BNG COUNSELING

Initial Screening Form

Date of Screening: _____

Client Name: _____

Date of Birth: _____ Social Security Number: _____-_____-_____

Address: _____

_____

City, State: _____ Zip_____

Primary Phone Number: _____

May we leave a message? Y/N May we text you? Y/N

Secondary Phone Number: _____

May we leave a message? Y/N May we text you? Y/N

Responsible Party/Legal Guardian (if client is a minor):

_____

Primary Phone Number: _____

May we leave a message? Y/N May we text you? Y/N

Secondary Phone Number: _____

May we leave a message? Y/N May we text you? Y/N

Email Address:

_____

Emergency Contact Name and Number: _____

_____

BNG COUNSELING

Brief Description of Current Situation or Need: _____

_____

_____

_____

_____

_____

Please mark all that apply:

___Anger	___Grief	___Paranoia
___Anxiety	___Guilt	___Physical Aggression
___Behavioral Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Suicidal Thoughts/Attempts
___Delusions	___Interpersonal Conflict	___Weight Gain
___Depressed Mood	___Irritability	___Weight Loss
___Disruption of Thought Process	___Manic	___Worthlessness
___Emotional/Physical/Sexual Trauma	___Mood Swings	___Other (Please Specify)
___Family Conflicts	___Oppositional	
	___Panic Attacks	

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Is the client currently receiving services from another therapist, counselor, psychiatrist, agency? If so, please list providers and current services.

_____

_____

Are you aware of a current mental health diagnosis? If so, when was the client diagnosed and who provided the diagnosis?

_____

_____

Is the client currently taking prescribed medications? Y/N

If yes, please list each medication and dosage.

Medication	**Dosage**	**Medication**	**Dosage**

Does the client have insurance? If so, please provide this information.

_____

_____

Has client expressed any suicidal ideation or demonstrated any self-harming behaviors in the last 30 days? If yes, please explain. _____

_____

_____

BNG COUNSELING

Has the client expressed any homicidal ideation or plans in the last 30 days? If so, when and who is/was the intended target?

_____

_____

_____

Does the client have a history of trauma?

_____

_____

_____ When does the client wish to begin therapy?

_____

_____

_____ What is the best time for us to contact you to set up your first appointment? (A therapist will be assigned to the client and contact can be expected via the method requested above.)

_____

Have you previously received services from this provider at another organization or facility?

Yes No

If yes: I confirm that i intatiated contact with this provider on my own and no soliticitation occured.

BNG COUNSELING

Consent to Treatment

- I have chosen to receive psychotherapy services from BNG COUNSELING (BNG).
- I understand that there are both risks and/or benefits associated with treatment.
- I understand that psychotherapy often involves painful or problematic experiences and that there may be some discomfort and/or an increase in the intensity of emotions during the process of change. This is typically an indicator that the desired changes are in process and that progress in treatment is occurring. Psychotherapy has been shown to have benefits for people who complete it. I agree to discuss any and all noticeable differences in interpersonal relationships, conflict solutions, and significant changes in feelings of distress.
- I am aware that treatment is a collaborative process and that progress depends on my willingness to actively engage in the therapy process.
- I understand that there are no guarantees that progress will occur.
- I understand that I have a right to be informed about the purposes and limitations of my treatment, the clinicians' qualifications, credentials, and relevant experience.
- I understand that I have the right to discontinue services at any time. I also understand that there may be times when there are consequences to terminating treatment, such as when treatment is court ordered.
- I understand that BNG can terminate my treatment at any time if my needs cannot be met by this agency. I understand that BNG will refer me to an appropriate provider(s) if this should occur.
- I understand that there are fees associated with attending therapy and that, under certain circumstances, an inability to pay these fees could result in an interruption or termination of services.

BNG COUNSELING

- I understand that services may be terminated if I demonstrate any of the following behaviors while on BNG premises: acts of physical aggression, acts of verbal aggression/abuse, possession of a weapon, engagement in any illegal behaviors to include the use of/being under the influence of drugs or alcohol, display of any behaviors that disrupt the safety and security of the treatment setting.
- I understand that my right to informed consent may be waived if I am at risk of harm to myself or others.
- I understand that a surrogate decision maker may provide informed consent on my behalf if a physician, psychiatrist, and/or another mental health professional have determined that I do not have the capacity to make informed decisions for myself. A surrogate decision maker can only consent to specific mental health services permitted by the Mental Health and Developmental Disabilities Code.

(Your signature below indicates that you have read and understood the BNG Consent to Treatment statements above)

_____	_____	_____
Client Name (Print)	Client/Guardian Signature	Date

BNG COUNSELING

Privacy Practices Form

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:

a) Type of therapy needed (individual, group, medication referral, etc.)

b) Frequency of therapy sessions (weekly, biweekly, etc.)

c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 45-50 minutes. At the end of each appointment you can discuss future appointments with your therapist.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. If you do not pay in full at the time of service. Charges for services in addition to therapy may be levied (i.e., involvement in client litigation, document preparation, etc.). These fees will be negotiated individually with your therapist. We accept cash and check. Please make checks out to “BNG COUNSELING (BNG)”.

BNG COUNSELING

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through BNG COUNSELING (BNG) are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gatekeeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at BNG COUSNELING (BNG) and is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists at the office as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions. Y/N

I have received a copy of the Privacy Practices Form. Y/N

BNG COUNSELING

I consent to the exchange of treatment information between BNG and my primary care physician. Y/N

(Your signature below indicates that you have read and understood the BNG Privacy Practices statements above)

_____	_____	_____
Client Name (Print)	Client/Guardian Signature	Date

BNG COUNSELING

Request for Electronic Communication

I request that the following communication from BNG COUNSELING (BNG) be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating risk of improper disclosure to unauthorized individuals. I am willing to accept the risk and will not hold the agency responsible should such an instance occur.

Communications Include:

Appointment Reminders Y/N Information Y/N Other Y/N

Preferred method: Email Y/N Address: _____

Text Y/N Number: _____

This request for delivery of communication will extend throughout the time that the client(s) are receiving services through SSN.

Acknowledgements and Agreements: I understand that this form of communication may not be secure, creating risk of improper disclosure to unauthorized individuals. I am willing to accept the risk and will not hold the agency responsible should such an instance occur.

_____ _____

Signature of BNG Rep. Date Signature of Client or Guardian Date

BNG COUSNELING

Financial Agreement

If you have medical insurance, please fill out the Authorization for Filing Insurance page of this packet. In order to best serve you, we want to help you receive your maximum allowable benefits. To achieve this goal, we need your assistance and understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. Please ensure that the information that is provided to our office on the patient information form is accurate and current. If there is a change in insurance information, please let us know immediately.

If you are self-pay, payments are due at the time services are rendered, unless payment arrangements have been approved by our Billing Officer. BNG COUSNELING (BNG) accepts cash, checks, credit cards, and debit cards.

We realize that temporary financial problems may arise and affect your timely payment of your account. If such problems do arise, we encourage you to contact our billing officer promptly at (573)366-6349 to assist in the management of your account.

If therapist is ordered to court, there will be an additional fee for the day of court. If a therapist is subpoenaed to attend court and or testify in a case in which the client is a part of, an additional fee of one thousand dollars ($1000) to cover the expense of travel and missed or rescheduled appointments that would have otherwise occurred on that date. This fee will also apply if court is cancelled and therapist is not notified with a two week notice due to the loss of clients on that day. Therapist or facility notes may be subpoenaed to court for a fee of two hundred and seventy-five dollars ($275).

_____ _____ _____

Client Name (print) Client Signature Date

BNG COUSNELING

Authorization for Filing Insurance

Primary Insurance Plan

Insurance Company Name: _____ Phone: _____

Address: _____

Member ID#: _____ Group or Policy #: _____

Primary Insured Name (if different than client): _____

Secondary Insurance Plan

Insurance Company Name: _____ Phone: _____

Address: _____

Member ID#: _____ Group or Policy #: _____

Primary Insured Name (if different than client): _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION TO PROCESS INSURANCE CLAIMS. I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO BNG COUNSELING (BNG).

_____ _____ _____

Client Name (print) Client Signature Date