Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

Client Background

Client Name _____ _____ _____
First Name Middle Last

Date of Birth____ _____ _____ Preferred Pronoun _____

Address _____
Street City State Zip

Phone Number ❑ Cell ❑ Home _____

Proof of Guardianship _____

Address (if different from above) _____

Phone Number (Cell) _____ Work _____

Do you give permission for therapist to contact you by cell/home phone ____Yes ____ No

Emergency Contact

Name _____ Relationship to Client _____

Preferred Phone Number _____

Client Medical and Birth Information

Primary Care Physician _____ Phone _____

Date of last Physical Exam _____ Allergies _____

Please list any current medications _____

Physical Disabilities _____ Developmental Disabilities _____

Does client have a history of head injury? Yes_____ No_____

Does client (or family) have a history of alcohol or drug use/abuse? Yes _____ No_____

Is there a family history of suicide? Yes_____ No _____ (To be further discussed in first session)

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****Please complete if using Insurance – including Medicaid/Medicare*****

Client Name _____ _____ _____
Last Name **First Name** **Middle Name**

Client Date of Birth _____ /_____ /_____ Client Social Security _____ - _____ - _____

(If applies) Medicaid MMIS# _____ MCO Billing # _____

Relationship to Primary Insured: ❑ Self ❑ Spouse ❑ Child Other: _____

Cell Number _____Home number_____ Work Number_____

Name of Primary Insured _____ _____
Last Name **First Name** **Middle Name**

Date of Birth of Primary Insured _____ / _____ / _____

Social Security Number of Primary Insured _____ - _____ - _____

Address of Primary Insured _____
Street City State Zip

Employer of Primary Insured _____

Insurance Company Name _____

HIC# (If Medicare) _____

Group # _____

Subscriber or ID # _____

Providers Phone # _____

In consideration of behavioral health and/or AoD services provided, I assign to Your Story Counseling Service, LLC all my rights to any and all insurance benefits to which I am or may be entitled to. If payment is received by me, I will forward it to Your Story Counseling Service, LLC. I authorize Your Story Counseling Service, LLC to release the information necessary: 1) To disclose to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be paid to Your Story Counseling Service, LLC from whom I am seeking service. 2) To utilize the Medical Information technology System (MITS), which is the shared computer payment system used by the Ohio Job and Family Service, or other insurance portals, to determine my eligibility for publicly funded services and pay claims for services I receive. 3) To report information required regarding characteristics of individuals seeking services, service planning and evaluation purposes. 4) To report information required to measure effectiveness of services and evaluate treatment outcomes in my case and others like it. 5) To report information, as required by Ohio law, about reportable incidents (including g Major unusual incidents and reportable incidents for residential treatment providers) that may occur white I am receiving services. 6) To share information and conduct investigations relevant to clients rights issues and reportable indicants required by Ohio law that may occur white I am receiving services.

I understand that Your Story Counseling Service, LLC may disclose information necessary to be paid for mental health and/or AoD services and I understand that the information disclosed is protected by law and may not be disclosed further without my written authorization or as otherwise permitted by law. I understand that I may revoke this authorization at any time, except to the extent action has been taken in reliance on it. I understand that Your Story Counseling Service, LLC cannot control the use of this information once it has been disclosed.

_____ _____ _____
Client or Parent/Guardian Signature (if client under age 18) Client or Parent/Guardian Printed Name Date

520 S. Main St., Akron, Ohio 44311 (Office) 330-687-4439 (Fax) 330-319-6592

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AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby grant my permission to Your Story Counseling Services, LLC and any of its agents to
Name of Client or parent Guardian (if client under age 18)

Release obtain or verbally exchange any information indicated below regarding _____, _____
Client Name Date of Birth

_____
Name of Person or Organization to Exchange Information

_____
Address City State Zip

_____ _____
Phone Fax

For the purpose of ❑ Continuity/coordination of care and/or treatment
❑ obtaining assessment information for care/treatment planning
❑ Other _____

Date(s) of service of documents to be included in this release
❑ Birth to present
❑Other _____

Note: Do not indicate a single date of service unless you are releasing information only for that date

Mental Health	**Alcohol/Drug**	**Misc.**
❑ Reason for referral	❑Reason for referral	❑Psychiatric Evaluation
❑ Diagnostic assessment	❑Diagnostic Assessment	❑IEP/Behavioral Data/ Teacher
❑ Treatment Plan	❑Treatment Plan	Observations/Grades/Attendance
❑ Treatment Summary	❑Treatment Summary	❑Medications
❑ Recommendations	❑Recommendations	
❑ Treatment Compliance	❑Treatment Compliance	
❑ Discharge Summary	❑Discharge Summary	
❑ Other (specify) _____		

I further state that I have read or had read to me and fully understand the above statements as they apply to me and do herein expressly consent to disclosure of the above stated information for the purpose or need to the extent stated above. I further understand that this authorization is voluntary and that I may revoke this consent in writing addressed to the Your Story Counseling, LLC Client Rights Officer at any time, except when disclosure has already been made. A copy of this release will be considered as valid as the original and will expire 365 from the date it is signed. The parent/guardian/client, if age 14 or older, may shorten or lengthen the authorization period, not toe exceed one year.

I UNDERSTAND THAT THE CLINICAL RECORD MAY CONTAIN INFORMATION REGARDING PSYCHIATRIC CONDITONS, DRUG/ALCOHOL ABUSE, HIV TEST RESULTS, A DIAGNOSIS OR AN AIDS-RELATED CONDITION, AND I EXPRESS CONCENT TO THE RELEASE OF SUCH INFORMATION, CONTRAINED IN THE RECORDS DESIGNATED ABOVE

❑ I have received a copy of this release ❑I do not want a copy of this release

Client Signature (required if age 14 or older) _____ Date _____
Parent/Guardian Signature _____ Date _____
Relationship to Client _____
Witness Signature (required) _____ Date _____

Note: This information has been disclosed to you from records whose confidentiality is protected from and disclosed by Federal and State Law O.R. C. 512122.31, 42 CFR Part 2, and O.R.C. 3701.243 prohibit you from making any further disclosure of it without the specific and informed released the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general release of information is not acceptable for this purpose.

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EMAIL AND TEXTING

If you decide you want to utilize either form of communication, you must acknowledge that there are risks inherent in such communications and you accept those risks. At your request, a list of those risks will be provided to you by the therapist / office staff. If you wish to use texting or email for communication with your therapist or the office, please place your initials below:

_____ (By initialing this section, you agree that you understand the risks involved in texting and emailing and agree to accept such risks in communication from either Your Story Counseling Services, LLC to you or from you to us that involve scheduling and/or therapy). Please provide the number (if different than number provided) you agree for texting and/or email below:

Phone number to TEXT:_____. EMAIL: _____

- CANCELLATION POLICY - Please be advised that appointment reminders are sent approximately 24 hrs. prior to scheduled appointment. If a person does not cancel prior to 24 hours of appointment, or does not show for any scheduled appointment, please note there may be a $20.00 charge in addition to any subsequent scheduled appointments being canceled.

Acknowledgement of Client Rights and HIPAA Privacy Practices

I have received a copy of the HIPAA privacy practices and client rights and have had the ability to review them.

_____ _____ _____ _____
Client Signature Date

_____ _____ _____ _____
Parent or Guardians Signature (If under 18) Date

Consent for Services

I consent for Your Story Counseling Service, LLC to conduct an assessment and to provide mutually agreed upon, medically necessary services. I have received an explanation about the risks and benefits of any proposed services, alternative services and of having no services at all.

_____ _____ _____
Print Client Name Client Signature Date

_____ _____ _____
Parent/Guardian Signature (If Client is under age 18) Parent/Guardian Signature Date

_____ _____
Witness Signature Date

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