Client Name: _____
Client ID#: _____

ADULT INTAKE FORM

Name:_____ Age:_____ DOB:_____

Address (City, State and Zip): _____

Marital Status:_____Male/Female:_____

Phone: H(____)_____ W(____)_____ C(____)_____

OK to say BBHP? Yes_____No_____

Emergency contact (name and phone #) _____

Email:_____

I would like to receive email reminder/updates from BBHP ☐**Yes** ☐**No**

Employment status:_____Employer's name and address: _____

_____

Significant medical problems: _____

Serious illnesses, accidents, or surgeries inthe past: _____

Current and past psychiatric treatmentor counseling: _____

Currently prescribed medications: _____

Current alcohol/drug use (amount, how often, intoxication frequency): _____

_____

History of alcohol/drug use? _____

History of arrest? _____

Primary Care Physician: _____

Psychiatrist: _____

****

History of Problem

Please describe what concerns you have: _____

_____

_____

How long has the problem existed? _____

_____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

_____

_____

_____

What attempts have been made to resolve the difficulties? _____

_____

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Name:_____
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Severity of symptom
None Mild Moderate Severe
0 1 2 3

*Symptom*_____*Name(s)*_____*How Long?*_____

Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive Thoughts			
Tension and Anxiety			
Panic Attacks			
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			
Head Aches			
Bed Wetting			
Phobias			
Others			

How did you hear about BBHP? _____

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (☑ all availability)						
60 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						

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Name:_____
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First Name _____ Last Name _____

You are about to take a very important step in your mental wellness plan, and you are seeing a mental health professional. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.

_____ **(Initial)**

You are our client and have confidentially rights. Confidentiality does not apply under certain situation: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

I,_____(client), do hereby seek and consent to take part in the treatment provided by Bloom Behavioral Health Partners, PLLC. If I am attending group services I also understand and consent that confidentiality still applies and that BBHP is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____ **(Initial**

I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

_____ **(Initial)**

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, BBHP is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone _____ Email _____

_____ **(Initial)**

Client Name (please print)_____

Client Signature _____ Date _____

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Name:_____
Client ID#: _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION
FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACYPRACTICES

Patient Name: _____
Patient Address: _____
Patient Phone Number: _____

In the course of providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this Personal Information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your Personal Information to treat you, to obtain payment for our services, and to operate Bloom Behavioral Health Partners. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature:_____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ Print Name: _____

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Name:_____
Client ID#: _____

Consent for Treatment

Please read carefully

This is to certify that I give permission to Bloom Behavioral Health Partners (BBHP) for treatment.

Name: _____Date of Birth:_____Age: _____

I. Fees and Appointments

1. Appointments are 55 minutes, and ordinarily take place one time per week. Your family/child's specific hour is held by their counselor from week to week. If your family/child is unable to keep an appointment, please contact their counselor to cancel as soon as possible.
2. Benefits will be obtained prior to your first appointment. We ask that you pay your counselor at the beginning of each session for any copays, deductible balances, etc. We reserve the right to suspend therapy for services rendered and not paid for after three sessions.
3. You **are allowed one no-call no-show. After the first missed appointment that you did not give 24 hours notice, you will be charged $45 for each missed appointment.**
4. **If you need to reschedule an appointment and have not contacted your counselor at least 24 hours prior, you will be responsible for a partial fee of $25. Too many late cancellations/reschedules can result in being discharged from the practice.**
5. You can and should discuss any concerns regarding your financial status with your counselor especially if your financial situation should change or improve.

II. Confidentiality

1. Communication between you and your family/child's counselor is both privileged and confidential. This means that without your written permission the counselor cannot discuss your family/child's case orally or in writing, except with **Bloom Behavioral Health Partners** providers and staff.
2. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
   a. If there is a reason to believe there is an occurrence of child, elder or dependent adult abuse or neglect.
   b. If there is reason to believe that you or a member of your family has serious intent to harm themselves, someone else, or property by a violent act they may commit.
   c. If you introduce a family member's emotional condition into a legal proceeding, or your counselor is subpoenaed to give testimony.
   d. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
   e. If there is a court order for release of your records.

III. Counselor Availability and After Hours Emergencies

Counselors check for voice mail messages during normal business hours. Messages left outside of normal **BBHP** hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department.

IV. Client Rights and Responsibilities

1. You have the right to end your therapy at any time, for whatever reason, without any obligation except for fees already incurred.
2. You have the right to question any aspect of your treatment with your counselor and to expect that we will work with you to meet your needs for adjunctive or alternative treatment.

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Name:_____
Client ID#: _____

3. You have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, which would greatly compromise the therapeutic relationship.
4. Therapy involves a partnership between therapist and client. Your therapist will contribute knowledge, skills, and a willingness to do his/her best. The determination of success, however, is largely dependent upon your commitment to your family's personal growth and care. Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to **BBHP** to provide counseling services and that this contract is binding for all future sessions you may have with this agency.

Signature:_____ Date: _____

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