Hope Restored
COUNSELING SERVICES LLC

600 W. Loveland Ave., Ste. 2A | Loveland, OH 45140 | Phone: 513.683.HOPE (4673) | Fax: 513.683.4108

General Information

Patient Information: Date:_____

Patient Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

Home Phone: ( )_____ Cell: ( )_____
Which is the best number to Call: [ ] Home [ ] Cell
Where May We Leave a Message: [ ] Home [ ] Cell
Preferred Contact Method: [ ] Home [ ] Cell [ ] Email

Patient Social Security #: _____ Date of Birth: _____-_____-_____

Gender: [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] NA (children)

Employment Status: [ ] Employed [ ] Student [ ] Unemployed [ ] Retired

Primary Care Physician:_____ Phone: ( )_____

Subscriber's Information:
If the insurance you are using is provided to you through a family member you must complete the following for us to bill the insurance on your behalf.

Subscriber's Name:_____

Subscriber's Social Security #:_____ **Date of Birth:**_____-_____-_____

Subscriber's place of employment:_____

If different from above
Address:_____

City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Employer: _____

In Case of Emergency, Contact:

Name:_____ Relationship:_____

Phone: ( )_____

Who referred you to our practice? _____

Are you seeking counseling related to a court order or legal proceedings? [ ] Yes [ ] No

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Informed Consent for Receipt of Counseling Services (Adult)

This form is to document that I, _____ give voluntary permission and consent to receive counseling from Hope Restored Counseling Services. My signature also verifies my right to give such permission.

Purpose and Background:
The purposes, goals and treatment procedures of the counseling to be provided have been explained to me. I understand that my therapist is licensed in the state of Ohio to provide counseling and/or counseling. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise. While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Hope Restored Counseling Services. Potential benefits, risks and limitations of counseling have been explained to me as well as alternative procedures or interventions if they exist.

Confidentiality:
I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena (ordered by a judge or magistrate) and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

Legal Proceedings:
I understand that it is the policy of Hope Restored Counseling Services to avoid being involved in legal proceedings, if at all possible, in order to protect the therapeutic relationship and maintain confidentiality. In addition, the Ohio Revised Code (457-6-01) is specific in regards to custody court cases as it states that a treating clinician is prohibited from making any recommendations regarding custody or visitation if requested to do so by a client (parent) or attorney.

HIPPA:
I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Hope Restored Counseling Services' "Notice of Privacy Practices", that were effective of as their start of business in June, 2008. I acknowledge I was offered this policy statement on the date indicated by my signature below.

Contact Information:
The office address for Hope Restored Counseling Services is: 600 W. Loveland Ave., Suite 2A, Loveland, OH 45140. I understand that for routine appointments and information I may call (513)683-4673. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible. I understand that if I have a mental health emergency, I need to call 911 or go to the nearest emergency room.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.
I release and hold harmless Hope Restored Counseling Services, and its staff and agents from any action or liability arising out of my participation in treatment.

_____ _____
Signature of client/responsible party Date

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Consent To Bill Third Party Payer

Use of Insurance:
As a part of receiving counseling through Hope Restored Counseling Services, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will definitely mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and at times may constitute the release of treatment planning information.

Charges for Services:

Diagnostic Assessment	$140
Court Related Fee	$500 (for first 4 hours or less, $500 for next 4 hours or less)
Psychotherapy Session (45-50 min)	$125
Case Management (per 15 minute)	$35
Missed Appointment/Late Cancellation	$70
Phone Calls (lasting more than 15 minutes	$25 for over 15 minutes, $50 for 30 minutes, etc.
Education/Support Group	$40 per hour
Copies of Records	$3.07/page for first 10 pages, $.64/page for pages 11-50
Letters/Reports	$30 per page

Payment:
I understand that payment is expected at time of service. If I wish to pay for services out of pocket, or for the purposes of making my co-payment, should I elect to use my insurance, I may make payments via cash or check. I understand all checks returned unpaid will be subject to a $25.00 service fee. Any and all balances unpaid for more than 3 months may be turned over to a collection agency for the purpose of recovering lost funds and you will be responsible for your balance plus an additional **30% collection fee.**

Use of Insurance and Authorization for Treatment:
If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits. I understand I will be charged $70.00 for missed or cancelled appointments unless prior notification is given 24 hours prior to the time of the appointment, I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.

I, _____,

☐ wish to use my medical insurance to offset the cost of treatment, and in so doing give Hope Restored Counseling Services permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

☐ do not wish to use any medical insurance benefit to cover services I receive through Hope Restored Counseling Services. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service.

_____ _____
Signature of Client/Responsible Party Date

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Missed Appointment Policy

I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of **$70 per missed appointment**. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice. **In addition, if I miss more than two appointments in a 6 week period, a subsequent appointment time cannot be guaranteed**.

_____ _____

Signature of client/Responsible Party Date

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Credit Card Authorization on File

Please complete this form if you would like **Hope Restored Counseling Services** to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment. Information to be completed by the cardholder:

Client's Name: _____
Card Number: _____
Cardholder Name: _____
Card Type (please circle): Visa MasterCard Discover AmExpress
Expiration Date: _____
Security Code: (3 digit code on back) _____
Billing Zip Code: _____
Email: _____

I, _____, authorize **Hope Restored Counseling Services** to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature: _____ Date: _____

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Adult Intake

Name: _____ Date: _____

Date of Birth: _____ Age: _____

1. Why have you come to Hope Restored Counseling Services (Presenting issue for Client)?

_____

_____

_____

2. How long has this been an issue? _____

3. What have you tried to do to resolve this issue?

_____

_____

4. What are your goals for counseling?

_____

_____

5. Previous Treatment History (Please include outpatient counseling or services, hospitalization or emergency room visits for mental health issues, alcohol problems, and chemical dependency/use):

_____

_____

_____

6. Has any other member of your family (including extended family) been diagnosed or had significant problems with mental health issues and/or alcohol use or chemical dependency? Please explain:

_____

_____

_____

7. Who resides with you in your home?

Name and Relationship:	Age:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

8. Medical History:

Health (describe your general health as well as any chronic conditions including pain)

_____

_____

9. Who is your primary care physician? _____

When was your last complete physical exam by an M.D.? _____

Are you currently under the care of an M.D. for any condition? Yes ____ No ____

If yes, please explain: _____

_____

Please list all current medications including over-the-counter and prescription medications:

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please prior medication for mental health issues, chemical dependency or alcohol use:

Name of Medication:	Dosage:	Date Started:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Please check any of the following that apply:

[ ] Significant weight gain/loss in the last six months
[ ] Dieting
[ ] Food/drug allergies
[ ] Overeating or eating too little
[ ] Problems chewing or swallowing

If any box is checked, please explain:

_____

_____

_____

11. Do you have any functional limitations that affect your daily living (ex: physical impairments, problems with self care, speech, vision, or hearing)? Yes_____ No_____

If yes, please explain: _____

_____

12. Legal History:

Please write an **"N"** for none, **"C"** for currently experiencing, or **"P"** for experienced in the past.

DUI _____ Bankruptcy _____ Divorce _____

Unemployment _____ Domestic Violence _____ Custody Dispute _____

Disability Claim _____ Workman's Compensation _____

13. Financial Problems: _____

14. Educational Background (highest grade completed): _____

15. Employment History (Please describe current job briefly):

_____

_____

16. Military Service: _____

17. History of Abuse:

Please place an **"N"** for none, **"C"** for currently experiencing, or **"P"** for experienced in the past.

Verbal Abuse _____ Emotional Abuse _____ Childhood Abuse _____

Physical Abuse _____ Spouse Abuse _____

Sexual Abuse _____ Elder Abuse _____

18. Alcohol and Drug Use:

Do you drink alcohol? Yes____ No_____ If yes, how often?_____

When was the last time you had a drink? _____

How much did you drink at that time? _____

Do you have any history of using or abusing drugs/medications? Yes____ No____

Do you currently abuse any drugs/medications? Yes____ No____

What substances have you used in the last 6 months? (check all that apply)

[ ] Marijuana/ "Pot" [ ] Cocaine [ ] Inhalants/ "Huffing"

[ ] LSD/ "Acid" [ ] Amphetamines/ "Speed" [ ] Other

[ ] Pain Killers [ ] Sedatives/ "Downers" [ ] None of Above

If "Other" is checked, explain below:

_____

_____

_____

Check any of the following that has occurred as a result of your drinking or drug use:

[ ] Arrest [ ] DUI [ ] Family Problems

[ ] Public Intoxication [ ] Financial Problems [ ] Arguments

[ ] Work Problems [ ] Health Problems [ ] Relationship Problems

Do you use Nicotine? Yes [ ] No [ ] Amount? _____

Do you use Caffeine? Yes [ ] No [ ] Amount? _____

19. Sexual/Affectionate History:

Are you satisfied with your sex life? Yes_____ No_____

Do you have any concerns or question about your sexual orientation or experiences? (If so, please explain)

_____

_____

20. Religious/Spiritual History:

Do you have an identified religious preference?

_____

21. History of Harm to Self or Others:

Do you currently have any urges/thoughts of hurting yourself?	Yes_____	No_____
Any current urges/thoughts of hurting another?	Yes_____	No_____
Any history of hurting self or suicide attempt?	Yes_____	No_____
Any history of physical aggression toward another?	Yes_____	No_____

If yes on any of these questions, please describe in the space below:

_____

_____

_____

_____

_____