Bridgeway
Counseling Center, Inc.

# New Child / Adolescent Information Sheet

Child's name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: (____)_____ Cell: (____)_____ Cell: (____)_____

Birth date: _____ Age: _____ SSN: _____

Mother's name: _____ DOB: _____

Father's name: _____ DOB: _____

Who is best to contact: _____ Phone #:_____

Parents' marital/relationship status: _____whom does the child live with: _____

Parent's employer(s): Mother: _____ Father: _____

Child/teen's current school and grade: _____

Names and ages of other children in the home: _____

_____

Who referred you to Bridgeway Counseling Center Inc.?_____

Who shall we contact in case of emergency? Name: _____Phone (___)_____

Primary physician:_____ Do you want records sent to your physician? Y N

What problems brought you here?_____

_____

_____

_____

_____

Please describe any past or current health problems:

| Current | Past |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Please list your current medications and dosage or submit a list to the receptionist to copy for our records:

| Name of Medication | Dosage | When did you start the medication? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please indicate if your child or teen is having any of the following problems, or if he or she had them in the past.

| | I have this now | I had it in the past |
|---|---|---|
| Difficulty falling asleep or staying asleep | | |
| Sleeping too much | | |
| Frequently defiant | | |
| Frequent crying | | |
| Toileting problems | | |
| Refuses to go to school, or cuts class frequently | | |
| Inappropriate sexual behavior | | |
| Changes in appetite, weight loss, or weight gain | | |
| Uses laxatives or exercised excessively to lose weight | | |
| Problems concentrating | | |
| Difficulty controlling my temper | | |
| Worry that something is wrong with his or her body | | |
| Panic attacks or anxiety attacks | | |

| | | |
|---|---|---|
| Made self throw up in order to lose weight | | |
| Frequent arguments with the people I live with | | |
| Talks about killing or hurting myself | | |
| Attempts to kill or hurt myself | | |
| School Performance has gone down | | |
| Problems remembering things | | |
| Periods of daily sadness lasting more than two weeks | | |
| Startles easily | | |
| Physically hurts other people | | |
| Throws or breaks things | | |
| Worries a lot | | |
| Often complains of feeling tired | | |

Please complete the table below with your insurance information or submit your insurance card to the receptionist to copy.

| **INSURANCE INFORMATION** | | | | | |
|---|---|---|---|---|---|
| (Please give your insurance card to the receptionist.) | | | | | |
| Person responsible for bill: | Birth date: / / | Address (if different): | | Home phone no.: ( ) | |
| Is this patient covered by insurance? ❑ Yes ❑ No | | | | | |
| Subscriber's name: | | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |
| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | | Policy no.: | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bridgeway Counseling Center Inc. or my insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*

## CONFIDENTIALITY AGREEMENT

The therapy relationship is a professional and confidential relationship. What is revealed in this setting is confidential and is protected by professional and ethical standards. All material is confidential and cannot be released without your written consent. The laws of the State of South Dakota make certain exceptions to this confidentiality privilege.

If there is reasonable suspicion that you may harm yourself or others, then the therapist is responsible by law to inform others in order to protect them or yourself. If there is reasonable suspicion of child abuse, a verbal report will be made to the Child Protection Services.

## APPOINTMENTS

If you are unable to attend a scheduled session, it is your responsibility to let this office know your intent to cancel your appointment. Appointments must be cancelled at least 24 hours prior to the session in order to avoid being charged.

## PROFESSIONAL FEES AND INSURANCE

Most services are covered by insurance. The fee for the initial consultation will be $265. Subsequent appointments are 45 minute sessions with a fee of $175. Psychological testing, report writing, and other related services will be billed on an hourly basis. Although health insurance typically covers the fees of psychological services, you will be responsible for paying for services and appointments that are not covered by your insurance policy.

Your insurance provider may have contracted with Bridgeway Counseling Center Inc. to provide services and we will attempt to collect from your insurance provider. Co-pays are expected at the time of the appointment. Please be aware of your deductible, as your insurance may not pay for psychological services until your deductible has been met. In the case that your appointment was a court ordered session or an evaluation for adoption, payment will be expected in-full at the time of the appointment as insurance cannot be billed.

## Acknowledgement of Receipt of Notice of Privacy Practice

I have access to a copy of the notice of privacy practices that describes how my health information is used and shared. I understand Bridgeway Counseling Center reserves the right to change this notice at any time. I may obtain a copy by contacting the office.

*My signature below indicates that I have read the above policies, which I intend to abide by them, and consent to treatment by Bridgeway Counseling Center Staff.*

**All providers are supervised by Dr. Robert Buri, Clinical Psychologist.**

Client/Guardian Signature: _____ Date: _____

Relationship if not client: _____

Client Name: _____

Bridgeway
Counseling Center, Inc.
Medical Arts Building
600 4th Street NE, Watertown, SD 57201
Phone: (605) 886-5262; Fax: (605) 886-5228

# Authorization to Release/Request Information

**Patient's Name** _____ **Date of Birth** _____

I authorize Bridgeway Counseling Center Inc. to release and/or request my health information to the person or organization designated below.

Name/ Facility _____

Address _____

City, State _____ ZIP: _____

Phone: _____ Fax: _____

Name/ Facility _____

Address _____

City, State _____ ZIP: _____

Phone: _____ Fax: _____

I understand that I have the right to cancel this authorization by sending written notification to Bridgeway Counseling Center Inc. However, I understand my cancellation will not be effective to the extent that Bridgeway Counseling Center Inc. has already taken action regarding the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the recipient of this information may re-disclose it and that the information will no longer be protected by the HIPAA Privacy Rule. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

_____ _____

**Signature of Patient or Guardian** **Date**

Bridgeway
Counseling Center, Inc.

# Payment Policy

(Effective March 1, 2016)

**Payment** ***initials*_____**

Payment is due at the time of service unless insurance reimbursement has been verified prior to the session.

Bridgeway Counseling Center accepts Visa, MasterCard and Discover, as well as cash and checks.

**Insurance** ***initials*_____**

Co-payments are required at the time of service.

Many insurance plans require preauthorization of treatment prior to the session. Please provide your insurance information to us as you schedule your initial appointment. If you change insurance plans or company, please provide your new insurance information to us as soon as possible.

**Late Cancellations and No-Shows** ***initials*_____**

In order to provide the best care and treatment to all of our clients, please give 24 hour notice if you are unable to make your appointment in order to allow open appointments for others seeking treatment. Failure to provide this notice will result in a fee of *$100.00* billed directly to the client which must be paid prior to receiving further care. Bridgeway Counseling Center reserves the right to terminate services after two late cancellations or no-shows.

**Fee Arrangements** ***initials*_____**

If you are currently experiencing financial difficulties, please discuss this with the billing personnel for possible fee arrangements.

**Returned Checks** ***initials*_____**

A fee of $40.00 will be assessed for a returned check.

**Print Name**_____

**Signature**_____ **Date**_____

**Staff Signature**_____ **Date**_____