Patient Information Sheet

General Information **Todays Date:____________**

Last Name ____________________ First _______________Middle ________________Birthdate ______/______/______

Address ____ City ____________________ State _______ Zip __________

Sex [ ] M [ ]F [ ] NB Marital Status _________________Social Security # _______ - _______ - _______ Pronouns __________

Employer _________________________ Relation to Insured ________________ Referred by ___________________

Phone: (___) _____-_____ May we leave a message? [ ] YES [ ] NO E-Mail Address_____________________________

Work/Other #(___) _____-_______ May we leave a message? [ ] YES [ ] NO

Emergency Contact: Name _______________________ Relationship _______________ Phone # ______________

Insurance Information- Primary Insurance or EAP Company _______________ Authorization Number:_______________

Insured Last Name___________________ First ________________ Middle _______________Birthdate ____/____/____

Address ____________________________________ City ____________________ State _________ Zip _________

Telephone (___)______-________ Sex [ ]M [ ]F [ ] NB Marital Status ________ Social Security # ______-______-______

Employer ____________________ Insurance Company ____

Address __________________________________ City ___________________ State ________ Zip ___________

Insurance Phone # (__)_____-_______Member ID/Subscriber Number _________________________ Group Number ______________

Insurance Information – Secondary Insurance

Insured Last Name___________________ First ________________ Middle _______________Birthdate ____/____/____

Address ____________________________________ City ____________________ State _________ Zip _________

Telephone (___)____-________ Sex [ ]M [ ]F [ ] NB Marital Status ________ Social Security # ______-______-______

Employer ____________________ Insurance Company ____

Address __________________________________ City ___________________ State ________ Zip ___________

Insurance Phone # (__) ____-_______Member ID/Subscriber Number _________________________ Group Number _______________

Coordination of Care

It is important for your health care providers to speak to each other, so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate care.

Primary Care Physician:____________________________________Phone:__________________ Fax:__________________

Address:____ City:_________________ State:_________Zip:__________

May we contact your physician____Yes ____No _______ I do not have a physician

Psychiatrist:________________________________Phone:____________________ Fax:_____________________

Address:____ City:_________________ State:_________Zip:__________

May we contact your psychiatrist _____Yes ______No ____ I do not have a psychiatrist

Assignment & Release: I herby assign my insurance benefits to be paid directly to the undersigned therapist. I am financially responsible for non-covered services. I also authorize the therapist to release any information requested.

____ __________________

Client Signature or Authorized Parent/Guardian **Date**

Deerfield Twp. Family Counseling Center FINANCIAL AGREEMENT

FULL NAME ____ TODAY'S DATE ___________

FEE FOR SERVICES

I understand that unless another payment schedule is specifically arranged the following fee agreement applies:

- $175 Initial Assessment/Consultation (90791); $155 Individual or Couples Therapy (90834, 47 or 37)
- ** $35 Phone/In-Person Consultation (15 minutes) **
- **$150 Anger Management** $175 Drug & Alcohol Assessment** (include: Clinical Interview, letter & case management/collaboration) **

** indicates that these services are **NOT** billed to insurance. Note: The client must be present in Ohio for any telehealth services.

MISC SERVICE FEES

These are any extra services not covered by your insurance.

- **Report and Letter writing**: $35 per 15-minute increment.
- **Telephone/Email/Messaging Services**: If you need your therapist to speak to another professional, $35 per 15-minute increment.
- **Court Related Charges**: Therapists do not attend court proceedings voluntarily. A therapist's appearance in court necessitates the cancellation of other clients' appointments for the day. A subpoena from the Magistrate or Judge presiding over the case is required to mandate the therapist's attendance. All court appearance requests must be submitted a minimum of two weeks in advance of the court date.
  - There is a fee of **$350 per hour** for all work related to the legal matter, including preparation, phone calls, submission of records, filing court documents, meeting with client's representatives or attorneys, transportation time, depositions, testimony time, and all attorney communications, fees, and costs incurred by the therapist as a result of the legal action. <u>If the fee is not paid within one week prior to the scheduled court appearance, the therapist has the right to cancel the agreed court appearance</u>.
  - The office must receive a retainer cost of **8-hour/$350 ($2800 total)** prior to therapist blocking out their schedule to appear in court at least one week in advance of the court appearance. Any additional charges over that will be billed to you following the hearing.
  - In the event the therapist believes that testifying in court would be detrimental to the therapeutic process, the therapist may hire their own attorney to have the subpoena overruled. Any legal fees resulting from this action will be charged to the client that has requested the therapist's appearance.
- **Medical Record Request**: Actual cost of postage, if mailed. The second occurrence, the cost plus $35.
- **Late Cancellation or Missed Appointment**: Clients are required to provide a minimum of **24 hours' notice** if they are unable to attend a scheduled appointment. DTFCC will charge a **$75.00 fee** for any appointment canceled with less than 24 hours' notice, as well as for any missed appointments. If you are more than 10 minutes late for a scheduled appointment <u>without prior notification</u>, you forfeit your appointment time, and the late cancellation fee will apply. Please notify DTFCC of a true emergency where a fee may not apply. Emergencies do not include having another scheduled appointment or work/school obligation. This cannot be billed through insurance.
  - Failure to attend three appointments in a 6-month window will result in the termination of counseling services. If a consistent pattern of cancelling appointments with little notice is demonstrated by the client, it will also result in termination of counseling services.

initial

HEALTH INSURANCE

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. It is my responsibility to notify DTFCC of any changes in my health care coverage. In consideration of services received or to be received, the undersigned requests that

payment of authorized insurance benefits be made on the client's behalf to DTFCC for any services provided to the client.

Some, or all of your fees may be covered by your health insurance, if you have outpatient mental health coverage. However, insurance companies **DO NOT** reimburse all conditions that may be the focus of therapy. We will do initial verification of benefits as a consideration to you. Services are charged to you, not your insurance company, so you are responsible for verifying specifics of your coverage and for payment of fees. Out-of-pocket fees that you pay for services not reimbursed by insurance may be deductible medical expenses if you itemize deductions on your tax return.

Initial

CREDIT CARD AUTHORIZATION

I understand that DTFCC requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, late cancel (less than 24 hours) or missed appointments, and charges that may not be covered by your health insurance. This form will be kept confidential and only authorized staff will have access to the information.

I authorize DTFCC to charge my credit card to pay for therapy sessions, missed appointments/late cancellations, charges not covered by insurance or to make payments on my account. initial

NAME, AS IT APPEARS ON CREDIT CARD:
____

Credit Card : ____ Zip Code: __________________

EXPIRATION DATE: ____/_____ VERIFICATION CODE (3 or 4 DIGITS) ___________

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

I understand that if I am unable to honor my financial commitment that this may be grounds for a therapeutic conversation about financial issues, negotiating my therapeutic & financial agreement, exploring other options and or terminating from treatment.

I understand that DTFCC may, in its discretion, charge a fee for any check returned by my financial institution, regardless of reason. In such event, I agree to pay DTFCC a returned check fee of up to $40.00.

I understand that DTFCC may turn my account over to a collection agency, if I do not pay on a timely basis. I also understand that if my account is sent to a collection agency, a 35% surcharge will be applied to the balance.

I acknowledge that I am financially responsible for all charges associated with mental health services provided by DTFCC to me (or the client named below). I understand that payment for services is due at the time services start (prior to starting the scheduled appointment) unless special arrangements are made in advance.

____ __________________________

Print Client's Name **Date**

____ __________________________

Signature of Client or Responsible Party **Date**

____ __________________________

Staff Signature **Date**

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Deerfield Twp. Family Counseling Center offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed professional counselors, licensed clinical social workers, and Marriage and Family Therapists. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your therapist will determine your concerns, and if both agree that Deerfield Twp. Family Counseling Center can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your therapist, services to you may be terminated.

The goal of Deerfield Twp. Family Counseling Center is to provide the most effective therapeutic experience available to you. If at any time, you feel that you and your current therapist are not a good fit, please discuss this matter with your therapist or the Intake Coordinator to determine if transferring to a more suitable therapist is right for you. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50-55 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your therapist. If you must cancel or reschedule your appointment, we ask that you call our office at (513) 770-3231 or e-mail us at famcounse@gmail.com at least 24 hours in advance, whenever possible. This will free your appointment time for another client. We do assess a $75 late cancellation and/or no-show fee for situations that are not emergencies. **Please see your financial agreement**

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your therapist is out of town, you will be advised and given the name of an on-call Therapist.

CONFIDENTIALITY: Deerfield Twp. Family Counseling Center follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law, with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

______________________________ ______________________

Name **Contact Number**

______________________________ ______________________

Name **Contact Number**

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I voluntarily agree to receiving a mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

______________________________ ______________________

Signature – Client/Parent Date

______________________________ ______________________

Signature – Parent Date

______________________________ ______________________

Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

______________________________ ______________________

Client/Parent Date

I authorize the payment of medical benefits to the provider of services.

______________________________ ______________________

Client/Parent Date

Deerfield Township Family Counseling Center, LLC
7567 Central Parke Blvd, Suite E, Mason, OH 45040
Phone: (513) 770-3231 Fax: (513) 770-5541 deerfieldtwpfamilycounseling.com

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:____
DOB: ______________________________ SSN:__________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of **Deerfield Twp. Family Counseling Center's** Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 7567 Central Parke Blvd. Suite E, Mason, OH 45040

____
Signature of Patient/Client

____
Signature or Parent, Guardian or Personal Representative*

____
Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Patient/Client Refuses to Acknowledge Receipt:

____
Signature of Staff Member Date

Deerfield Township Family Counseling Center
Child & Teen History

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All the information you provide us will be confidential as required by state and federal law.

Section I: Please answer all questions. To be filled out by a parent or legal guardian.	
Today's date:	
Child's Full Name:	
Child prefers to be called:	Grade:
Name of Person completing this form:	
Relationship to child:	
Who is allowed to transport your child to and from therapy appointments?	
Who may the therapist get information from and/or share information with about your child's treatment?	
What is the current presenting problem?	
List any family members with a diagnosed mental health condition and their relationship to your child.	

Child's Name: Today’s Date:

Who has physical custody?	What is the custody arrangement?
☐ Mom and Dad	☐ None, not applicable
☐ Mom—days per week:	☐ Full:
☐ Dad—days per week:	☐ Shared:
☐ Other:	☐ Visitation:
	☐ Other:

If applicable, how old was your child when their parents seperated?

Does your child have step-parents or a parent’s significant other in their lives? If so please list these individuals, how long then have been part of the child’s life and what the child calls them.

List your child’s siblings, including step-siblings, and the children of a parent’s significant other.

First Name	Age	Do they live with the child?

What school does your child attend?

Does your child recieve any special services at school? ☐ Yes ☐ No

☐ IEP (individual education plan)	☐ Therapy or Counseling
☐ 504 Plan	☐ Group Therapy
☐ Gifted and Talented Program	☐ Speech Therapy
☐ Occupational Therapy	☐ Physical Therapy
☐ Other:	

Child's Name: Today's Date:

Has your child experienced any of the following problems at school?

- ☐ Fighting
- ☐ Suspension
- ☐ Incomplete assignments
- ☐ Lack of friends
- ☐ School refusal
- ☐ Bullying/Teasing
- ☐ Learning disabilities
- ☐ Drugs, alcohol, smoking, or vaping
- ☐ Behavior problems
- ☐ Poor attendance
- ☐ Grade changes
- ☐ Other:

Does your child take any medications on a daily basis? ☐ Yes ☐ No

If Yes, list medications and dosage:

Any complications during pregnancy or during infancy? ☐ Yes ☐ No

If Yes, please explain:

Any developmental delays currently or in the past? ☐ Yes ☐ No

If Yes, please explain:

Has your child witnessed or experienced a traumatic event or abuse? ☐ Yes ☐ No

If Yes, please explain:

Please list any current medical problems or physical disabilities:

Child's Name: Today's Date:

Has your child experienced any of the following medical problems?

- [ ] A serious accident
- [ ] Eye/vision problems
- [ ] Ear/hearing problems
- [ ] High fever
- [ ] Asthma
- [ ] Meningitis
- [ ] Loss of consciousness
- [ ] Digestive problems
- [ ] Head injury
- [ ] Allergies
- [ ] Hospitalization
- [ ] Surgery
- [ ] Seizures
- [ ] Speech/language problems
- [ ] Weight change
- [ ] Appetite change

Please indicate if your child has experienced any of the following in the past 6 months. 0=None 1=Mild 2=Moderate 3=Severe

Relationship problems			Upset stomach/digestive issues	
Problems with peers			Vomiting	
Discipline problems			Eating problems/change in appetite	
Loss of someone close			Lying/dishonesty	
Nervousness			Memory problems	
Moodiness			Wetting/soiling self	
Meltdowns			School Problems	
Very active			Tics	
Anxious			Vision/hearing problems	
Easily upset, sensitive			Picky eating	
Crying a lot			Stealing	
Feels unhappy/depression			Sexualized behavior	
Lacks self-confidence			Aggression	
Feels lonely			Fidgety/restlessness	
Destructive behavior			Excessive worry	
Anger			Apathetic/boredom	
Irritability			Fighting	
Easily distracted			Problems concentrating	
Nightmares/night terrors			Confusion	
Fatigue			Obsessions	
Trouble sleeping			Phobias/fears	
Sleeping too much			Hearing/seeing things that aren’t real	
Sleeping too little			Separation anxiety	

Child's Name: Today's Date:

Section II: Please answer all questions. To be completed by the child if they are age 12 or older. For children aged 11 and younger, their parent or legal guardian may answer the questions on the child's behalf.

Have you ever experienced any abuse (physical, sexual, verbal, emotional, or spiritual)? If so, please describe.

Have you ever had any thoughts of seriously hurting yourself, someone else, or an animal?

Have you ever purposely hurt yourself, someone else, or an animal?

Have you ever experienced any serious emotional losses, such as a death or physical separation from a family member or caretaker? If yes, please explain.

What are your greatest strengths?

What recreation activities do you participate in?

	Activity	Which Type(s)?	How Often?
☐	Sports		
☐	Fine Arts		
☐	Religious activities		
☐	Social Activities		
☐	Other		

Child's Name: Today's Date:

On average, how much time do you spend with each activity on a screen per day?				
	Activity	What shows, games, or apps?	Hours on school days?	Hours on off days?
☐	Watching TV/ movies			
☐	Schoolwork on a computer/laptop			
☐	Games (on any device)			
☐	Watching videos like TikTok, YouTube, etc.			
☐	Social Media			

Is your screen time supervised by a parent/guardian? ☐ Yes ☐ No

Is your screen time limited by a parent/guardan? ☐ Yes ☐ No

Do you have your own devices, if yes, which ones? ☐ Yes ☐ No

☐ Tablet/iPad ☐ Phone ☐ Computer ☐ TV in your room

☐ Video game console ☐ No, but I share devices with family members

Do you, your friends or your family members use the following substances?

Substance	You	Your Friends	Family Member(s)
Drugs			
Pills			
Marijuana or weed			
Cigarettes			
Vape			
Alcohol			

Child's Name: Today's Date:

Do you, your friends or your family members struggle with the following addictions?			
Addiction	You	Your Friends	Family Member(s)
Pornography			
Gambling			
Drugs or Alcohol			

How many energy drinks do you consume in an average week?

Do you have concerns about your gender identity or sexual orientation?

Have you previously seen a mental health professional like a counselor, therapist, psychologist, or psychiatrist? If yes, please share when, where and if you found it helpful.

Is there anything else you would like the therapist to know?

Parent/Guardian Signature: ____

Child signature: ____

Therapist Signature: ____