How did you hear about us?

BRIDGESTONE COUNSELING

☐ Facebook ☐ Instagram ☐ Google ☐ Referral from family ☐ Referral from professional ☐ Other: _____

Personal Information				
First name / Middle initial / Last name				Today's date
Mailing/Street address / City / State / Zip			Home phone	Business phone Cell phone
Birth date	Sex: ☐ Male ☐ Female		Social security number	
List present or previous health problems			List any medications you are currently taking	

☐ **Spouse** ☐ **Parent Information if client is under 18**				
First name / Middle initial / Last name				Marriage date
Street address / City / State / Zip			Home phone	Business phone
Birth date	Sex ☐ Male ☐ Female		Social Security Number	
List present or previous health problems				
List any medications you are currently taking				

Insurance Information	**Payment Arrangements: ☐ Client ☐ Church ☐ Insurance**		
Insurance company name	**Policyholder**	**Policyholder's date of birth**	Applicant's relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Holder Address City / State / Zip		Phone	Sex ☐ Male ☐ Female
Policy number		**Co-payment amount**	**Group number**
Secondary Insurance company name	Policyholder	Policyholder's date of birth	Applicants relationship to policyholder ☐ Self ☐ Spouse ☐ Child ☐ Other
Street address City / State / Zip		Phone	Sex ☐ Male ☐ Female
Policy number		Co-payment amount	Group number

Other Information (PLEASE COMPLETE THIS SECTION)	
If using EAP benefits, please provide authorization number, Name of program and any phone numbers for that program below:	
What do you hope to change or accomplish by seeking help at this time?	
List any agencies or other professionals who have provided you counseling services in the past.	
Signature	Email:

Counseling Services Authorization for Release of Confidential Information

Bridgestone Counseling

1st Client Name	2nd Client Name

I authorize the therapists licensing the name of Bridgestone Counseling as well as the employees of Bridgestone Counseling and the persons or entities listed below, or their representatives, to mutually release and disclose my health information.

I have received and reviewed Bridgestone Counseling's *Notice of Privacy Practices*.
I understand that only employees of Bridgestone Counseling and Therapists licensing the name of Bridgestone Counseling may ask me to sign this authorization.

I understand that by signing this *General Authorization* I am authorizing Bridgestone Counseling and therapists Licensed by Bridgestone Counseling to disclose my health information to the persons and entities listed below and that any health information or other confidential information in the possession of the persons and entities listed below may be disclosed to Bridgestone Counseling and Therapists licensed by Bridgestone Counseling. My health information includes, without limitation, any records, reports, test results, opinions, assessments and any other information relating to medical, emotional, educational or psychological condition. Disclosure may also be made to describe my condition and progress and to discuss treatment.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to the Director at Bridgestone Counseling office where I am receiving counseling. I understand that my revocation of this *General Authorization* will not affect a disclosure that Bridgestone Counseling has already made under this authorization.

I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Bridgestone Counseling's confidentiality rules.

I waive any right of privacy that I may have in connection with the disclosures hereby authorized.

This authorization is only valid until _____ [fill in date], or until three months after my file is closed at Bridgestone Counseling.

Primary Insurance Company	**Address**	**Client's Initials**
Secondary Insurance Company	Address	Client's Initials
EAP (Employee Assistance Program)	Address	Client's Initials
Bishop/Pastor/Ecclesiastical Leader	Address	Client's Initials
Name (parent, relative, friend, doctor, etc.)	Address	Client's Initials
Name (parent, relative, friend, doctor, etc.)	Address	Client's Initials
Name (parent, relative friend, doctor, etc.)	Address	Client's Initials

Signatures

1st Client's signature	Date	2nd Client's signature	Date
Name of parent or guardian (if client is under 18)		Name of parent or guardian (if client is under 18)	
Signature of parent or guardian (if client is under 18)	Date	Signature of parent or guardian (if client is under 18)	Date

DESCRIPTION OF SERVICES AND PRIVACY POLICY – BRIDGESTONE COUNSELING

We welcome you to Bridgestone Counseling, and hope that your visit will be worthwhile. The following information is important for your consideration. Your goals are more likely to be met when you understand the nature and limitations of counseling.

Goals and Outcomes
Generally, counseling is most useful in helping individuals help themselves or improve their relationships by changing feelings, thoughts, and/or behaviors. You determine the nature and amount of change you wish to make.

Benefits and Risks
Most people experience improvement or resolution to the concerns that brought them to counseling, but of course, there are no guarantees; and there are some risks.

Privacy Policy
We understand that the information you share in counseling can be very personal and that you may not want us to disclose this information to others without your authorization. By signing this *Description of Services,* you acknowledge and have read *Bridgestone Counseling's Notice of Privacy Practices.* This document describes your rights and our obligations regarding the use and disclosure of that information. All clients will be asked to sign an Authorization for Release of Confidential Information. Office personnel will not release confidential information without this written authorization unless such release is otherwise authorized or required by law. For example, the law may require us to disclose confidential information if there is reason to believe that a child has been abused or neglected, or that you may be in danger of harming yourself or others.

Payment for Services
The fee for services is based on each therapist's personal fee schedule. Cost ranges between $90 to $120 per 50-minute session. Additional time will be charged in one-half hour increments. Clients are responsible for payment of services. Payments are made to the office **BEFORE** each visit. If there are three or more unpaid visits in a row; future sessions may freeze until balance is paid in full. For your convenience, we accept all major credit cards (debit or credit) in addition to cash and checks. Health savings cards are also accepted. For your protection and convince, you may be asked to have your credit card on our secure service to ensure ease of payment before each session.

Be aware that insurance companies may require a mental health diagnosis and additional information. If you are using insurance and have concerns, please discuss them with your counselor.

As a courtesy to our clients who have insurance, we will submit services to your insurance company. Client is ultimately responsible for payment if insurance does not make payment and co-payment is due at time of service. Be aware that your insurance company may require a co-pay.

The initial assessment, in-home therapy and play therapy may be a slightly different charge and are covered differently by insurance companies.

Cancellation of Appointment
On occasion, a situation may arise which prevents you from keeping a scheduled appointment with your counselor. As a courtesy to your counselor and the office, please notify us at least ***24 HOURS*** in advance of your appointment if you cannot keep it. Except in emergency situations, you will be personally charged the current hourly fee for late cancellations or not showing for an appointment.

Should collection become necessary, I/We agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 33.3% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay a finance charge of 1 1/2% per month (annual percentage rate of 18% per year) of the unpaid balance.

Follow-Up
Occasionally, we follow-up with clients to determine if treatment was successful and results were lasting over time.

May we contact you in the future? YES NO

If you change your mind about allowing us to contact you in the future, you must send a letter to us to advise us of your decision.

Grievance

If you have concerns about any aspect of the services you are receiving, you should address the matter with your counselor.

I have read the above information, and understand that I am encouraged to ask questions, and give input regarding the counseling process at anytime. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.

CLIENT SELF-PAY: $_____ INSURANCE CO-PAY: $_____Bishop/Pastor/Ecclesiastical: $_____

_____
Print Name - Client 1

_____ _____
Signature *Date*

_____
Print Name – Client 2

_____ _____
Signature *Date*

Bridgestone Counseling
6800 Weiskopf Ave
Suite 150
McKinney, TX 75070

MISSED APPOINTMENT POLICY

I _____, understand and agree that I am personally responsible for payment for appointments missed without notice in advance, and that it is not the responsibility of the insurance carrier or any third party payer to make payments on my missed appointments.

Missed appointments are billed at the same fee as my regular office visits, and I am aware of the existing fee presently in effect.

A photocopy of this form shall be as valid as the original.

PATIENT SIGNATURE: _____

GUARDIAN SIGNATURE: _____

DATE SIGNED: _____