



Patient Information
(Please print clearly)

PATIENT'S NAME _____ Date of Birth _____ Age _____ Sex _____

_____ Last First Middle

Minor Unmarried Married Separated Divorced Widowed

Address _____ Cell # _____

_____ Number & Street City State Zip

Occupation _____ Work # _____

Patient's Employer _____ Email _____

_____ Name

_____ Employer Address

SPOUSE OR PARENT'S NAME _____ Date of Birth _____ Age _____

Spouse or Parent's Employer _____ Cell # _____

_____ Name

_____ Employer Address

_____ Work # _____ Email _____

_____ Occupation

CLOSEST FRIEND OR RELATIVE NOT LIVING AT YOUR HOME, TO CONTACT IN EVENT OF EMERGENCY

Name _____ Phone # _____

_____ Last First Middle Relationship

Address _____

_____ Number & Street City State Zip

REFERRED BY _____ Phone # _____

_____ Name Address Relationship

Have you or any member of your family ever been treated by Building Bridges CC? No Yes When (approximately) _____

INSURANCE
Building Bridges Christian Counseling's policy is that **all fees for counseling are to be paid in full at the time of each session.** Any exceptions must be made in writing. We are willing to assist in your efforts to bill your insurance carrier. If you are seeing a pre-licensed counselor it is very likely that your insurance carrier will not cover services rendered by the pre-licensed counselor.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT
I authorize treatment for the person(s) named above and agree to pay all fees and charges for such treatment at the time of service. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment, unless credit arrangements are agreed upon in writing. I agree to pay a \$20 charge for each returned check.

I give my permission to **allow referring person or agency to be thanked** for referring me to Building Bridges Christian Counseling. I further give permission to **place my name on the mailing list** so that I may be informed of upcoming events, services, or resources. **Building Bridges CC's** mailing list will not be given or sold to any other individual or agency.

I understand that all CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OTHERWISE A CHARGE OF \$45 WILL BE MADE. I will be fully responsible for such charges.

Signature(s) _____ Date _____

Signature(s) _____ Date _____



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Consent for Treatment of Minors

Name _____

Date of Birth _____

Counselor _____

This is to certify that I give permission to Building Bridges Christian Counseling and the counselor listed above for treatment of my child.

This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may include consultations with other Building Bridges Christian Counseling associates including psychologists, MFT interns, career counselors, and/or nutritionists.

California state law mandates the reporting of certain types of child abuse, including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will be reported to the appropriate agency.

This treatment may also include referral to other appropriate State and County agencies for further counseling.

Signature of Parent/Guardian

Date

Printed name of Parent/Guardian

Witness/Title

Street address
code

State

Zip

City

Phone number

Phone number



Confidentiality Policy

Confidentiality and privileged communication remain the rights of all clients of professional counselors according to law. However, there are limits such as communication some of which are mandated by state law. It is very important that you and those seeking counseling with you carefully read and understand the following limits of confidentiality.

Duty to Warn

Some courts have held that if an individual intends to take harmful, dangerous, or criminal action against another human being, or against themselves, it is the counselor's duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as:

1. The person or the family of the person who is likely to suffer the results of harmful behavior.
2. The family of the client who intends to harm him/herself or someone else.
3. Associates or friends of those threatened or making threats.
4. Law enforcement and medical emergency officials.

Child Abuse

California State Law mandates the reporting of incidence or *suspected* incidence of child abuse including physical abuse, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agencies. (Article 2.5 Penal Code 11165 and 11166)

“Dependent Adult” and Elder Abuse

California law requires the incidence of “dependent adult” or elder physical abuse reported to your counselor must also be reported to California authorities. (Welfare and Institutional Code, Sec. 15630)

Therapeutic Criminal Involvement

The State Law in the Evidence Code 1018 reads that “There is no privilege (confidentiality) under this article if the services of the psychotherapist were sought or obtained to enable or aid anyone to commit or plan to commit a crime or a tort or to escape detection or apprehension after the commission of a crime or a tort.” (Evidence Code 1024, 1965. Chp. 299)

Continued on other side



Family and Couple Therapy

Family members and couples may be seen at times individually or conjointly. Information shared during these sessions or in related settings (e.g., telephone calls) is considered part of the overall family or couple therapy process and is not confidential from the other participating family members or partners. Your therapist will use his or her discretion in handling these matters. This is simply our “no secrets” policy. It is important that you understand this policy before treatment begins. It supports our belief that healthy relationships are built on openness and truth.

Case Evaluation

In order to ensure the best treatment possible for each client, your counselor may consult with other professional counselors regarding cases. This is traditional in both out-patient and in-patient counseling facilities and is referred to as “case conference” or “peer review”. If you have any concerns regarding this practice, please notify your therapist.

Neglect of Outstanding Debt

In the event a client fails to honor, after reasonable efforts to collect his/her debt, we may place the account in the hands of an agency or attorney for collection or legal action. This will necessitate the release of pertinent demographic information as accounting information.
NO THERAPEUTIC INFORMATION WILL BE RELEASED.

Please be sure that you have read the above very carefully. If you are not sure that you fully understand any of the above areas of confidentiality limitations, please ask your counselor before you sign below.

I/We the undersigned, have read and fully understand the limits of my/our confidentiality. I/We further agree to abide by the policy set out above. I/We have had a chance to ask my/our counselor for additional clarification regarding the limits of confidentiality.

Signature	Date	Signature	Date
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Signature	Date	Signature	Date
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BICHOF CHILD FAMILY INVENTORY

NAME _____

DATE OF BIRTH _____

DATE OF TEST _____

CIRCLE ONE: 0 = No Difficulty 1 = A Little 2 = Moderate 3 = Quite a Bit 4 = Extreme

RATE THE DIFFICULTY YOU AS PARENTS AND/OR SIGNIFICANT OTHER ADULTS INVOLVED IN PARENTING THE ABOVE NAMED CHILD HAVE WITH:

1	Problems arguing constructively in a fashion that leads to resolution or understanding.	0	1	2	3	4
2	Problems recognizing and dealing with differences of opinion between/among ourselves.	0	1	2	3	4
3	Difficulty working as a team on child rearing, financial decisions, and other major decisions concerning our child/adolescent.	0	1	2	3	4
4	Trouble getting along, feeling appreciated, respected.	0	1	2	3	4
5	Difficulty applying consistent disciplinary responses, positive and negative behavior in our child/adolescent.	0	1	2	3	4
6	Difficulty holding our child/adolescent responsible for his/her behavior.	0	1	2	3	4
7	Lack of variety in our approach to parenting.	0	1	2	3	4
8	Find ourselves in a repetitive unproductive approach to discipline (i.e., repeated power struggles, grounding, or giving in).	0	1	2	3	4

RATE THE DEGREE OF DIFFICULTY YOUR CHILD IS HAVING WITH:

9	Bullies, threatens, and/or intimidates others.	0	1	2	3	4
10	Physical fights or arguments.	0	1	2	3	4
11	Sassy, talks back.	0	1	2	3	4
12	Breaking rules, stealing, lying.	0	1	2	3	4
13	Unable to accept responsibility for mistakes, blames others.	0	1	2	3	4
14	Basically an unhappy child.	0	1	2	3	4

15	Appears lost or helpless at times.	0	1	2	3	4
16	Isolated feelings of loneliness.	0	1	2	3	4
17	Depressed, irritable, complains, cries easily.	0	1	2	3	4
18	Self-destructive statements, thoughts, or behavior.	0	1	2	3	4
19	Fearful of new situations, places (i.e., going to school).	0	1	2	3	4
20	Shy.	0	1	2	3	4
21	Worries more than others.	0	1	2	3	4
22	Afraid of being alone.	0	1	2	3	4
23	Afraid of people.	0	1	2	3	4
24	Worries about illness or death.	0	1	2	3	4
25	Impulsive, acts without thinking.	0	1	2	3	4
26	Restless in a squirmy sense.	0	1	2	3	4
27	Up and on the go “as if driven by a motor”.	0	1	2	3	4
28	Distractible or attention span problem.	0	1	2	3	4
29	Disturbs others in an intrusive, disruptive way.	0	1	2	3	4
30	Fails to finish things (i.e., homework, routine tasks).	0	1	2	3	4
31	Has few or no friends.	0	1	2	3	4
32	Feels easily hurt.	0	1	2	3	4
33	Feels picked on or cheated.	0	1	2	3	4
34	Disturbs other children.	0	1	2	3	4
35	Difficulty performing at his/her level of capability.	0	1	2	3	4
36	Does not like to go to school.	0	1	2	3	4
37	Is not learning.	0	1	2	3	4
38	Will not obey school rules.	0	1	2	3	4