Bridgeway
Counseling Center, Inc.

New Child / Adolescent Information Sheet

Child's name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: (____)_____ Cell: (____)_____ Cell: (____)_____

Birth date: _____ Age: _____ SSN: _____-_____-_____ Gender: M F

Mother's name: _____ DOB: _____

Father's name: _____ DOB: _____

Who is best to contact: _____ Phone #:_____

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

Email _____

Parents' marital/relationship status: _____whom does the child live with: _____

Parent's employer(s): Mother: _____ Father: _____

Child/teen's current school and grade: _____

Names and ages of other children in the home: _____

_____

Who referred you to Bridgeway Counseling Center Inc.?_____

Who shall we contact in case of emergency? Name: _____Phone (___)_____

Primary physician: _____ Do you want records sent to your physician? Y N

What problems brought you here?_____

_____

_____

_____

_____

Please describe any past or current health problems:

Current	Past

Please list your current medications and dosage or submit a list to the receptionist to copy for our records:

Name of Medication	Dosage	When did you start the medication?

Please indicate if your child or teen is having any of the following problems, or if he or she had them in the past.

	I have this now	I had it in the past
Difficulty falling asleep or staying asleep		
Sleeping too much		
Frequently defiant		
Frequent crying		
Toileting problems		
Refuses to go to school, or cuts class frequently		
Inappropriate sexual behavior		
Changes in appetite, weight loss, or weight gain		
Uses laxatives or exercised excessively to lose weight		
Problems concentrating		
Difficulty controlling my temper		
Worry that something is wrong with his or her body		
Panic attacks or anxiety attacks		
Made self throw up in order to lose weight		
Frequent arguments with the people I live with		

Talks about killing or hurting myself		
Attempts to kill or hurt myself		
School Performance has gone down		
Problems remembering things		
Periods of daily sadness lasting more than two weeks		
Startles easily		
Physically hurts other people		
Throws or breaks things		
Worries a lot		
Often complains of feeling tired		

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

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
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 Inc. or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Bridgeway Counseling Center, Inc.

600 4th St. NE

Watertown, SD 57201

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**

Bridgeway
Counseling Center, Inc.

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 Inc. However, I understand my cancellation will not be effective to the extent that Bridgeway Counseling Center Inc. 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**

NOTES: *(For clinicians use only)*