Brightside LCSW Services, PLLC/dba
Brightside Counseling Services
3719 Union Rd. Ste. 122
Cheektowaga, NY 14225
(716) 783-0407 Fax: (716) 393-3430

Thank you for choosing Brightside Counseling Services.

Contingent on where you scheduled your initial appointment our 2 office locations are:

- 3719 Union Rd., Ste. 122 Cheektowaga, NY 14225 (behind Sakura's restaurant)/ or
- 37 Maple Road, Williamsville, NY 14221.

24 Hour No Show/Cancellation Policy

Our no show/ 24 hour cancellation policy requires that you contact our office 24 hrs. in advance of your appointment if you are unable to attend or you will be charged a flat rate fee of $95.

We hold your appointment time open for you so please call ahead if you are unable to attend. This allows us to serve another client who is waiting for counseling.

If you are unable to reach us, please leave a message on our confidential voicemail.

What to bring with you to the session:

- **Please bring a completed copy of all of the attached Intake documents, Please do not fold them or copy back & front, for they will become part of your record. Complete it to the best of your ability and questions will be answered upon your first visit.**
- **Please bring a list of your medical and mental health conditions and a list of any associated medications with their dosages.**
- **As applicable, the name and address of your psychiatrist or Primary Dr.**
- **Your insurance Card**
- **Cash or check for any co-pays, co-insurances or deductibles you may be responsible for up to full payment of up to $125 for the initial visit.**

Thank you for your anticipated cooperation. We look forward to serving you.

Intake Paperwork

- Please complete all paperwork associated to intake form, also including all releases, copy and bring with you to initial session.
- If you are attending as a couple for couples counseling, each person is to complete all adult forms and bring with you to your initial session.
- Children under 18 yrs. old are to complete Child Intake form plus all other consents signed by a parent or guardian. Must have parent in attendance for initial session.

CHILD INTAKE FORM
Under 18 years old
***Please complete all questions on this form (Please Print)**

Today's date: ____/____/____
Name of person completing this form: _____
Relationship to client_____

Child's Name: _____ **Gender:** Male Female

Address: _____ **Date of Birth** ____/____/____

City Zip: _____ **Age:** _____

Home Phone: (____)_____ Work: (____)_____ Cell: (____)_____

Parents are currently: Married Separated Divorced Remarried Single (circle one)

Child's legal guardian is: _____
If parent's not together, child's primary residence _____

Mother's Name: _____
Address/ Street/ City/ Zip _____
Home Phone: _____ Work: _____ Cell: _____

Father's Name: _____
Address/Street/City/Zip (if different): _____
Home Phone: _____ Work: _____ Cell: _____

Stepparent's Name: _____
Address/Street/City Zip _____

Home Phone: _____ Work: _____ Cell: _____

Please list the names and ages of any siblings, including step and half siblings: _____
_____ _____
_____ _____ _____

Name of School _____ Grade _____

Has there been a change in your child's performance at school? Yes No
If yes, please describe: _____

Please describe your child's strengths/ positive characteristics, interests/ special activities:
_____
_____

1. Has your child ever received counseling, psychological, alcohol or drug treatment before? Yes No
If yes, please indicate: Where? For what? When? With what results?
_____
_____
_____

2. Has your child ever been prescribed medications for psychiatric or emotional problems? Yes No
If yes, please indicate if past or current.
From Whom? For what? Name of Medication(s)… With what results?
_____
_____

3. List any inpatient psychiatric hospitalization(s): (include dates of treatment)
_____

3a. Any past or current homicidal/suicidal thoughts? Yes No
If yes, please explain: _____
_____

4. Name of your child's primary care physician: _____
Address/Street/ City Zip _____ Phone Number: _____

5. Did your child achieve the following milestones Early (E), Average (A), or Late (L) compared with others his/her age (please explain if late): **Language** (age at first using words, sentences, etc…) ____
Fine motor skills (building towers with cubes, drawing circle) ____
Gross motor skills (rolling over, standing, walking)? ____ **Toilet training?** ____

5a. Has your child experienced any regression of these? Yes No
If yes, explain: _____

6. List any current medical illnesses, or health-related concerns/include allergies:
_____

7. List all current medications/including over the counter and herbal remedies (include name of doctor prescribing:
_____
_____

8. List any hospitalizations or surgeries: (include approximate dates) _____
_____

9. Does your child have any current legal charges, court involvement or under court order to receive services? Yes No If yes, please explain: _____
_____

10. List family history (parents/aunts uncles grandparents/siblings) of mental health problems or alcohol/drug dependency:_____
_____

11. What are your goals for counseling? _____
_____

12. **PLEASE CIRCLE ALL THAT APPLY**:

*Parents/guardian, if possible, please allow your child to complete this section. If your child is too young, complete symptom check list from your observations of your child.

Headaches	Memory problems	Isolating self
Sleep problems	Heart palpitations	Feeling tense or nervous
Academic concerns	Drug use	Alcohol use
Worries about money	Feeling shy around others	Not confident
Having a lack of friends	Stomach problems	Concerned about eating habits
Feelings of panic, fear, phobias	Trouble concentrating	Disorganized thoughts
Feeling sad or depressed	Grief or loss	Nightmares
Feeling restless	Feelings of hopelessness	Feelings of worthlessness
Low self-esteem	Disturbing thoughts	Hallucinations

Aggression	Mood swings	Recurring thoughts
Chest pain	Trembling	Relationship problems

Client Name: _____

Sexual concerns	Sexual identity concerns	Anger
Ideas of harming self/others	Memory problems	Chronic pain
Blaming or criticizing self	Abusing others	Dizziness
Feeling tired	Feeling a need to be on the go	Problems at home
Anxiety	Antisocial or illegal behavior	Poor judgment
Concerned about family members	Impulsive	Distractibility
Irritability	Abused by others	Sick often

13. Has your child ever been the victim of abuse/trauma or neglect? Yes No
    If yes, please check all that apply.

Physical ___ Emotional ___ Neglect ___ Sexual ____ Accidents___ Disasters (ie.fires/flood) ___ Witness of violence ___ Other: _____

Please add any other information about your child that would be helpful for the counselor to know.

_____
_____
_____

Counselors Additional Comments

_____
_____
_____
_____

Diagnosis

Axis I Clinical _____

Axis II MR/Personality _____

Axis III Physical _____

Axis IV Psycho/Social/Environmental _____

GAF: _____

Preliminary Goals:

_____

_____

Initial recommendations? Yes _____ No _____ If yes: _____

How will goals be addressed?: Individual Group Family Couples

Anticipated time frame to achieve goals: _____

Recommended follow up session in: 1 2 3 4 5 Week(s)

Counselor's Name/Cred.: _____ _____
Date

Consent for Child Treatment

I am the parent/legal guardian of _____ with full legal authority to consent to treatment. I give permission for Brightside Counseling Services to provide treatment for this child, which may include assessment, advocacy, referral and mental health counseling.

Signature: _____
Print name: _____

Relationship to child: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	add columns:		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

Total:

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all ____
- Somewhat difficult ____
- Very difficult ____
- Extremely difficult ____

Brightside Counseling Service Office Policies

Cancellation Policy

Because your appointment time is time reserved for you, we require that you contact our office 24 hrs in advance to cancel or you will be charged $50 for the missed session.

Please leave a message on the voicemail if no one is available. The payment for this missed visit will be expected prior to being seen for your next scheduled visit. If you do not return for counseling, you will be sent a bill for the time missed.

Emergency Calls

Primary office hours are Monday through Thursdays. *Please leave a confidential message with your telephone number for a return call if no one is available. If this is a Crisis, please contact Crisis Services at 834-3131, 911 or call Brightside to obtain backup counselor's number.*

Insurance/Other Payment Policy

If you have questions regarding billing matters please feel free to contact our office. Insurance companies set their own deductibles and co-pays therefore we are only able to tell you what the insurance representatives are telling us at that time we call for authorization for your sessions. If they provide us with misinformation and there is a balance due beyond what was initially indicated by your insurance you are fully responsible for balance of payment to Brightside.

I understand and agree to payment to Brightside Counseling if my insurance company or other payment agent does not pay for visits at this office. I understand I will be held responsible for any and all charges incurred as a result of your/ or your responsible party's visits.

Patient Record Fees

Please be aware that ***your records, if copied, will cost 25 cents per copied/faxed page****. If you are requesting them to be sent to someone* ***aside from a disability claim*** *you will incur the 25 cent per copy/ fax fee.*

Records requested by other health care professionals are free of charge. All court appearances *will be charged at the flat rate fee of $100/hr. beginning from the office location to return.*

I have read, understand and agree to these policies.

_____ Date ___/___/___

Signature of Client

_____ Date ___/___/___

Parent/ guardian/ or other responsible party

Brightside Counseling Services
3719 Union Rd. Ste. 122
Cheektowaga, NY 14225
716-783-0407

Client's Consent to Release Information to Insurance/Payer for Payment

Client's Name _____ Date of Birth _____

Insurance ID _____ Insurance Name _____

I authorize my insurance company or other agents, including but not limited to, EAP benefits paying for my treatment to receive information regarding my mental health/substance abuse care for the purposes of quality assurance monitoring/auditing, and payment of claims. Additionally, Brightside and my insurance company may consult with each other and other health care professionals regarding the appropriateness of my treatment. I am allowing contact with my physician or psychiatrist relative to any billing authorization related matters.

If not signed and authorized, claim will not be paid by insurance company or other payer.

Authorized by:

_____	_____	_____
Print Name	**Patient Signature**	**Date**
_____	_____	_____
Parent/ Guardian Name	**Parent Guardian Signature**	**Date**

Standard Authorization to Exchange Information Regarding Mental Health/ or Substance Abuse Treatment

To communicate with Doctor or Psychiatrist

I, _____ **[Client],**whose **Date of Birth** is _____/_____/____, authorize Brightside LCSW Services PLLC dba Brightside Counseling Services to disclose to and/or obtain from: **Primary Medical Dr/ or Psychiatrist's name/ address(es)**
Drs. name_____ at the following **address(es)**

_____, the following information:

Description of Information to be Disclosed as appropriate

__x___ Assessment
__x__ Diagnosis
__x___ Psychosocial Evaluation
_____ Psychological Evaluation
__x___ Psychiatric Evaluation
__x___ Treatment Plan or Summary
__x___ Current Treatment Update
__x___ Medication Management Information
__x___ Presence/Participation in Treatment
___x___ Nursing/Medical Information
_____ Toxicological Reports/Drug Screens
_____ Educational Information
___x__ Discharge/Transfer Summary
___x__ Continuing Care Plan
___x__ Progress in Treatment
___x__ Demographic Information
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If the purpose is other than as specified-
_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Brightside Counseling Services at 3719 Union Rd. Ste 122 Cheektowaga, NY 14225. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____ or until treatment is completed.

Conditions

I further understand that Brightside Counseling Services will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: lack of coordination of treatment, or
_____*Explanation of the consequences, if any, of not signing this authorization, will depend on the services being provided.*

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable HIPPA law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. I can request a copy of this authorization for my records.

_____
Signature of Patient/Client Date

_____
Signature of Parent, Guardian or Personal Representative or Power of Atty. Date

HIPPA Confidentiality

Notice of Policies and Practices to Protect the Privacy of your Health Information

This notice explains how your protected health information about you may be disclosed as necessary for treatment, payment and health care operations and the exceptions and rights therein.

Uses and Disclosures for Treatment, Payment and Health Care Operation Activities

A client has the right to impose restrictions on the use or disclosure of PHI in some circumstances in which use or disclosure would otherwise be permitted under HIPPA

1. **Uses and Disclosures for treatment, payment, and health care operations**

I may use or disclose your protected health information (PHI), for *treatment, payment and health care operation purposes with your consent*. PHI is information in your health record that could identify you.
Treatment is when I provide, coordinate or manage your health care and or other services related to your health care. An example of treatment would be when I consult with another health care provider, your family, physician or psychiatrist.
Payment is when I obtain reimbursement for your healthcare and other services related to your healthcare. For example, this would be information necessary to get insurance reimbursement and determine your insurance eligibility.
Health Care Operations are activities that relate to the performance and operations of my counseling services. Such as…Quality assessment, and improvement activities, business related matters such as audits and administrative services and case management and case coordination.
Use applies only to activities within my office, clinic, practice, or group the sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
Disclosure applies to activities outside of the office, clinic, practice group etc. such as releasing, transferring, or providing access to information about you to other parties.

2. **Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. *An Authorization* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need an authorization signed by you or your legally responsible party before I can release the progress notes we keep about you in your file. *You may revoke each release in writing except* (1) to the extent I have relied on it or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. You have the right to request a restriction of the Privacy Officer and a determination will be made as to whether it was permissible and notify you regarding the results of the review of your request.

3. **Uses and Disclosures with Neither Consent Nor Authorization**

a. **Child Abuse-**If in my professional opinion, I have reasonable suspicion or a child comes before me indicates they are abused or maltreated, or where a parent, guardian, custodian or other person legally responsible for the child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child abused or maltreated, I am mandated to report such abuse or maltreatment to the statewide central register of child and maltreatment, or the local child protective services.

b. **Health Oversight-**If there is a question regarding a professional conduct complaint and the MYS Commissioner is investigating regarding your case, the relevant records relevant to this inquiry will be disclosed

c. **Judicial or Administrative Proceedings** If a judge orders your record due to you being involved in a court proceeding you will be notified of the request however we cannot deny access to your record. If it ordered by an attorney an authorization is necessary from you.

d. **Serious threat to Health or Safety of yourself or another** I may disclose your confidential information to protect you or others from a serious threat or harm by you.

e. **Medical Emergency** In case of a medical emergency your information the minimal amount of contact with your emergency contact and those medical professionals involved will be notified of the basic information necessary in order for you to get the proper emergency medical attention you may need.

4. **Patient's Rights and Counselor's Duties**

Right to request restrictions- you have a right to request restrictions on certain uses and disclosures of PHI about you.
You may request that the Covered Entity restrict use or disclosure of PHI for purposes of treatment, payment and health care operations, and may request a restriction on information given to family members, friends, and others involved in your care. This restriction request will be reviewed y the Privacy officer and you will notified of the result and a copy of the result will be kept in your file. Requests for restrictions on the use of PHI for treatment, payment and health care operations must be made in writing on a request for Restriction on Use and Disclosure of Health Information Form. The Privacy Officer (owner of operation) will review the request and may accept or reject as permitted by law. You will be notified of the disposition on your request in writing. A copy of this letter will be kept in your file.

Right to receive your confidential communication by alternate means/or locations Any correspondence from this office can be sent to alternate location to protect your confidentiality.

Right to inspect and copy You have the right to inspect or obtain a copy(or both) of PHI and psychotherapy notes in my mental health and billing records however I may deny your access in certain circumstances, and in some circumstances you may have this decision reviewed.

Right to an accounting You have a right to the accounting of PHI sent without your consent nor authorization as described in a-e above.

You have a right to a paper copy of this agreement.

I understand the above.

X _____ Date _____