BRIGHTER HORIZONS COUNSELING, LLC
CHILD INFORMATION FORM

Today's Date:_____ Counselor:_____

Client's Name:_____
(First) (Middle Initial) (Last)

Address:_____
(Street) (City) (State) (Zip) Mailing Address (if different)

Phone #:_____ Leave messages at this number (please circle)-**Yes/No** Alt.#_____

Social Security Number:_____-_____-_____ Date of Birth:____/____/_____ Age____ Sex: M____ F____

Is this child living with both parents?_____ If no, which one?_____

School Attending:_____ Grade:_____ Physician:_____

Current Medications:_____ Referred By:_____
(Friend, Family, Doctor, School, Internet)

INSURANCE INFORMATION

Policy Holder Name:_____ D.O.B. ____/____/____Phone#_____

Employer:_____ Relationship to Client:_____

Insurance:_____ ID#_____ Group#_____ Start Date: _____

A copy of your Insurance card is required in order to bill insurance

SIBLINGS

_____ _____
(Name) (Birthdate) (M/F) (Name) (Birthdate) (M/F)

_____ _____
(Name) (Birthdate) (M/F) (Name) (Birthdate) (M/F)

_____ _____
(Name) (Birthdate) (M/F) (Name) (Birthdate) (M/F)

EMERGENCY CONTACT INFORMATION

Emergency Contact:_____

Phone#:_____ Address:_____ Relationship:_____

******OVER PLEASE******

MOTHER'S INFORMATION

Name:_____
(Last) (First) (M.I.)

Address:_____
(Mailing and Physical)

Home Phone#:_____ Work Phone#:_____ Cell Phone#:_____

Social Security#:_____-_____-_____ Birthdate: _____/_____/_____ Age:_____

Mother's Employer:_____ Work Phone#:_____

Insurance Company:_____ ID#_____ Group #:_____

FATHER'S INFORMATION

Name:_____
(Last) (First) (M.I.)

Address:_____
(Mailing and Physical)

Home Phone#:_____ Work Phone#:_____ Cell Phone#:_____

Social Security#:_____-_____-_____ Birthdate:_____/_____/_____ Age:_____

Father's Employer:_____ Work Phone#:_____

Insurance Company:_____ ID#_____ Group #:_____

STEP PARENT'S INFORMATION

Name:_____
(Last) (First) (M.I.)

Address:_____
(Mailing and Physical)

Home Phone#:_____ Work Phone#:_____ Cell Phone#:_____

Social Security#:_____-_____-_____ Birthdate:_____/_____/_____ Age:_____

Step Parent's Employer:_____ Work Phone#:_____

Insurance Company:_____ ID#_____ Group #:_____

BRIGHTER HORIZONS COUNSELING, LLC

PERMISSION FOR MINORS TO SEE COUNSELOR

I, _____, hereby give permission
(Parent or Guardian Name)

for my child, _____,
(Name of Minor Child)

born,_____, to receive treatment from the counselor at
(Month/Day/Year)

Brighter Horizons Counseling, LLC.

_____ _____
(Parent or Guardian Signature) (Date)

_____
(Witness)

CONFIDENTIALITY POLICY

Unless you give written consent to release information to specific other persons, what is discussed in therapy is confidential and will remain within the Brighter Horizons Counseling offices except for the following:

I will need and am compelled by law, to inform an appropriate other person:

A. If I hear and believe that you are in danger of hurting yourself or someone else.
Or
B. If there is reasonable suspicion that a child has been abused or neglected.

I understand that only with my written consent, will the agency be able to release or obtain specific information concerning my records. These records may or may not be protected by Federal Regulations under 42 CFR Part 2. ** **For Drug and Alcohol Clients-** I understand that my records are protected under the federal and state Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations (42 CFR Part 2.) Federal regulations prohibit you from making any further disclosure without the specific written consent of the person who it pertains, or is otherwise permitted by such regulations. In criminal proceedings, I further understand that this consent is revocable after the final date cited above or upon the final disposition of the criminal proceeding against me. **"The person receiving this information may re-disclose and use only to carry out that persons official duties with regard to the clients criminal proceeding with which this consent is given."**

In signing below this authorization, the undersigned acknowledges that the records disclosed with written permission might be subject to re-disclosure by/to the persons not covered by HIPPA. In the unlikely event that it becomes necessary to go to small claims court or a collection agency, your name will have to be reported to the appropriate persons. However, no clinical information will be disclosed.

I have read the foregoing, understand its content and agree to the conditions stipulated therein.

_____

Signature Date

_____

Printed Name

_____

Witness

PAYMENT POLICY

It is the goal and responsibility of this office to provide high quality service. In return, it is your responsibility to pay in full for this care. Even though we may file an insurance claim for you, **you are still solely responsible for the total amount of your account.** This office will gladly file claims for you or provide you information necessary for you to file your insurance claims and assist you if you have problems, but we cannot accept responsibility for negotiating a settlement on a disputed claim. Special requests for billing or other clerical work will be charged for and require a minimum of 7 days notice.

If, for any reason you are not able to come in at your scheduled time, it is important that you call as soon as possible. A meeting that is not cancelled will be billed at the half hour rate. (Insurance and Medicaid does not pay for no shows or late cancellation charges)

I understand that there may be restrictions to types of services covered by my insurance, managed care or EAP. Services such as crisis phone call sessions, extended time sessions (multi units of service), diagnostic evaluations with reports, assessments, consults with special persons for whom I have signed a release), court work and requested special reports that may be used to enhance my therapy, but may not be included in my coverage. I am aware of these possible limitations and agree to have these services performed as agreed necessary to enhance my treatment and to be responsible for the Brighter Horizons Counseling customary fee where applicable.

Sixty (60) days after the date of service, a service charge of 18% per annum will be added to the unpaid balance, unless you are complying with a payment plan previously arranged with the staff of Brighter Horizons. _____initials

****We do ask that payment be made in full for the first session unless your sessions are paid through an EAP or co-payment has been verified through your insurance****

OVERDUE ACCOUNTS: There will be a $30.00 charge on Insufficient Funds Checks. Should you have circumstances that would not allow payment of your account please discuss it with us as soon as possible. At that time a payment schedule may be discussed. Brighter Horizons Counseling will take legal measures against persons who do not abide by their payment agreements. In the event that it becomes necessary to go to small claims court or a collection agency, only your name and relevant information will need to be released.

*In the event this agreement is assigned to a collection agency for collection the debtor will pay a collection fee of 40% of the unpaid balance due under this agreement which is in addition to the unpaid balance due.

**The debtor will pay all reasonable attorney fees and court costs incurred by the service provider in the collection of any and all amounts due under this agreement.

_____

Signature of responsible party for payment Date

PAYMENT AGREEMENT: We find it helpful to have a clear agreement with our clients as to the method of payment. We ask that you complete both sides of the information forms which will be used as our contract for your payment. We will make every attempt to work with you and will submit your claims for you at no additional charge. Please understand that you are responsible for the payments of the account.

Contractual amount of initial session is _____ per session

Contractual amount of subsequent sessions is _____ per session

I HAVE READ AND UNDERSTAND THE ABOVE PAYMENT POLICY AND AGREE TO PAY MY ACCOUNT IN THE FOLLOWING MANNER:

PAYMENT PLAN

1._____I will pay in full at each meeting.

2._____At each meeting I will pay the part that insurance does not pay.

3._____Meetings are paid through my EAP (Employee Assistance Program) at work.
(Company Name) _____.

4._____I will need to make payment arrangements with Brighter Horizons Staff.

5._____ Paid by Medicaid.

****

AUTHORIZATION AND ASSIGNMENT

I hereby authorize Brighter Horizons Counseling, LLC to apply for benefits on my behalf for service rendered. I request that payment be made directly to Brighter Horizons Counseling, LLC. I certify that the information provided regarding insurance coverage is true and accurate. I further authorize the release of necessary medical or other information for this or any related claim to any insurance company. I permit a copy of this authorization and assignment to be used in place of the original. This will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs and reasonable attorney fees.

_____

(Signature of party responsible for payment) (Date)

OFFICE POLICIES

Brighter Horizons Counseling is a private therapeutic service. We are not subsidized. We will help you with your primary insurance forms and keep accurate records. If some clients do not pay for their services, the cost of others must be raised to make up the losses. When clients are late in paying their accounts we are still obligated to pay for the rent of office space, staff and so on.

APPOINTMENTS: An initial session may be up to 90 minutes in length (with the exception of EAP's). Subsequent appointments will typically be up to 55 minutes. This allows the therapist time to complete therapy notes, (as well as do other work on your behalf, between sessions). Ongoing therapy is done by mutual agreement; it will not be assumed that you will automatically be continuing therapy. Appointment times need to be worked out with your therapist at the end of each session.

EMERGENCIES: Whenever possible you will be able to speak with your therapist. If that is not possible and it is a medical emergency you are instructed to contact Campbell County Memorial Hospital. You may leave a message with the secretary and every attempt will be made to reach your therapist.

FEES: You are billed for all time spent with you, or on your behalf. This may include therapy, diagnostic testing, printed materials, reports, letters, consultations, travel time for "out of office" services and telephone calls.

CANCELLATIONS AND MISSED APPOINTMENTS: Some cancellations are inevitable. However, if we are not given sufficient notice, the session is a loss for someone else wishing to use the therapy time. The only thing that creates more problems than a late cancellation is when people don't show. Not only is the time not used by someone else, but the therapist has spent time preparing and will sit and wait for you. If you know that you have made an appointment that you cannot keep, please make arrangements to change or cancel at the earliest possible time. No shows will be charged at a minimum of half the regular rate. Those arriving more than 10 minutes late to an appointment will be charged a no show fee and must reschedule their appointment. (Be aware, that a no show is not covered by insurance or Medicaid). _____initial

TAX RECORD: Keep a copy of your statements for your own records. Psychotherapy is a medical expense. Depending on your medical cost and financial circumstances, you may be able to take an income tax deduction.

I have read and understand the information in this document.

Signature:_____ Date:_____

BRIGHTER HORIZONS COUNSELING, LLC

CLIENT RIGHTS

1. You have the right to humane treatment in an atmosphere of dignity and respect regardless of race, religion, age, sex, national origin, sexual orientation or disability.

2. You have the right to an individualized treatment plan and the right to be involved in its development and to review that plan with the therapist or outside consultant throughout your treatment.

3. You have the right to have your family involved in your treatment.

4. You have the right to privacy and confidentiality of all treatment information to the fullest extent provided by the law.

5. You have the right to refuse treatment to the extent permitted by the law and you must be told of the legal consequences (and medical, if applicable) if you exercise this right.

6. You have the right to discuss complaints and concerns with your therapist and initiate a grievance procedure to address your concerns to your satisfaction. If you are not comfortable in discussing this with your therapist you may e-mail your concern to carrie@brighterhorizonswy.com and that will be reviewed by Brighter Horizons owner, Carrie Strawn, who will contact you to assist you in the process.

7. You have the right to receive copies of all contracts and agreements that you have signed during treatment.

8. You have the right to the explanation of cost for treatment and a copy of your financial records.

9. You have a right to review your treatment records (except when contraindicated) after making a written request to the therapist.

10. You have a right to information concerning the credentials of the therapist and any other employees of Brighter Horizons Counseling, LLC.

11. It is policy and required that all clients' records are maintained for a period of 7 years from date of closure. Minor's records are maintained for a period of 7 years following majority.

****I have reviewed my rights and consent to treatment provided by Brighter Horizons Counseling.**

_____

Signature/Signature of Parent or Guardian Date

_____

Witness Signature Date

BRIGHTER HORIZONS COUNSELING, LLC
301 Richards Ave.
Gillette, WY 82716
(307) 685-6982

DISCLOSURE STATEMENT

As of March 1, 1999, Wyoming has implemented a privileged communication statue. This law states , that, when involved in legal proceedings (civil, criminal, or juvenile) clients retain the right to privacy, unless these specific circumstances exist:

A. Abuse or harmful neglect of children, the elderly or disabled or incompetent individuals are known or reasonably suspected.
B. The validity of a will of a former client is contested.
C. Information related to counseling is necessary to defend against a malpractice action brought on by a client.
D. An immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor.
E. In a civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor.
F. The client alleges mental or emotional damages in civil litigation or his/her mental or emotional State becomes an issue in any court proceeding concerning child custody or visitation.
G. The patient or client is examined pursuant to a court order.
H. In the context of investigations and hearing brought by the client and conducted by the board, where violations of this act are at issue.

Brighter Horizons adheres to the Code of Ethics, as specified by the American Psychological Association, The American Counseling Association and the National Board of Certified Counselors.
Sexual intimacies between client and counselors are never appropriate.

Carrie L. Strawn, MA, LPC, NCC
Licensed Professional Counselor(LPC#820)
Masters of Arts, Counseling and Guidance,
Gallaudet University, Washington, D.C.
Counseling Approach: Cognitive Behavioral,
Educational, Adlerian Areas of Specialization
Individual, Group Therapy & Adolescents,
Families with special needs children and
Individuals who are Deaf & Hard of Hearing

Clients shall go through the Brighter Horizons formal grievance process to resolve any issues if the client is not satisfied with the outcome of the process, please contact Behavioral Health Division 6101 Yellowstone Rd. Cheyenne, Wy 82002. PH# (307) 777-6494 FAX# (307) 777-5849. This disclosure statement is required by the Mental Health Professionals Licensing Act., Wyoming Mental Health Professions Licensing Board, First Bank Plaza, 2020 Carey Ave., Ste. 201 Cheyenne, Wy 82002.
(307) 777-7788

Client Name/ Parent or Guardian Signature _____ Date

NOTICE OF PRIVACY PRACTICES (HIPAA)

We realize that these laws are complicated, but we must provide you with the following important information.
Please review it carefully!

This notice of "Privacy Practices" describes how we may use and disclose your "Protected Health Information" (PHI) and for any other purposes that are permitted or required by law. It also describes your right to access and control your "PHI". "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information (PHI)

Your "PHI" may be used and disclosed by your counselor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the counselor's practice and any other use required by law.

2. Treatment

We will use and disclose your "PHI" to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party, such as, your "PHI" may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

3. Payment

Your protected health information will be used, as needed, to obtain payment for your health care services.

4. Healthcare Operations

We may use or disclose, as needed, your "PHI" in order to support the business activities of your counselor's practice. We may use a sign in sheet at the registration desk where you will be asked to sign your name. We may also call you by name (first name only) in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary to contract you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include but are not limited to: as required by law; Public Health issues; communicable diseases; health oversight; abuse or neglect; food and drug administration requirements; legal proceedings; Criminal activity; Military activity and nations security; worker's compensation; inmates required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except the extent that your counselor or the counselor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. The following is a statement of your rights with the respect to your "PHI". You have the right to inspect and copy your protected health information, under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on your "PHI". This means you may ask us not to use or disclose any part of your "PHI" for the purposes of treatment, payment or healthcare operations. You may also request that any part of your "PHI" not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request must state a specific restriction requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your "PHI", your "PHI" will not be restricted.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. You have the right to have your counselor amend your "PHI". If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your "PHI". We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

5. Complaints

You may complain to us in writing or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to protected health information, your signature below is in acknowledgment that you have received this "Notice of Privacy Practices".

Print Name	Signature of Client or Guardian	Date