Adult Intake

Please provide the following information:

Client Name: ____

(Last) (First) (Middle Initial) (Nick Name)

Address: ______________________ City: ______________ State: _____ Zip: ________

Date of Birth:_____/_____/________ Age:________ SSN: _______-_______-__________

Cell/other:______________________________ May we leave a text message? □ Yes □ No

Home Phone:______________________________ May we leave a message? □ Yes □ No

Email:______________________________ May we email you? □ Yes □ No

Referred by: ______________________________

INSURANCE INFORMATION

Primary Insurance Carrier: ______________________ Phone: ______________________

ID#: ______________________ Group#: ______________________

Name of Policyholder: ______________________________

Date of Birth: ______/______/_________ Social Security Number: _______-_______-__________

Address: ______________________ City: ______________ State: _____ Zip: ________

Home Phone: ______________________ Work Phone: ______________________

Relationship of Patient to Policyholder: Self Spouse Child Other: ______________________

Secondary Insurance Carrier: ______________________ Phone: ______________________

ID#: ______________________ Group#: ______________________

Name of Policyholder: ______________________________

Date of Birth: ______/______/_________ Social Security Number: _______-_______-__________

Address: ______________________ City: ______________ State: _____ Zip: ________

Home Phone: ______________________ Work Phone: ______________________

Relationship of Patient to Policyholder: Self Spouse Child Other: ______________________

IDENTIFICATION:

Marital Status: ☐ Never married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Talk about later

Gender Identity: ☐ Male ☐ Female ☐ Other: ____________________ ☐ Talk about later

Sexual Orientation: ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Questioning ☐ Talk about later

Racial/Ethnic Identities: ____________________ ☐ Talk about later

Other ways you identify yourself and consider important: ____________________

MEDICAL HISTORY:

Primary Care- Clinic/Physician's Name: ____________________ Phone: __________

Address: ____________________

Please list any allergies and the reaction:

Allergy **Reaction/Symptoms**

____

____

____

Please list any current symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

____

____

____

Are you currently on any medications? ☐ Yes ☐ No

If yes, list medication(s) and prescribing physician(s): ____________________

____

____

____

List any previous operative procedures, and medical hospitalizations:

Date **Treatment/Procedure**

____

____

____

Have you had a physical (annual checkup) within the last year? ☐ Yes ☐ No

Has you ever had psychological testing? ☐ Yes ☐ No (If yes, please provide copies.)

EMERGENCY CONTACT INFORMATION:

In the event of a medical emergency, Bridges Behavior Therapy and Consulting, LLC should contact one or more of the following individuals:

Contact Name: ____________________ Phone: ____________________

Contact Name: ____________________ Phone: ____________________

Contact Name: ____________________ Phone: ____________________

Preferred Emergency Medical Facility: ____________________

In the event of a medical emergency, Bridges Behavior Therapy and Consulting, LLC has my consent to provide transport to a nearby emergency medical facility and to authorize medical treatment.

____________________ ____________________

Client Signature Date

PRESENT STATUS:

What prompted you to seek services?

____

____

____

____

Have you ever had or currently have…? (Check all that apply)

	YES	**NO**
Thoughts of hurting themself	______	______
Thoughts of committing suicide	______	______
Plans to commit suicide	______	______
Attempts to commit suicide	______	______
Admission to ER/hospitalized	______	______
Threats to commit suicide	______	______
Inflicted burns or wounds to yourself	______	______
Thoughts of harming someone	______	______
Plans to harm someone	______	______
Attempts to harm someone	______	______
Threats to harm someone	______	______
Actually harmed someone	______	______
Any family history of suicide, homicide, domestic violence	______	______
Feelings of depression	______	______

Treatment Goals: What would you like to see accomplished from therapy?

____

____

____

____

***I affirm by my signature that I have provided accurate information to all the questions contained in this client profile.**

____

Client Name (Print)

____ ____

Client Signature Date

CONSENT TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION TO/FROM ANOTHER (THIRD) PARTY

I authorize Bridges Behavior Therapy and Consulting, LLC to obtain / release confidential information regarding my medical condition to the following organization(s):

Organization:	Phone:	Address:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

I authorize Bridges Behavior Therapy and Consulting, LLC to obtain / release confidential information regarding my medical condition from the following person(s):

Name:	Phone:	Relationship:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

I authorize Bridges Behavior Therapy and Consulting, LLC to take pictures &/or record videos of myself to be used for the following purposes:

_______ Staff Training
_______ Workshops &/or Conferences
_______ Marketing &/or Advertisements

I understand and agree that this authorization will be valid until I give written notice to Bridges Behavior Therapy and Consulting, LLC. If I revoke or cancel this authorization, it will prevent any disclosures after the date it is received but can not change the fact that some information may have been sent or shared before that date.

____
Client Name (Print)

______________________________ ______________________________
Client Signature Date

____
Parent/Legal Guardian Name (Print)

______________________________ ______________________________
Parent/Legal Guardian Signature Date

PERMISSION / ASSIGNMENT RELEASE

I have voluntarily applied and give consent to services performed by Bridges Behavior Therapy and Consulting, LLC. I understand that I have the right to refuse services at any time and agree that my continued participation implies voluntary informed consent. I understand and agree that my disclosures and communications are considered privileged and confidential.

I authorize Bridges Behavior Therapy and Consulting staff to leave messages regarding my medical condition, such as reports, other assessment results, and appointment reminders. This authorization will be in effect until I give written notice to Bridges Behavior Therapy and Consulting.

Home Answering Machine	☐ Agree	☐ Disagree
Cell Phone Voicemail	☐ Agree	☐ Disagree
Cell Phone Text Messaging	☐ Agree	☐ Disagree
Work Phone	☐ Agree	☐ Disagree
Email	☐ Agree	☐ Disagree
With Individuals Listed on Authorization	☐ Agree	☐ Disagree

PLEASE USE THE OFFICE EMAILS FOR ELECTRONIC COMMUNICATIONWITH THE OFFICE, AS WE ARE NOT ALLOWED TO COMMUNICATE THROUGH SOCIAL MEDIA.

I certify that the signature below shall serve as "Signature on File" for all insurance companies claims on my behalf by Bridges Behavior Therapy and Consulting.
I understand that information disclosed pursuant to this release may be disclosed by the authorized recipient and no longer protected by the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA).

I acknowledge receipt of Bridges Behavior Therapy and Consulting's Notice of Privacy Practices.

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments; however, the patient is responsible for ALL fees, regardless of insurance coverage. Payment is due when services are rendered, unless other arrangements have been made in advance with the office manager. Co-Pays are due at the time of service.

I authorize payment of medical benefits to Bridges Behavior Therapy and Consulting. I also authorize the release of any medical or financial information necessary to obtain payment on my behalf. The patient is responsible for the deductible, co-insurance, and non- covered services.

Should my account be referred to an outside agency for collection, the undersigned shall pay all cost of court and/or all collection agency fees. I hereby waive all rights of exemption under the laws of the state of Alabama and any other state. I agree that in any event court action becomes necessary, that the plaintiff's case shall be tried in the location of the plaintiff's choice, regardless of the defendant's county or state of residence.

______________________	______________________	__________
Client Name (Print)	Client Signature	Date
Parent/Legal Guardian Name (Print)	Parent/Legal Guardian Signature	Date

HIPAA Notice of Privacy Practices

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

We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we obtain from you and store in your file. Specific health information that is stored includes session data, progress notes, behavior plans, claim reports from billing submissions, and personal information.

Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Protection from Harm

For treatment:

- Information obtained will be recorded and kept in your file and used to help determine the appropriate treatment options.
- We may also provide information to others (if given permission to release information)

For Insurance Reimbursement:

- When requesting information from your health insurance plan we are asked for information including diagnoses, procedures performed, address, phone number, identification number/social security number, date of birth, and dates of service.
- For billing and payment purposes we may disclose information to insurance or a managed care company, Medicaid, private insurance, or another third-party payer. These uses and disclosures are necessary to manage the agency and our quality of care.

To Protect the Client or Others from Harm:

- If we have reason to suspect that a minor, elderly, or disabled person is suffering from abuse, Bridges Behavior Therapy and Consulting, LLC is required to report this to the appropriate state agency. If there is any indication that a client is threatening serious harm to him/herself or others, we are required to take protective actions which may include notifying the police (others who may provide protection), intended victim, child's parents, or hospitalization.

Your Health Information Rights

The health and billing records we create and store are the property of Bridges Behavior Therapy and Consulting, LLC. However, the Protected Health Information belongs to you and you have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us and we will try to comply with any request made;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing and mail it to 112 Titan Drive Florence, AL 35630
- Ask us to change your health information or ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.

Our responsibility regarding you/your child's protected health information:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice.
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to make changes to this notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. Any changes made will affect the protected health information we maintain at that time. We will provide a revised copy of the notice to parents/legal guardians upon request on or after the effective date of revision.

To Ask for Help or to Register a Complaint:

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may call us at (256) 275-7089.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also mail a written complaint to 112 Titan Drive Florence, AL 35630 or file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will take your complaint as constructive criticism and will not retaliate against you.

We may use and disclose your protected health information without your authorization as follows:

- For certain purposes involving workplace illnesses or injuries.
- For Public Health and Safety Purposes as Allowed or Required by Law.
- To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- To public health or legal authorities.
- To protect public health and safety.
- To prevent or control disease, injury, or disability.
- To report vital statistics such as births or deaths.
- To Report Suspected Abuse or Neglect to public authorities.
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.
- For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

____

Client Name (Print)

____

Client Signature Date

____

Parent/Legal Guardian Name (Print)

____

Parent/Legal Guardian Signature Date