Bridgeway
Counseling Center, Inc.

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

*Name*_____ *Birth date*_____ *Age*_____ *Date*_____

Address _____ *SSN*_____

**If 17 y/o or younger:*

Mother's name _____ Phone #_____ DOB _____

Father's name _____ Phone #_____ DOB _____

Who is best to contact _____

Child/teen's current school and grade _____

**If 18 y/o or older:*

*Home Phone*_____*Cell Phone* _____ *Work Phone*_____

Would you like to receive appointment reminders through text message? ( ) Yes ( ) No

Email (optional) _____

Primary Care Physician _____

Do you give permission for ongoing regular updates to be provided to your primary care physician?_____

Who referred you to Bridgeway Counseling Center _____

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____
_____
_____

***Current Symptoms Checklist:* (check once for any symptoms present, twice for major symptoms)**

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Racing thoughts
( ) Impulsivity
( ) Increase risky behavior
( ) Increased libido
( ) Decrease need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Suicidal Thoughts
( ) _____
( ) _____

***Past Medical History*:**

List ALL current prescription medications *and how often you take them*: (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

For women only: Date of last menstrual period_____Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Birth control method _____
How many times have you been pregnant?_____How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ( ) Yes ( ) No
Date and place of last physical exam: _____

Personal and Family Medical History:

	You	**Family**	**Which Family Member?**
Thyroid Disease ----------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease ----------	( )	( )	_____
Chronic Fatigue ----------	( )	( )	_____
Kidney Disease ----------	( )	( )	_____
Diabetes ----------	( )	( )	_____
Asthma/respiratory problems ------	( )	( )	_____
Stomach or intestinal problems ---	( )	( )	_____
Cancer (type) ----------	( )	( )	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ----------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____
Chronic Pain ----------	( )	( )	_____
High Cholesterol ----------	( )	( )	_____
High blood pressure----------	( )	( )	_____
Head trauma ----------	( )	( )	_____
Liver problems ----------	( )	( )	_____
Other ----------	( )	( )	_____

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

Past Psychiatric History:

Outpatient treatment/Hospitalizations: ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated/Hospitalized By Whom/Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Remeron (mirtazapine) _____

Pristiq (desvenlafaxine) _____

Viibryd (vilazodone) _____

Other _____

Mood Stabilizers

Tegretol (carbamazepine) _____

Lithium _____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Topamax (topiramate) _____

Other _____

Past Psychiatric medications /Antipsychotics/Mood Stabilizers

Seroquel (quetiapine) _____

Zyprexa (olanzepine) _____

Geodon (ziprasidone) _____

Abilify (aripiprazole) _____

Clozaril (clozapine) _____

Haldol (haloperidol) _____

Risperdal (risperidone) _____

Other _____

Sedative/Hypnotics

Ambien (zolpidem) _____

Sonata (zaleplon) _____

Rozerem (ramelteon) _____

Restoril (temazepam) _____

Desyrel (trazodone) _____

Other _____

ADHD medications

Adderall (amphetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Strattera (atomoxetine) _____

Vyvanse (lisdexamfetamine) _____

Other _____

Antianxiety medications

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Buspar (buspirone) _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
Anger	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
Suicide	( ) Yes ( ) No	Violence	( ) Yes ( ) No

If yes, who had each problem? _____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

Check if you have ever tried the following:	**If yes, how long and when did you last use?**
Methamphetamine ( )Yes ( ) No	
Cocaine ( )Yes ( )No	
Stimulants (pills) ( )Yes ( )No	
Heroin ( )Yes ( )No	
LSD or Hallucinogens ( )Yes ( )No	
Marijuana ( )Yes ( )No	
Pain Killers (not as prescribed) ( )Yes ( )No	
Methadone ( )Yes ( )No	
Tranquilizers/sleeping pills ( )Yes ( ) No	
Ecstasy ( )Yes ( )No	
Other	

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____
Energy Drinks _____

Tobacco History:
Have you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____
In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No
What kind?_____How often per day on average?_____How many years? _____

Your Exercise Level:
Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____
How much time each day do you exercise? _____
What kind of exercise do you do? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ( ) Yes ( ) No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom: _____
_____

Educational History:
Highest Grade Completed?_____ Where?_____
Did you attend college? _____Where?_____ Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____What is/was your occupation?_____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when?_____
Honorable discharge ( ) Yes ( ) No Other type discharge _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? ____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No

How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual
( ) transsexual ( ) unsure/questioning ( ) asexual ( ) other
( ) prefer not to answer

What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other:

_____

Have you had any prior marriages? ( ) Yes ( ) No If so, how many? _____
How long? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Describe the relationship with your children: _____
List everyone who currently lives with you: _____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( )stressful

Is there anything else that you would like us to know?

_____

_____

_____

_____

_____

_____

_____

_____

Signature _____ *Date* _____

Guardian Signature (if under age 18) _____ *Date* _____

Emergency Contact _____ *Telephone #* _____

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

INSURANCE INFORMATION

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 or my insurance company to release any information required to process my claims.

Patient/Guardian signature *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**_____

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. However, I understand my cancellation will not be effective to the extent that Bridgeway Counseling Center 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**