PATIENT INFORMATION TODAY'S DATE_____

Patient Name_____

DOB_____Gender_____ Email_____

Address_____ City_____State_____Zip_____

Home #_____ Cell _____ Work _____

Preferred number for contacting:

☐ Home ☐ Work ☐ Cell

Can we leave a message?

☐ Yes: How would you like us to identify ourselves?

☐ Bray Wellness ☐ Therapist first name only

☐ Personal phone call ☐ Doesn't matter

☐ No

EMERGENCY CONTACT INFORMATION

Name_____Relationship_____

Address_____City_____State_____Zip_____

Home # _____ Cell_____ Work _____

☐ **Medical information can be shared with this person.**

EMPLOYMENT INFORMATION

☐ Minor

☐ Employed ☐ Self-employed ☐ Unemployed ☐ Other

Occupation type: _____

PARENT/GUARDIAN/SPOUSE/PARTNER (MUST COMPLETE IF PATIENT IS UNDER 18 YEARS.)

☐ **Not a minor nor need of guardian**

Name_____

Address_____ City_____State_____Zip_____

Home # _____ Cell _____

PHYSICIAN AND HEALTH INFORMATION

Primary

Care_____Phone_____

Address_____ City_____State_____Zip_____

☐ **Medical information can be shared with this physician if request by patient or doctor.**

Psychiatrist_____Phone_____

Address_____ City_____State_____Zip_____

☐ **Medical information can be shared with this physician if request by patient or doctor.**

Previous Therapist_____Phone_____

Address_____ City_____State_____Zip_____

☐ **Medical information can be shared with this practitioner if request by patient or practitioner office.**

Are you a patient of The Craniofacial and TMJ Institute?

☐ Yes ☐ No

Would you like information shared with The Craniofacial and TMJ Institute?

☐ Yes _____(initials) ☐ No

List of current medication and/or vitamins _____

_____

_____

How would you describe your overall current health?

☐ Poor ☐ Satisfactory ☐ Very Good

☐ Unsatisfactory ☐ Good

Please circle any of the following conditions you have had with your health:

Anemia	Bladder trouble	Diabetes	Jaw pain	Poor circulation
Allergies	Broken bones	Epilepsy	Kidney trouble	Seizures
Anxiety	Cancer	Heart trouble	Migraines	Sinus trouble
Arthritis	Chronic back pain	Hepatitis	Migraines	Tuberculosis
Artificial joints	Convulsions	High blood pressure	Neck pain	Poor circulation
Asthma	Dermatitis	Indigestion	Osteoporosis	
OTHER:				

Bray Wellness Counseling

TREATMENT FOCUSED

Please circle any of the following symptoms/troubles you have had:

Anxiety	Eating issues	Financial problems	Pain
Depression	Headaches	Head injuries	Headaches
Anger	Worried	Nausea	Stress
Lack of concentration	Sleeping	Attention	Day dreaming
Phobias	Past childhood abuse	Don't trust others	Hearing things
Increased talking	Past sexual abuse	Worry	Fearful
Drugs/alcohol/substances	Nightmares	Self-inflicted pain	People out to get me
Easily startled	No motivation	Sadness	Hopeless
Seeing things	Irritable	Poor memory	Brain fog
Avoid crowds	Sleepy/can't stay awake	Feelings of worthlessness	No sleep/insomnia
Nervous	Crying	Uncontrolled laughing	Feeling restless/on-edge
Increased heart rate	Panic	Loss of interest	Change in weight
Unwanted thoughts	Childhood issues	Grief	Neglect
Experienced natural disaster	Partner issues	Friendships	
OTHER:			

Please briefly describe your reason for seeking treatment today?

_____

_____

_____

_____

Rate the intensity of the problem 1 to 5 (1 being mild and 5 being severe):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

When did your problem first start?

☐ Within the last: 30 days
☐ 6--12 months
☐ 2 years or more
☐ During adolescence During childhood

How is the problem interfering with your day-to-day functioning? _____

_____

_____

If you could change one thing today what would it be? _____

_____

What do you hope to achieve in therapy?_____

_____

_____

How have you tried to address the problem in the past?

- ☐ No
- ☐ Yes

  What have you tried in the past? And what were the outcomes?

  _____

  _____

  _____

How do you handle stress or stressors and cope in you daily life?

_____

_____

Do you know what causes these stressors? List any known causes:

_____

_____

SELF-HARM/SUICIDAL IDEATION/HARMING OTHERS

Have you ever had thoughts of harming yourself or committing suicide in the past?

- ☐ No
- ☐ Yes _____

Do you currently have thoughts of harming yourself or committing suicide?

- ☐ No
- ☐ Yes _____

Have you ever attempted suicide?

- ☐ No
- ☐ Yes _____

Has anyone in your family or friend attempted suicide?

- ☐ No
- ☐ Yes _____

PAST DIAGNOSIS HISTORY

Have you been diagnosed with a mental health concern in the past?

- ☐ No
- ☐ Yes (Please list your diagnosis) _____

_____

FAMILY HISTORY

Marital Status

- ☐ Minor
- ☐ Married
- ☐ Separated
- ☐ Single
- ☐ Divorced
- ☐ Widowed

Please list other family members either living in the household or are significant in Patient's life:

Name	Age	Relationship	Gender	Currently lives with
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Do you have any cultural or religious beliefs that are important for us to be aware of?

- ☐ No
- ☐ Yes _____

Any family history that is important to know for therapy?

- ☐ No
- ☐ Yes _____

Do you feel safe in your family or household?

☐ No ☐ Yes

History of mental illness in family?

☐ No

☐ Yes

_____

Please let your therapist know if there is any other information that you feel is important for us to know.

_____

_____

_____ _____

Patient Signature Date

PATIENT AGREEMENT

CONSENT TO TREAT

I, _____ (print name) , give my permission and consent to Bray Wellness Counseling to provide me psychotherapeutic treatment to _____(print name) .

While Bray Wellness will endeavor to provide you with standard of care treatment, I fully understand that because of factors beyond Bray Wellness's control, particular outcomes cannot be guaranteed. Furthermore, I understand the I/he/she/ we may experience emotional strains because of the counseling or therapy, feel worse during the treatment and make life changes which could be difficult.

I understand that Bray Wellness is not providing emergency services, and I have been informed of whom to call upon in an emergency or during such time as treatment from Bray Wellness is unavailable.

I understand that regular attendance as recommended by Bray Wellness will facilitate maximum therapeutic benefits, but that I/we am/are free to discontinue treatment at any time. If I decide to do so I will notify Bray Wellness at least two weeks in advance so that effective planning for continuing care can be implemented.

Sign_____Date_____

INSURANCE

I understand that Bray Wellness Counseling is a fee for service physical therapy provider and Bray Wellness Counseling will **not** bill my insurance company directly. Further, I understand that I am responsible for asking for an itemized receipt from Bray Wellness Counseling which I may provide to my insurance company, if I have insurance. I understand that I am considered a ***self pay patient*** and I am financially responsible for the total amount of the services provided. Bray Wellness Counseling does not verify insurance coverage prior to providing services and does not guarantee reimbursement for services from my insurance company.

_____(initials)

PAYMENT

I understand that I am considered a ***self pay patient*** and am responsible for payment at the time of service. Billing will appear on my credit card or debit under the name of *Bluegrass Doctors of Physical Therapy*. I understand the cost of session are $80.* The Craniofacial and TMJ Institute patients being seen by Dr. Bray may differ.

_____(initials)

At Bray Wellness Counseling we highly recommend keeping your credit or debit card on file as a convenient method of payment. Your credit card information is kept confidential and secure and payments to your card are processed the day of your session.

I _____ (print name) authorize Bray Wellness Counseling to charge the portion of my bill to the following credit or debit card:

Account Type:

☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover

Credit Card #: _____Expiration Date _____CVV_____

Cardholder Name (printed)_____Signature _____

☐ **I do not want my credit card on file**

APPOINTMENTS/CANCELLATIONS
Bray Wellness Counseling requires 24 hours notification of cancellations and/or reschedule. In the event I cancel a regularly scheduled appointment with less than 24 hours notice I am responsible for a cancellation fee, $25. If I am not present or available (no show) for a scheduled appointment I will incur a full session fee, $80. If there are 3 consecutive lapses in scheduled attendance I may be removed from the therapist's schedule & will have terminated this agreement.
_____(initials)

OTHER INFORMATION
I understand I may also be charged for therapy products, educational materials and for other administrative expenses, including copies of medical records past the one copy I am entitled, & that I will be notified of these charges at the time of service. I understand that Bray Wellness is part of The Craniofacial and TMJ Institute and only uses Bray Wellness Counseling to differentiate patients schedule and needs.
_____(initials).

PATIENT'S SIGNATURE
This agreement must be signed by Bray Wellness patient/Patient unless the patient/Patient is a minor, incompetent, or physically incapable of signing. I have read and fully understand the content of this Patient Agreement and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I', "me" and "my" refer to and include, in addition to the undersigned, the patient/ Patient named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging Bray Wellness Counseling to provide services to the patient/Patient.

By signing this agreement, I acknowledge that I have read, understand and agree to the above terms and conditions

Patient Signature:_____Date:_____

CONFIDENTIALITY

PLEASE READ ALL CAREFULLY

PRIVACY NOTICE ACKNOWLEDGEMENT

I understand that Bray Wellness Counseling will maintain my privacy to the highest standards and may use or disclose my health information for the sole purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and/or payment**.**

_____(initials)

LIMITS OF CONFIDENTIALITY

The contents of counseling, intake and/or assessment sessions are confidential. Both verbal information and written records about a Patient cannot be shared with another party without the written consent of the Patient or the Patient's legal guardian, except as required by law. It is the policy of this center not to release any information about a Patient without a signed release of information, or as otherwise required by law. Noted exceptions are as follows:

DUTY TO WARN AND PROTECT

When a Patient discloses intentions or a plan to harm another person, Bray Wellness is required by law to warn the intended victim and report identifying information to legal authorities. In cases in which the Patient discloses or implies a plan for suicide, Bray Wellness is required to notify legal authorities and make reasonable attempts to notify the family of the Patient.

ABUSE OF CHILDREN AND VULNERABLE ADULTS

If a Patient discloses 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 vulnerable adult) is in danger of abuse, Bray Wellness is required to report this information to the appropriate social service and/or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Bray Wellness is required by law to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A PATIENT'S DEATH

In the event of a Patient's death, the spouse or parents of a deceased Patient have a right to access a Patient's treatment records.

PROFESSIONAL MISCONDUCT

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

COURT ORDERS

Health care professionals are required to release records of Patients when a court order has been entered.

MINORS/GUARDIANSHIP

Parents or legal guardians of non-emancipated minor Patients have the right to access the Patient's records.

COMMUNICATION

In the event Bray Wellness must telephone or e-mail the Patient for purposes such as appointments, cancellations or reminders or to give or receive other information, efforts are made to preserve confidentiality. Please state on page 1 where we may reach you by phone and/or e-mail and if you would like us to identify ourselves other than Bray Wellness how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below) we will adhere to the following procedures when making phone calls: First we will ask to speak to the Patient (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that this is a personal call. We will not identify the clinic to protect confidentiality. If we reach an answering machine or voice mail we will follow the same guidelines.

I AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND RAMIFICATIONS.

Patient_____ Signature_____Date_____

(Please print) (Patient or Guardian's)