Bridgeway
Counseling Center, Inc.

Please complete all information on this form in pen and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. Thank you!

*Date*____/____/____

*Name*_____ *Birth date*_____ *Age*_____ *Gender (circle) M or F*

Address _____ *City, State* _____ *Zip Code*_____

**If 17 y/o or younger:* *SSN*_____

Mother's name _____ Phone #_____ DOB _____

Father's name _____ Phone #_____ DOB _____

Who is best to contact _____

Child/teen's current school and grade _____

**If 18 y/o or older:*

*Home Phone*_____*Cell Phone* _____ *Work Phone*_____

Would you like to receive appointment reminders through text message ( ) and/or email ( )? ( )Yes ( )No

Email _____

Primary Care Physician _____

Who referred you to Bridgeway Counseling Center _____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: **(check once for any symptoms present, twice for major symptoms)**

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Suicidal Thoughts
( ) _____
( ) _____

***Past Medical History*:**

List ALL current prescription medications *and how often you take them*: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No

Date and place of last physical exam: _____

Is there any relevant personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

Past Psychiatric History:

Outpatient treatment/Hospitalizations: ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated/Hospitalized By Whom/Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Please list any past psychiatric medications? _____

_____

Dates Dosage Response/Side-Effects

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

Substance Use:

Have you ever been treated for drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

Alcohol History:

Have you ever used alcohol? ( ) Yes ( ) No

Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

Have you ever been treated for drug use or abuse? ( ) Yes ( ) No

If yes, for which substances?_____

If yes, where were you treated and when?_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Energy Drinks _____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____

In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No

What kind?_____How often per day on average?_____How many years? _____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No

How many days a week do you get exercise? _____

Family Background and Childhood History:

Were you adopted? ( ) Yes ( ) No Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with?_____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____

_____

Educational History:
Highest Grade Completed?_____ Where?_____
Did you attend college? _____Where?_____ Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____What is/was your occupation?_____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when?_____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? ____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Have you had any prior marriages? ( ) Yes ( ) No If so, how many? _____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____
_____
Describe the relationship with your children: _____
List everyone who currently lives with you: _____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____

Is there anything else that you would like us to know?

_____

_____

_____

_____

Signature _____ *Date* _____

Guardian Signature (if under age 18) _____ *Date* _____

Emergency Contact _____ *Telephone #* _____

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Please complete the form below with your insurance information or submit an insurance card to the receptionist to copy.

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No					
Subscriber's name:		Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:		Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bridgeway Counseling Center or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Payment

Payment is due at the time of service unless insurance reimbursement has been verified prior to the session. Bridgeway Counseling Center accepts Visa, MasterCard and Discover, as well as cash and checks. A fee of $40 will be assessed for a returned check. If you are currently experiencing financial difficulties, please discuss this with us to be set up on a payment plan.

Insurance

Co-payments are required at the time of service. Many insurance plans require preauthorization of treatment prior to the session. Please provide your insurance information to us as you schedule your initial appointment. If you change insurance plans or company, please provide your new insurance information to us as soon as possible.

Late Cancellations and No-Shows

Please give 24 hour notice if you are unable to make your appointment in order to allow open appointments for others seeking treatment. Failure to provide this notice will result in a fee of *$100.00* billed directly to the client which must be paid prior to receiving further care. Bridgeway Counseling Center reserves the right to terminate services after two late cancellations or no-shows.

Collateral Telephone, Letter, and Court Compensation Agreement

Insurance typically covers face to face treatment of patients but does not cover telephone communication, written communication, generation of treatment summaries or court related requests. While some correspondence is expected, regular telephone, email or written communication will be billed to the patient as an out of pocket expense. Our clinicians are happy to fulfill these requests but doing so is time consuming and falls outside of our therapeutic provision and insurance compensation. The following rates will be billed to the patient. Pre-payment of fees may be required, especially for large commitments of time such as legal testimony. Should a balance accrue, and no payment is received, Bridgeway reserves the right to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency.

- Telephone correspondence will be charged to the patient or responsible party at the following rates: calls over 10 minutes will be billed $60 and longer phone calls requiring a significant amount of time will be charged based on time.
- Generation of treatment summaries provided to schools, courts or other entities will charged at the rate of $125/hr.
- Court appearances and testimony will be charged $200/hour. Reviewing documentation, depositions, and other preparation for court appearances will also be charged $200 per hour.
- Other meetings that are attended and professional expertise is requested will be charged $125/hr.

- Any meetings or court appearances that occur outside of Watertown will be charged $.50 per mile and a $125 hourly charge will be charged for travel time.

Signature:_____ Date:_____

Bridgeway
Counseling Center, Inc.
Medical Arts Building
600 4th Street NE, Watertown, SD 57201
Phone: (605) 886-5262; Fax: (605) 886-5228

Authorization to Release/Request Information

Patient's Name _____ **Date of Birth** _____

I authorize Bridgeway Counseling Center Inc. to release and/or request my health information to the person or organization designated below.

Name/ Facility _____

Address _____

City, State _____ ZIP: _____

Phone: _____ Fax: _____

Name/ Facility _____

Address _____

City, State _____ ZIP: _____

Phone: _____ Fax: _____

I understand that I have the right to cancel this authorization by sending written notification to Bridgeway Counseling Center. However, I understand my cancellation will not be effective to the extent that Bridgeway Counseling Center has already taken action regarding the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the recipient of this information may re-disclose it and that the information will no longer be protected by the HIPAA Privacy Rule. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

_____ _____

Signature of Patient or Guardian **Date**

Bridgeway
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Informed Consent for Assessment and Treatment

Name:_____ **Date of Birth:**_____

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is ethically bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to take steps to protect the child, and to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client Signature **Date**

_____ _____

Parent/Guardian Signature (for minor) **Date**

NOTES: *(For clinicians use only)*