



## FIRST APPOINTMENT ORIENTATION

Thank you for choosing the Brief Therapy Institute of Denver, Inc for your behavioral healthcare services. We recognize you have many choices and we appreciate your trust in us.

We appreciate your downloading and completing the paperwork prior to your first session. Completing the paperwork allows your therapist the opportunity to spend a greater amount of time on clinical rather than administrative issues.

Some things to keep in mind:

- ü Remember, you can download and print, review, or ask for a complete set of Brief Therapy Institute of Denver, Inc. Privacy Policies.
- ü Your therapist will review and answer any questions about this paperwork or other matters.
- ü Please bring your authorization number, if given to you by your insurance company.
- ü Please bring your insurance card.
- ü We will need information about your copayment and/or deductible. If you do not know this information, please contact your insurance company and ask for an explanation of benefit coverage for mental/behavioral health issues.
- ü We will need your primary care physician's telephone number.
- ü If you have seen a counselor or psychiatrist within the last two years, we will need a telephone number to contact them.
- ü It is very helpful for the therapy process if you bring a list of goals for therapy. This will help you and your therapist make better use of the first session.

### **GOALS FOR THERAPY, PLEASE LIST.**

Office use only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

**Brief Therapy Institute of Denver, Inc.**  
All Information is kept in strict confidence

**CLIENT INFORMATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

street city state zip

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: \_\_\_ MALE \_\_\_ FEMALE

SOCIAL SECURITY #: \_\_\_\_\_

RELATIONSHIP STATUS: \_\_\_ MARRIED \_\_\_ SEPARATED \_\_\_ SINGLE  
\_\_\_ DIVORCED \_\_\_ COHAB. \_\_\_ CHILD

I AGREE TO PAY MY CO-PAY OF \_\_\_\_\_ AT THE END OF EACH SESSION

IF I AM SELF PAYING, I WILL PAY \_\_\_\_\_ AT THE END OF EACH SESSION

WHOM SHOULD WE THANK FOR THE REFERRAL? \_\_\_\_\_

**CONTACT INFORMATION**

HOME PHONE: \_\_\_\_\_ BEST TIME TO CALL: \_\_\_\_\_

Can we leave a message? \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ MAY WE CALL YOU IN CONFIDENCE AT WORK: \_\_\_\_\_

Can we leave a message? \_\_\_\_\_

PARENT TO CONTACT IF PATIENT IS CHILD: \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF INSURED (if different than patient) : \_\_\_\_\_

ADDRESS OF INSURED (if different than patient): \_\_\_\_\_

GENDER: \_\_\_ MALE \_\_\_ FEMALE BIRTHDATE: \_\_\_\_\_ SS#: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MEMBER ID# \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

INSURED'S EMPLOYER: \_\_\_\_\_ STATUS: EMPLOYED TERMINATED LOA

AUTHORIZATION # \_\_\_\_\_ INSURANCE TYPE: HMO PPO OTHER DEDUCTIBLE: \_\_\_\_\_

**WHO WOULD YOU LIKE NOTIFIED IN CASE OF EMERGENCY?**

NAME: \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

Office use only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_



## Privacy Notice

To comply with federal health insurance portability and accountability act guidelines the Brief Therapy Institute of Denver, Inc. has implemented the following policy regarding patient privacy and confidentiality. You may request a copy of our complete set of guidelines, you can review the guidelines posted in the waiting room, or you may review and download the policies from our web site. Our office holds patient record information confidential and we will only use your information for the following reasons: treatment, payment and health care operations. The following is a partial list of whom your information can be disclosed, if needed, to:

- Primary care physicians
- Psychiatrists
- Medical specialists
- Diagnostic facilities
- Hospitals, including psychiatric
- Labs
- Insurance companies
- Billing and collection services
- School officials: administrators, counselors, teachers

### Disclosing Record Information

Release of information to any other entity not listed above will require a signed authorization from you or your guardian. This request must be dated, show who the information is to be released to or requested from, the specific information to be released or acquired. These authorizations will have an end date. Additional requests beyond the end date will require a new authorization. We will keep a record of all disclosures in your file. This information will be available for you to review.

### You Have a Right to Access Your Records

You can review and obtain copies of your records. Our office requires a written request, and we will make the records available within 10 days of your request.

### Record Storage

The Brief Therapy Institute of Denver, Inc stores paper copies of administrative records for the appropriate length of time per clinician regulations. Clinical records are stored electronically for the appropriate length of time per clinician regulations.

### Miscellaneous

If we need to contact you by telephone and leave a message we will only leave our name and our phone number. We will not leave any information on an answering machine or with anyone other than the patient or guardian unless we have your consent. It will be your responsibility to return the call.

### Acknowledgment

I acknowledge that I have reviewed this privacy notice and that I may request or download the Brief Therapy Institute of Denver's full privacy policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Office use only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

Medical Information—Please complete for all participants in therapy

Name	Last 2 years Major medical events	Current medications Prescribed and over the counter	Dosage	Allergies? To what?

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Tobacco Use: Cigarettes \_\_\_\_\_ Chewing \_\_\_\_\_ Other \_\_\_\_\_ How much \_\_\_\_\_

Who \_\_\_\_\_

Alcohol and Drug Use:

Who?	Type?	Amount?	Frequency?
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Family history of alcohol/drug use, mental health, physical conditions:

Member:	History:
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Office use only:

Name: \_\_\_\_\_

Chart #: \_\_\_\_\_

If you use herbal supplements or vitamins, please list: