Center For A Brighter Tomorrow, PLLC
372 Applegate Lane, Chattanooga, TN 3742.
423-994-7264 Fax 423-661-3418

ADULT FORMS

Client Information Form

This form is completely confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Social Security #: _____

Home street address: _____

City: _____ State: _____ Zip: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

_____

How would you like to be reminded of your appointments? Phone call/ Text/Email.

Referred by: _____

- May I have your permission to thank this person for the referral?
  Yes, No
- If referred by another clinician, would you like for us to communicate with one another?
  Yes, No

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?

**The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing. **

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____
Do you consume caffeine? YES, NO If YES, how much per day? _____
Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____
Do you use any non-prescription drugs? YES NO
If YES, what kinds and how often? _____
Have any of your friends or family members voiced concern about your substance use? YES NO
Have you ever been in trouble or in risky situations because of your substance use? YES NO
Previous medical hospitalizations (Approximate dates and reasons): _____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____
Sexual Identity: Heterosexual__ Lesbian__ Gay__ Bisexual__ Transgender__ In Question__

FAMILY:

How would you describe your relationship with your mother?

_____

_____

_____

How would you describe your relationship with your father? _____

_____

_____

Are your parents still married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____
How many brothers do you have? _____ Ages? _____
How would you describe your relationships with your siblings? _____
_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____
_____

List the names and ages of those living in your household: _____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____
_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: _____
_____
_____

Is spirituality important in your life and if so please explain: _____
_____

Briefly describe your diet and exercise patterns: _____
_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment? _____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant?_____
_____

What do you think are your strengths?_____
_____
_____

PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Anxiety			People in General			Nausea		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			"Nervous Breakdown"		

Any additional information you would like to include:

_____

_____

_____

_____

Center For A Brighter Tomorrow, PLLC

INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	SUBSCRIBER ID	GROUP NUMBER

Important Information regarding fees for service and our cancellation policy

Client Initial *(please initial each section below indicating you understand and agree to fees and policies)*

_____ **General Fee and Payment Policy:** Here at Center for a Brighter Tomorrow, PLLC we have a range of practitioners and services. We will file your insurance as a courtesy, however if your claims are not paid, **you are responsible for the full amount of the charge. Filing insurance does not guarantee payment.** Our typical fees are listed below, although there may be a discount for services, if you qualify. Please speak to us if you have any questions regarding your fee. Payment is due on date of service.

Counseling Sessions

Intake with Therapist - $150
60-minute Individual Counseling Session - $150
45-minute Individual Counseling Session - $125
Family or Couples Counseling Session - $125
Group Counseling Session - $75
Crisis Assessment - $150.00

_____ **Psychological Testing with Senior Psychological Examiner:** Cost varies depending on what type of testing is necessary (Disability, ADHD, IQ, etc). Generally, fees are as follows and may not be covered by your insurance company. Fee includes intake, tests, and report which occur in 3-4 separate sessions. IF a person cannot pay the lump sum: One half of the fee is due at time of service and the other half is due before the results are released to the patient.

Adult - $600 Child - $750

_____ **Court Fees:** If subpoenaed, the cost for attending as an expert witness is $125.00 per hour. One half of the fee is due prior to the court date and the other half is due the day of court.

_____ **Supervised Visitation:** If supervised visitation is needed with a non-custodial parent the fee is $65.00 per hour and can be scheduled with a therapist that works with children and/or families.

_____ **Case Management Services:** Phone calls more than 10 minutes with clients, insurance companies, pharmacies, etc. will result in the following charges and will need to be paid before the next session.

10 minutes - $25 30 minutes - $50 45 minutes - $100

_____ **Administrative Fee for Paperwork/Records:** Our providers are happy to complete paperwork for Social Security, Short-Term and/or Long-Term Disability, FMLA, etc. free of charge *during your regularly scheduled counseling session.* A $25 charge will apply for paperwork completed outside of your session.

_____ **Late Cancellation and No-Show Fees:** Our providers maintain a full case load and often have waiting lists; therefore, our center strictly enforces a late cancellation/no-show fee of $35 ($50 for psychiatrists). This must be paid before you are seen again. These fees can only be waived by your provider, so if you have an extenuating circumstance, please talk with them.

_____ **Returned Checks:** $30 fee

_____ **Unpaid Invoices:** Invoices that go unpaid for 30 days will incur a $35 late payment fee. After 90 days, an unpaid invoice will be sent to a collection agency.

Please sign below that you understand these charges and policies. Please feel free to ask any questions regarding your payment responsibility.

Print Patient Name: _____ Date: _____

Patient Signature: _____

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. Typically, treatment is provided over the course of several weeks.

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, but agree to discuss this decision first with my provider.

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.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have.

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: Date
(for minor)

NOTICE OF PRIVACY PRACTICES Date

Effective April 29, 2015

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.
Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- Required by Court Order

- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider:

Right of Access to Inspect and Copy. In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
(202) 619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service.

Client Name: _____ _____
Client Signature:

_____ _____
If signed by other than client, indicate relationship: Date

INSTRUCTIONS FOR RELEASE OF INFORMATION

The next page is a Release of Information Form.

If you would like us to share information with your primary care provider, pediatrician, psychiatrist, previous counselor, or another professional, please complete the form on the following page.

If you need more than one form, just ask the front desk staff at the time of your appointment.

If you do not want us to release any information at this time, write "N/A" in the Second Party category (section 2) and leave the rest of the form blank.

Records Release Authorization

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient Name: _____ Patient Date of Birth: _____

1. ☐ I authorize my provider to ☐ RELEASE ☐ RECEIVE psychological/psychiatric mental health information to/from the SECOND PARTY as directed below:

2. SECOND PARTY

Name: _____

Address: _____

Fax Number: _____ Phone Number: _____

3. TYPE OF INFORMATION TO BE DISCLOSED

- ☐ I authorize disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy
- ☐ I authorize only the disclosure of the following information:

_____

4. PURPOSE

- ☐ My health information is being disclosed at my request or at the request of my personal representative; or
- ☐ My health information is being disclosed for the following purpose:

_____

5. Note any exclusions or limitations here: _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. This authorization will expire one year following the date signed unless revoked in writing.

_____ _____

Signature Date:

☐ Authorization is given on this patient's behalf due to being a minor or unable to sign.

_____ _____

Legal Guardian/Personal Representative Signature: Date: