Patient Information Sheet

General Information **Date:**_____

Last Name _____ First _____ Middle _____Birthdate _____/_____/_____

Address _____ City _____ State _____ Zip _____

Sex _____M _____F Marital Status _____ Social Security # _____ - _____ - _____

Employer _____ Relation to Insured _____ Referred by _____

Emergency Contact: Name _____ Relationship _____ Phone # _____

Phone: Home # (___) _____-_____ May we leave a message? YES NO E-Mail Address_____

Cell# (___) _____-_____ May we leave a message? ☐YES ☐NO Work #(___) _____-_____ May we leave a message? ☐YES ☐NO

Insurance Information- Primary Insurance **Authorization Number:**_____

Insured Last Name_____ First _____ Middle _____Birthdate ____/____/____

Address _____ City _____ State _____ Zip _____

Telephone (___)____-_____ Sex ____M ____F Marital Status _____ Social Security # _____-_____-_____

Employer _____ Insurance Company _____

Address _____ City _____ State _____ Zip _____

Insurance Phone # (__)____-_____Policy/Subscriber Number _____ Group Number _____

Insurance Information – Secondary Insurance

Insured Last Name_____ First _____ Middle _____Birthdate ____/____/____

Address _____ City _____ State _____ Zip _____

Telephone (___)____-_____ Sex ____M ____F Marital Status _____ Social Security # _____-_____-_____

Employer _____ Insurance Company _____

Address _____ City _____ State _____ Zip _____

Insurance Phone # (__)____-_____Policy/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 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

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Adult History

Name: _____ **Date:** _____

CURRENT SITUATION **(presenting problem(s), precipitant(s), recent major stresses or life changes)**

_____
_____
_____
_____

HEALTH AND WELLNESS HISTORY

Primary Care Physician: _____Date of Last Visit to Physician: _____

Date of Last Physical:_____ Insurance: _____

Please describe what you do to relax or take care of yourself: _____

Do you exercise? ☐Yes ☐No If yes, how many times per week? _____ Intensity: ☐High ☐Medium ☐Low

Height _____ Weight _____ Do you have any drug/food allergies? ☐Yes ☐ No If yes, please specify.

_____
_____

Do you have any physical health problem(s)? ☐Yes ☐No If yes, what _____

_____
_____

How would you describe the nutritional value and balance of your diet: ☐Excellent ☐Good ☐Fair ☐Poor

Have you had significant appetite change over the past month? ☐Yes ☐No

Comments: _____

Have you had any weight change in the past 6 months? ◯Yes ◯No If yes, amount +/- _____

Comments: _____

Have you experienced any sleep disturbance in the past month? ◯Yes ◯No

Comments: _____

Are you **currently** on any prescriptions, "over the counter" vitamins, herbs, supplements for anxiety, depression, mental health conditions or other medical conditions? ◯Yes ◯No If yes, list all medications:

Medication/Purpose: _____ _____

In the **past,** have you taken any medication for anxiety, depression or mental health condition? ☐Yes ☐No If yes, list all medications: _____ _____

Are you having any problems or concerns with your sexual functioning? ◯Yes ◯ No

Comments: _____

Name:_____

BEHAVIORAL HEALTH

Have you had prior mental health services, counseling, or alcohol/drug treatment? ☐Yes ☐No

If Yes, please list names and dates below.

Out Patient		Inpatient	
Therapist or Program Name	Date	Hospital	Date

Regarding past or current treatment, what have you found most helpful? What has not been particularly helpful or effective? _____

_____

Have you ever experienced:

Physical abuse	☐Yes ☐No	Domestic violence	☐Yes ☐No
Sexual abuse	☐Yes ☐No	Emotional abuse	☐Yes ☐No
Rape/sexual assault	☐Yes ☐No	Other significant trauma	☐Yes ☐No

If Yes to any of the above explain:

_____

_____

_____

Are you now or have you in the past experienced any suicidal feelings/behavior? ☐Yes ☐No If yes, please describe._____

_____

Do you have any history of violent/aggressive behavior? ☐Yes ☐No If yes, please describe below

_____

_____

Are you having difficulty with any activities of daily living? ☐Yes ☐No

If yes, indicate with which activities the client requires assistance from another person:

☐ Grooming/hygiene	☐ Homemaking	☐ Mobility	☐ Leisure Skills
☐ Bathing	☐ Shopping	☐ Transportation	☐ Time Management
☐ Dressing	☐ Banking	☐ Communication	☐ Stress Management
☐ Cooking	☐ Budgeting	☐ Child Care	☐ Other _____

Describe any recent difficulties:_____

_____

Adult History

Name:_____

CULTURAL/ETHNIC/SPIRITUAL

Cultural/ethnic/racial issues that need consideration? ☐ Yes ☐ No

If Yes, explain:_____

_____

Sexual Orientation issues that need consideration? ☐ Yes ☐ No

If Yes, explain:_____

_____

Religious/spiritual issues that need consideration? ☐ Yes ☐ No

If Yes, explain:_____

_____

FAMILY/CURRENT LIVING SITUATION

List household members:

Name	Age	Relationship to client

List children not residing in the home:

Name	Age	Living Arrangements

Describe any concerns about family members:_____

_____

_____

Is there any history of emotional or mental problems in the family? ☐ Yes ☐ No

If Yes, explain:_____

_____

Name:_____

MILITARY SERVICE ☐ Yes ☐ No

If Yes, Type of Discharge:_____

Were you involved in combat duty? ☐ Yes ☐ No

If Yes, please describe combat situation: _____

EMPLOYMENT

☐ Full-time ☐Part-time ☐Unemployed Since _____ ☐Student

☐ Homemaker ☐Volunteer ☐Retired Since _____ ☐Disabled Since_____

How long at current job?_____ How long at last job?_____

Are you having any problems at your workplace? ☐Yes ☐No

If Yes, describe: _____

_____

FINANCIAL

Are you having financial problems? ☐Yes ☐No

If Yes, please describe:_____

_____

LEGAL

Have you ever had involvement with the legal system? ☐Yes ☐No

If Yes, explain when, what involvement, and the outcome: _____

_____

Do you have any current pending legal charges? ☐Yes ☐No

If Yes, explain:_____

Are you on probation or parole? ☐Yes ☐No

If Yes, list PO's name and contact information: _____

_____

Have you ever been incarcerated (in jail)? ☐Yes ☐No

If Yes, explain: _____

Name:_____

ALCOHOL AND DRUG USEAGE

Do you smoke cigarettes or use tobacco in any other form? ◯Yes ◯No

If yes, describe (how often, how much):_____

Do you drink alcohol? ◯Yes ◯No

If yes, describe (how often, how much):_____

Have you ever had concerns about your use of alcohol, prescription medications, or other drugs? ◯Yes ◯No

If yes, what were your concerns?_____

_____

Has anyone else expressed concerns about your use of alcohol, prescription medications or other drugs? ◯Yes ◯No

If yes, who was concerned and what were their concerns?_____

_____

Have you ever made a decision to cut down or quit using alcohol and/or other drugs? ◯Yes ◯No

If yes, what made you decide to cut down or quit and what was the outcome of your efforts to cut down or quit?

_____

_____

Have you ever experienced any of the following in connection with your use of alcohol, prescription medications, or other drugs?

◯Yes ◯No	Financial Problems	◯Yes ◯No	Relationship Problems
◯Yes ◯No	Work Problems	◯Yes ◯No	Increased Tolerance
◯Yes ◯No	Physical Problems	◯Yes ◯No	Emotional Problems
◯Yes ◯No	Blackouts	◯Yes ◯No	Withdrawal Symptoms
◯Yes ◯No	Cravings	◯Yes ◯No	Legal

Has anyone in your family ever had problems with alcohol or other drug use? ◯Yes ◯ No

If yes, describe:_____

_____

Client's signature	Date
Reviewed/completed by Clinician	Date
Reviewed/updated by clinician	Date

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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 45-50 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 $70 late cancellation and/or no show fee for situations that are not emergencies.

*Written Reports (insurance companies, supervisors, etc. pro-rated at $ 75/hour unless otherwise arranged.
*Conferences with 3rd parties and court appearances will be charged at $350 per hour including travel time.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Deerfield Twp. Family Counseling Center will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months. If for any reason your account needs to be sent to a collections agency, a 35% of your total collection fee will be assessed to cover collections costs.

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 Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and 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	Telephone 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 Client Information and 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 am voluntarily agreeing to receiving 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 – Spouse/Partner/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