INSTRUCTIONS FOR ENCLOSED FORMS

Each Client Please Complete the Following:

1. "Contact Information" form. This form provides us with your contact information and allows you to specify how you would like to be contacted in the future by Bevill and Associates LLC.

2. "Informed Consent and Authorization for Services" form. This form summarizes important information about confidentiality, fees, cancellation policies, and other practices and policies of Bevill and Associates LLC. Please review it, initial and sign where necessary.

3. Intake Questionnaire". This questionnaire aids assessment and treatment planning by giving your clinician a quick overview of your background and current situation at a glance. Please bring these forms with you to your initial session. All information you provide in this form will be kept as part of your confidential file. Feel free to discuss any questions with your therapist before signing

INTAKE INFORMATION

Printed Name: _____ ____
(Last) (First) (Middle Initial)

Name of parent or guardian (if minor):
_____
(Last) (First) (Middle Initial)

Birth date: _____/_____/_____Age:_____ Gender: Male Female

Mailing Address:_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Drivers License Number Social Security Number

This must be an address to which we can send correspondence, as needed. The name "Bevill and Associates LLC" will not be displayed on the envelope.

Home Phone: (_____) _____ May a message be left at this number? Yes ▫ No ▫
Cell Phone: (_____) _____May a message be left at this number? Yes ▫ No ▫
Work Phone: (_____) _____May a message be left at this number? Yes ▫ No ▫

Email Address: _____

▫ I understand that writing in my email address (above) is giving explicit consent to Bevill and Associates LLC to use that email address to correspond with me in all matters directly related to the provision of services (includes invoicing; appointment bookings, confirmations and reminders; follow-up on services, etc.).

Would You Like to be on Our Email Newsletter List? (Please Check One of the Statements below): Our newsletter contains articles on building strong relationships and mental and emotional wellness, links to online resources and book recommendations that you can use to improve your situation, as well as notices of upcoming workshops or new services.

▫ Yes, I would like to receive monthly email newsletters from Bevill and Associates LLC
▫ No, I do not wish to receive monthly newsletters

Help us better reach others who also need Help

Please let us know who recommended us to you or how you otherwise learned about Bevill and Associates LLC.

- □ My Insurance Provider
- □ My Employer
- □ My Physician or Psychiatrist
- □ Another Psychologist or Therapist
- □ My Lawyer
- □ My Priest, Pastor, Bishop or other Church Leader
- □ A Family Member, Friend or Personal Acquaintance

On the internet:

- □ I found you primarily by doing a search on the internet: I clicked on a Google Advertisement at the top of the page
- □ I found you primarily by doing a search on the internet: I clicked on one of the organic search results that came up
- □ I found you primarily by doing a search on the internet: I found you in the Psychology Today Online Directory

- □ I am a returning client
- □ My spouse/partner or other family member was referred to you or found you
- □ Other _____

_____ _____

Signature Date

INFORMED CONSENT AND AUTHORIZATION FOR SERVICES

Welcome to Bevill and Associates LLC, This form provides information about the practice and privacy policies of Bevill and Associates LLC This information is intended to help you make an informed decision about accepting services from us. If you have any questions or concerns about anything on this form, please do not sign the form until you have discussed your concerns with your therapist.

Legal Disclaimer

Your therapist is legally affiliated or employed with either Bevill and Associates LLC or Boyle & Associates LLC or Bevill and Boyle Partnership, for the purpose of this agreement Bevill and Associates LLC represents the above entities.

Frequency of Sessions

Weekly or bi-weekly 50-minute sessions are most common. The frequency of sessions is based largely on your needs and situation. How Long is Therapy? The amount of sessions needed varies depending on the nature of each person's concerns, the complexity of the issues involved, the strength of our working relationship, and each person's commitment to work on the presenting issues. There is a direct relationship between effort applied between sessions and progress over time. Anywhere between 1 and 20 sessions is typical, though more sessions may be needed in some situations.

Appointment Cancelation

As a courtesy, we will contact you the business day prior to your appointment to remind you of the time. However, we are sometimes unable to contact or we are unable to reach you. **YOU ARE STILL RESPONSIBLE FOR COMING TO YOUR APPOINTMENT OR CANCELING 24 BUSINESS HOURS IN ADVANCE**, even if you do not receive a call, email or text.

Fees

Individual, Couples and Family Sessions……$150.00*
Individual Therapeutic Groups……..$50.00
Couples Therapeutic Groups…… ……$65.00
Psychological Testing / Assessment……$110.00

We prefer payment at each session rather than a regular billing process.

Additional time beyond the 50-minute hour is billed in 10-minute increments.

Billable services include: face-to-face and telephone consultations (not including the initial intake or dealing with brief scheduling matters), report writing and other requested correspondence, and review of written records from other professionals.
Fees are payable by cash, checks, credit card or debit card

Insurance

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is your responsibility to verify your benefits prior to your first session. Any insurance claim that is denied you are responsible for payment of the fees for the session. We do not refile insurance claims after the first denial. For other insurance plans, if requested, we can provide you with a monthly statement for you to submit to your insurance company so they can reimburse you directly for all eligible fees. In all cases, you, not your insurance company, are responsible for full payment of my fees at each session (see "Billing and Payments" above).

It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. You will want to ask, "What are my out of network, outpatient mental health services benefits?"

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I am asked to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the potential problems described above.

Privacy

All information you share with your therapist is private and confidential. Your information will not be released to anyone without your written permission (with some exceptions as explained below). When information is to be released with your consent you will be consulted regarding what information is to be released. Your information will be kept on file in a secure and private location.

If your therapist should find themselves in a social setting where you are present (e,g., grocery store, restaurant, social event), They will respect your privacy by not initiating contact or seeking to engage you in a conversation unless initiated by you. Should a colleague, friend, or family member accompany me, They will not introduce them t you.

You may review the contents of your own counseling file upon request. The full privacy policy for Bevill and Associates is available

upon request. It can also be viewed at https://www.bevillandassociates.com/privacy

Many of our clients consist of multiple family members (i.e. spouses and partners in couple's therapy, family members in family therapy). In such cases, no information obtained from multiple family members may be released to an outside party without the prior written consent of each person from whom the information was obtained, unless 1) a different agreement has been established ahead of time and documentation of such an agreement is attached to this form or 2) information about the non-consenting party can be entirely removed from the information that is shared.

As part of the assessment phase of therapy or as otherwise indicated, your therapist may request to meet with each of you on an individual basis for one or more sessions. Unless you have collectively made a different agreement ahead of time with your therapist and documentation of such an agreement is attached to this form, please be aware that your therapist is free to use his or her clinical judgment to decide whether, when and how to incorporate information you've shared privately with your therapist into your conjoint sessions and that disclosure of such private information by the therapist to others in therapy with you is not considered a breach of confidentiality.

The rationale for this policy is that it can be detrimental to the progress of your therapy or your relationship for your therapist to be in a position of having knowledge of sensitive information that the other spouse is not privy to, as it may put your therapist into a conflict-of-interest position.

Minors

If you are under fourteen (140 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Exceptions to Privacy

A client's confidential information may be released without their consent under the following conditions: When the purpose is to protect individuals (including a client) who are at foreseeable and imminent risk of bodily harm or death as a result of a client's actions.

Under law that requires reporting of child and elder abuse/neglect to authorities.

Under subpoena from a court of law.

In the unlikely event of a client's account becoming 120 days past due or in the event of a dispute over a financial transaction, limited information may be shared with financial or legal agencies connected with the business of Bevill and Associates LLC. (i.e. credit card companies, collection agencies, etc.) as necessary to resolve such disputes or to collect on unpaid accounts. In such cases, any personal information disclosed is limited to only that which is necessary to resolve the dispute or to settle the account (i.e. dates, transaction amounts, etc.) and does not include any clinical information.

Exceptions that apply to personal information disclosed by minors: Generally, but not always, the legal guardian(s) of a minor must give consent for the minor to receive treatment and has a legal right to information disclosed in therapy by the minor in order to provide nurture and protection that is in the best interest of the minor. However, if everyone agrees at the outset of therapy to terms of confidentiality between the minor and his or her guardian(s) then the therapist is bound to abide by these terms. The therapist may subsequently only disclose confidential information obtained from the minor without written consent under the terms agreed upon, or as required by law, or under the exceptions outlined above. Your therapist will discuss these exceptions further with you in session, as applicable. If you disclose in confidence that you have done something illegal, your therapist is not obligated to report this to the authorities, unless the circumstances involve child abuse, abuse against a dependent adult, or a direct threat to another person (as outlined above).

Initial Here 

I have carefully read the preceding sections on privacy and exceptions to privacy (or have had them explained to me) and I am satisfied that I fully understand the above stated policies on confidentiality and the limits of my confidentiality rights and I agree to proceed with counseling under these terms. _____. Initials

Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of] communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with your therapist.

Email and Text Communication

We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Because text messaging is a very un-secure and impersonal mode of communication, we do not text message to nor do we respond to text messages from anyone in treatment with me. So, please do not text message use unless we have made other arrangements.

Social Media

We do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if we discover that we have accidentally established an online relationship with you, I will cancel that relationship This is because these types of casual social contacts can create significant security risks for you.

Your therapist participates in various social networks, but not in a professional capacity. If you have an online presence, there is a possibility that you may encounter your therapist by accident. If that occurs, please discuss it with your therapist during your appointment We believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to cont

Websites

We have a website that you are free to access. We use it for professional reasons to provide information to others about our practice. You are welcome to access and review the information that we have on our website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

Your therapist will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, We understand that you might choose to gather information about me in this way. In this day and age, there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about your therapist through web searches, or in any other fashion for that matter, please discuss this with your therapist during your time together so that it can be dealt with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews

of me or any professional with whom you are working, please share it with your therapist so he or she can discuss it and its potential impact on your therapy. Please do not rate your therapist's t work with you while you are in treatment on any of these websites. This is because it has a significant potential to damage our ability to work together.

In Case of an Emergency

Our office number is not an emergency number and Bevill and Associates does not offer 24-hour crisis coverage. Therefore the following procedure is to be followed if you experience a crisis:
Call 911 if your in immediate danger; or go to the nearest emergency room
Call the local crisis center (205) 323-7777

Appointment Cancelation Policy

Initial Here 

All appointments must be reschedule or canceled at least 24 hours in advance for Monday - Friday appointments and 48 hours advance notice for Saturday or Sunday appointments to avoid being charged for the appointment.. Group sessions do not require advance notice of attendance. _____**Initials**

Consent for Treatment

Initial Here 

I hereby consent to the treatment provided by Bevill and Associates LLC and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. _____ **Initials**

Authorization of Release of Personal Health Information

Initial Here 

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Bevill and Associates LLC. I authorize Bevill and Associates LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Bevill and Associates LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. _____ **Initials**

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ AND UNDERSTAND THE ABOVE NOTIFICATIONS AND THAT YOU ARE CONSENTING TO RECEIVE TREATMENT BY Bevill and Associates LLC:

► _____Date _____

Signature

PARENTAL CONSENT FOR TREATMENT

I / we, _____ and _____
(Name of custodial parent/ guardian) (Name of other custodial parent/ guardian, if necessary – see below)

consent to, _____ providing counseling services to:

Therapist

_____ _____

(Name of minor dependent adult) Date of Birth

_____ _____

(Name of minor dependent adult) Date of Birth

Please select the appropriate custodial arrangement that applies to your situation: Check one

- ☐ Biological parents residing together - Consent for treatment form can be signed by one biological parent
- ☐ Biological parents not residing together – sole custody agreement - Consent for treatment form must be signed by the parent with sole custody
- ☐ Biological parents not residing together – joint custody agreement - Consent for treatment form must be signed by both biological parents

_____ _____

(Signature of Custodial Parent / guardian) Date

_____ _____

(Signature of Custodial Parent / guardian) Date

_____ _____

(Signature of Witness) Ad(Date)

Payment Information

Terms of agreement regarding payment for sessions at Bevill and Associates LLC

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes direct with the counselor or professional.
2. If I, the patient, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees will be charged and I will be responsible for payment.
3. I understand that if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.
4. Services including phone calls, emails, record reviews, and professional consults at times other than the scheduled therapy session are the patient's responsibility. These services will be billed per quarter of an hour.
5. I authorize my health insurance to provide payment of benefits to name of clinic.
6. I understand records of my treatment may be shared with my insurance company when necessary to process claims.
7. I understand I am responsible for payment if my insurance company declines payment.

I have reviewed this document and understand the contingencies stated above.

Initial Here  **_____ Initials**

Credit Card Authorization (All clients must maintain a current credit card in file)

I, authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "Bevill and Associates LLC."

Cardholder Name: _____

Circle Card Type: Visa MC Discover AmEx

Billing Address: _____City: _____Zip:_____

Credit Card # _____

3 digit CVV code: _____

Expiration date ___ / ___

Email Address: _____

Cardholder/Client Signature: _____Date: __/ ____/___

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. I understand that if I commit to joining a weekly therapy group, In the event that I dispute a credit card charge without first trying to resolve my concern directly with Bevill and Associates LLC I agree to reimburse Bevill and Associates LLC. $25 per disputed transaction to compensate Bevill and Associates LLC for the costs incurred in trying to recover disputed funds. I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session.I have read, understand and agree to the information, authorization and guarantee stated above.

Signature _____Date _____

Printed Name _____

Insurance Information (Blue Cross only)

Primary Insurance Company_____

Policy Holder Name _____DOB:_____

Social Security #_____

Policy Number_____

Group Number_____

Relation to Patient_____

Employer Name_____

Employer City/State:_____

Copay/Coinsurance_____

Deductible_____ Deductible met? YES NO

Bevill and Associates LLC

2524 Valleydale Road Suite 100 Birmingham, AL 35244

205-610-9319

Your Information. Your Rights. Our Responsibilities.

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.***

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choice

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.
We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
• We can use or share health information about you:
• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Name of Person Responsible for HIPAA Notification:

Al Bevill

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes To The Terms Of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective - January 1, 2017

This Notice of Privacy Practices applies to the following organizations Bevill and Associates LLC, Boyle and Associates LLS and Bevill and Boyle Partnership.

Privacy officer:
Al Bevill
2524 Valleydale Road Suite 100
Birmingham, AL 35244
206-610-9319

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.
I, _____, hereby acknowledge that Bevill and Associates LLC has either offered me or provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.
I understand that if I have questions or complaints I may contact:

Al Bevill
2524 Valleydale Rd Suite 100
Birmingham. AL 35244
205-610-9319

I also understand that I am entitled to receive updates upon request if Bevill and Associates LLC amends or changes the Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient

_____
Date

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE

- Given to above signee
- Sent home via U.S. Mail
- Advised person bringing in patient that policy is available on our website www.bevillandassociates.com

In either situation the parent/legal guardian must sign and return this form either in person or by mail to:

Bevill and Associates LLC
Attn: HIPAA Contact.
2524 Valleydale Road
Suite 100
Birmingham, AL 35244

THIS SECTION IS TO BE COMPLETED BY MENTAL HEALTH PROVIDER

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:
( ) Patient declined to sign this Written Acknowledgement.
( ) Other (specify): _____

_____ _____
Name and Title Date

CHILD / ADOLESCENT INTAKE QUESTIONNAIRE

Today's Date: _____

Child's Name: _____

Child's Birthdate: _____

Age: _____

Child's Biological Mother: _____ _____Age; _____

Child's Biological Father: _____. Age: _____

Child Primarily Resides With:
□ Biological Mother and Father in same house
□ Biological Mother □ Biological Father
□ 50/50 Biological Mother & Father

Name of School: _____

Grade Level: _____

Average Grades: Math: _____ Science: _____
L.A.: _____ Social Studies: _____

GPA: _____

Does your child have a job? □ Yes □ No

Current Job: _____

Years at Current Job: _____ Hrs per week: _____

SYMPTOM CHECKLIST On a scale of 0-4 (0=none, 1=rarely, 2=sometimes, 3=frequently, 4=many times) rate how much you have observed each symptom in your child over the past year (circle the number).

a. Withdrawal from family 0 1 2 3 4
b. Irritability or mood changes 0 1 2 3 4

c. Stealing 0 1 2 3 4
d. Lying 0 1 2 3 4
e. Loss of interest in extracurricular activities 0 1 2 3 4
f. Being secretive 0 1 2 3 4
g. Defying parents/house rules 0 1 2 3 4
h. Angry outbursts 0 1 2 3 4
i. Negative attitude to school 0 1 2 3 4
j. Drop in grades 0 1 2 3 4
k. Frequent change in friends 0 1 2 3 4
l. Worrying excessively 0 1 2 3 4
m Difficulties sleeping 0 1 2 3 4
n. Loss of drive/motivation 0 1 2 3 4
o. Difficulties making friends 0 1 2 3 4
p. Low self-image 0 1 2 3 4

Symptoms Total: _____ / 64

How much do these symptoms interfere with the following?
Personal well-being 0 1 2 3 4
School performance 0 1 2 3 4
Family relationships 0 1 2 3 4

Does your child: Have any Medical problems? ▫ Yes ▫ No If yes, please list them:
_____ _____

Take any prescription Medications? ▫ Yes ▫ No If yes, please list them:

_____	_____	_____	_____
Medication	Dose	Purpose	Since
_____	_____	_____	_____
Medication	Dose	Purpose	Since
_____	_____	_____	_____
Medication	Dose	Purpose	Since
_____	_____	_____	_____
Medication	Dose	Purpose	Since

Do any Extracurricular Activities? ▫ Yes ▫ No If yes, please specify:
_____
_____

Are you concerned that your child is using alcohol and/or illicit drugs? ▫ Yes ▫ No

Has your child ever threatened self-harm? ▫ Yes ▫ No If yes, when?
_____

Has your child experienced any past trauma? ▫ Yes ▫ No If yes, please specify:
_____
_____

PREVIOUS TREATMENT Has your child participated in therapy or counseling in the past?
▫ Yes ▫ No If yes, please specify:

_____	_____	_____	_____
Date	Duration	Therapist / Location	Was it Helpful?
_____	_____	_____	_____
Date	Duration	Therapist / Location	Was it Helpful?
_____	_____	_____	_____
Date	Duration	Therapist / Location	Was it Helpful?

OTHER INFORMATION Please include here any additional background information you feel would be helpful for your therapist to know:
_____
_____
_____
_____
_____
_____

Thank-you very much for taking the time to fill out this questionnaire.