Brighter Beginnings Counseling Services, Corp.

CONFIDENTIAL MINOR CLIENT INFORMATION SHEET

Date: _____

The term "Client" refers to the person receiving treatment

Client Name:_____

Address: _____City:_____ State: _____ Zip: _____

Mother's Name: _____Father's Name: _____

Home Phone: _____ Cell Phone: _____ Other:_____

May We Leave a Message: ☐ No ☐ Yes (If yes, please specify home, cell, or other)_____

Emergency Contact/ Relationship: _____Phone: _____

SS#_____ __ DOB: _____ AGE: _____ Gender: _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Hispanic ☐ Other

Employment: ☐ Full Time ☐ Part-Time ☐ Unemployed ☐ Student

Name of Employer or School:_____

Insurance: _____ Name of Policy Holder/Relationship: _____

Policy #_____Group #_____Referred by:_____

Primary Care Physician: _____ Are you Pregnant? ☐ No ☐ Yes (due date) _____

Living Situation: ☐ Alone ☐ with Family ☐ with Non-Related Persons

Please List Children or Other Household Members (Name, Age, Gender and Relation):

_____

_____

Presenting Problems:_____

_____

_____

_____

_____

Brighter Beginnings Counseling Services, Corp.

Individual Child Intake

Please answer the following questions to the best of your ability. The term client refers to the person receiving treatment.

Client Name_____ **Date**_____

Name of Person Completing this Form _____ **Relationship to client**_____

Please describe the reasons client is seeking therapy: _____

_____

_____

Client is experiencing problems with the following (Please check all that apply):

☐ Thoughts ☐Feelings/Mood ☐ Behaviors ☐ Relationships

☐ Home ☐ Family ☐ School ☐ Development

☐ Divorce ☐ Trauma ☐Grief/Loss ☐ Friends/Peers

☐ Bullying ☐ Sexual Acting Out ☐ Sexuality ☐ Pornography

☐ Self Care ☐ Employment ☐ Drug Use ☐ Alcohol Use

☐ Aggression ☐ Fire Setting ☐ Cruelty to animals

(Other)_____

_____

Client has problems getting along with the following (Please check all that apply):

☐Parents ☐Siblings ☐Family ☐ Peers ☐ Teachers ☐ Community

Please describe how long client has experienced the problems checked above?

☐ Days ☐ Weeks ☐ Months ☐ Years

_____

_____

_____

Has client previously received any type of mental health treatment or mental health diagnosis?

☐ No ☐ Yes (If yes, please describe.) _____

_____

Does client have any current thoughts of harming himself/herself or others? ☐ No ☐ Yes (If yes,

please describe.)_____

_____

_____

Has client had thoughts or actions of suicide or harming of others in the past? ☐ No ☐ Yes (If yes, please describe action and how long ago.)_____

_____

Please rate client's current physical health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Does client have any serious or chronic medical conditions? ☐ No ☐ Yes (If yes, please describe.)_____

_____

Please list any medications (including over the counter) client is currently taking, dosage and who prescribes them._____

_____

Does client have any chronic pain? ☐ No ☐ Yes (If yes, please describe.)_____

_____

How would you rate client's current sleeping habits? ☐Poor ☐Fair ☐Good ☐Excellent

Please list any specific sleep problems client is experiencing._____

_____

Family Medical History: Please indicate a family history of the following and relationship below:

☐ Alcohol/Substance Abuse ☐ Anxiety ☐ Depression ☐ Domestic Violence ☐ Bipolar Disorder

☐ Eating Disorder ☐ Obsessive Compulsive Disorder ☐ Schizophrenia ☐ Suicide Attempts

☐ Other_____

Mental Health: Within the last 3 months has client had a significant period in which he or she experienced any of the following?

1. Serious Depression (sadness, hopelessness, loss of interest, change in appetite or sleep pattern, difficulty going about daily activity?) ☐ **No** ☐ **Yes**
2. Serious Anxiety (Worried, feeling uptight or unable to relax)? ☐ **No** ☐ **Yes**
3. Being prescribed medication for psychological or emotional problems? ☐ **No** ☐ **Yes**
4. Hallucinations (heard or seen things others do not hear or see)? ☐ **No** ☐ **Yes**

5. Thoughts of harming himself or herself? ☐ **No** ☐ **Yes**
6. An attempted Suicide? ☐ **No** ☐ **Yes**

Trauma: During the past 12 months has client experienced any of the following?

1. Experienced a traumatic event, natural disaster, war accident, injury, loss of a loved one?

   ☐ **No** ☐ **Yes**
2. Had period of time where client felt that could not trust family or friends? ☐ **No** ☐ **Yes**
3. Ever been afraid of client's partner and/or family member? ☐ **No** ☐ **Yes**
4. Ever been hit, slapped, kicked, emotionally or sexually hurt or threatened? ☐ **No** ☐ **Yes**
5. Been Abducted or kidnapped? ☐ **No** ☐ **Yes**
6. Experienced a serious accident or life threatening illness? ☐ **No** ☐ **Yes**
7. Has client been exposed to violence, or threat of violence? ☐ **No** ☐ **Yes** (If yes, please describe.)_____

   _____
8. If client has been exposed to violence or victim of abuse was it reported? ☐ **No** ☐ **Yes** (If **yes,** please list who was it reported too and date.) _____

   _____

Substance Abuse: During the past 12 months has client:

1. Been exposed to substance use/abuse by others**?** ☐ **No** ☐ **Yes**
2. Been preoccupied with drinking alcohol and/or using drugs? ☐ **No** ☐ **Yes**
3. Tried to stop drinking alcohol and/or use other drugs? ☐ **No** ☐ **Yes**
4. Had problems caused by drinking/using drugs, and client kept using? ☐ **No** ☐ **Yes**
5. Need to drink and /or use more to get the same effect? ☐ **No** ☐ **Yes**
6. Drunk alcohol and/or used other drugs more than intended? ☐ **No** ☐ **Yes**
7. Experienced a period of time keeping his or her thoughts? ☐ **No** ☐ **Yes**
8. Drunk alcohol and/or used other drugs to alter the way client feels? ☐ **No** ☐ **Yes**
9. Used Illegal drugs including inhalants? ☐ **No** ☐ **Yes**
10. Misused any prescription medications or over the counter products? ☐ **No** ☐ **Yes**

Has client experienced any recent change or stressful event? ☐ **No** ☐ **Yes** (If yes, please

describe). _____

_____

_____

Does client have difficulty with social interaction, conflict, difficulty making/keeping friends, associating with negative peer group or withdrawal? ☐ No ☐ Yes (If yes, please describe.)_____

_____

_____

_____

Who is client's support system? _____

_____

Does client have any spiritual or religious beliefs? ☐ No ☐ Yes (If yes, please describe.) _____

_____

Please describe client's strengths? _____

_____

_____

_____

Is there any further information you would like to provide?_____

_____

_____

_____

_____

What are the changes and or goals client would benefit from accomplishing in therapy?_____

_____

_____

_____

_____

_____

_____

Personal Disclosure Statement

Ella L. Robertson

COUNSELING DISCLOSURE STATEMENT

As a State licensed mental health provider (LPC/LMFT-0504), I must inform you of your rights as a mental health consumer and to provide you with information related to my professional qualifications, therapeutic orientation, treatment methods, and business practices in order to assist you in selecting a counselor who best suits your needs and purposes. This document, in conjunction with those attached, is provided to you for this reason.

Professional Qualifications:

I hold a master's of science in counseling psychology from Northeastern State University and am currently a licensed professional counselor (#3059) in good standing with the state of Oklahoma. I am also a professional member of the American Counseling Association (#6457753). I participate in clinical consultations with other behavioral health professionals and attend continuing education trainings to ensure that my skills stay honed and remain up to date. As a counselor for more than 20 years, my experience and training includes working with adults seeking individual counseling, adolescents, and children seeking individual or group counseling in a community mental health or home based setting. In addition, my formal education prepared me to counsel individual adolescents, adults, groups, and couples.

Nature of Counseling:

Counseling provides the opportunity for growth and self-discovery in the context of a safe, supportive, and therapeutic relationship. My therapeutic orientation draws on several counseling theories. Together we work to identify thoughts and beliefs that may impact your feelings, as well as deepen your understanding of choices you make and patterns in your life.

Basic to my approach is a respect for a person and his or her ability to grow and change. All aspects of a person's life- family and relationship history, work, health, creative outlets, and spiritual beliefs- may need to be considered. Please don't feel you need to put your "best foot forward". Meeting you where you currently stand will be the most helpful to a productive therapeutic journey. Therapy can take time and will require effort and commitment from you and me. The outcomes are variable because they depend significantly on the decisions you make and the action you take because of them.

I believe people possess a desire to heal and grow. Therapy, to me, is a collaborative process where we explore what is holding you back from achieving your desired goals.

INFORMED CONSENT

Counseling Relationship:

During the time we work together, we will usually meet for sessions that last approximately 45-60 minute. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. You will be best served if our interactions address your concerns exclusively.

Our in-person contact will be limited to counseling sessions you arrange with me. I work during limited hours that do not include overnights, weekends, or school holidays and breaks. You may leave messages for me on my cell phone, and I will return your call as soon as possible. If you experience a mental health emergency, obtain crisis services by calling 911 and/or by going to a nearby hospital emergency room. You may contact COPES psychiatric mobile emergencies at 918/744-4800 if you are in crisis.

I conduct all counseling sessions *in English* or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, sexual orientation, or physical disability. If significant differences, such as in culture or belief system, exist between us, I will work to understand those differences. Unless you prefer otherwise, I will call you by your first name; please call me Ella.

_____Initial

Effects of Counseling:

At any time, you may initiate with me a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. Although I expect you to benefit from counseling, I cannot guarantee any specific results. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. You may feel distressed, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. *In particular, one risk of couple counseling is the possibility of exercising the divorce option.* Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you.

_____Initial

Client Rights:

Some clients achieve their goals in only a few counseling sessions; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful.

I render counseling services in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know.

_____Initial

Appointments, Cancellation, and Crises:

Our in-person contact will be limited to counseling sessions you arrange with me.

In the event that you will not be able to keep an appointment, please notify me at least 24 hours in advance, whenever possible at 918/973-0434. Your growth and our collaboration depend on your regular attendance. Therefore, if you are absent three weeks in a row, I will close your file, unless prior arrangements have been made. Likewise, if you intend to discontinue counseling, please inform me so your case file can be closed. If you fail to attend a session without 24 hour notice of cancellation, you will be responsible for paying the full cost of the session.

24 hour notice is required for appointment cancellation. Please call 918/973-0434. You must leave a voicemail message indicating the cancellation of an appointment. Failure to appear, canceling or rescheduling with less than 24 hour notice, a full session fee will be charged. Any fees incurred do to late cancellation or failure to appear for scheduled appointments must be paid prior to a new appointment being rescheduled or at the time of your next regularly scheduled appointment.

_____Initial

If you wish to reach me between sessions, you may leave messages for me at the number provided (918/973-0434); in these cases, I will return your call as soon as possible. If you experience a mental health emergency, obtain crisis services by calling COPES psychiatric mobile emergencies at 918/744-4800 or 911 and/or by going to a nearby hospital emergency room.

_____Initial

Fees:

In return for a previously agreed upon fee, I agree to provide counseling services for you. If the fee represents a hardship to you, please let me know. The fee for each session will be due and must be paid at the conclusion of each session. Cash or personal checks made out to Brighter Beginnings Counseling Services, Corp. are acceptable for payment. I do not file for reimbursement from health insurance companies. Upon request, I will provide you with a receipt so that you may file for reimbursement.

In order for Brighter Beginnings Counseling Services, Corp, to file insurance claims on your behalf, we have contracted with Millennium Information Services billing services.

You give permission for Brighter Beginnings Counseling Services, Corp, to give certain private information about you to Millennium Information Services and to your insurance or health care company. Typically, this includes the dates of service and your diagnosis. Other data may be necessary from time to time in order to ensure that you receive appropriate benefits. Some mental health treatments and diagnostic procedures are not covered by insurance. In that case you will be responsible for payment.

_____Initial

INSRUANCE: If you have health insurance it is your responsibility to verify your insurance benefits. You will be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due on the date services provided. You will be responsible for all charges not covered by your insurance company. You give Brighter Beginnings Counseling Services, Corp. consent to bill your insurance company.

_____Initial

FEE FOR SERVICES: Fee for services is $125.00 for a 50 minute face-to-face psychotherapy session. Payment is collected on the date service is provided. You are responsible for any debt incurred for services rendered to you by your therapist.

_____Initial

METHOD OF PAYMENT: Payment for services is accepted in the form of cash, check, or money order or by credit card. There will be a $35.00 charge for all returned checks.

_____Initial

COURT RELATED SERVICES: A $120.00 fee per hour with a half hour minimum charge for phone consultation with your attorney or other court officials will be assessed. Report preparation is charged at the rate of $120.00 per hour, with a half hour minimum charge. Fees are paid when service is rendered. All other court related services (waiting to be called, testimony, consulting, etc.) are charged at $300.00 per hour, are based on door to door time. A four hour minimum ($1200.00) charge must be paid in advance. Therapist from Brighter Beginnings Counseling Services, Corp. do not provide child custody evaluations or forensic assessments.

_____Initial

Confidentiality: Discussions between you and me, and even the fact that you are in counseling with me, are confidential. For this reason, if I see you in public, I will protect your confidentiality by greeting you only if you greet me first.

However, exceptions to confidentiality do exist. These exceptions include, but are not limited to, the following situations: a) you or your legal representative direct or consent in writing that I release your records; b) I am consulting with another mental health professional about how best to serve you, in which case I will not use your name or will use your first name only; c) I learn that you are involved in the abuse, neglect, or exploitation of a child, elderly, or disabled person or a patient in a mental health facility; d) I learn that you are infected with a potentially life-threatening illness that could be transmitted to a specific uninformed person, e) you disclose sexual contact with another mental health professional with whom you had a professional therapeutic relationship, in which case I must file a complaint and you have a right to confidentiality in the filing of the complaint; f) I am testifying in a child custody or visitation case involving you, g) I am testifying in a lawsuit in which your mental health is at issue; h) you have been charged with a crime; i) you bring a negligence suit against me, j) I am ordered by a court to disclose information; or k) I am otherwise required by law to disclose information.

_____Initial

In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person in danger and to contact the following persons, in addition to medical and/or law enforcement personnel:

Name_____

Telephone Number_____

_____Initial

You consent for me to communicate with you by mail, e-mail, and/or phone at the following addresses and phone numbers, and you will IMMEDIATELY advise me in the event of any change:

Street Address_____

E-Mail Address_____

Telephone Number(s)_____

If at any time you have any questions regarding confidentiality, you should bring them to my attention. By signing this information and consent form, you are giving your consent to me to share confidential information with all persons mandated by law, with the agency or mental health professional who referred you, and with my supervisor(s) and counseling students in my supervision group(s), and you are also releasing me and holding me harmless from any departure from your right of confidentiality that may result.

_____Initial

No session may be video or audio recorded without prior written permission from Brighter Beginnings Counseling Services, Corp.

_____Initial

Records:

All of our communication becomes part of the clinical record, which is maintained in the form of paper and electronic files. Records are the property of my practice and are stored in a lockable file cabinet or on a secure server. Adult client records are destroyed seven years after the file is closed. Minor client records are destroyed seven years after the client's 18th birthday.

_____Initial

Conditions of Ongoing Counseling:

While you are in counseling with me, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with me and sign a release that enables me to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional against my advice, I may consider this your decision to change counselors, and I reserve the right to terminate your counseling.

I also reserve the right to postpone and/or terminate counseling with you in any of the following circumstances: a) if you come to session under the influence of alcohol or drugs; b) if you do not comply with the medication recommendations of your psychiatrist or physician; c) if I believe you are not benefiting from counseling; d) if, in couple counseling, I learn that you are battering your partner/spouse; e) if I am impaired in providing competent counseling to you; or *f) if I am seeing you in couple counseling and you and your spouse decide to divorce*. In the case of group counseling, I reserve the right to deny group entry to anyone I consider inappropriate for the group and to terminate from the group anyone whose behavior I consider detrimental to

the therapeutic effectiveness of the group. In all of the aforementioned cases involving termination, I will provide you with referrals. If you choose to decline the referrals, I will terminate our counseling relationship, nevertheless.

_____Initial

Referrals:

I recognize that not all conditions presented by clients are appropriate for treatment with me. For this reason, you and/or I may believe that a referral is needed. In that case, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternative to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

_____Initial

Consent to Treatment:

By your signature below, you are indicating 1) that you voluntarily agree to receive mental health assessment and mental health care, treatment, or services, and that you authorize me to provide such assessment and care, treatment, or services as I consider necessary and advisable; 2) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such care, treatment, or services that you receive through me; 3) that you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you; and 4) that I provided you with a copy of this statement. By my signature, I verify the accuracy of this document and acknowledge my commitment to conform to its specifications.

I understand and agree to these policies, and accept responsibility for any debt for services rendered to me by Brighter Beginnings Counseling Services, Corp.

Client's Signature (14 yrs. and up)_____Date _____

Legal Guardian's Signature (for minor)_____Date_____

Therapist's Signature _____Date_____

RELEASE OF MEDICAL INFORMATION:

Brighter Beginnings Counseling Services, Corp. is not a Medicare provider. If Medicare is your primary insurance you will be responsible for full payment.

I authorize payment of insurance benefits to Brighter Beginnings Counseling Services, Corp. I understand that I am financially responsible for any charges not covered by insurance or third party payer. I authorize the release of any medical information necessary to process this claim. Oklahoma State Law (O.S. 63 sec 1-5022) requires the following statement: The information may include records which may indicate the presence of a communicable or venerable disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immune Deficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS).

Client Signature: _____ Date_____

Signature of Parent or Guardian: _____Date:_____

Patient Health Information Consent Form

I want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations I must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of policies and procedures concerning the privacy of your Patient Health Information I encourage you to read the HIPAA NOTICE that is available to you to review before signing this consent.

1. The patient understands and agrees to allow this office to use Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. Clinical records, psychotherapy notes, and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have the right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. Psychotherapy contact notes are not available for the patient to review. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Southside Behavioral Health, LLC is obligated to agree to those restrictions only to the extent they coincide with state and federal law.

4. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

6. For your security and right to privacy, staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in the office. I have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

7. Patients have the right to file a formal complaint with the privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.

8. My office reserves the right to make changes to this notice and to make new notice provisions effective for all protected health information that it maintains. You will be provided with the new notice at your next visit following any change.

9. This notice is effective on the date stated below. You may revoke that permission in writing at any time.

10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these

policies and procedures.

Patient signature (14 yr. and up): _____ Date: _____

Legal guardian signature for minor child: _____ Date: _____

For further information regarding this notice, please contact Ella L. Robertson 918/973-0434.