Eric Lichtenfeld, LISW

4242 Tuller Road Suite B-2 Dublin, OH 43017
614-706-2228 x 722

DEMOGRAPHIC INFORMATION

CLIENT INFORMATION
Date: _____
Name:
Last _____First _____Middle_____
Preferred name:_____ Date of Birth:_____
Gender Identity *(preferred pronouns, etc.)*:_____
Sex: _____

Address: _____
City, State, Zip: _____
Primary Phone: _____
Secondary Phone: _____
Email:_____

Permission to call & leave a detailed message?

- Yes
- No

Permission to text?

- Yes
- No

Permission to email?

- Yes
- No

Parent/Guardian Name (for minor clients): _____
Occupation and employment status:_____
Employer:_____
Relationship Status:

- Single
- Married

- Divorced
- In long-term relationship
- Separated
- Domestic Partnership
- Widowed
- Other:_____

If partnered, partner's name:_____
Name(s) of children and ages:_____

Relevant cultural information *(any information about identities you hold that you want your counselor to know about)*:_____
_____
_____

Referred By (if applicable): _____
May I thank them for the referral? Y / N

EMERGENCY CONTACT PERSON
Full Name: _____
Relationship to Client:_____
Phone:_____

RESPONSIBLE PARTY INFORMATION *(Only complete if client is a minor)*
Name: Last_____First_____Middle_____
Relationship to client:_____
Address:_____City, State, Zip:_____
Phone:_____Email:_____
Date of Birth:_____

INSURANCE INFORMATION
Primary Insurance Company:
Policy Holder's Name *(if different from client)*:_____
Policy Holder's Date of Birth:_____
Policy Holder's Phone Number:_____
Policy Holder's employer:_____
Policy Holder's Home
Address:_____
Insurance Company:_____
Policy/ID number:_____
Group number:_____
Claims address:_____

Claims Phone:_____

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting your therapist. This authorization will remain in effect until cancelled. Credit cards will be processed through Therabill.

Credit Card Information	
Card Type: ☐ MasterCard ☐ VISA ☐ Discover	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (mm/yyyy):	CVV (back of card):
Cardholder ZIP Code (from credit card billing address):	

I, _____authorize Seasons Counseling Services to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Client Signature _____

Date _____

CLIENT INFORMATION & FINANCIAL AGREEMENT

Seasons Counseling Services will bill your insurer directly for applicable services. Please remember that it is your responsibility to pay any deductible, co-pay or co-insurance amounts. For your convenience, we will keep your credit card information on file. We will then bill your credit card at the conclusion of each visit. Client is responsible for their part of the fee associated with their insurance policy.

Fee Structure
Initial Diagnostic Interview: $350
Counseling Session (50 min): $300
Telephone calls over 5 minutes: $120/hour (pro-rated in 10-minute increments)
Services out of office: (e.g. court appearances): $150/hour (including roundtrip travel time)

Health Insurance: Sessions billed to health insurance are billed at a rate contracted with each specific insurance company. *That rate may be higher or lower than the rate listed above.* Client is responsible for their part of the fee associated with their insurance policy. That fee may include a deductible, a co-pay, or co-insurance depending on the individual insurance policy. Your credit card / HSA will be charged by Seasons Counseling once the Explanation of Benefits is processed.

Appointments should be cancelled or changed 24 hours prior to the scheduled time in order to avoid missed or late cancelation fees:

24 hours to 1 hour prior to session: $75

Up to 60 minutes or not appearing for session within ten minutes of start time: $145

These fees are not billable to health insurance.

This information is required by the counselor, social worker, and marriage and family therapist board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state.

Ohio Counselor, Social Worker, and Marriage and Family Therapist Board,
77 South High Street, 24th Floor, Room 2468 Columbus, Ohio 43215-6171 (614) 466-0912

I understand that I am required to remit payment to Seasons Counseling Services for services provided. By completing the Credit Card Authorization Form above I give Seasons Counseling Services permission to store my credit card information as needed. I understand that I may be held responsible for the cost of missed sessions that are cancelled or rescheduled without 24 hours-notice.

I authorize the release of any information necessary to process insurance claims. All credit card payments are processed through Therabill. I understand that Seasons Counseling Services, will only release information necessary for the processing of payment.

Signature: _____

Date: _____

I consent and authorize Seasons Counseling Services to communicate with me using email/text for the purpose sending credit card billing receipts and for communication about appointment times only. I understand that clinical information is not to be communicated through email. I understand that Roy Bobbitt, LISW-S cannot ensure confidentiality of email communications.

Signature: _____

Date: _____

THIRD PARTY PAYER INFORMATION (party responsible for payment of services): (Do not complete this section if the Responsible Party information is the same as the client information)

Organization/Business Name: _____ ***OR***
Last Name: _____ First Name: _____
Address: _____ City: _____ State: _____ ZIP Code: _____Phone_____
Fax: _____

I acknowledge that my insurance provider/plan may not cover the provided services, and that I am responsible for such costs.

_____ _____
Client Signature Date

Client Information and Acknowledgment of Informed Consent to Treatment

Seasons Counseling Services, LLC (hereinafter "Seasons") provides counseling through Ohio licensed mental health therapists which are independently contracted with Seasons and are part of an Organized Health Care Arrangement between Seasons and Ohio Health Group programs. This Agreement applies to the therapist you will be seeing, and it will also describe the business practices of the therapists at Seasons. You will be seeing the therapist listed above.

Mental Health Services

The purpose of mental health services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. Using your therapist's knowledge of human development and behavior, he or she will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress, the development of a trusting and confidential professional relationship where the client and therapist work together towards specific and identified goals. There is great benefit to forging a therapeutic alliance with a professional therapist, although outcome cannot be guaranteed.

It is the client's responsibility to be both open and honest in order to maximize the potential for positive benefit. The process of counseling can be an intense experience for some clients.

Professional Disclosure
Eric Lichtenfeld is a Licensed Independent Social Worker and hold a Master of Social Work degree from The Ohio State University. His license is issued by the State of Ohio Counselor, Social Worker & Marriage and Family Therapist Board. His license number is I.2103118.

Areas of Competence
● Diagnosis and Treatment of Mental and Emotional Disorders ● Counseling: Individual and Marital
● Populations: Adults and Adolescents

Appointments
Appointments are made by calling the phone number listed above.

Cancellation/Rescheduling Policy: Your clinician will make every effort to accommodate requests to reschedule appointments in keeping with the professional and personal values their practice. If you need to cancel or reschedule an appointment, please do so *at least* 24 hours before the scheduled time. Appointments cancelled or rescheduled within a 24-hour window are subject to a missed-session fee that is not billable to health insurance. The clinician, at their discretion, may waive the fee if the session is rescheduled for another time during the same business week. If the new appointment is cancelled, the late cancellation charge will be reinstated regardless of the amount of notice given.

The cancelation/missed appointment structure is as follows:

24 hours to 1 hour prior to session: $75

Up to 60 minutes or not appearing for session within ten minutes of start time: $145.

Appointments are approximately 45-60 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and your

therapist will discuss this as part of your treatment planning. Since there is no way a therapist can see another client when they have a late arrival, no reductions are provided when a client arrives late for an appointment. Some insurance companies will only pay for the actual time during which services are rendered. In that case you, the client, will be billed for the portion of the appointment time when no services could be rendered. Some governmental insurance or employee assistance programs do not allow billing for missed or partially missed appointments and if that is the case you will be billed in accordance with those programs' rules.

Relationship

Your therapist's relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. In an effort to maximize the benefits of counseling and to protect the professional relationship, communication outside of session should be limited to scheduling and billing matters, and clients should refrain from attempting to connect with their therapists on social media, offer them gifts, or invite them to events.

Counseling is voluntary (except where a client is ordered by a court to attend therapy), as are your choices about what to disclose. You your therapist are entering into a counseling relationship with no undue influence, and each of your is free to terminate counseling should we deem that action appropriate. Ideally, your and your therapist will work together to decide when to terminate the counseling relationship. If your therapist determines that your needs are beyond the scope of my practice, or if you wish to terminate, your therapist will help find referrals to other counselors for you if you so desire. Files may be considered closed 2 months after our most recent session. Files are maintained for 7 years after termination and are then destroyed.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment your therapist recommends and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and your therapist will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. Your therapist will let you know if he or she feels that you are not a good fit or if you might obtain better help with someone else. Your therapist will always retain the right to terminate therapy with you. Some examples of when this may happen is in the event that he or she feels you would be better served with another therapist, for rude or abusive behavior, for a pattern of missed or cancelled appointments, if he or she feels you are not complying with treatment requests, or if payments due remain unpaid. In the event that your therapist terminates services with you he or she will offer you referrals.

Confidentiality

Laws protect the privacy of all communications between a client and a therapist. In most situations your therapist can only release information about your treatment to others if you sign a written authorization. There are some situations where they are permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, your therapist cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order your therapist to disclose information;
- If a government agency is requesting the information, your therapist may be required to provide it;
- If you file a complaint or lawsuit against your therapist, he or she may disclose relevant information about you as part of a defense to your charges;
- If you file a worker's compensation claim, your therapist may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which your therapist is legally obligated to take actions that he or she believes is necessary to attempt to protect others from harm, and in such cases they might have to reveal some information about your treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action, if they deem that to be appropriate under the circumstances, and will limit disclosure to what is necessary. For instance:

- If your therapist has reason to believe that a child, a developmentally or physically disabled, an elderly adult or for some types of licensees an animal, is being neglected or abused, the law may require them to report that information to the appropriate state or local agency;
- If your therapist believes you present a clear and substantial danger of harm to yourself and/or others, he or she may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that the practice may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time your therapist may have the need to consult with his or her practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). The practice attorney is bound by confidentiality rules also. In addition, your therapist will reveal only the information that he or she needs to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that your therapist may practice with other mental health professionals and that the practice may employ administrative staff or your therapist may need to consult with outside medical professionals. In addition, your therapist may need to coordinate your care with your other healthcare providers. In most cases, protected information may need to be shared with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance. If your therapist or the practice does that only the information necessary in order for them to provide help to you, the client, will be released. All of the mental health and medical professions are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Also, the practice may have a contract with a collection agency. If that is the case, the practice will have a formal contract with this business, in which the business promises to maintain the confidentiality of the data except where release of certain information is allowed in the contract or is required by law. Only limited information, just enough to collect the amount you owe, will be disclosed by the practice in this situation.

In addition, the practice may have a contract with a billing service or other third-party business tools. As required by HIPAA, the practice will have a formal business associate contract with these entities, in which they promise to maintain the confidentiality of this data except where release of the information is allowed in the contract or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with your therapist any questions or concerns that you have.

Legal Situations

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require your therapist's participation you will be expected to pay for all of their professional time, even if they are called to testify by another party. Your therapist will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts

will be refunded. Your therapist's professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that they wait in court prior to or after they may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, your therapist charges $150.00 per hour for these services including round trip travel. You will also be responsible for any legal fees that they may incur in connection with the legal proceeding, which may include responding to subpoenas.

Please be advised that as a treating therapist, your therapist cannot ethically provide any recommendations on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings.

Professional Records

The laws and standards of your therapist's profession require that your therapist keep Protected Health Information about you in your Clinical Record. Your Clinical Record may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that your therapist receives from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record if you request it in writing, unless your therapist determines for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law they may exercise the option of turning the records over to another mental health therapist designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, it is therefore recommended that you initially review them with your therapist or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, your therapist is allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so he or she will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, and if we store the information in an electronic format, your therapist will provide the information to you in an electronic format if you agree to accept the potential risks involved in sending the records that way.

Your therapist may also keep a set of psychotherapy notes which are for their own use and which are designed to assist them in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except in rare legal circumstances. Their release requires a separate

authorization in addition to one for the Clinical Record. Your therapist will discuss with you whether or not they are maintaining psychotherapy notes on you.

Fees, Payments, and Billing

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that your therapist's services are paid for. Meeting this responsibility shows your commitment and maturity.

Seasons current regular fees are as follows. You will be given advance notice if these fees should change. Regular therapy services are $350.00 for the first diagnostic session, with following sessions at $300.00 for each 45-60 minute session. You will be asked to provide a credit card on file and after any insurance payments are received by Seasons, your credit card will be charged for any amounts that you owe. Other payment or fee arrangements must be worked out before the end of the first session. Insurance reimbursement levels may be affected by insurance company agreements, so for clients choosing to use their insurance final costs will be in accordance with the agreements Seasons has with in-network insurance companies.

Telephone consultations: Your therapist believes that telephone consultations may be suitable or even needed at times in therapy. If so, he or she will charge you their regular fee, prorated for the time needed. If your therapist needs to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with your therapist in advance so you and they can set a policy that is comfortable for both of you. Of course, there is no charge for calls about appointments or similar business issues. Insurance companies will typically not provide reimbursement for telephone consultations.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes your therapist will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis. Insurance may not pay for the extended portion of a session.

Reports: Your therapist will not charge you for his or her time spent making routine reports to your insurance company, but will charge fees on a prorated basis for other types of written reports that you request.

If you think you may have trouble paying your bills on time, please discuss this with your therapist. Your therapist will also raise the matter with you so you can arrive at a solution. If your unpaid balance reaches $1,000.00, your therapist will notify you in writing. If it then remains unpaid, he or she may stop therapy with you if you and they cannot agree on a payment plan. Fees that continue unpaid after this may be turned over to small-claims

court or a collection service and you agree to allow the practice to do that. If you challenge a credit card fee, then you allow the practice to respond to the credit card company. If the practice chooses to do that, they will report only enough information to collect fees due to your therapist.

Because your therapist is a licensed mental health therapist, many health insurance plans will help you pay for therapy and other services he or she offers. Because health insurance is written by many different companies, your therapist cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of your therapist's fee, the practice will provide appropriate billing. However, please keep some things in mind: Your therapist had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. You are responsible for paying the fees that are agreed upon. If you ask the practice to bill a separated spouse, a relative, or an insurance company and payment is not received on time, then you agree to pay this amount. In addition, the plan may have rules, limits, and procedures that should be discussed, and your therapist may not be on one of their panels.

The practice will provide information about you to your insurance company with your consent, and by signing below you agree that it may do that. By signing this form, you agree to assign any reimbursement you receive from your insurance company to the practice.

If you choose to not have your therapist send information to your insurance company, you must select this option before each session and then pay for the session in full and it will not be done through Seasons, but may be handled with your individual therapist. With this option no report of any information will be made to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

Minors

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if your therapist feels that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that your therapist will have to turn them over to, unless otherwise required by federal law. Before giving your parents any information your therapist will discuss the matter with you,

if possible, and do their best to handle any objections you may have. Except in unusual circumstances, your therapist likes to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before your therapist sees a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see a therapist on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of your therapist's intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Emergencies and After-Hours Care

Your therapist may be reached at the phone number listed at the beginning of this form. He or she will make every effort to return messages within 24 hours; however, he or she may not always be able to do that. Current clients will be notified during sessions of upcoming travel or vacation plans. Your therapist does not provide emergency mental health services. If you have an emergency, you should go directly to a hospital emergency department or call 911. The National Suicide Prevention Lifeline number is 1-800-273-8255. Emergencies are urgent situations and require your immediate action. Netcare Access has a 24/7 emergency hotline for mental health issues in the Columbus area and it may be reached at: (614) 276-2273 (CARE).

Incapacity or Death of Therapist

In the event that your therapist is incapacitated or dies, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional or another person who will be under an agreement to maintain the confidentiality of the records whom your therapist or the practice designates to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice.

Disclosing Information to Family Members, Relatives, or Close Friends

_____ **Initial Here.** By initialing this section you agree to allow your therapist, if you are incapacitated, in an emergency situation, or are not available, to contact a family member, a relative, a close friend or any other person you identify, to disclose your personal health information that directly relates to that person's involvement in your healthcare. This information will be disclosed as necessary only if your therapist determines that it is your best interest based on his or her professional judgment.

Email, Texting, and Electronic Communications

The therapists and this practice do not like to use e-mail, texting, or electronic communications unless you and your therapist both agree that is appropriate. If you decide you want to utilize any form of electronic communication, you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks. If you wish to use unencrypted electronic communications, please place your initials in the space below:

_____ **Initial Here.** By initialing this section you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either your therapist and the practice to you or you to your therapist or the practice that involve scheduling and/or therapy. If you do not want your therapist or the office to contact you at a certain address or phone number, please let your therapist know at your first meeting with him or her.

Complaints or Concerns

Please bring any complaints or concerns directly to your therapist. Part of the therapeutic process is working through these types of concerns with your therapist. If you have concerns about your fit with your counselor, bring those up with them and they will address them or help you to seek alternative care options. If the complaint is not handled to your satisfaction, you can then also make a complaint with Dr. Andy Erkis at andy@seasonscounselingservices.com or with the Counselor, Social Worker, and Marriage and Family Therapist Board. They can be contacted at cswmft.info@cswb.state.oh.us or 614-728-7791 (this number is for complaints only). More information about the Board can be found online at http://www.cswmft.ohio.gov/.

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision your therapist has made about access to your records, you may contact your therapist, the State of OH Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist I will be seeing at the practice to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third party payer to obtain reimbursement, unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through a therapist at the practice at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor or a ward with a court approved guardian is the client I am signing on behalf of the minor or the ward as the authorized parent/guardian. (Information on minor rights will be shared with the minor, as appropriate.)

I also acknowledge that I have received a copy of the Notice of Privacy Practices for the practice listed at the top of this form.

Client Name(s) (please print) _____

_____

Client(s) Signature

_____ _____ Date

_____ _____ Date

Parent(s) or Guardian Signature (for minor child or children or disabled adults)

_____ _____ Date

_____ _____ Date

SEASONS
COUNSELING SERVICES

Eric Lichtenfeld, LISW
4242 Tuller Road Suite B-2 Dublin, OH 43017
614-706-2228 x 722

Date: _____
Client's Name:
_____ Date of Birth:_____ Relationship Status: _____
Gender: _____ Pronouns_____
Address:
_____
City/State_____ ZIP: _____
Email Address:
_____
Telephone Number(s)
Primary: _____ Cell Home Work OK to leave message? Y / N
Secondary: _____ Cell Home Work OK to leave message? Y / N

Parent/Guardian Name (for minor clients):
_____

Reasons for Seeking Counseling
_____
_____
_____
_____

Mental Health History
Have you ever been diagnosed with a mental health disorder Y / N / Unsure
If yes, what was the diagnosis?
_____

Please list any previous mental health services or counseling you received
_____ Time Period: _____

_____ Time Period: _____

_____ Time Period: _____

Was previous mental health treatment effective? Y / N

Please share any thoughts about experience: _____

_____

_____

_____

Are you feeling hopeless or that life is not worth living? Y / N

Are you having thoughts of harming yourself or others? Y / N

Have you ever attempted suicide? Y / N

Do you have access to weapons/firearms? Y / N

Medical History

Your physical health (check one): Excellent ____ Good ____ Average ____ Declining ____

Are you under the care of a physician? Y / N

Physician: _____ Phone: _____

Address: _____

Date of last medical exam: _____

Do you authorize Eric Dean Counseling & Consultation LLC to contact the physician listed above in order to share clinical information regarding your treatment and to receive clinical information from the physician that may be helpful for treatment? **Please initial**: _____ Yes _____ No

Please list all significant present or past medical challenges (illnesses, injuries, disabilities):

_____

_____

_____

_____

Please list all prescribed or OTC medications currently being taken:

Medication Purpose Dosage/day Date first prescribed

_____

_____

_____

_____

Alcohol and Other Substances (Current Usage)

Alcohol: Y / N If yes, how often? _____ Amount: _____

Other substance(s): Y / N, If yes, how often? ? _____ Amount: _____

Abuse History

I have never been abused _____ I have witnessed abuse _____ I have experienced abuse _____

Type of Abuse	Age(s)	Relationship to abuser	Witnessed or experienced?	Effects and Outcomes
Physical				
Sexual				
Emotional				
Neglect				
Other				

Family History

Relationship	Name	Age	Major Mental and/or Physical Health Challenges	Living or Deceased?
Mother				
Father				

Describe your parents' relationship: _____

_____

Describe your relationship with your parents/stepparents: _____

_____

_____

Your birth order(examples: "oldest", "3rd out of 5", etc.): _____

Any other family background information that could be relevant : _____

_____

_____

_____

_____

Describe relationship with current partner or spouse (if applicable): _____

_____

_____

_____

Children in Household/Family

Name	**Age**	**Sex / Gender**	**Relationship** (Biological parent, step-parent, adoptive parent, grandparent, etc.)

Please describe your relationship(s) with the child/children: _____

_____

_____

_____

Spirituality, Education, and Employment

Religious affiliation (if applicable):_____

Do wish to incorporate your faith in the counseling process? Y / N / Unsure

Check last year of education completed:

Grade school ____ High School ____ College ____ Graduate/Professional School ____

If employed, who is your employer? _____

Do you have military experience? Y / N If yes, please describe: _____

_____

_____

What hobbies/free time activities do you enjoy? _____

_____

_____

The information these and the following forms is correct to the best of my knowledge. I understand that it is my responsibility to inform my therapist of any significant changes to this information.

Client's Printed Name: _____

Client Signature (parent, if client is a minor): _____ Date: _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

SEASONS
COUNSELING SERVICES

Central Office Mailing Address:
130 Northwoods Blvd., Ste. A,
Columbus, OH 43235
Ph: (614) 706.2228

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We, the therapists independently contracted with Seasons Counseling Services, LLC, are part of an Organized Health Care Arrangement involving Seasons Counseling Services, LLC, and Ohio Health Group programs which are designed to provide effective and clinically integrated care. In connection with those programs, we may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under HIPAA, but we will obtain consent in another form for disclosing PHI for other reasons, including disclosing PHI outside of this practice or the Organized Health Care Arrangement, except as otherwise outlined in this Policy. In all instances we will only disclose the minimum necessary information in order to accomplish the intended purpose. To help clarify these terms, here are some definitions:

• "*PHI*" refers to information in your health record that could identify you.

• *"Treatment, Payment and Health Care Operations"*

– *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another therapist.

- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer, to Seasons Consulting Services, LLC or the Ohio Health Group to obtain reimbursement for your health care or to determine eligibility or coverage, which would include an audit.

- *Health Care Operations* are activities that relate to the performance and operation of our practice and participation in the Organized Health Group arrangement. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

• "*Use*" applies only to activities within our practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

• "*Disclosure*" applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information, including uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Examples of disclosures requiring an authorization include disclosures to your partner, your spouse, your children and your legal counsel. Any disclosure involving psychotherapy notes, if any of us maintain them, will require your signed authorization, unless we are otherwise allowed or required by law to release them. You may revoke an authorization for future disclosures, but this will not be effective for past disclosures which you have authorized.

III. Uses and Disclosures Requiring Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization as allowed by law, including under the following circumstances:

• **Serious Threat to Health or Safety:** If we believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person we may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to us an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and we believe you have the intent and ability to carry out the threat, then we may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). We will inform you about these notices and obtain your written consent, if we deem it appropriate under the circumstances.

- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to give your mental health information to relevant parties and officials.
- **Felony Reporting:** We may be required or allowed to report any felony that you report to us that has been or is being committed.
- **For Health Oversight Activities:** We may use and disclose PHI if a government agency is requesting the information for health oversight activities. Some examples could be audits, investigations, or licensure and disciplinary activities conducted by agencies required by law

to take specified actions to monitor health care providers, or reporting information to control disease, injury or disability.

- **For Specific Governmental Functions*:*** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, and for national security reasons, such as for protection of the President.
- **For Lawsuits and Other Legal Proceedings*:*** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order and at times an administrative subpoena, unless the information was prepared for a third party. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information. If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- **Abuse, Neglect, and Domestic Violence*:*** If we know or have reason to suspect that a child under 18 years of age or a developmentally disabled or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child or developmentally disabled individual under 21, the law requires that we file a report with the appropriate government agency, usually the County Children Services Agency. Once such a report is filed, we may be required to provide additional information. If we have reasonable cause to believe that a developmentally disabled adult, or an elderly adult in an independent living setting or in a nursing home is being abused, neglected, or exploited, the law requires that we report such belief to the appropriate governmental agency. Once such a report is filed, we may be required to provide additional information. If we know or have reasonable cause to believe that a patient or client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the patient's or client records.
- **To Coroners and Medical Examiners*:*** We may disclose PHI to coroners and medical examiners to assist in the identification of a deceased person and to determine a cause of death.
- **For Law Enforcement:** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Required by Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Other uses and disclosures will require your signed authorization.

IV. Patient's Rights and Our Duties Patient's Rights:

• ***Right to Request Restrictions and Disclosures***–You have the right to request restrictions on certain uses and disclosures of protected health information about you for treatment, payment or health

care operations. However, we are not required to agree to a restriction you request, except under certain limited circumstances, and will notify you if that is the case. One right that we may not deny is your right to request that no information be sent to your health care plan if payment in full is made for the health care service. If you select this option then you must request it ahead of time and payment must be received in full each time a service is going to be provided. We will then not send any information to the health care plan for that session unless we are required by law to release this information.

- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. If your request is reasonable, then we will honor it.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, except under some limited circumstances. If we maintain the information in an electronic format you may obtain it in that format. This does not apply to information created for use in a civil, criminal or administrative action or proceeding. We may charge you reasonable amounts for copies, mailing or associated supplies under most circumstances. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to your PHI, you may ask that our denial be reviewed.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request, but will note that you made the request. Upon your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – With certain exceptions, you generally have the right to receive an accounting of disclosures of PHI, not including disclosures for treatment, payment or health care operations, for paper records on file for the past six years and for an accounting of disclosures made involving electronic records, including disclosures for treatment, payment or health care operations, for a period of three years. On your request we will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Our Duties:

- We are required by law to maintain the privacy of PHI, to provide you with this notice of our legal duties and privacy practices with respect to PHI, and to abide by the terms of this notice.
- We reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all of the PHI we maintain.
- If we revise our policies and procedures, which we reserve the right to do, we will make available a copy of the revised notice to you on our website, if we maintain one, and one will always be available at our office. You can always request that a paper copy be sent to you by mail.
- In the event that we learn that there has been an impermissible use or disclosure of your unsecured PHI, unless there is a low risk that your unsecured PHI has been compromised, we will notify you of this breach.

V. Complaints and Effective Date

If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may file a complaint with us and we'll consider how best to resolve your complaint. Contact our Privacy Officer, listed below, if you wish to file a complaint with us. In the event that you aren't satisfied with our response to your complaint, or don't want to first file a complaint with us, then you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., 200 Independence Avenue S.W., Washington, D.C. 20201, Ph: 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/compliants/.

There will be no retaliation against you for filing a complaint. This notice is effective as of October 1, 2018.

VII. Privacy and Security Officer The Privacy and Security Officer for Seasons Counseling Services, LLC is Kimberly Burns. You may contact her if you have any questions about any Privacy or Security Policies or if you wish to file a complaint with the practice. Her contact information is at the beginning of this form.

ACKNOWLEDGEMENT OF RECEIPT OF SEASONS NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Season's Notice of Privacy Practices. I also acknowledge that I have had a chance to ask questions about it.

_____	_____	_____
Name of Client (Print)	Signature	Date

OR GUARDIAN/PERSONAL REPRESENTATIVE
(Has Legal Authority over Health Care of Resident)

_____	_____	_____
Name of Client (Print)	Signature	Date

_____

Provide description of legal authority (For example: Legal Guardian, Durable Power of Attorney for Health Care, or other legal authority)

Seasons Use Only
Reason acknowledgement was not obtained: (List date mailed to Guardian/Personal Representative and/or other attempts made to obtain signature)

_____

_____

Eric Lichtenfeld, LISW

4242 Tuller Road Suite B-2 Dublin, OH 43017

614-706-2228 x 722

TELEHEALTH/ELECTRONIC SERVICE DELIVERY INFORMED CONSENT

Electronic Service Delivery is defined as mental health therapy in any form offered or rendered primarily by electronic or technology assisted approaches when the mental health therapist and the client are not located in the same place during delivery of services. While working with your therapist you will always have the opportunity to ask any questions that you have about the therapy, electronic communications in general, and other issues involving your therapy. Your therapist will also assess your ability to handle computers and the internet, so that you and he or she may work in this way.

As a client receiving mental health services through electronic service delivery methods, you should understand:

1) This service is provided by technology (including but not limited to video, phone, text, and email) and may or may not involve direct, face to face, communication. There are benefits and limitations to these types of services. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information may not be direct, and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery. Your therapist will assess whether or not therapy through means of electronic service delivery is appropriate for addressing your issues and whether or not you have the knowledge and skills to use the technology involved.

2) As a therapist licensed in Ohio, your therapist may only deliver services to people located in Ohio, unless he or she obtains a license or is allowed to practice in the state where the person is located. If you plan on leaving Ohio for any length of time

in the future, please let your therapist know as soon as possible so that you and he or she can make proper arrangements for future work or referrals, as appropriate. If you are going to be out of state during therapy, then your therapist will have to comply with the licensing laws of the state where you will be located. You agree to provide the street address where you will be receiving services and agree to update it if it changes.

3) If a need for direct, face to face services arises, it is your responsibility to contact providers in your area, or to contact this office for a face to face appointment. You understand that an opening may not be immediately available.

4) You may decline any electronic service delivery service at any time without jeopardizing your access to future care, services, and benefits.

5) These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet or through other electronic services that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. Your therapist and you will regularly reassess the appropriateness of continuing to deliver services through the use of technology. When using these services you agree to accept the risks involved with the unencrypted exchange of information, if it is provided in that way.

6) Your therapist will need to verify your identity in a face to face meeting, which may be via video/audio electronically and then at subsequent sessions. At the initial session you and your therapist will address imposter concerns. You should be aware that misunderstandings are possible with telephone, text-based modalities (e.g., email), and real-time internet chat, since non-verbal cues are relatively lacking. Even with video chat software, since bandwidth may be limited and images may lack detail, misunderstandings may occur. Your therapist is an observer of human behavior. He or she will gather information from body language, vocal inflection, eye contact, and other non-verbal cues. Cultural differences and how they affect non-verbal cues may also be involved and your therapist will assess whether or not this type of therapy is appropriate for your cultural experiences, your environment and your therapeutic needs. If work is being done with families or groups with different levels of technology competence, power dynamics will be acknowledged. Please let your therapist know if you have any type of audio/visual or cognitive impairment prior to beginning therapy. If you have

never engaged in online counseling, you need to have patience with the process and request clarification if you believe that you are not being understood by your therapist or you do not understand something that your therapist says. He or she will regularly review whether or not electronic service delivery is meeting the goals of therapy. Your therapist will also discuss with you how to handle disruptions in services and all methods of delivering services that are compliant with commonly accepted standards of technology safety and security at the time at which services are rendered.

7) In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

a) In emergency situations: If it is an imminent situation that requires face-to-face contact call 911 or go to the nearest emergency room. If it can be managed over the phone, you can call your therapist but if your therapist does not respond immediately or within a short period of time, you should contact local emergency services (for example, call 911 or go to your local hospital's emergency room, or call the National Suicide Prevention Hotline number -1-800-273-8255.) Also, other local hotline crisis phone numbers may be available to call, and you can check on the internet to find those. Netcare Access in the Columbus area has a 24-hour mental health hotline service and it may be reached at (614) 276-2273 (CARE).

b) Should service be disrupted: Try to regain contact using the same medium. If that does not work, attempt to make contact using text or e-mail. Your therapist will also make every effort to regain contact. If service is disrupted during a therapy session before the pre-agreed time frame has ended, you will have the opportunity to use the remaining time as soon as contact is made. If contact is not re-established within one hour, you will have the choice to end the session and be charged a pro-rated amount or allowed to schedule an additional session to use the remaining time.

c) For other communications: Your therapist and you may agree to communicate via a phone call, videoconferencing, e-mail, text, fax, or mailed letters.

(8) The potential benefits of online counseling include flexibility in scheduling and allowing you to engage in counseling outside of the office, which eliminates issues like transportation and other psycho-social barriers that might make it difficult for you to handle in a traditional office setting. The provision of online counseling may

include risks related to the technology used, the distance between you and your therapist, and issues related to timeliness. For example, the potential risk of confidentiality may pertain to your accessing the internet from public locations. You should consider the visibility of your screen and being overheard when in public settings. It is recommended that you be in a private setting when engaging in online counseling. You should also always use strong passwords to protect any information shared with your therapist. Never use a work computer for therapy as your employer may have access to the information shared in electronic communications. Be cautious when using a shared network with others.

(9) Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than it is in person. You are responsible for confidentiality in your own environment, including securing your hardware, internet access points, chat software, email, and passwords. Please develop passwords that are appropriate and strong and not use auto-fill for user names or passwords. Although your therapist will take steps to protect your information, he or she will have policies in effect to notify you of a breach of any of your confidential information which is required to be reported to you.

(10) Your therapist may utilize alternative means of communication in the following circumstances: if you do not respond to text, your therapist may call. If you do not respond to a call, your therapist may follow up with text or e-mail. If you do not respond to a call, text, or e-mail, your therapist may follow up with a mailed letter. In case of emergency (or concerns over your welfare), your therapist may contact your emergency contact if you have provided one.

(11) Your therapist will attempt to respond to communications and routine messages within 48 hours if he or she is available.

(12) Insurance Providers that are involved with the Organized Health Care Arrangement with Ohio Health Group and Seasons Counseling Services do reimburse for telehealth sessions in most situations. If insurance does not cover reimbursement, then you agree to pay the fee for the service.

(13) You need to take the following precautions to ensure that your communications are directed only to your therapist or other individuals: Ensure that you use the correct e-mail address, telephone number, Zoom or other online link or online name, fax number, and physical address to contact the appropriate

individuals. Only leave voice messages after ensuring that the correct phone number was dialed and the voicemail introduction identifies the correct individual.

(14) Your communications exchanged with your therapist, if capable of being put into written form, will be stored in the following manner: e-mails, texts, and other electronic communication relevant to treatment will be printed and kept in your file. Mailed letters and documents will also be kept in your file. Notes outlining electronic service delivery treatment sessions will be written and kept in your file. Your file will be kept in a locked file cabinet or stored electronically and will be accessible only by those who require or are allowed access and will be available to you or someone named by you for the length of time required under Ohio law. Your therapist will not record sessions without first discussing it with you and obtaining your permission to do that. Please see your therapists regular Informed Consent form for information on access to your records, including who will have access to them.

(15) The laws, ethics and professional standards that apply to in-person therapeutic services also apply to services delivered by electronic means. This document does not replace other agreements, contracts, or documentation of informed consent covering other issues. If you want licensing information on your therapist, you can find it at one of the licensing board websites. Psychology Board statutes, rules and other helpful information may be found at www.psychology.ohio.gov, the Counselor, Social Worker & Marriage and Family Therapist Board's website may be found at www.cswmft.ohio.gov, the Chemical Dependency Professionals Board's website may be found at www.ocdp.ohio.gov, and the Ohio State Medical Board's website may be found at www.med.ohio.gov.

Acknowledgment of Informed Consent to Treatment via Electronic Service Delivery Means

You voluntarily agree to receive mental health assessment, care, treatment, or services and authorize your therapist to provide such care, treatment or services as are considered necessary and advisable via electronic service delivery means.

By signing this Electronic Service Delivery Informed Consent, you, the undersigned client, acknowledge that you have both read and understood all the terms and information contained herein and you agree to be bound by the provisions in this agreement. Ample opportunity has been offered to you

to ask questions and seek clarification of anything unclear to you. If a minor is the client, you are signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor)

You also acknowledge that you have received a copy of the regular Informed Consent and Notice of Privacy Practices for the practice listed at the top of this form.

Client Name(s) (please print)

_____

_____

Client(s) Signature(s)

_____ _____ Date

_____ _____ Date

Parent(s) or Guardian Signature (for minor child or children or disabled adults)

_____

Client Printed Name

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Other Parent Date

SEASONS
COUNSELING SERVICES

Eric Lichtenfeld, LISW | 4242 Tuller Road Suite B-2 Dublin, OH 43017 | 614-706-2228 x 722

STANDARD AUTHORIZATION FORM

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis or treatment of HIV/AIDS, psychiatric and/ or drug/alcohol treatment, and/or sexual assault.*

AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I

First Name *	M . I.	Last Name*	Date of Birth *	Social Securitv Number

Address	Citv	State	Zip Code

I hereby authorize the disclosure □ or exchange □ of health information about the above individual as follows (check one)

Section II

Disclosing Entity* *(Covered Entity such as a health plan/insurer or provider)*

Address	Telephone Number

Citv	State	Zip Code

Recipient (Person or Entity) *

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*

Section III

Reason for Disclosure*

Health information to be disclosed*

Specify time period, ifdesired:
Release only information from the period_____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below . I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entit y, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will

Expiration Date or Event

- I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and

Signature of Individual *	Date * *(mm/dd/vwv)*
Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*

□ Parent □ Legal Guardian □ Healthcare Power of Attorney □ Executor /Administrator □ 0ther □ N/A

For administrative use only:

Method of Delivery (e.g. paper,fax, electronic,) Date Released ___

SEASONS
COUNSELING SERVICES

Eric Lichtenfeld, LISW | 4242 Tuller Road Suite B-2 Dublin, OH 43017 | 614-706-2228 x 722

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Address	Telephone Number

Citv	State	Zip Code

Recipient (Person or Entity) *

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*

Section III

Reason for Disclosure*

Health information to be disclosed*

Specify time period, ifdesired:
Release only information from the period_____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

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- I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and

Signature of Individual *	Date * *(mm/dd/vwv)*
Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*

□ Parent □ Legal Guardian □ Healthcare Power of Attorney □ Executor /Administrator □ 0ther □ N/A

For administrative use only:

Method of Delivery (e.g. paper,fax, electronic,) Date Released ___