

**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 hereby 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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**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](mailto: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 3<sup>rd</sup> 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

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**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

# 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?

- Mom and Dad
- Mom—days per week:
- Dad—days per week:
- Other:

What is the custody arrangement?

- None, not applicable
- Full:
- Shared:
- 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.

<u>First Name</u>	<u>Age</u>	<u>Do they live with the child?</u>

What school does your child attend?

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

- |  |  |
|--|--|
| <input type="checkbox"/> IEP (individual education plan) | <input type="checkbox"/> Therapy or Counseling |
| <input type="checkbox"/> 504 Plan                        | <input type="checkbox"/> Group Therapy         |
| <input type="checkbox"/> Gifted and Talented Program     | <input type="checkbox"/> Speech Therapy        |
| <input type="checkbox"/> Occupational Therapy            | <input type="checkbox"/> Physical Therapy      |
| <input type="checkbox"/> Other:                          |  |

Child's Name:

Today's Date:

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

- |   |   |
|---|---|
| <input type="checkbox"/> Fighting               | <input type="checkbox"/> Learning disabilities              |
| <input type="checkbox"/> Suspension             | <input type="checkbox"/> Drugs, alcohol, smoking, or vaping |
| <input type="checkbox"/> Incomplete assignments | <input type="checkbox"/> Behavior problems                  |
| <input type="checkbox"/> Lack of friends        | <input type="checkbox"/> Poor attendance                    |
| <input type="checkbox"/> School refusal         | <input type="checkbox"/> Grade changes                      |
| <input type="checkbox"/> Bullying/Teasing       | <input type="checkbox"/> 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?

- |  |   |
|--|---|
| <input type="checkbox"/> A serious accident    | <input type="checkbox"/> Head injury              |
| <input type="checkbox"/> Eye/vision problems   | <input type="checkbox"/> Allergies                |
| <input type="checkbox"/> Ear/hearing problems  | <input type="checkbox"/> Hospitalization          |
| <input type="checkbox"/> High fever            | <input type="checkbox"/> Surgery                  |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Meningitis            | <input type="checkbox"/> Speech/language problems |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Weight change            |
| <input type="checkbox"/> Digestive problems    | <input type="checkbox"/> 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?

	<u>Activity</u>	<u>Which Type(s)?</u>	<u>How Often?</u>
<input type="checkbox"/>	Sports		
<input type="checkbox"/>	Fine Arts		
<input type="checkbox"/>	Religious activities		
<input type="checkbox"/>	Social Activities		
<input type="checkbox"/>	Other		

Child's Name:

Today's Date:

On average, how much time do you spend with each activity on a screen per day?

	<u>Activity</u>	<u>What shows, games, or apps?</u>	<u>Hours on school days?</u>	<u>Hours on off days?</u>
<input type="checkbox"/>	Watching TV/ movies			
<input type="checkbox"/>	Schoolwork on a computer/laptop			
<input type="checkbox"/>	Games (on any device)			
<input type="checkbox"/>	Watching videos like TikTok, YouTube, etc.			
<input type="checkbox"/>	Social Media			

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

Is your screen time limited by a parent/guardian?  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?

<u>Substance</u>	<u>You</u>	<u>Your Friends</u>	<u>Family Member(s)</u>
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?

<u>Addiction</u>	<u>You</u>	<u>Your Friends</u>	<u>Family Member(s)</u>
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: \_\_\_\_\_