

**Patient Information Sheet**

**General Information**

**Today's 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 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**

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. 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.
  - 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 without prior notification, 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

# *Deerfield Township Family Counseling Center, LLC*

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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 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

## Adult History

This questionnaire is for the purpose of getting to know you better to provide the best possible mental health services. All the information you provide us with will be confidential as required by state and federal law.

Please complete this form as honestly and completely as possible.

Questions with an \* are required.

*Today's date:			
*Full Name:			
*Name we should use for you (Nickname):			
*What is the current presenting problem? (presenting problem(s), precipitant(s), recent major stresses or life changes)			
How long have you been experiencing this problem?			
What race/ethnicity do you identify as?			Prefer not to say: <input type="checkbox"/>
What are your pronouns?			Prefer not to say: <input type="checkbox"/>
*What is your current relationship status? (Check all that apply)			
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> In a committed relationship	
<input type="checkbox"/> Engaged	<input type="checkbox"/> Widowed	<input type="checkbox"/> It's complicated	
<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Casually dating	
How long have you been in this relationship?			
*List your family members and/or members of your household.			
<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Do they live with you?</u>

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\*If you work: What is your job? Where do you work? How long have you been at this job?

\*Do you have any concerns about your job? If yes, please explain:

\*What is the highest level you completed in school?

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> Little/No Formal Education | <input type="checkbox"/> GED          | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> Grade Reached:             | <input type="checkbox"/> Trade School | <input type="checkbox"/> Master's Degree   |
| <input type="checkbox"/> High School                | <input type="checkbox"/> Some College | <input type="checkbox"/> Doctorate, Ph.D.  |

Are you currently in school? If yes, please share what school and program you are enrolled in.

\*If you do not work:

Retired Since:

Unemployed Since:

Stay-at-Home Parent Since:

Disabled Since:

Full time Caregiver Since:

\*Have you or are you currently serving in the military? If yes, please list branch, rank, discharge type and any deployments.

What languages do you speak?

\*What do you enjoy doing in your spare time?

What are your strengths?

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\*Do you have any physical health problems? If yes, please explain:

\*Do you take any medications or supplements? If yes, list below:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking</u>

\*Have you experienced any of the following:

- |  |  |
|--|--|
| <input type="checkbox"/> A serious accident        | <input type="checkbox"/> Domestic violence               |
| <input type="checkbox"/> A significant trauma      | <input type="checkbox"/> Emotional abuse                 |
| <input type="checkbox"/> Physical abuse            | <input type="checkbox"/> Incarceration                   |
| <input type="checkbox"/> Sexual abuse/rape/assault | <input type="checkbox"/> Inpatient psychiatric treatment |

\*Have you ever had any thoughts of seriously hurting yourself, someone else, or an animal? If yes, elaborate.

\*Have you ever purposely hurt yourself, someone else, or an animal? If yes, elaborate.

\*Have you ever been involved with the legal system? If yes, explain when, what involvement, and the outcome

\*Are you on probation or parole? If yes, list PO's name and contact information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\*Indicate if you are experiencing any of the following symptoms now or have been in the last 30 days.

0=None 1=Mild 2=Moderate 3=Severe

Angry, irritable		Thoughts of death / dying	
Anxiety		Suicidal thoughts	
Avoidance		Self-harm	
Fear of crowds		Restless	
Prefer being alone		Reoccurring nightmares	
Difficulty concentrating		Little/no need for sleep	
Depression		Sleeping too little	
Easily distracted		Sleeping too much	
Easily startled		Guilt	
Fatigue, no energy		Shame	
Feeling helpless		Grief / loss	
Feeling like a burden		Panic attacks	
Feeling overwhelmed		Nervousness	
Feeling worthless		Stress	
Lack of interest in activities		Substance use	
No motivation		Impulsive	
Hopeless		Talk too fast	
Poor memory		Paranoid	
Sadness		Feeling that others are out to get me	
Unintentional weight loss		Feeling that others are watching me	
Unintentional weight gain		Hearing things that others don't	
Increase in appetite/hunger		Seeing things that others don't	
Decrease in appetite/hunger		Have special powers	
Self-esteem problems		Other:	
Relationship problems			
Sexual dysfunction			
Worried, fearful			

Name: \_\_\_\_\_ Date: \_\_\_\_\_

\*Do you exercise? If so, how often?

\*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 work days?</u>	<u>Hours on off days?</u>
<input type="checkbox"/>	Work / school			
<input type="checkbox"/>	Shows / movies			
<input type="checkbox"/>	Games			
<input type="checkbox"/>	Watching videos (i.e. TikTok, YouTube)			
<input type="checkbox"/>	Social media			

How many caffeinated drinks (coffee, energy drinks) do you have on an average day?

\*Do you use the following substances?

<u>Substance</u>	<u>Currently</u>	<u>Frequency</u>	<u>In the past</u>
Alcohol	<input type="checkbox"/>		<input type="checkbox"/>
Marijuana, weed	<input type="checkbox"/>		<input type="checkbox"/>
Cigarettes, tobacco products	<input type="checkbox"/>		<input type="checkbox"/>
Vape (nicotine)	<input type="checkbox"/>		<input type="checkbox"/>
Pills	<input type="checkbox"/>		<input type="checkbox"/>
Other:	<input type="checkbox"/>		<input type="checkbox"/>

\*Do you or your household members struggle with the following addictions?

<u>Addiction</u>	<u>Self, currently</u>	<u>Self, past</u>	<u>Household member</u>
Pornography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs or Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you previously seen a mental health professional like a counselor, therapist, psychologist, or psychiatrist? If yes, please list.

<u>Provider Name, Title OR Program Name</u>	<u>Start-End Date</u>

Have you ever had inpatient mental health or addiction treatment? If yes, please list.

<u>Hospital or Facility</u>	<u>Date</u>

Did you find your past/current treatment helpful? Please explain what you found helpful or not helpful.

\*Do you consider yourself spiritual or religious?  Yes  No

Are you part of a spiritual or religious community? If yes, which one?

What importance does your faith, belief, or spirituality have in your life?

Is there a group of people you really care about who are important to you? If yes, please list/elaborate.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_