BROADVIEW
COUNSELING & ASSESSMENT

**Providing Counseling, Consultation, and Assessment**
243 Broad Street, Milford, CT 06460
(203) 850-7709 | BroadviewCounseling.com

# Client Information

Welcome! As part of beginning the counseling process, please take some time to provide us with the following information. This will help us better understand you, and will help us both find solutions to the situations that are creating difficulties for you.

**Today's Date** _____

**Type of services sought**
(Check all that apply)

☐ Individual ☐ Child / Teen ☐ Marital / Couple ☐ Family

**Name of person filling this out** _____

**Name of Primary Client** (if different) _____

**Primary Phone Number** _____

**Secondary Phone Number** (If available) _____

**Primary Email Address** _____

## Relationships to Primary Client

**Name individuals living in the primary household and their relationship to the primary client.**

_____

_____

**List any immediate family members of influence to the primary client who are not living in the primary household of the client.**

_____

_____

## Sources of Stress

**What are the primary issues for which you are seeking counseling for yourself or your child?**

1 _____

2 _____

3 _____

**What are the most important things you think we should know about these issues?**

_____

_____

_____

**In what ways have you attempted to cope with these issues?**

_____

_____

_____

**Do you or your child have any particular concerns or fears regarding therapy?**

_____

_____

_____

## Mental Health & Social History

**Have you or anyone in the family attended therapy previously, or are currently in treatment?**

Yes No

**Have you had any psychiatric hospitalizations?**

Yes No

If yes, please indicate:

Date(s) hospitalized: _____

Type of problem / condition: _____

Therapist / Program: _____

Dates of treatment: _____

Any relevant information regarding psychiatric treatment:

_____

_____

**Have you, your child or anyone in the family had suicidal thoughts / attempts / self-harm (cutting, etc.) recently or in the past?**

Yes No

If yes, please indicate circumstances and dates of treatment (if applicable):

_____

_____

**Have you, your child, or anyone in the family been a victim of child abuse (physical, sexual, emotional, neglect), domestic violence, rape, or other violent act?**

Yes No

If yes, please circle whether abuse was:

Physical Sexual Emotional Domestic Other

Age abuse(s) occurred: _____

**Have you, your child, or anyone in the family had trouble with alcohol or other substances, now or in the past?**

Yes No

If yes, please indicate:

Substance Used: _____

Frequency / Amount: _____

Relevant details

_____

_____

## Medical History

**Physician(s) currently treating primary client:**

Physician's Name: _____ Physician's Name: _____

Phone number: _____ Phone number: _____

Reason: _____ Reason: _____

**Please provide any relevant information:**

_____

_____

**Is anyone in the family being treated for a medical problem(s) and / or disability?**

Yes No

If yes, briefly describe:

_____

_____

**Current medications or homeopathic interventions if any** (for primary client)**:**
Medication / Dosage:

_____

**Prescribing physicians:**
Please describe relevant details:

**Please provide any other relevant information below that you feel would be beneficial for us to know about yourself, your child, and your family.**

*Thank you very much for your time in completing this document.*

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# Health Insurance Information Form

**Client Name**

_____

**Name of Parent** **(For client under age 18)**

_____

**Name of Insurance Company**

_____

**Member ID #**

_____

**Address of Cardholder (Street address, city, state, zip code)**

_____

**Client Date of Birth**

_____

**Phone Number**

_____

**Do you have a deductible?**

Yes No

**What is your deductible amount?**

_____

**Co-Pay Amount** **(If applicable)**

_____

**Number of sessions covered**

_____

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# GENERAL INFORMATION AND INFORMED CONSENT

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this form, it will constitute a binding agreement between us.

## Psychological Treatment

Psychotherapy is not easily described in general statements. It varies depending on the nature of the problems the patient is experiencing, and the personality of both the therapist and patient. Psychotherapy entails talking with a therapist on a regular basis about the difficulties you are experiencing for the purpose of understanding their etiology and finding solutions to the problems they are causing in your life. Unlike visiting a medical doctor, psychotherapy requires an active effort on your part.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits, including a significant reduction in feelings of distress, better relationships, and the resolution of specific problems. There are no guarantees about how therapy will impact any one person's life. However, psychotherapy is most successful when you expect and tolerate the ups and downs inherent in the process. It is useful to talk about your concerns about how therapy is going when they arise.

Our first few (2-4) sessions will involve an evaluation of your needs. Psychological evaluation entails talking about what is troubling you, and providing a history of the difficulties you are having, the symptoms you are experiencing, previous treatment for psychological difficulties, your life history and family situation, information about the use of medication and any substance abuse, and all other relevant information. By the end of the evaluation, our therapists will be able to offer you some initial impressions of the nature of the difficulties you are having, an assessment of whether on-going treatment is needed, and if so, what treatment would entail. We will both have the opportunity to decide whether the therapeutic relationship is adequate to provide the services you need in order to meet your treatment objectives. In deciding whether you wish to continue on after the initial assessment, you should evaluate the information we provide along with whether you feel comfortable working with one of our therapists. Therapy involves a large commitment of time, money, and energy, so it's important to think carefully about whom you want to work with as your therapist. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will help you to secure a consultation with another mental health professional.

If we agree to continue psychotherapy after the initial evaluation, we will schedule one or more

50-minute sessions per week (or 90-minute sessions for group therapy) at a mutually agreeable time. Once the appointment times are scheduled, you will be expected to pay for them unless you provide 24 hours advance notice of cancellation. Your insurance company cannot be billed for cancelled or missed appointments and therefore if you are charged for a missed appointment, you will be responsible for the payment of that session in full.

If you are late for an appointment, we will meet for the remainder of the scheduled time. If your therapist is late for an appointment, we will make up the time at the end of the session.

You have the right to stop treatment at any time. To avoid premature termination, we ask patients to not discontinue therapy by phone, letter, email, or nonattendance. Please inform us prior to any session you plan to be your last, so we have one session to summarize and conclude our work together.

**Contact Information**

We are often not immediately available by telephone. While we are usually in the office or at school between 7AM and 7PM, we may not be available if we are in a meeting. When we are unavailable, the telephone is answered by voicemail, which is monitored frequently. We will make every effort to return your call as quickly as possible. We also monitor email frequently. It is often helpful if you leave some times when you will be available for a return call. If you are experiencing an emergency situation over the weekend or in the evening, you may try to reach us by telephone. If you are unable to reach us, and you feel that you cannot wait for us to return your call, you should call either your general physician or 911.

If you are having problems related to medication you might be taking, please call the health professional prescribing the medication, or 911 in the event of an emergency.

If we will be away on vacation, we will provide you with the name of a trusted colleague whom you can contact if necessary.

**Professional Fees**

Our fee is $150.00 for a 50-minute session, or $50.00 for a 90-minute group therapy session. It is our practice to charge this fee on a prorated basis for other professional services you may require such as report writing, telephone conversations which last longer than 10 minutes, consultations with other professionals which you have authorized, preparation of treatment summaries, or the time required to perform any other service which you may request of us.

If you become involved in litigation that requires our participation, you will be expected to pay for the professional time required even if we are compelled to testify by another party. Because of the complexity and difficulty of legal involvement, we charge $200 per hour for preparation for and attendance at any legal proceeding.

For testing and assessment, you are required to pay 50% of the agreed upon fee upon beginning the assessment and 50% of the fee upon presentation to you of the assessment, unless otherwise documented and agreed upon. This fee includes a full review of the assessment and a question and answer session upon submission to you at no additional cost.

Additional interpretation of the assessment, including consultation with other service providers, family members, educational organizations, etc. requires hourly prorated fees discussed above.

**Billing and Payments**

Unless we make a different arrangement, payment is due at the time services are rendered. If you are using out-of-network insurance benefits, you are expected to pay your bill in full and then have your insurance reimbursement sent to you. If you will be paying with insurance reimbursement through health insurance, your co-pay is expected at each session.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, I will initiate legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of pursuing the legal action will be included in the claim. In most cases, the only information that I would release under these circumstances would be the patient's name, the nature of the services provided, and the amount due.

**Insurance Reimbursement**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with assistance in facilitating your receipt of the benefits to which you are entitled by providing the information your insurance company needs on your bill. You, and not your insurance company, are ultimately responsible for the full payment of the fee that we have agreed to. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits that sometimes makes it difficult to determine how much mental health coverage is available. Managed Care plans such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short-term approach designed to resolve specific problems that are interfering with one's usual level of functioning. They often require that the therapist seek additional approval before providing more than a few sessions. Many clients have the desire to continue treatment even after their insurance benefits expire.

If you are going to use insurance to cover some of the costs of psychotherapy, your insurance company might require information about the dates of sessions, your clinical diagnosis, the goals of treatment, how your therapy is progressing, and other specific information. This information will become part of the insurance company files, and in all probability, some of it will be managed in a cloud based server. Most insurance companies claim to keep such information confidential; however, once the information is in the hands of an insurance company, we have no control over what they do with it. You will need to authorize us to provide this information to your insurance company. If you would like, we can review with you any information provided to your insurance carrier.

You have the right to pay for psychotherapy yourself and avoid the complexities described above.

**Confidentiality and its Limits**

In general, the confidentiality of all communications between a patient and a therapist is protected by law, and we can only release information about our work to others with your written permission. However, there are a number of exceptions. The following are legally imposed limits on confidentiality:

- In most judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require our testimony if he or she determines that resolution of the issues demands it. This means that others may sometimes issue a subpoena seeking either treatment records or testimony from your present or former therapist as evidence in a court case. If we receive such a subpoena, we will inform you immediately and, with your consent, will cooperate with your attorney in filing motions to quash the subpoena and request that the confidentiality of the therapeutic relationship be protected. However, only the judge may decide whether or not the requested information or records must be disclosed.
- There are some situations in which we am legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if we believe that a child, an elderly person, or a disabled person is being abused, we are required to file a report with the appropriate state agency.
- If we believe that a client is threatening serious bodily harm to another person, we are required to take protective actions that may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization for the patient, or to contact family members or others who can help provide protection, for the purpose of insuring the patient’s safety.

Should one of these situations occur during your treatment, we would make every effort to fully discuss it with you before taking any action.

In addition to the legally imposed limits to confidentiality outlined above, our office policies lead to us providing others with information about clients in the following instances:

- If you are taking psychiatric medication, it is helpful for your psychiatrist (or other prescribing health professional) to consult with us about our work on your behalf. Both the psychiatrist and Broadview Counseling and Assessment LLC are bound to keep the information exchanged during our consultations confidential.
- If we will be away for an extended period of time, a colleague may cover the practice and take emergency calls. If he or she will need information about you in order to be prepared to assist you in our absence, we will provide the colleague with the necessary information. We will discuss this issue with you ahead of time if possible.
- Sometimes it is useful for us to seek additional consultation or supervision from a colleague about the best way to address certain problems or issues. We can usually do this without

disclosing any identifying information about the patient. Unless you object, we will consult on an as-needed basis without talking with you first, unless we feel it is important to our work in therapy.

The decision about whether to release information to an insurance company (or other third party payor) rests with you. Initially, that involves providing information about dates of treatment, type of treatment and the nature/diagnosis of your problem. Requests for further information will be discussed with you as they arise.

While this written summary of exceptions to confidentiality should prove helpful, it is important that we discuss any questions or concerns that you may have at our next meeting. The laws governing these issues are quite complex and we are not attorneys. While we are happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

**Informed Consent**

I HAVE REVIEWED THE INFORMATION ABOVE. I CONSENT TO PSYCHOLOGICAL EVALUATION AND/OR TREATMENT WITH BROADVIEW COUNSELING AND ASSESSMENT LLC. I UNDERSTAND THAT I HAVE THE RIGHT TO WITHDRAW FROM TREATMENT AT ANY TIME. I AGREE TO ABIDE BY THE TERMS SET FORTH IN THIS DOCUMENT DURING OUR PROFESSIONAL RELATIONSHIP.

I UNDERSTAND THE POLICIES REGARDING CONFIDENTIALITY. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THEM, AND MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I ACCEPT THE LIMITS OF CONFIDENTIALITY.

I UNDERSTAND THE POLICIES REGARDING FEES AND BILLING AND AGREE TO THE TERMS STATED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT.

IF I CHOOSE TO USE INSURANCE TO PAY FOR PART OF MY BILL, I AUTHORIZE THE RELEASE OF ANY INFORMATION AS REQUIRED BY MY INSURANCE COMPANY OR OTHER REIMBURSING AGENCY.

I HAVE BEEN GIVEN A COPY OF THE 'GENERAL INFORMATION AND INFORMED CONSENT' DOCUMENT AND HAVE FAMILIARIZED MYSELF WITH THIS DOCUMENT.

Signature _____

Print Name _____

Date _____

Parent Signature

(If client is under age 18) _____

Print Name _____

Date _____