Brazos Valley Mental Health and Wellness, LLC

Client Intake Form

CLIENT INFORMATION

_____
Date

_____ _____ _____
Last Name *First Name* *Middle Initial*

_____ ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced ☐ Separated
Date of Birth *Gender* *Marital Status*

_____ _____
Street Address *Apartment #*

_____ _____
City *Zip Code*

_____ _____
Primary Telephone *Secondary Telephone (Work, Home)*

_____
E-Mail Address

Preferred appointment reminder: ☐ Text Message ☐ Voice Mail ☐ Email
(Check all that apply)

Do we have permission to leave a voice message on your primary phone number? ☐ Yes ☐ No

EMPLOYMENT STATUS

☐ Employed ☐ Unemployed

_____ _____
Employer *Occupation*

OR

☐ Full-Time Student ☐ Part-Time Student

_____
School or University

_____
Year or Grade

EMERGENCY CONTACT

_____ _____
Name *Relation to Client*

_____
Emergency Contact's Phone Number

Brazos Valley Mental Health and Wellness, LLC

Payer Information

Please check ONE BOX below and provide the required information.

☐ I ***DO NOT*** have health insurance and I am personally responsible to pay for therapy sessions on each date of service.

OR

☐ I have health insurance and would like Brazos Valley Mental Health and Wellness to send claims to my insurance company. I will provide a copy of my insurance card. I understand that I am responsible to pay deductible charges, co-insurance and co-payments.

_____
Insurance Company Name

_____ _____
Member ID or Certificate Number *Group Number*

Relationship to Policy Holder Self Spouse Child

_____ _____ _____
Policy Holder's Last Name *First Name* *Middle Initial*

_____
Policy Holder's Address

_____
Policy Holder's Phone Number

_____
Policy Holder's Date of Birth

OR

☐ A ***THIRD PARTY*** is responsible for paying for all professional services rendered to me by Brazos Valley Mental Health and Wellness, LLC.

_____
Name of Business or Organization

_____
Billing Address

_____ _____
Name of Contact *Telephone Number*

OR

☐ I was referred to Brazos Valley Mental Health and Wellness, LLC for ***BIPP*** or ***Anger Management***, and I am personally responsible to pay all evaluation and class fees.

_____ _____
Name of Parole or Probation Officer *County or Department*

_____
P.O.'s Telephone Number

Brazos Valley Mental Health and Wellness, LLC

Adult Initial Evaluation

_____
Date

_____ _____
Patient's Name Date of Birth ((MM/DD/YYYY)

_____ _____
Name of person completing this form if not the patient Referred By

Gender Identity ____Male ____ Female

____ Transgender male/Trans Man/FTM _____ Transgender Female/Trans Woman/MTF

____ Genderqueer, neither exclusively Male nor Female _____ Other

Sexual Orientation _____ Straight or Heterosexual _____ Lesbian, Gay or Homosexual

_____ Bisexual _____ Something Else, please describe _____

_____ Choose not to disclose

Briefly describe the events that led you here today:

_____

_____

_____

_____

Have you seen a doctor, counsellor/therapist for this issue in the past? _____

If yes, please list these contacts and approximate dates of treatments and/or hospitalizations.

_____

_____

_____

Describe your current employment and financial situation: _____

_____

_____

Describe any relevant legal issues: _____

_____

Describe any relevant stress: _____

_____

Please circle any of the following symptoms or complaints that apply to your situation.

sad mood low energy hopelessness worthlessness crying spells guilt irritability

decreased motivation loss of interest in usual activities hyperactivity impulsiveness

elevated mood racing thoughts concentration/memory difficulties increased sexual interest

decreased sexual interest decreased appetite difficulty falling asleep early morning awakening

difficulty staying asleep excessive sleeping suicidal thoughts thoughts of harming others

anxious/worried panic attacks fear of leaving the house fear of embarrassing oneself in public

intruding, uncomfortable, upsetting thoughts repetitive thoughts or behaviors excessively orderly/perfectionism

periods of "lost" time excessive anger/aggressiveness difficulty trusting others binging/purging cutting

Have you been a victim of abuse? (Circle any that apply) Emotional Sexual Physical

Have you been an offender of abuse? (Circle any that apply) Emotional Sexual Physical

Use the table below to describe your current living situation:

NAME	Relation to self	Age	Education/Occupation	How would you describe this person?

Do any of the people in your current living situation have a mental health, alcohol or drug problem? If yes, please describe:

_____

_____

_____

Use the table below to describe your family of origin/family you grew up in:

NAME	Relation to self	Age	Education/Occupation	How would you describe this person?

Do any of the people in your family of origin (currently or in the past) have a history of mental health, alcohol or substance abuse problems? If yes, please list and describe _____

_____

_____

Medical Issues: (Circle any that apply) Blood Pressure diabetes thyroid heart lungs kidneys Stomach seizures headaches

Other (please specify) _____

Who is your Primary Care Doctor? _____

When was your most recent physical? _____

Date of your most recent blood work: _____

Have you ever had an EEG, CT, MRI of the head? Yes No

If, so, were there abnormal findings? _____

List all current medications: _____

_____

Allergies (including allergies to medication): _____

_____

Please complete the following table and answer the questions below:

Substance	Age at first use	Use last 30 days	Average Quantity Used	Last Used	Amount Used
Alcohol					
Sedatives/Barbiturates					
Heroin/Opioids					
Cocaine					
Other Stimulants					
Marijuana					
Hallucinogens					

In the past two years, has there been one or more episodes of memory loss due to substance abuse? _____

Have you had any personality changes due to the use of substances? _____

In the past 5 years, have you had any legal issues (arrests, incarceration) related to your substance/alcohol use? _____

_____

Does someone think you have a serious substance use problem? _____

In the past year, has there been an out-of-control experience due to substance use? _____

_____

Do you have a history of serious problems with the use of substances? _____

_____

Do you have a history of substance abuse treatment (including 12-step programs)? _____

_____

Please describe your religious/spiritual belief system (i.e. Christian, atheist, agnostic, other religion) _____

_____

Is there anything else you'd like your therapist to know? _____

_____

_____

_____

Brazos Valley Mental Health and Wellness, LLC

Cancellation Policy

If you fail to cancel a scheduled appointment with at least a 24-hour notice, **you will be billed $50 for your missed appointment**.

This fee is charged for missed appointments or cancellations with less than a 24-hour notice, unless the absence is due to illness or emergency. We require a credit card number upon your initial appointment, which we will use to collect the missed appointment fee. Your card will be charged on the day of the missed appointment.

Reminder calls, emails and texts are made as a courtesy. If you have an appointment scheduled and do not show up or give us advanced notice, you will be charged the $50 fee.

Brazos Valley Mental Health and Wellness, LLC reserves the right to discontinue treatment when a client has three No-Show cancellations.

Thank you for your consideration regarding this important matter.

_____

Credit Card Number

_____

Expiration Date (MO/YR) CVV Billing Zip Code

I have read and agree to the Brazos Valley Mental Health and Wellness, LLC Cancellation Policy.

_____

Client Signature (Parent/Guardian Signature if under 18)

_____

Today's Date

Brazos Valley Mental Health and Wellness, LLC

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (required by the Health Insurance Portability and Accountability Act, 45C. F.R. Parts 16- and 164)

AUTHORIZATION:

I, _____, authorize Brazos Valley
Printed name of client
Mental Health and Wellness, LLC, to use and disclose the protected health information described above to:

_____
Name of person/organization you will release information to (example: Primary Doctor, Insurance Company, EAP, Parole or Probation Officer, Attorney)

NOTE: You must include any insurance you plan to use for your visits. Please include the name of your primary doctor, if you were referred by him/her to our office.

EXTENT OF AUTHORIZATION

I authorize the disclosure of my complete mental health record to the above persons, effective for all past, present and future periods of service. This disclosure will be effective until death, unless otherwise specified below.

_____
Initial

Initial the following items ONLY IF YOU WISH TO LIMIT THE EXTENT OF YOUR HEALTH RECORD DISCLOSURE.

I authorize the release of my complete health record with the exception to the following: _____

_____

This authorization only covers the period from _____ to _____ _____
Date *Date* *Initial*

This medical information may be used by the person I authorized to receive the information for the medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization IN WRITING at any time. I understand that a revocation is note effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my treatment, payment or eligibility for benefits will not be conditioned on whether I sign this authorization.

_____ _____
Printed Name *Signature (Parent/Guardian Signature if under 18)*

_____
Today's Date

Brazos Valley Mental Health and Wellness, LLC

Limits of Confidentiality

Contents of all therapy sessions are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Notes exceptions are as follows:

- DUTY to WARN and PROTECT
  When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

- ABUSE of CHILDREN and VULNERABLE ADULTS
  If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or a vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or local authorities.

- PRENATAL EXPOSURE to CONTROLLED SUBSTANCES
  Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

- MINORS/GUARDIANSHIP
  Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

- AGENCY CONSULTATION
  Our agency regularly engages in treatment consultation between therapists. By signing below, client gives permission for his/her case to be discussed amongst BVMHW therapists/staff in order to allow for additional treatment planning.

- INSURANCE PROVIDERS (when applicable)
  Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates and times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

I have read the above Limits of Confidentiality. I understand and agree to their meanings and ramifications.

_____ _____

Printed Name Today's Date

_____

Signature (Parent/Guardian Signature if under 18)