Bridges Family Center, LLC

Client Data and Confidentiality Agreement

Date: _____

Last Name: _____ First Name: _____ MI/Maiden: _____

Social Security number: _____ Email Address: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Main Phone: _____ Alt Phone: _____

If Client is under 18 please complete the following:

Parent/Guardian 1:	Parent/Guardian 2:
Name: _____	Name: _____
Address: _____	Address: _____
City/St/Zip: _____	City/St/Zip: _____
Phone: _____	Phone: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Gross Annual Family Income (if client is a child please put parent/guardian income): _____

Occupation: _____ Employer: _____

Check any that apply:

Race:

____ Black / African-American
____ White / Caucasian
____ American Indian / Alaskan Native
____ Asian / Japanese American
____ Native Hawaiian / Pacific Islander
____ Hispanic Origin
____ Unknown / Not Collected

Veteran Status:

____ No Military Service
____ Active Duty no deployment
____ Active Duty Deploy to Non-Combat
____ Active Duty Deploy to Combat
____ Prior Duty no deployment
____ Prior Duty Deploy to Non-Combat
____ Prior Duty Deploy to Combat
____ Unknown

Method of Contact:

(THIS DOES NOT INCLUDE MAIL, EMAIL OR CALLS MADE IN AN EFFORT TO GAIN PAYMENT FOR PAST SERVICES RENDERED.)

May we mail information that identifies the agency to your home address?	____ Yes	____ No
May we leave a message, which identifies the agency, at your home phone number?	____ Yes	____ No
May we email your appointment reminders?	____ Yes	____ No

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I acknowledge that as a participant in the clinical programs of Bridges Family Center, LLC I may gain information about other consumers. The very fact of my admission into one of their programs creates a highly likely opportunity that I will acquire personal and private information about others, which begins with the fact that other individuals are also participants in these programs. I understand that information disclosed to me or that I acquire while in these programs, is protected by Federal Regulations (42 .C.F.R. Part 2). I further understand that, as a condition to my admission, I hereby agree, to hold this information strictly confidential, as I expect others to hold in confidence information they learn about me. I realize that this regulation prohibits me from disclosing this information to anyone outside the program, without the expressly written consent of the person to whom the information pertains. I am making this agreement of confidentiality voluntarily and understand that I am bound by this regulation for as long as I am a client of Bridges Family Center, LLC.

Confidentially:
In general, the law protects confidentially of all communication between the client and the counselor. Information about your therapy can only be released with your written permission (in the form of a release of information form). The following however, are ways in which your information may be shared without your permission:

- Client has expressed harming or thinking about harming him/herself or another person
- Client reports abuse, suspected abuse, an/or neglect of children, elderly, or individuals with disabilities
- Client is involved in or reports a domestic violence relationship
- Counselor is subpoenaed by the court to testify under a court order
- A complaint is filed with the Kentucky Board of Licensed Professional Counselors
- Counselor is engaged in a systematic supervision process
- Client is below the age of 18, guardians have the right to therapeutic information
- An insurance company requests a diagnosis and/or relevant clinical information

I have read and understand the above.

_____
Client Name

_____
Signature of Client/Parent/Legal Guardian:

_____
Date