BROWNSBURG GUIDANCE & COUNSELING CENTER

1103 E Main Street
Brownsburg, IN 46112
Phone: (317) 852-6603
Fax: (317) 350-2939

Date: _____

The information provided should pertain to the **individual who will be receiving services at BGCC**. If that person is you, please provide this information about yourself. If the patient is your child, please provide information about your child. Below, you will be able to give us information about the other spouse or parent (in the case of a child as the patient).

Patient Information

Name: _____ Date of Birth: _____Age: ____Gender: ____
Address: _____ Social Security #: _____
_____ City:_____ Zip: _____
Mother's name:_____ Phone: _____{ } Home { } Cell { } Work
Father's name:_____ Phone: _____{ } Home { } Cell { } Work
Child Phone (if applicable): _____ Permission to contact: { } Yes { } No
Mother's Email: _____ Father's Email: _____
Child Email (if applicable): _____
Permission to leave a message/email via any and all above communications: { } Yes { } No

Patient Employment/School Information

{ } Employed { } Student { } Other:_____
Current School: _____ Grade: _____
Spel Ed: { } Yes { } No If yes: { } IEP { } 504 { } No current accommodations
School contact person (if needed): _____ Phone: _____
Highest Level Education Completed: _____
Employer: _____ Length of time at current employer: _____

Responsible Party

Name: _____ Employer: _____
Address: _____ Phone: _____
_____ Social Security #: _____
City: _____ Date of Birth: _____
State: _____ Zip: _____

Primary Insurance Holder

{ } Same as Patient { } Same as Responsible Party { } Other: _____
Name: _____ Relationship to Patient: _____
Address: _____ Insured Phone: _____
City: _____ State: _____ Zip: _____ Insurance Company: _____
Insured SS#: _____ ID #: _____
Insured DOB: _____ Group #: _____

Family Information

List Name(s) Below	**Resides in the home**	**Age**	**If Deceased, Age & Year of Death**	**Significant Mental health Information/history**
Father (include significant other if applicable)	**Yes No**			
Mother (include significant other if applicable)	**Yes No**			
Siblings (Order of Birth)	**Yes No**			

Income Information

Total Household Annual Income: _____

Living in the home (including if not listed above): Adults: _____ Children: _____

Medical/Treatment History

Family Physician: _____ Phone: _____

Medical Condition(s):_____

Previous/Current Diagnosis:_____

Medication (prescribed/OTC)	Reason	Dose	Frequency	Prescriber
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Counseling/Psychotherapy: { } Yes { } No If yes, complete the following:

Date(s)/Length	Location	Therapist	Reason	Beneficial?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

How did you first learn of Brownsburg Guidance & Counseling? Check all that apply:

{ } Internet { } Yellow Pages { } Friend/Relative { } Physician { } Current or Former Client

{ } Other: _____

Who can we thank? _____

Reason for seeking treatment:

_____

_____

_____

HIPAA / HITECH Acknowledgement

My signature below indicates I have read and understand all of the information presented in this form. My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic & Clinical
Health Act (HITECH). I understand this information will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly or indirectly.
- Obtain third party payment for my mental health care services, as applicable.
- Conduct mental health care operations such as quality assessment and improvement activities.

I have been informed of Brownsburg Guidance & Counseling Center's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected mental health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my mental health provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or mental health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I hereby authorize and assign all payments made directly to Brownsburg Guidance & Counseling Center for all insurance benefits otherwise payable to me. I agreed to pay all accumulated charges not covered by verified and assigned insurance.

Consent to Treat

This signed consent authorizes Brownsburg Guidance & Counseling Center Clinicians to provide counseling/ therapy services and other services as indicated by your provider and further affirms that all statements in this form are true and accurate, including custodial status of minor children.

Patient Signature: _____ Date: _____

Printed Name: _____

Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

PLEASE COMPLETE THIS PAGE IF THE PATIENT IS A MINOR

CONSENT FOR TREATMENT OF A MINOR MUST BE GIVEN BY AT LEAST ONE PARENT IF THE PARENTS ARE MARRIED. IF THE BIOLOGICAL PARENTS ARE DIVORCED, THE PARENT WITH SOLE LEGAL CUSTODY MUST GIVE CONSENT OR BOTH PARENTS, IF THEY SHARE JOINT LEGAL CUSTODY. YOUR THERAPIST MAY REQUEST A COPY OF YOUR DISSOLUTION DECREE FOR VERIFICATION OF CUSTODIAL STATUS, IF NECESSARY.

LEGAL STATUS

(Check Appropriate)

[ ] Biological Parents are Married
[ ] Parents Divorced/Biological Parents have Joint Legal Custody
[ ] Parents Divorced/Biological Mother has Sole Legal Custody
[ ] Parents Divorced/Biological Father has Sole Legal Custody

RESIDENTIAL STATUS

(Check Appropriate)

[ ] Minor lives with both Biological Parents
[ ] Minor lives with Biological Mother
[ ] Minor lives with Biological Father
[ ] Minor lives with Legal Guardians
_____

NOTE: by checking the appropriate box above, you are affirming, under the penalties for perjury, that the box indicated is true and accurate.

WHO IS BRINGING THE MINOR FOR TREATMENT SERVICES:

[ ] Both Parents
[ ] Father
[ ] Mother
[ ] Other _____

MINOR'S FATHER

FIRST NAME _____ MIDDLE INITIAL _____ LAST _____
ADDRESS 1 _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE (_____) _____ WORK PHONE (_____) _____ (EXT.____)
CELLPHONE (_____)_____ E-MAIL _____
MARITAL STATUS (Check Appropriate):[ ] Married to Child's Mother [ ] Divorced & Single
[ ] Divorced & Remarried - Stepparent: _____
LEGAL CUSTODY STATUS: [ ] Sole Legal Custody [ ] Joint Legal Custody
County where Divorced: _____

MINOR'S MOTHER

FIRST NAME _____ MIDDLE INITIAL _____ LAST _____
ADDRESS 1 _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE (_____) _____ WORK PHONE (_____) _____ (EXT.____)
CELLPHONE (_____)_____ E-MAIL _____
MARITAL STATUS (Check Appropriate):[ ] Married to Child's Father [ ] Divorced & Single
[ ] Divorced & Remarried – Stepparent: _____
LEGAL CUSTODY STATUS: [ ] Sole Legal Custody [ ] Joint Legal Custody
County where Divorced: _____