CLIENT DEMOGRAPHIC FORM

Date _____

Last Name _____First Name_____DOB_____

Mailing Address _____

City_____State _____Zip_____

Home Phone_____Cell Phone_____

Emergency Contact Name/Number:_____

Best number to call_____Permission to Leave Message Y____N_____

Insurance:_____

Insurance ID #:_____Insurance Group #:_____

Name of Benefit Holder_____Birth Date:_____

Benefit Holder's Relationship to Client_____

Benefit Holder's Employer_____

Who referred you?_____

Client Symptom Self Evaluation

Your Name:_____ **Date**:_____

WHAT CONCERNS DO YOU HAVE?_____

_____

Symptoms (please mark all that apply):

Emotional:

□ Feeling of extreme happiness
□ Feeling of extreme sadness
□ Feeling stressed
□ Feeling nervous or anxious
□ Feeling fearful
□ Excessive worry
□ Indecisiveness
□ Depression
□ Easily irritated
□ Paranoid thoughts
□ Self-esteem problem
□ Feeling guilty
□ Sudden feelings of panic
□ Perfectionism
□ Change in sleeping habits
□ Procrastination
□ Crying spells
□ Problems with anger
□ Exaggerated startle response
□ Lack of enjoyment of usual activities
□ Increased use of alcohol / drugs
□ Avoiding things
□ Trouble performing your job
□ Poor interpersonal skills
□ Reckless behavior
□ Trouble concentrating
□ Not getting along with friends / family
□ Hearing voices
□ Fear of situations where escape is difficult
□ Obsessions or compulsions
□ Thoughts about hurting yourself
□ Thoughts about hurting others
□ Thoughts about killing yourself
□ Thoughts about killing others
□ Suicide attempts
□ Acting violently
□ Intrusive thoughts
□ Chest pain
□ Change in sexual interest

Physical:

□ Lack of energy
□ Dry mouth
□ Memory problems
□ Chronic weakness
□ Chronic pain
□ Muscle tension / aches
□ Numbness
□ Sweating / clammy hands
□ Nerve problems
□ Trembling / twitching
□ Hot flashes
□ Dizziness
□ Frequent urination
□ Stomach or bowel problem
□ Weight changes
□ Change in eating habits
□ Self-starvation
□ Shortness of breath
□ Heart symptoms
□ Trouble swallowing

HOW LONG HAVE YOU HAD THE SYMPTOMS CHECKED ABOVE? _____

PROBLEMS AT WORK OR SCHOOL:_____
On a Scale of 1-5, how would your rate your distress? (1 is low, 5 is severe distress)_____

Medical Condition You Have: (If yes check)

___Diabetes
___Blood Problems
___Skin/Hair/Nail Problems
___Genital
___Allergies
___Chronic Pain
___High Blood Pressure
___Bone/Joint Problems
___Liver Disease
___Kidney/Bladder
___Eyes
___Gastrointestinal
___Heart Disease
___Brain Problems
___Respiratory Problems (Breathing)
___Cancer
___Autoimmune
___Head Injury

Other problems not listed above:_____

_____

Sleep Problems:_____

Appetite Problems: _____

Past Health Problems (include difficulties with developmental milestones under age 18) _____

_____

Medication currently using: If NONE, write your initials here_____

Medication	Dosage	Time Taken	Prescribing Doctor	Reason Prescribing

PAST TREATMENT INTERVENTIONS:

Date	Medical & Surgical	Provider/Program/Hospital
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Conditions that Run in Your Family: (If yes check)

___Diabetes ___High Blood Pressure ___Heart Disease
___Blood Problems ___Bone/Joint Problems ___Brain Problems
___Skin/Hair/Nail Problems ___Liver Disease ___Respiratory Problems (Breathing)
___Genital ___Kidney/Bladder ___Cancer
___Allergies ___Eyes ___Autoimmune
___Chronic Pain ___Gastrointestinal

HEALTH HABITS INFORMATION:

For the following questions please base your answers on **the past month** (approximately).

Y N Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
Y N Have you been dieting to lose weight?
Y N Have you smoked cigarettes on a daily basis?
Y N Have you experienced any increased feelings of sadness or hopelessness?
Y N Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol? (Circle your answer):

A) I do not drink at all
B) About once a month.
C) Two to three times a month.
D) One to three times a week.
E) Once a day or more.

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

Y N In the past **year** have you used any illicit or non-prescription drugs?

Y N During the past **month** have you participated in leisure/social/spiritual activities?

Y N "In the past year, have you ever drunk or used drugs more than you meant to?" Or "have you spent more time drinking or using than you intended to?"

Y N "Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?"

Y N "Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?"

Y N "Has anyone objected to your drinking or drug use?"

Y N "Have you ever found yourself preoccupied with wanting to use alcohol or drugs?"

Y N "Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?"

FAMILY RELATIONSHIPS (Members of the family you are/were close to)

Name	**Relationship**	**Age (or Year of Death)**	**Quality of Relationship: Excellent, Good, Fair, Bad**	**Lives with you:**
				Y N
				Y N
				Y N
				Y N

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

Partner's First Name	**Indicate:** Married (M) Live together (LT)	**Length of Relationship**	**Reason ended**

WORK HISTORY: (Start with most recent)

Place	**Position**	**From**	**To**	**Reason ended**

Highest Level of Education: _____

PERSONAL & FAMILY HISTORY:

Were you or any family member physically abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member sexually abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member emotionally abused? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member had a problem with drugs or alcohol? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member ever tried to commit suicide? YES NO (circle)

If yes: Self - family (circle one or both)

Is there any history of anxiety, depression or mental illness in your family? YES NO (circle)

If yes: Self - family (circle one or both)

What are your Spiritual/Religious Beliefs? _____

PERMISSION TO TREAT/FEE AGREEMENT

THIS CONSENT TO TREAT/FEE AND AGREEMENT dated below BETWEEN:_____(client/guardian) and _____(therapist) at 8479 S. Mason Montgomery Rd Unit 4 Mason, Ohio 45040.

BACKGROUND:

The Responsible Party (RP) is of the opinion that the Service Provider has the necessary qualifications, experience and abilities to provide services in connection with the Client and hereby gives permission to treat same Client (If not RP_____)

The Service Provider is agreeable to providing such services to the Client, on the terms and conditions as set out in this Agreement.

IN CONSIDERATION OF the matters described above and of the mutual benefits and obligations set forth in this Agreement, the receipt and sufficiency of which consideration is hereby acknowledged, the parties to this Agreement agree as follows:

Engagement: The Client hereby agrees to engage the Service Provider to provide the Client with services consisting of Individual, Group or Family Counseling/Therapy, and such other services as the Client and the Service Provider may agree upon from time to time.

Term of Agreement: The term of this Agreement will begin on the date of this Agreement and will remain in full force and effect until completion of the Services.

Performance: Both parties agree to do everything necessary to ensure that the terms of this Agreement take effect.

Confidentiality: The Service Provider acknowledges that a material term of the Agreement with the Client is to keep confidential information belonging to the Client confidential and protect its release to the public. The Service Provider agrees not to divulge, reveal, report or use, for any purpose, any confidential information which the Service Provider has obtained or which was disclosed to the Service Provider by the Client or RP, except as outlined in a., b., or c., below. The obligation to protect the confidentiality of the Client's confidential information will survive the termination of this Agreement and will continue indefinitely.

The Service Provider may disclose the minimum necessary confidential information:

a. To a ***third-party insurance provider*** where the Client or RP presents an insurance card/company as a reimbursement source.

b. To the extent ***required by law*** or by the request or requirement of any judicial, legislative, administrative, or other governmental body. However, the Service Provider will first give notice to the Client or RP of any possible or prospective order (or proceeding pursuant to which any order may result), and the Client or RP will have been afforded a reasonable opportunity to prevent or limit any disclosure.

c. ***In the event*** Client or RP ***accounts have gone unpaid for 90 days***, the Service Provider may release a copy of this agreement, Client or RP contact information and a copy(s) of any billing sent to the client to a third-party collection service. No other confidential information will be released.

Modification of Agreement: Any amendment or modification of this Agreement or additional obligation assumed by either party in connection with this Agreement will only be binding if evidenced in writing signed by each party or an authorized representative of each party.

Governing Law: It is the intention of the parties to this Agreement that this Agreement and the performance under this Agreement, and all suits and special proceedings under this Agreement, be construed in accordance with and governed, to the exclusion of the law of any other forum, by the laws of the State of Ohio, without regard to the jurisdiction in which any action or special proceeding may be instituted.

Self-pay Fees:

$155 Initial Assessment
$145 Individual Session
$50 First No Show/late cancellation (less than 24-hour notice)
$75 for subsequent No show/late cancellation (less than 24-hour notice)
$25 per 15-minute increment for reading/responding to emails, phone calls, letter/report writing, insurance billing issues
$225 per hour for third party conferences/court appearances
$25 fee for failure to pay within 30 days of invoice **(Denied insurance claims due within 10 days)**
$25 flat fee for requested copy of records with additional .25 per page copied

BY THE CLIENT/PARENT/GUARDIAN SIGNATURE BELOW, the client/parent/guardian has duly executed this Fee Agreement/Consent to treat

_____

Client/Parent/Guardian Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. **Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization, such as your primary care physician.**

For Payment. **We may use and disclosed PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility of coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.**
For Health Care Operations. **We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.**

Required by Law. **Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.**

Without Authorization.
Video and audio recording is prohibited in office without mutual signed consent.
Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required or allowed by law, such as, included, but are not necessarily limited to: the reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department), or abuse involving the elderly or the developmentally disabled/mentally retarded.
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or to other persons as permitted by law, including you.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked, unless we have already relied on it.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Laura Vail Sage, LISW – 5134 Cedar Village Drive, Mason, OH 45040.

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although e are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have a right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with_____ at 8479 S. Mason Montgomery Rd. #4 Mason, OH 45040 or with Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601. Voice Ph. (312)886-2359; Fax (312) 886-1807; TDD (312) 353-5693.

We will not retaliate against you for filing a complaint.

The effective date of this notice is March 1, 2016.

NOTICE OF PRIVACY PRACTICES

I, _____(Print your name)
hereby acknowledge that I have received the Notice of Privacy Practices.

_____ _____
Signature of Client or Client's Guardian Date

If client and/or guardian refuse to sign, please note this here:

_____ _____
Counselor Signature Date

OFFICE POLICY

Your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations and then help me track the number of sessions allowed or you may be responsible for payment.

If you are in an emergency situation, call 911 or go to the emergency room so that you are safe and can receive the care you need.

Termination of treatment: if you miss three scheduled appointments in a row or are not seen for more than three months then you will no longer be considered an "active" client in my practice. For legal purposes this policy must be defined. If you wish to return for treatment, simply call me and you case will become active again at the time of your first appointment.

Please remember to check your insurance authorization needs prior to your first appointment.

Please inform me immediately of any change in insurance coverage, personal address or phone numbers as well as employment changes. Failure to update information regarding insurance coverage could result in your sessions not being reimbursed by your insurance company and you would be responsible for the charges.

If after termination of therapy, you have a balance due and have not begun paying on it within 30 days, the account will be charged a service fee of 2% of the balance per month. If regular payment is not occurring, your account may be turned over to collection.

CLIENT RIGHTS

- Clients have the right to be treated with dignity and respect.
- Clients have the right to impartial services and access to treatment, regardless of race, religion, gender, ethnicity, age, disability or source of payment.
- Clients will be assured that all information is kept confidential.
- Information will not be released without their prior consent, except in an emergency, or as required by law.
- Clients have the right to be treated by staff/providers who communicate, or arrange for communication in a language and format they understand.
- Clients have the right to be provided with a complete, easily understood explanation of their condition and
- treatment.
- Clients have the right to be informed of all treatment options regardless of the cost of benefit coverage.
- Clients have the right to receive information about services and their role in the treatment process.
- Clients have the right to receive information on availability of providers and the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on policies, services and their rights and responsibilities offered by their insurance company(s).
- Clients will be informed of the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.
- Clients will be afforded all of his/her rights and privileges guaranteed by state and federal laws.
- Clients have the right to be informed of their rights and responsibilities in the treatment process.
- Clients have the right to participate with providers in decision-making regarding their treatment planning.

Limitation in rights:
The main limitation is in the area of confidentiality. In the following situations, confidentiality does not apply: (1)An order by the Court, (2) in the case of suspected child, elder or domestic abuse, and (3) for you own welfare (suicide) or that of others (homicide) in serious and imminent life-threatening situations.

For those clients using their insurance to pay for therapy, a consultation with your attending/primary care physician and your insurance company may be needed. Disclosure of your diagnosis, review of your treatment sessions and a review of your treatment plan may be required to access your insurance benefits. You may choose not to authorize the release of this information, however this may prevent you from using your insurance benefits. ***Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use these benefits.***

THE PROCESS OF COUNSELING/THERAPY:

- Possible benefits derived from therapy include:
  - Better ways to deal with social, familial and occupational relationships.
  - Better personal adjustment and contentment.
  - Better ability to cope with problems and stress.
  - Better productivity.
- It is important to note that professional ethic do not permit a guarantee that you will receive these benefits. It is believed that a better life is possible for most people and that an individual's investment and commitment in therapy can determine the outcome.
- Therapy may also involve some feelings of discomfort. These feelings can occur when you begin to work on changing your beliefs and/or behaviors. This discomfort is viewed as a stepping-stone to a more effective and satisfying life.

☐ **Please check box if allowing credit card to be kept on file and authorize the payment of service fees using my credit, debit, HSA or FSA card that was given to my clinician or practice.**

Service fees will be deducted from the designated account at the time services are rendered or when we receive notice from your insurance company that you have out of pocket expenses (copays, deductible amounts or co-insurance amounts.

I fully understand the above agreement and I freely agree to the above conditions:

_____ _____

Client Signature Date

My Clinician conforms to the Counselor and Social Worker Board that regulates the practice of professional counseling and therapy and requires this information be given to clients.

The Counselor, and Social Worker and Marriage & Family Therapist Board
77 South High Street, 24th Floor, Room 2468
Columbus, Ohio 43215-6171
Phone: (614) 466-0912

Email Communications/Text Reminders

There is no assurance of confidentiality of information when communicated this way. Nevertheless, you may request that we communicate with you via email.

I certify the email address I am providing is accurate and that I, or my designee on my behalf, accept full responsibility for messages sent to or from this address. I agree to hold my therapist associated with it harmless from any and all claims and liabilities arising from or related to the request to communicate via email. If you have an emergency situation you should not use email as a means to communicate with your therapist, call 911.

_____I DO wish to receive text message reminders for appointments. **Cell Carrier:**_____

_____I DO wish to have the ability to communicate with my therapist via email, and understand the risks outlined above. **EMAIL ADDRESS**_____

_____I DO NOT wish to have the ability to communicate with therapist via email.

_____I DO NOT wish to receive text message reminders for appointments.

My email address is: _____

Client/Guardian Signature _____Date_____

For those clients using their insurance to pay for therapy, a consultation with your attending/primary care physician may be needed. In addition, disclosure of your diagnosis, review of your treatment session, summaries and a review of your treatment plan may be required to access your insurance benefits. You may choose not to authorize the release of this information; however, this may prevent you from using your insurance benefits. Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use those benefits.

Insurance Financial Responsibility

Client/Subscriber and/or Guarantor Information

Insurance Information: Primary Insurance Information Only

Member/Subscriber ID_____Group#_____

Insurance Company_____

Co-Pay Amount $_____

Deductible $_____

EAP/ Insurance Authorization #_____

Dates of Authorization/ Number of Sessions_____

Name of Benefit Holder & Relationship _____

Benefit Holder's Date of Birth _____

Benefit Holder's Mailing Address (if different from client) _____

_____

Benefit Holder's phone Number (if different from client) _____

It is your responsibility to contact the insurance provider to determine eligibility for behavioral health services and if the assigned clinician is a participating provider. It is also your responsibility to determine benefits, deductibles, copays and any limits to number of visits for mental / behavioral health.

TCP does not accept or bill secondary insurance.

Signature of Client or Representative_ _____Date _____

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, the undersigned understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

Patient Authorization:

___I agree to release any applicable mental health/substance abuse information to my PCP

My Primary Care Physician is_____

Address_____

Telephone Number:_____

___I agree to release only mediation information to my PCP

___I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.

___I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

Patient Signature Date_____

Patient Rights:

·You can end this authorization (permission to use or disclose information) any time by contacting:

_____

·If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous

permission.

·You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.

·You have a right to a copy of this signed authorization. Please keep a copy for your records.

·You do not have to agree to this request to use of disclose information

Information to be completed by Behavioral Health Provider

I saw on_____on_____for_____

(Patient Name) (Date) (Reason/Diagnosis)

Provider: Please send a copy of this signed form to the PCP and keep the original in the treatment record.