Bridges Counseling Connection

8717 Dimond D Cir ~ Anchorage, Alaska 99515
Office: (907) 771-0536 ~ Fax: (907) 771-0537

Pre-Evaluation Questionnaire

*To better help us serve you, please provide us with the following information prior to your evaluation with your clinician. All information is confidential and will be part of your clinical record. If you need more space feel free to use the back of the paper. Please feel free to ask us questions about any of the information requested. Thank you. (Attention: **Parents** completing form, provide child's information)*

USE BLACK PEN ONLY

Date: _____

Name of Client: _____ **DOB:** _____ **Gender: M / F**

Name and Relation to Client:

_____

Marital Status of Client: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

Who referred you to our facility?

Please describe the main reason for your visit/current concerns: *including behaviors, thoughts, and feelings*

In what situations, at what time or day(s), in what place(s) does this occur?

How *often* do you feel this way or have this problem?

Rate the *intensity* of the problem on a scale of 1-10: 1 2 3 4 5 6 7 8 9 10
less intense more intense

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Medical Information

Please be as specific as possible

Do you have any drug allergies? ☐ Yes ☐ No *If yes please list all drugs and the reactions they cause*:

Are you currently taking any medications? ☐ Yes ☐ No *If* yes, *please list all medications, dosages, times taken per day, and how long you have been taking them. (also include supplements (ie vitamins, herbs, etc.)*

Do you have any currently active medical illnesses? ☐ Yes ☐ No *If yes, please list them:*

Do you have a history of any other medical illnesses? ☐ Yes ☐ No *If yes, please list them*:

Have you had any surgeries? ☐ Yes ☐ No *If yes, please list the procedures, approximate dates, and any problems or complications*:

Obstetrical/Gynecological history: ☐ *Not applicable*

Number or pregnancies: _____

Number of children: _____

Date of my last menstrual period: _____

Was it normal?: ☐ Yes ☐ No *If no, please explain:*

Who is your family Physician?

_____

When was your last check-up and why? -

_____

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Do you have a pharmacy that you prefer? ☐ Yes ☐ No

Who is your family Dentist?

_____

When was your last check-up and why? _____

When was the last time you had any blood-work done? _____

Have you ever been knocked out or diagnosed with a concussion? ☐ Yes ☐ No *If yes, please explain:*

Have you ever had a seizure or undergone an EEG? ☐ Yes ☐ No *If yes, please explain:*

Have you ever had any neuro-imaging: (ie brain CT scan or MRI?) ☐ Yes ☐ No *If yes, please explain:*

What was your birth-weight? ☐ Can't recall _____

Are you aware of any pre-natal exposures: (*did your Mother drink or use any other substances while she was pregnant with you*?) ☐ Yes ☐ No ☐ Not sure *If yes, please explain:*

Are you aware of any problems with your own pregnancy? (*when your mother was pregnant with you, during or shortly after delivery*?) ☐ Yes ☐ No ☐ Not sure *If yes, please explain:*

Were you ever formally diagnosed with any developmental delays – *learning to talk (and requiring a speech therapist), or to walk, or motor coordination*? ☐ Yes ☐ No *If yes, please explain:*

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Tell us about your *biological* family history: (*this will help us understand what health issues may be of concern to you*)

Do you have any *biologically related relatives* with a history of the following?

Depression? ☐ Yes ☐ No *If yes, who:*

Bipolar or *manic-depressive illness*? ☐ Yes ☐ No *If yes, who:*

Schizophrenia? ☐ Yes ☐ No *If yes, who:*

Anxiety disorders such as *Panic*, *Post-traumatic stress disorder*, or *OCD*? ☐ Yes ☐ No *If yes, who:*

Eating disorders such as *Anorexia Nervosa*, *Bulimia*, or *Binge Eating disorder*? ☐ Yes ☐ No *If yes, who:*

Addiction? ☐ Yes ☐ No *If yes, whom, what:*

☐ Alcohol
☐ Marijuana
☐ Cocaine
☐ Amphetamines
☐ IV drugs
☐ Prescription drugs
☐ Other drugs/substances: _____

General medical illnesses? ☐ Yes ☐ No *If yes, whom, what:*

Have you ever seen a psychiatrist? ☐ Yes ☐ No *If yes, who, where, and when:*

Have you ever seen a counselor or therapist? ☐ Yes ☐ No *If yes, who, where, and when*

Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No *If yes, please explain what diagnosis, when, and by whom:*

Have you ever been on psychiatric medications? ☐ Yes ☐ No *If yes, please list names, doses, and approximate dates*:

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Have you ever been hospitalized for psychiatric reasons before? ☐ Yes ☐ No *If yes, please list location and dates*:

Have you ever attempted or seriously considered suicide? ☐ Yes ☐ No *If yes, when:*

Are you currently considering suicide? ☐ Yes ☐ No

Do you have a plan? ☐ Yes ☐ No

Current or Historical Substance Use

Do you currently use, or do you have a history of using in the past? ☐ Yes ☐ No

Please check those that apply

☐ Tobacco/Chew/Nicotine gum or patch
☐ Caffeine/ *How Much* _____
☐ Alcohol
☐ Marijuana
☐ Cocaine
☐ IV drugs
☐ Inhalants
☐ Prescription drugs
☐ Heroin
☐ Amphetamines (include methamphetamine)
☐Hallucinogens
☐ Illicit prescription drugs (ie oxycontin)
☐ Other drugs/substances: _____

If you have a history or are currently using alcohol or other substances please answer the following questions: ☐ Not Applicable

Have you ever experienced withdrawal symptoms from alcohol or other drugs? ☐ Yes ☐ No

Has anyone ever told you that they thought you had a problem with drugs or alcohol? ☐ Yes ☐ No

Have you ever felt guilty about your drug or alcohol use? ☐ Yes ☐ No

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? ☐ Yes ☐ No

Have you used drugs or alcohol first thing in the morning? ☐ Yes ☐ No

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Social History

Where were you born and raised?

Do you have any siblings? *How many, gender, ages?*

Tell us about your educational history. *Currently in school, grades, difficulties, diploma, GED, degree(s) attained?*

Tell us about your work history? (*types of jobs have you held, where, what is your current employment status, military*)

Do you have any current legal involvement and/or history of legal involvement? ☐ Yes ☐ No
If yes, *please describe*

Have you ever been convicted of a crime (assault, DWI, theft)? ☐ Yes ☐ No
If yes, please describe (don't include parking or minor traffic tickets)

Have you experienced any significant traumas in your life? ☐ Yes ☐ No
If yes, please describe

Have you felt unsafe or at risk of violence in any of your relationships? ☐ Yes ☐ No
If yes, please describe

Is there any other relevant information which you would like to be sure we discuss during our interview time? *Please provide additional information*?

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OFFICE REGISTRATION FORM ***DATE***_____

PLEASE FILL OUT COMPLETELY

Clients Legal Name: _____ DOB:_____
(LAST) (FIRST) (M)

☐ Male ☐ Female

Mailing Address: _____
(City) (State) (Zip Code)

Physical home address:_____
(City) (State) (Zip Code)

Home Phone #:_____ Client's SSN#:_____

If you are filling out data on yourself, please proceed to next box and fill in additional lines.

1ST Guardian's Name:_____ DOB:_____
(LAST) (FIRST) (M)

Employer:_____Relationship to Client:_____ SSN#:____

Personal Mailing Address:_____
(City) (State) (Zip Code)

Home Phone #:_____ Work Phone #:_____

Cellular Phone #:_____ Which # is best?_____

2ND Guardian's Name:_____DOB:____
(LAST) (FIRST) (M)

Employer:_____Relationship to Client:_____SSN#:_____

Personal Mailing Address:_____
(City) (State) (Zip Code)

Home Phone #:_____ Work Phone #:_____

Cellular Phone #:_____ Which # is best?_____

Who Referred You To Our Clinic?_____

Relationship To Client _____

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FORM OF PAYMENT FOR SERVICES
If you have insurance cards please give them to the receptionist for copying.

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____

Claims Address:_____

Policy Holder's Name:_____Relation to Client:_____

Policy I.D. Number:_____Group:_____

Policy Holders SSN: _____ DOB:_____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

Claims Address:_____

Policy Holder's Name:_____Relation to Client:_____

Policy I.D. Number:_____Group:_____

Policy Holders SSN: _____ DOB:_____

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR ANY AND ALL CHARGES FOR SERVICES RENDERED TO ME OR MY CHILD BY BRIDGES COUNSELING CONNECTION (BBC). MY INSURANCE WILL BE BILLED AS A COURTESY TO ME ONLY IF I PROVIDE ACCURATE INSURANCE INFORMAION TO BCC. I AM RESPONSI BLE FOR ANY POR- TIONS OF MY BILL AT THE TIME THAT SERVICES ARE RENDERED, UNLESS INSURANCE IS PREDETERMINED TO COVER IT BY BCC. I HEREBY AUTHOR IZE PAYMENT BY MY INSURANCE DIRECTLY TO BCC. I FURTHER AUTHORIZE RELEASE BY BCC OF ANY INFORMATION NECESSARY TO MY INSURACE COMPANY FOR PAYMEN T OF CLAIMS.

(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY)	**(DATE)**	**1ST YR**
(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY)	**(DATE)**	**2ND YR**
(GUARDIAN OR PATIENT SIGNATURE—PLEASE SPECIFY)	**(DATE)**	**3RD YR**

BRIDGES COUNSELING CONNECTIONS

8717 Dimond D Circle Anchorage, AK 99515
Office 907.771.0536 Fax 907.771.0537

BRIDGES COUNSELING CONNECTION COMMITMENTS & EXPECTATIONS

Bridges Counseling Connection (BCC) chief goal is to run an effective, efficient Center for all of our patients. Being up-front and direct with you at the start of our work together is meant to ensure a mutually satisfying treatment relationship. In seeking the best care, we maintain a collaborative practice model. The collaborative practice model requires that cases be presented for review and critiqued by peers within our facility. In this way you are assured that you are given the best possible care and that standards of care are always met, if not exceeded. If you have questions, please ask your clinician for details.

Please carefully review the following items and sign at the end of the document to indicate your agreement with them. If you have any questions or concerns, please let us know so that we may address them. Thank you.

COMFORT ZONE

With consideration of the work we do at BCC, we request clients recognize the facility, and the grounds, as a safe and comfortable zone for all clients. Things we request:

Safety - BCC is a weapon free zone. No weapons of any type are allowed on the premises. We will ask you to leave weapons secured in your vehicle.

Medical - Cigarettes, cigars, pipes; electronic or natural, are not allowed within the facility or 20ft from building.

Animals - please register your animal at the front desk. We will ask you to sign a liability waiver, making you solely responsible for the animals actions and behaviors. Any aggressive behaviors will bar your animal from returning.

Children - It is often inappropriate to bring children into your session, please do not leave them unattended in our lobby. You may be asked to reschedule if they become unruly and disrupt other clients experience at our facility.

KEEPING APPOINTMENTS

We will attempt to place a courtesy call to remind you of your appointment. However, it is ultimately your responsibility to keep the appointment you have scheduled with BCC.

Cancellation parameters:

Weekday appointments, e.g. Tuesday thru Friday, we require 24 hours notice if you decide to cancel or reschedule an appointment.

Mondays requires 72 hours notice if you decide to cancel or reschedule an appointment.

This will allow us to schedule another patient who may need to be seen quickly, since our schedules are usually booked several weeks in advance. We consider a late-cancelled appointment to be the same as a missed or a 'no show' appointment . If we have to postpone your appointment due to a reason on our part, we will do our best to get you in quickly for your rescheduled appointment.

Keeping your appointments is an extremely important part of your care. Please read and initial the next section:

The first no show or late cancellation will carry no charge.

A second no show or cancellation will require that you register a credit card number with our billing company before a third appointment can be made, again - no charge for a second no show.

A third no show or late cancellation will be automatically charged on your credit card at the full rate of the scheduled appointment.

All cancellation will be counted within a calendar year.

This may be difficult for some and if you wish you can be given the names of other qualified providers with whom you may be able to develop a treatment relationship which better suits your needs.

We value your time and will do our best to run on time for your appointments. However, please keep in mind that situations arise that require extra time and attention, in person or by telephone, and may cause us to run late. We may choose to spend extra time with those in crisis, as we would with you in your time of need.

ALASKA MEDICAID

All clients who receive benefits through Alaska Medicaid or Denali Kid-Care need to be aware that it is a state requirement that you must receive an annual evaluation from our medical personnel.

This evaluation would preferably schedule prior to meeting your therapist, but may occur after. These evaluations are lengthy and may require, due to complexity, multiple visits. If you fail to make an appointment (no show or late cancel), miss appointments, or fail to complete the evaluation appointments we can no longer offer you services of any kind.

Our clinic can only offer services to Medicaid or Denali Kid-Care clients who fulfill the state requirements.

All Medicaid or Denali Kid-Care clients are held to this standard. Minors or adults who have legal guardians are also held accountable.

PAYMENT FOR SERVICES

If you use private insurance or Medicaid, we require payment of the portion of your bill not covered by your insurance at the time of each of your follow-up appointments. If you are being seen and have two private insurances (i.e. you have “double coverage”), or use Medicaid/Denali Kidcare combined with any type of supplemental insurance, no payment is necessary at the time of your follow-up appointments.

Many new insurance have large deductibles or long waits for payment. Given that timely payment for our services is expected, if your account becomes more than 60 days past due, we will expect you to set up a payment plan through our billing service. When your company reimburses us and a credit appears on your account, a reimbursement check will be written to you the following billing cycle.

Should your insurance status or personal financial situation status change such that you foresee having difficulty paying your bill, let us know immediately. Once you have engaged our services, it is important to

us that you are able to continue. We will attempt to work with you through our billing department to make that happen.

If your account becomes 90 days past due without any attempt on your part to set up a payment plan, or if you do not abide by your payment plan, we reserve the right to cease providing services to you. All accounts reaching the 120-day mark will be turned over to a collection agency. All fees associated with the collection of accounts will be at the client's expense. In that event, we will provide you with the names of other qualified psychiatric providers with whom you may seek treatment.

"MANAGED CARE" PARTICIPATION

Any Pre-certification requirements that BCC agrees to do, on your behalf, must be done as a scheduled appointment, and with the client present. This is to ensure that you are fully aware of any information being released to your insurance company. We reserve the right to refuse any pre-certification requirements that we find excessive.

PRESCRIPTIONS AND PRESCRIPTION REFILLS

Part of your treatment may include the use of a prescription medication if it appears to be indicated, has been thoroughly discussed with you, and you decide to use it.

We require four (4) business days' notice to process all medication refill requests. Please plan accordingly. If you have run out of refills on a particular prescription, please call your pharmacy and ask them to fax us a prescription refill request. Of course, you may always call the office directly to request refills; however, the faxing route is the most expedient.

I HAVE REVIEWED THE COMMITMENTS AND EXPECTATIONS SET FORTH IN THIS DOCUMENT AND AGREE TO ABIDE BY THEM WHILE I AM WORKING WITH Bridges Counseling Connection.

DATE:

SIGNTURE:

BRIDGES COUNSELING CONNECTIONS

8717 Dimond D Circle Anchorage, AK 99515
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HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to make changes to this Notice at any time, provided such changes are permitted by applicable law, and to make such changes effective for all health information we may already have about you. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health in- formation we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for the purposes of treatment, payment, and health care operations. For example:

Treatment: HIPAA allows us to use and disclose your health information to provide, coordinate, or manage your health care and related services. BCC will not disclose your protected health information without your written or (in rare cases) verbal authorization for release of information, except in cases of emergency.

Payment: We may use and disclose your health information to obtain payment for services we pro- vide to you.

Health care operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.

Your authorization: in addition to our use of your health information for treatment, payment, or health care operations, you may give us additional written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons involved in care: We may use or disclose health information to notify or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common medical practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. Marketing health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect or copy your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access from us directly, or by using the contact information listed at the end of this Notice. We will charge you a reasonable fee for document production expenses. If you request an alternative format, we will charge a reasonable fee for providing your health information in that format. Disclosure of Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, and certain other activities, for the last six years.

I hereby acknowledge receipt of BCC Notice of Privacy Practices. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

SIGNATURE:

DATE: