rheumatic Fever
_____ Respiratory
_____ Ulcers

_____ Cancer
_____ Liver
_____ Kidney
_____ Scarlet Fever
_____ Encephalitis
_____ Chlamydia
______ Seizures

_____ Gonorrhea
_____ Glaucoma
_____ Gynecological
_____ Neurological Exam
_____ Hepatitis (type) ____
_____ Herpes
_____ Meningitis

Have you ever been or are now concerned about HIV/AIDS?
_____ yes _____ no

_____ Syphilis
_____ Arthritis
_____ Hemophilia

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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	____
___________________	_______________	___________	_______	____Yes ____No	____
___________________	_______________	___________	_______	____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 #:

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BILLING DAILY RECORD

Client Name: ____

Is this a SELF-PAYING CLIENT? ________Yes ________No

INSURANCE COMPANY: _____________________________________ CO-PAY AMT: _______________

Date	Appt. Time	Co-pay Rcvd.	Amt. Billed	Insurance Discounted	Date Ins. Rcvd.	Cash/ Check #
_______	__________	_______	_______	_________	_______	__________
_______	__________	_______	_______	_________	_______	__________
_______	__________	_______	_______	_________	_______	__________
_______	__________	_______	_______	_________	_______	__________
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