120 N 50th Ave Suite B Yakima, WA 98908 Phone: (509) 574- 5000
bethelridge@gmail.com Website: bethelridge.org

Today's date:				Male □ Female □ Minor □	
Last Name:				Single□ Married□ Divorced□ Widowed□	
First Name: Middle:				SSN:	
Address:				Date of birth:	Email:
City:	State:	Zip:		Home Phone:	
Employer:				Work Phone:	
Referred to Counseling by:				Cell Phone:	
Emergency Contact (Please include relationship to patient)					
Name:		Relationship:		Phone:	
Insurance Information: Primary **Attach a copy of Insurance Card Front and Back**					
Insured Name:					
Insured Date of Birth: Insured SSN:					
Address:		City,St,Zip,:		Phone:	
Name of Insurance Co.			Address:		
City:	State:	Zip:	Phone:	Employer:	
Policy No:		Group No:		Employer No:	
Insurance Information: Secondary **Attach a copy of Insurance Card Front and Back**					
Insured Name:					
Insured Date of Birth				Insured SSN:	
Address:		City,St, Zip:		Phone:	
Name of Insurance Co.			Address:		
City:	State:	Zip:	Phone:	Policy and Group No:	

Insurance Client Lifetime Authorization, Assignment and Release:

I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on my behalf of my dependents. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have read, understand and agree to the above.

Date | Signature of Guarantor

Medicare Clients Lifetime Authorization

I request that payment of authorized MEDICARE benefits to be made to my attending Provider, for services furnished me by the Provider. I agree to be held personally responsible for services provided to me that are not authorized by MEDICARE. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION, aka CMS and its agents any information to determine these benefits or the benefits payable for related services.

Date | Signature of Guarantor

Counseling Agreement

Description of Counseling

I, as a counselor, will be talking with you about what you think, feel and the choices you make. You will learn how the things you believe and feel are affecting your choices. Change can happen as you view life and choose differently. Counseling may include the recommendation of various materials, evaluation tools and possible exercises/assignments.

Clinical/Office Setting: All sessions are **50** minutes unless otherwise scheduled. Sessions are located at 120 N 50th Ave. Suite B, Yakima, WA

Teletherapy sessions: Teletherapy sessions are offered through Zoom, FaceTime and other on-line platforms as agreed. Teletherapy sessions are **50** minutes unless otherwise scheduled.

Doctrinal Statement

I believe there is a God who created us. We are spiritual beings in need of a relationship with Him. He loves us and has provided a way for us to know and experience a loving relationship with Him. The Bible describes God, Jesus and the Holy Spirit clearly. Creation also helps us know God. God, the Creator knows all about life and reveals this in the Bible. As a counselor, this doctrine is foundational to my thinking and counsel.

Confidentiality

Washington State laws provide client confidentiality in counseling sessions. Without your written consent, I cannot, and will not, release any information regarding you and or your counseling time. For more info, see Privacy Practice Notice.

Fees

Our typical office fee is $100 - $150 for a fifty-minute session. New client diagnostic intakes are $240 for you first session. At times, I do extend the session time and the fee is adjusted accordingly. Insurance clients may be required to pay cash for extended time the insurance will not pay for. Appointments with interns under our supervision will be offered for cash pay only at a rate of $20 - $40.

Appointment Reminders

I give my permission for Bethel Ridge Family Counseling Office/Reception to give me appointment reminders by:

____ Phone Number_____

____ Text Number_____

_____ _____

Signature Date

Insurance Information: _____Initial (you have read)

The relationship is between you and your insurance company. We bill your insurance company as a courtesy to you. You are responsible for the full-service amount for any and all services incurred with our office. You also need to be aware that we are not contracted with all insurance companies as a '*preferred' or' in network provider'*. You will need to check with your insurance company regarding your specific benefits. You may need to get special authorization or a referral from your primary care doctor. You are responsible for payment in full if your insurance company does not cover services provided by this office. We will bill your insurance and notify you only if there is an unpaid balance that is your responsibility. **Any insurance questions can be directed to Jasmine with our billing company, Medical Billing By Jasmine (509)379-1379.** Due to contracts signed with your insurance company, we are to collect your co-pay, co-insurance and/or deductible amount *at the time of each and every service*.

Clients without insurance _____ Initial (you have read)

You are expected to make payment in full when checking in at the front desk or before leaving. If you wish to make payment arrangements, the arrangements must be made before your counseling begins and must be made *with the billing department, not the counselor*.

Phone Consultation and E-Mail After Hours Appointments _____ Initial (you have read)

It may be necessary for you to call me after hours, and I want to be able to meet your need. Calls and emails will be charged upon the length of the time-spent conferencing. **Your insurance company may not reimburse this type of session**. **Therefore, you will be personally responsible for non-reimbursed charges.** The fee will be computed by the hourly rate. Please know that I would like to be available for you if possible.

Monthly Service Charge _____ Initial (you have read)

On any personal balance older than 30 days, there will be a $5 minimum fee added to your balance monthly. This is added to all accounts regardless of if you have insurance or not because it will be charged on your personal balance. This is a very small fee but necessary to compensate carrying balances past 30 days.

I have read and understand the above material and agree to the described conditions.

_____ _____

Signature Date

_____

Please print client name or guarantor name

Client Symptom / Status – *Please, Print Clearly*

CLIENT INFORMATION

Client Name:_____

Client Reasons for Counseling / Desired Goals (results)

_____

_____

_____

_____

CURRENT SYMPTOMS

Affect/Energy

- ☐ depressed mood
- ☐ diminished energy
- ☐ diminished interest
- ☐ increased irritability
- ☐ feelings of guilt
- ☐ feelings of worthlessness
- ☐ inability to concentrate
- ☐ inability to make decisions

Anxiety

- ☐ generalized fear
- ☐ shortness of breath
- ☐ depersonalization
- ☐ chest pains
- ☐ hot/cold flashes
- ☐ fears of dying
- ☐ fear of going crazy

Sleep Disturbance

- ☐ difficulty falling
- ☐ early morning
- ☐ restless sleep
- ☐ excessive sleep
- ☐ nightmares
- ☐ night terrors

Eating

- ☐ increased appetite
- ☐ decreased appetite
- ☐ weight gain
- ☐ weight loss
- ☐ purging

Avoidance Symptoms

- ☐ fear of specific places
- ☐ fear of social situations
- ☐ constriction of lifestyle

PTSD Symptoms

- ☐ intrusive memories
- ☐ hypervigilance
- ☐ distress from
- ☐ numbing

Alcohol/Drug Use (*Write "**R**" for regular; "**O**" for occasional; "**I**" for infrequent; "**N**" for never)*

___ alcohol ___cocaine ___ marijuana ___ methamphetamine ___opiates ___other specify

use of other drugs _____ **CURRENT**

MENTAL STATUS: Instructions: Please check *all* that apply

Thought process: ◯ intact ◯ circumstantial ◯ tangential ◯ flight of ideas ◯ loose associations

Hallucinations: ◯ none ◯ auditory ◯ visual ◯ olfactory ◯ command

Delusions: ◯ none ◯ persecutory ◯ grandiose

Memory: ◯ intact ◯ impaired: ◯ immediate ◯ recent ◯ remote

Judgment: ◯ intact ◯ impaired: ◯ mild ◯ moderate ◯ severe

Suicidal: ◯ not present ◯ ideation ◯ contemplation ◯ plan ◯ activity

Homicidally: ◯ not present ◯ ideation ◯ contemplation ◯ plan ◯ activity

Impulse Control: ◯ within normal limits ◯ impaired

Other: _____ ***For***

CURRENT TREATMENT PLAN

Instructions: Please document treatment goals, interventions, & time frames to address current diagnosis and symptoms.

	Treatment Goal	***Intervention***	***Time Frame***
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Client History

Today's Date _____

Name_____ Date of Birth _____

Phone _____ Email _____

Spouse_____ Date of Birth_____

Employer _____ Occupation _____

Phone _____

Personal History

Marital History*/Significant Relationships (client)*

_____

_____

_____

Spouse *(current) marital history*

_____

_____

_____

Children/Dependents #Boys _____ #Girls _____

Name _____ Age_____

Name_____ Age_____

Name _____ Age_____

Name_____ Age_____

Additional Children: _____

Client's Family History

Father's Name _____ Age (if living)_____ Occupation_____ Marital Status _____

Mother's Name _____ Age (if living)_____ Occupation_____ Marital Status _____

Guardian's Name (if applicable)_____ Relationship _____

Reason for guardianship _____ Date of guardianship _____

Siblings # Brothers _____ *# Sisters* _____

Name _____ Age _____ Relationship _____Marital Status _____

Name _____ Age _____ Relationship _____ Marital Status _____

Name _____ Age _____ Relationship _____ Marital Status _____

Name _____ Age _____ Relationship _____ Marital Status _____

More than four siblings? Yes _____ No _____

Names: _____

Has anyone in your immediate family been hospitalized or received some form of professional help for psychological problems? If so, please specify who, when they received help, and the nature of the problem.

_____

_____

_____

_____

Occupational History

What positions have you held in the past?

_____

_____

Does you present work satisfy you, it not, please explain

_____

_____

_____

_____

Briefly list any additional information that you think would be helpful for your counselor to know.

_____

_____

_____

_____

_____

_____

Insurance Information Disclaimer/ Waiver

The purpose of this information sheet is to inform you of our office insurance billing process and your responsibilities.

Our gift to you

Billing is a courtesy. Our office bills your insurance company as a courtesy to you. The only insurance company we are **required** to bill is Medicare.

Insurance Information:

The relationship is between you and your insurance company.

It is **your responsibility** to confirm benefits, eligibility requirements, the need for referrals and/or authorizations, deductible amounts, visit limits, plan exclusions, in or out of network benefits, co-pays as well as co-insurance amounts with your insurance company. You can accomplish this by calling your insurance company or contact your employer or benefits administrator or check your Plan Benefit Booklet.

_____ _____

Client Signature Date

At the start of our work together, I wish to provide you with the following important information. It is important that you understand these issues. Please review this material carefully, so we may discuss any questions or concerns you may have. Bethel Ridge Counseling is a group of highly trained mental health professionals whose goal is to help individuals, couples, and families develop resources to eliminate or cope with problems and enjoy a more fulfilling life. The following information is provided to answer any procedural questions that may arise while using BRC services.

1. **Office Hours:** Appointments are available Monday through Friday, 9:00am to 5:00pm, and by special arrangements evenings may be scheduled.
2. **Appointments:** Services are available **by appointment only** and may be scheduled with individual therapists or through our receptionist at **509-574-5000**. Sessions are usually **50** minutes long. Between session, time is needed by the therapist to make notes, prepare for the next session, and perhaps return phone calls, etc. Please be respectful of the need to complete sessions during the allotted time.
3. **Cancellations/Missed Appointments:** Your appointment is reserved for you. It represents a commitment of time and resources for which payment is expected. If you need to cancel an appointment, please contact our office at 509-574-5000 as soon as possible. **No charge will be made for cancelled appointments if 24 hours notice is given**; **otherwise, you will be charged the full rate for the session. Please note that insurance companies do not reimburse for missed appointments or late cancel sessions.**
4. **Telephone:** When the receptionist is not answering the phone, you may leave a voicemail message at **509-574-5000.** She will be checking messages throughout the day and will return your call as soon as possible.
5. **Emergencies:** Bethel Ridge Counseling is not set up to handle emergencies. If you have an immediate or emergent need, assistance can be reached by calling **911**.
6. **Fees and Insurance:** You have the option of paying Bethel Ridge Counseling directly or using insurance benefits; in either case, you are financially responsible for the services for which you are arranging, even if your insurance refuses to pay for them. Fees are discussed during your first telephone contact. Please remember that **you will be billed for missed appointments not cancelled 24 hours ahead of time.**
7. **Confidentiality:** A key aspect of psychotherapy is the development of a trusting relationship between client and therapist. To achieve this goal, all information disclosed to your therapist is kept in strictest confidence according to professional ethical guidelines.

   Exceptions are made if the therapist believes that:

   - A client is contemplating a dangerous act against him/herself
   - A client is contemplating a dangerous act against another person
   - There is evidence of child abuse, abuse of a physically or mentally impaired person or abuse of an elderly person
   - Full confidentially might not be possible if a court subpoenas information
   - If you have a "Managed Care" type of insurance, your insurance company may require initial and periodic reports and information from your therapist in order to authorize treatment for you
   - If you are under 18 years of age, you should be aware that your parents have the right to receive some information concerning your treatment. While we are working together, we will give your parents general information on how the treatment is proceeding, but only after discussing it with you

I, the undersigned, have read and agree to the above guidelines.

_____ _____

Signature of the Patient Signature of Parent, Guardian, or Conservator

Private Pay, Co-pays, Missed Office Appointments, Late Cancellations and Balances over 30 days

We **require** a credit card or debit card to put in your file for private pay fee, co-pays, missed appointments, late cancellation fees and balances over 30 days because insurance companies will not pay for any of these.

Name on card _____

Please Print

Signature_____

Card Number_____

Expiration date _____ 3-digit code on back of card _____

Billing Zip Code _____

This page must be completed for you to receive services. No exceptions.