Bethany, Yates & Associates

Personal Counseling and Consulting

ADULT **Information for Confidential and Professional Use Only**

First Name_____M.I.____Last Name_____

Address_____

City_____ State_____ Zip Code_____

Home Phone (___)_____

Work Phone (___)_____Birthdate_____

Mobile Phone (___)_____ May we text/email you? [ ] Yes [ ] No

May we leave a message for you at home? [ ] Yes [ ] NO Work? [ ] Yes [ ] NO

E-mail address_____ Sex: [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Employed [ ] Student

Who referred you to us?_____

Insurance Company_____Insurance Co. Customer Service #(___)_____

Insured's Name_____ [ ] Self [ ] Spouse [ ] Child [ ] Other

Insured's SS Number_____-_____-_____ Insured's I.D. Number_____

Insured's address if different from client/patient_____

Phone: Home (___) _____ Work (___) _____ Mobile (___) _____

Insured's Birth date_____ Sex [ ] Male [ ] Female

Employer's Name_____

Reason for coming in: _____
Previous Treatment [ ] Yes [ ] No

Previous Therapist: _____Dates_____to_____

Medications currently taking:
1) _____Dosage/Freq. _____Start Date _____Purpose _____
2) _____Dosage/Freq. _____Start Date _____Purpose _____
3) _____Dosage/Freq. _____Start Date _____Purpose _____

Prescribed by_____ Date of last medical evaluation_____ Date of next appt._____

Adult Information Form

Name_____ Date of first appointment_____

Date of Birth_____ Age____ Sex_____

Marital Status: Single__ Married___ (___years) Separated___ Divorced ___Widowed___

Have you ever been hospitalized? Yes___ No___

Hospital	Month/Year	Reason
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? Yes___ No___

If yes, please list:

Type of Drugs	How much?	How often?
_____	_____	_____
_____	_____	_____

Do you drink alcohol? Yes___ No ___

If yes, please list:

Type of Alcohol	How much?	How often?
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? Yes___ (___cigarettes per day) No___

Do you have any close relatives (father, mother, brother, sister) who have experienced depression or other emotional problems? Please list: _____

_____

_____

Describe any other health problems or important medical history about yourself or close family members, including chronic ailments: _____

_____

_____

Education: Please list any schools or programs you have attended:

Name	Years	Year Graduated
High School_____	_____	_____
College _____	_____	_____
Other_____	_____	_____

Employment Information:

Employer	Days/Hours per Week
_____	_____

How would you describe your relationship with your employer? _____

_____

_____

How would you describe your relationship with your work peers? _____
_____
_____

Mother: Living___ Deceased___ Married___ Divorced____
Remarried___ (___# of times)
Describe relationship with mother while growing up: _____
_____
_____
Describe current relationship with mother: _____
_____
_____
Father: Living___ Deceased____ Married____ Divorced____
Remarried ___ (___#of times)
Describe relationship with father while growing up: _____
_____
_____
Describe current relationship with father: _____
_____
_____
Where do your parents currently live?
Mother_____
Father_____
Please list your brothers and sisters:

Name	Age	Natural/Step	Lives Where?	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Marital History: Current status: ___Married ___ Divorced ___Widowed ___Never been married
If married, how long have you been married? _____ Spouses Name:_____
How many times have you been married? _____
If living with someone, how long have you lived together? _____
Please list your children:

Name	Age	Natural/Step	Lives With	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Others living in the home with you:

Name	Relationship	Age	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____

Mental Status: Please circle any of the following that describe how you have been feeling lately: sad anxious depressed frightened guilty angry ashamed aggressive resentful worthless tearful irritable confused extreme ups &downs jealous hopeless helpless

Describe any other feelings you have had: _____
_____
_____

Have you had any changes in sleeping habits? Yes___ No___
Describe:
_____
_____

Have you had any changes in eating habits? Yes___ No___
Describe:
_____
_____

Have you ever considered suicide in connection to your current problems? Yes___ No___
If so, please give a brief description with dates:

Description	Dates
_____	_____
_____	_____

Have you ever considered suicide in the past? Yes___ No___
Have you attempted suicide recently or in the past? Yes___ No___
If so, please give a brief description with dates:

Description	Dates
_____	_____
_____	_____

Level of functioning: List or describe any current impediments or problems in daily psychological, social or occupational functioning, i.e. isolation from friends/family, significant difficulty getting to work or making yourself do daily tasks, severe financial strain, recent divorce, loss or separation from family or friend, problems with supervisor,
etc._____
_____
_____

Thoughts: Please check any of the following that apply to you:
___ I sometimes hear voices even though no one nearby is talking to me.
___ I sometimes feel that forces outside of me control me.
___ I sometimes feel that other people control my thoughts.
___ I sometimes have the same thought over and over and cannot control it.
___ I sometimes feel that someone is out to hurt me or do something against me.
___ I am sometimes unable to control my behavior. Please explain: _____
_____
_____

Please check coping skills that you are currently using: ___exercise ___relaxation
___prayer/meditation ___music ___reading ___hobby:_____
___ Church ___organization/clubs ___volunteering: _____
Please describe any spiritual orientation or belief (i.e. Christian, attend Catholic Church weekly):
_____
_____
_____
_____

Bethany, Yates & Associates
803 Stadium Dr. Suite 101
Arlington, Texas 76011
(817)459-2003

Adult Checklist of Concerns

Name: _____Date:_____

Please mark all of the items below that apply and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- o I have no problem or concern bringing me here
- o Abuse-physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- o Aggression, violence
- o Alcohol use
- o Anger, hostility, arguing, irritability
- o Anxiety, nervousness
- o Attention, concentration, distractibility
- o Career concerns, goals, and choices
- o Childhood issues (your own childhood)
- o Children, child management, child care, parenting
- o Codependence
- o Confusion
- o Compulsions
- o Custody of children
- o Decision making, indecision, mixed feelings, putting off decisions
- o Delusions (false ideas)
- o Dependence
- o Depression, low mood, sadness, crying
- o Divorce, separation
- o Drug use – prescription medications, over-the-counter medications, street drugs
- o Eating problems-overeating, underrating, appetite, vomiting (see also "Weight and diet issues")
- o Emptiness
- o Failure
- o Fatigue, tiredness, low energy
- o Fears, phobias
- o Financial or money troubles, debt, impulsive spending, low income
- o Friendships
- o Gambling
- o Grieving, mourning, deaths, losses, divorce
- o Guilt
- o Headaches, other kinds of pains
- o Health, illness, medical concerns, physical problems
- o Inferiority feeling
- o Interpersonal conflicts
- o Impulsiveness, loss of control, outbursts

- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Oversensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- Relationship problems
- School problems (see also "Career concerns . . .")
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- Shyness, oversensitivity to criticism
- Sleep problems – too much, too little, insomnia, nightmare
- Smoking and tobacco use
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolating
- Work problems, employment, workaholic/overworking, can't keep a job

Any other concerns or issues:

- _____
- _____

Please look back over the concerns you have checked off and choose the one that you most want help with.
It is:

_____

_____

Cynthia L. Bethany, LCSW, CTS
Linda L. Loveless, LCSW
Valerie Hyatt Martin, LCSW
Blanca McGee, LCSW

Charles A. Yates, LCSW
Cathy Stout, LCSW
Debra Wysoski, MA, LPC

Bethany, Yates & Associates
Personal Counseling & Consulting

Important Information

Please read and sign that you have read and understand the following.

By making your first appointment you have already made progress. Deciding to participate in therapy show your courage and willingness to take the steps necessary to improve your life. Therapy can be rewarding, and those who are willing to work and take the necessary risks can experience a life changing process. We look forward to working with you and hope that we can assist you in reaching whatever goals you set.

Effective Therapy is built from good working relationships and requires mutual understanding. It is in the mutual interest of both client and therapist to convey to you the policies and procedures we use in our practice; we are willing to discuss any questions or problems you may have.

Appointments are usually scheduled once or twice a week and last approximately 53 - 60 minutes. More frequent or intensive outpatient schedules are possible depending upon the circumstances. If you need to reschedule or cancel an appointment, please call (817)459-2003 and leave a message that you need to reschedule your appointment. Broken appointments create a loss to everyone. **It is important that communication of changes be made well in advance of your scheduled appointment time whenever possible; a missed appointment or an appointment canceled without 24 hour notice will result in a $25.00 charge.**

The Fee Schedule is as follows: Fees are based on time and are the same for individuals or couples/families within the same session.

Initial Intake and Assessment	$150.00
Regular Office Visits (53 – 60 minutes)	$125.00
(1 hour, 15 minutes)	$135.00
(1 hour, 30 minutes)	$180.00
Small Group Therapy (1.5 hours/week) per session	$ 35.00
Outside Office Work (Inpatient visits, court testimony, written deposition etc.)	$175.00/hour
Required Written Reports (Ins. Companies, supervisors, etc.)	$150.00
CORE Multidimensional Assessment Profile	$100.00
ThriveSphere Couples Assessment	$ 50.00
Anger Management Group (10 weeks, $30 session, or if prepaid)	$250.00

We do not discriminate on any basis. If we are unable to help with your case, or continued service is no longer in the client's best interest, the therapist will terminate and provide three referrals to other sources.

Payment of Fees: Fees are payable at each session. Monthly payment arrangements are possible for those who have already established a record of paying. Insurance claims will be filed if requested; otherwise, full payment is expected and a super bill will be given upon request for you to file your own insurance. Payment is your responsibility even when insurance is filed. **In order to take full advantage of your session time, it is requested that your check be prepared prior to beginning the session, this also helps to expedite the rescheduling of future appointments.**

Relationship: Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

Emergencies: A mental health professional is on call at Millwood Hospital 817-261-3121.

Therapist's Incapacity or Death: I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me the copies upon request, or to deliver them to a therapist of my choice.

Limits of Confidentiality: Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse, abuse of the elderly or disabled; abuse of patients in mental health facilities, sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this consent form, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing you mental health care services and payment for those services, and you are also releasing and holding harmless the therapist from any departure from your right of confidentiality that may result.

I have read and understood the above limits to confidentiality. Furthermore, I grant permission for my therapist to share my information with any therapist who covers for my therapist when they are unavailable. I also grant permission for my therapist to share my case in a Case Review if they deem it necessary.

Duty to Warn: In the event that the undersigned therapist reasonably believes that I am or my child is a danger, physically or emotionally to myself or another person, I specifically consent for the therapist to contact any person in a position to prevent harm to myself or any other person, including but not limited to the person in danger, and to contact the following persons in addition to medical and law enforcement personnel:

Name Telephone Number

_____

Consent to Treatment: I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through the undersigned therapist at any time.

By signing this client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Many opportunities have been offered for me to ask questions and seek clarification of anything unclear to me.
This signed copy will be kept in your file; if you want a copy for yourself, please ask and we will be happy to provide one.

_____ _____

Signature of Adult Patient or Parent/Guardian Date

_____ _____

Therapist Date

Bethany & Yates, PLLC
Bethany, Yates & Associates
Personal Counseling & Consulting
803 Stadium Dr. Suite 101
Arlington, Texas 76011
Telephone: (817)459-2003 Fax: (817)459-1898

CONSENT TO RELEASE INFORMATION

I hereby authorize_____to release information pertaining to the case

of _____
(Name of Patient)

TO/FROM: _____
Name of Person/Organization to Which Disclosure is Made

_____
Address

_____

PLEASE CHECK THE SECTIONS OF THE RECORD NEEDED:

_____Discharge Summary
_____School Reports
_____Speech/Language/Hearing Assessment
_____Verbal Communication
_____Other_____

_____Psychological Evaluation
_____Psychosocial Assessment
_____Psychiatric Assessment
_____Master Treatment Plan
_____Therapy Notes

I understand any of the above requested information may include results of Human Immunodeficiency Virus (HIV) or AIDS test, if one was performed.

Bethany & Yates, PLLC is hereby released from legal responsibility of the release of the records indicated and authorized herein.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire twelve (12) months from when it is signed unless another date is specified below.

Specification of the date, event or condition upon which consent expires:

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Witness Date

BETHANY, YATES & ASSOCIATES
PERSONAL COUNSELING & CONSULTING
803 Stadium Dr. Suite 101
Arlington, Texas 76011

(817) 459-2003
bethanyandyates@gmail.com
www.bethanyyatescounseling.com

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.**

<u>YOUR RIGHTS</u> –

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
We are not required to agree to your request, and we may say "no" if it would affect your care.
If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.
We will provide you with a paper copy promptly.

Choose someone to act for you.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

YOUR CHOICES –

For certain health information you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care.
Share information in disaster relief situation.

In these cases we never share your information unless you give us written permission:

Most sharing of psychotherapy notes.

OUR USES AND DISCLOSURES –

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you – We can use your health information and share it with other professionals who are treating you.

Run our organization – We can use and share your health information to run our practice, improve your care and contact you when necessary.

Bill for your services – We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information? We are allowed or required to share your information in other ways . We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with safety issues. We can share health information about you for certain situations such as:
Reporting suspected abuse, neglect, or domestic violence.
Preventing or reducing a serious threat to anyone's health or safety.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying the federal privacy laws.

Law enforcement and other government requests. We can share health information about you:
For law enforcement purposes or with a law enforcement official.
For special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES -

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing.
If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

This Notice of Privacy Practices applies to the following organizations.
Bethany, Yates & Associates.

Privacy Official – Cynthia L. Bethany, LCSW, CTS or Charles A. Yates, LCSW-S. (817) 459-2003 bethanyandyates@gmail.com.

The effective date of this notice is September 23, 2013.

Bethany, Yates & Associates
Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client:_____
Date of Birth:_____
Social Security #:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Bethany, Yates & Associates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Cynthia Bethany, LCSW, CTS or Charles Yates, LCSW.

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian or Personal Representative* **Date**

_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

- ❑ **Patient/Client Refuses to Acknowledge Receipt:**

_____

Signature of Staff Member **Date**

Bethany, Yates & Associates

Personal Counseling and Consulting
803 Stadium Dr. Ste. 101 Arlington, TX 76011
817-459-2003

Client's Name _____

Today's Date _____

CLIENTS FILING ON THEIR INSURANCE

_____ I understand that because my therapist participates with my insurance, most or all of my charges will be submitted to my insurance company. I also understand that my therapist may need to furnish medical information to my insurance company to complete the claim process.

_____ I understand that if my insurance coverage cannot be verified, or if coverage is denied, then I am responsible in full for these charges.

_____ I understand that I am responsible for co-payments / deductible amounts which will be due at the time of service.

Client's Signature/
Parent-Guardian if a minor _____Date_____