Bethany, Yates & Associates

Personal Counseling & Consulting

ADOLESCENT

Information for Confidential and Professional Use Only

Client's Name: First_____ M.I._____ Last_____

Address_____

City_____ State_____ Zip Code_____

Home Phone (____)_____

Mobile Phone (___)_____

Birthdate _____ Sex [ ] Male [ ] Female

Responsible Party:

First Name_____M.I._____Last_____

Address_____

City, State, Zip_____

Home Phone (____)_____ Work Phone (____)_____

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

Who referred you to us?_____ e-mail address_____

Insurance Company_____Insurance Co. Customer Service #(___)_____

Insured's name_____ Insured's ID#_____

Insured's address if different from client_____

Insured's birthdate_____

Employer's name_____

May we leave a message for you at work? ( ) Yes ( ) No

Reason for coming in:_____

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._____

CHILD/ADOLESCENT
INFORMATION FORM

Name of Patient_____ Date_____

Name of Parent/Guardian_____

Name of Person Giving Information_____

Chief Complaint_____

History of Presenting Problem

A. History of harm to self/suicidal behavior Yes___ No___

B. History of aggression/homicidal behavior Yes___No____

C. History of attention problems/hyperactivity Yes___No___

D. History of fire setting/cruelty to animals Yes___No___

E. History of hallucinations Yes___No___

F. History of abuse (physical, sexual, emotional) Yes___No___
(Including age of abuse and perpetrator information)

G. History of substance use Yes__No___

H. Criminal or delinquent activity Yes__No___

Developmental Medical History

A. Pregnancy (including prenatal care/birth)

B. Developmental Milestones
Achieved within normal limits Yes__No___

Complications_____

C. Problems with Enuresis/Encopresis (bedwetting/soiling) Yes__No__

D. History of Seizures Yes__No__

E. Problems with Sleep/Appetite/Early Separation Yes__No__

F. Medical Problems Yes__No__

G. Medications/Allergies Yes__No__

Previous Treatment

Social History

A. Family situation/living arrangements (who resides in the home)

B. Caregiver Employment

C. Additional Information

Spiritual History

Family History
(Including biological parents/caregivers)

A. History of substance abuse Yes___No___

B. History of Mental Illness Yes___No___

C. History of Abuse (Physical/Sexual/Emotional) Yes___No___

D. History of Criminal Activity Yes___No___

Educational/Vocational History

A. Name of School_____Grade_____

B. Special Education Placement_____

C. Educational Testing_____If yes, when?_____

Results_____

D. Behavior patterns in school (detention/suspension) Yes___No___

E. Employment_____

Child Protective Service Involvement

Discipline Intervention by Parents/Caregivers

Confidential Client History

For Teens

The purpose of this questionnaire is to help your counselor get a good picture of you. Completing these questions as best as you can; you will be helping your counselor to understand you and your particular situation and needs. Everything will be kept in private, between you and the counselor. The only time the counselor can tell your parents or anyone else anything is if you give your permission. The only other time, is if the counselor feels you are going to hurt someone or you are going to be hurt and a solution between you can't be worked out.

Name_____Nickname_____

What is your main problem today?

_____

_____

What are some ways you have tried to solve this problem before?

_____

_____

Health/Medical History

Please check those you have been having trouble with:

_____Headaches	_____Memory
_____Trouble concentrating	_____Unwanted thoughts
_____Feeling afraid	_____Hearing voices
_____Feeling all alone	_____Trouble falling asleep
_____Waking up a lot at night	_____Waking up real early
_____Nightmares	_____Less hungry lately
_____Overeating	_____Afraid to eat
_____Sad most of the time	_____Angry most of the time
_____Not being able to control your anger	_____Not interested in things you used to do anymore
_____Upset stomach or feeling that you need to throw up	_____Having to repeat the same things over and over

Have you ever thought of hurting yourself? _____Yes _____No
If yes, have you ever tried to hurt yourself? _____Yes _____No

Do you ever feel that you could hurt someone else? _____Yes _____No
Have you ever hurt someone else? _____Yes _____No

Family Information

What is the thing you like best about your parents or family?
_____

Who in your family do you feel the closest to?
Why?_____

Please check any that have happened in your family:

_____Parents don't live together
_____Somebody died
_____Someone takes drugs
_____Someone hits
_____Other_____
_____We have lots of money problems
_____Someone drinks too much
_____Someone is very sick
_____Someone has problems with the law

Alcohol/Drug History

Have you ever used alcohol or drugs? _____Yes _____No
If yes, what did you use? _____
When and why did you use? _____

Do you think anyone in your family has a problem with alcohol or drugs? __Yes __No
Who? _____

School History

Is there anything that bothers you about school? ___Yes ___No
If yes, what?
_____

What do you like best about school?_____

What are your friends like? _____
_____

Why did you choose them to be your friends? _____

Where do you usually go and what do you usually do after school? _____
_____

Self-Description

What do you like least about yourself? _____
_____

What do you like most about yourself? _____

If you could change anything in your life, what would it be? _____

Please tell me about any hobbies or things you are interested in (i.e. music, sports, church, other):
_____
_____

If you would like to tell me anything else, please use the bottom or back of this page.

I, _____, understand that this counselor might speak to his or her supervisor and consultant if they need help with my case. If they do, the supervisor and the consultant will also keep everything shared among themselves.
Everything will still be kept private.

Teen's Signature_____ Date_____

Cynthia L. Bethany, LCSW, CTS
Linda L. Loveless, LCSW
Teshia Kyser, LPC
Valerie Hyatt Martin, 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

Consent For Treatment Of A Minor

We, I, the undersigned_____parent(s), guardian(s) of a minor_____,birthdate_____ give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me, us as parent(s), guardian(s) of said child. It is distinctly understood that you are hereby fully released from claims and demands which might arise, grow out of , or be incident to the evaluation or treatment provided that your duties are performed with ordinary care, professional responsibility, and to the best of your ability.

Signed the_____day of_____, 20_____

_____
Father or Guardian

_____
Mother or Guardian

_____
Witness

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.**

YOUR RIGHTS –

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:_____

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

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_____