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:_____

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

Gender: [ ] Male [ ] Female

Primary Care Physician: _____ Phone: ( )_____

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

Mom's Name: _____ Social Security No.: _____

Dad's Name: _____ Social Security No.: _____

Parent/Guardian Email Address: _____

Home Phone: ( )_____ Cell: ( )_____

(Mom)Cell: ( )_____ (Dad) Cell: ( )_____

Preferred Contact Method: [ ] Home [ ] Cell, Mom/Dad [ ] Email
Which is the best number to Call: [ ] Home [ ] Cell, Mom/Dad
Where May We Leave a Message: [ ] Home [ ] Cell, Mom/ Dad

If Separated or Divorced or Other, Custody Status:
[ ] Birth Parents [ ] Mother Only [ ] Father Only [ ] Separated/Divorced – Shared Parenting*
[ ] Adopted: Age at Adoption _____ [ ] Ward of the Court [ ] Other Relative, Specify: _____

*If Parents are separated, divorced, or never married, what is the frequency of contact between non-custodial parent and your child/adolescent and their name, address and phone number:

Frequency: _____

Name & Address: _____

_____

Best Number to Call: ( )_____

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: _____

Permission to Treat a Minor:

I _____ (Print Parent's or Guardian's Name) give permission to Hope Restored Counseling Services, LLC to provide mental health services to _____ (Print Minor Client's Name). I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment.

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date

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 (Child)

This form is to document that I, _____ give voluntary permission and consent for my child to receive counseling from Hope Restored Counseling Services (HRCS). My signature also verifies my right to give such permission. * **I will provide HRCS with custody paperwork indicating my right to authorize treatment.**

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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Special Contract for Parents who are Separated, Pending Separation, Divorced or Engaged in Litigation

Child's name: _____ Date of Birth: _____

When a family is challenged with parental separation or divorce, it is very difficult for everyone, especially children. When the parental relationship is conflictual, it is even more important that therapy presents an emotionally safe environment. Our practice wishes to be clear about our position when parents are separated or divorced. We need your agreement that our involvement will be strictly limited to therapy or assessments that will benefit your child. Also, please be aware that a financial agreement for payment must be agreed upon by both parties at the beginning of our services.

If the clinician is asked to participate in any litigation, the clinician's neutral role with the family may be compromised. This is likely to jeopardize progress that may have been made in therapy, to hinder the likelihood of further progress and to possibly prevent the client's willingness to seek help from a clinician in the future

To be clear, we do not provide forensic or custody evaluations. The Ohio Revised Code 4757-6-01 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.

By signing this agreement, I am stating that I understand that the services at Hope Restored Counseling Services for my child are intended solely to provide treatment to address his or her psychological or emotional needs. I also understand and agree not to request information, including clinical session notes, for court or subpoena from the treating clinician for any issues related to custody or visitation.

_____ _____
Signature of Parent Date

_____
Printed Name of Parent

_____ _____
Signature of Parent Date

_____
Printed Name of Parent

_____ _____
Signature of Witness Date

_____
Printed Name of Witness

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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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Child Intake

Date of Birth: _____ Preferred Name: _____ 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. Who is primarily responsible for the care of your child? List all that apply.

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Who resides with you in your home?

Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. What are the most common disciplinary techniques used in the household? (Verbal reprimands, yelling, ignoring, grounding, removal of privileges, spanking, etc…)

_____

_____

_____

9. Are disciplinary techniques used consistently and with good follow-through?

☐ No ☐ Yes

10. Are current disciplinary techniques effective at controlling undesirable behaviors?

☐ No ☐ Yes

11. Does your child respond to one parent or care-taker's disciplinary measures better than another?

☐ No ☐ Yes: If yes, who _____

12. Has your child experienced any of the following?

□ Parental Divorce	□ Death of Parent	□ Parental Alcoholism
□ Domestic Violence	□ Death of Family Member	□ Parental Drug Abuse
□ Sexual Abuse	□ Death of Grandparent	□ Parental Separation
□ Physical Abuse	□ Death of Close Friend	□ Prolonged Marital Discourse
□ Verbal Abuse		□ Family Bankruptcy

13. Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism/

☐ No ☐ Yes: If yes please provide further details:

_____

_____

_____

14. Was your child born premature?

☐ No ☐ Yes If Yes, how premature? _____

15. Birth Weight: _____ lbs. _____ oz.

16. Approximate age when your child first began:

_____ Walking _____ Talking _____ Toileting

Medical History

17. Does your child have any immediate health problems (colds, injuries)?

☐ No ☐ Yes (If yes, please explain)

_____

_____

18. Does your child have any chronic (long term) health problems (asthma, seizures, allergies, etc.)?

☐ No ☐ Yes (If yes, please explain)

_____

_____

19. Has your child ever sustained any serious head injuries (unconscious, auto accident, fight, etc.)?

☐ No ☐ Yes (If yes, please explain)

_____

_____

20. Does your child have any developmental disorders (mental retardation, learning disabilities, hearing disabilities, speech problems, etc.)?

☐ No ☐ Yes (If yes, please explain)

_____

_____

21. Is your child currently under the care of a physician?

☐ No ☐ Yes: If yes, by whom and for what conditions?

Doctors Name: _____ Phone: ( )_____

Conditions being treated:

_____

_____

_____

22. Is your child currently on any medication?

☐ No ☐ Yes

Medication	Dosage	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

23. Please list all previous mental health medications:

Medication	Dosage	Date Started	Date Stopped

24. Please rate the nutritional value of your child's diet: ☐ Good ☐ Fair ☐ Poor

If fair or poor, please explain: _____

_____

Check any of the following that apply:

☐ Significant weight gain/loss in lat 6 months ☐ Problems chewing or swallowing
☐ Food/drug allergies ☐ Dieting
☐ Overeating or eating too little
If any box is checked please explain: _____

25. Has your child had a recent vision check?

☐ No ☐ Yes: If yes, describe results: _____

26. Has your child had a recent hearing exam?

☐ No ☐ Yes: If yes, describe results: _____

Educational History

27. What grade is your child currently in? _____

28. Where does your child attend school? _____

29. Circle any grade(s) failed: K 1 2 3 4 5 6 7 8 9 10 11 12 None

30. Circle any grades skipped: K 1 2 3 4 5 6 7 8 9 10 11 12 None

31. What grades does your child normally get in school? (Circle all that apply)

A B C D F

32. Have there been any tendencies toward improving or deteriorating school performance over the years?

☐ No ☐ Yes: If yes please provide further details.

_____

_____

33. What are your child's strongest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

34. What are your child's weakest subjects in school? (Circle all that apply)

Math History English Reading Spelling Science Social Studies N/A

35. Has your child ever been:

Reprimanded at school:	☐ No	☐ Yes
Served detention:	☐ No	☐ Yes
Been suspended:	☐ No	☐ Yes
Been expelled:	☐ No	☐ Yes

If yes to any, please explain: _____

_____

36. Has the school ever performed psychological or educational testing on your child?

☐ No ☐ Yes

If yes, describe results: _____

_____

Social Development

37. Does your child have many friends?

☐ No ☐ Yes

38. Does your child make friends easily?

☐ No ☐ Yes

39. What are the most common activities that your child engages in? (bike riding, playing with friends, TV, etc.)

_____

_____

_____

Behavioral Assessment

40. Has your child ever been in trouble with the law?

☐ No ☐ Yes: If yes, please explain:

_____

_____

_____

41. To your knowledge, does your child use tobacco?

☐ No ☐ Yes

42. To your knowledge, does your child drink alcohol?

☐ No ☐ Yes: If yes, how often, how much and for how long?

_____

When was the last time? _____ How many drinks? _____

43. What problems has your child suffered as a result of his/her drinking?

□ Arrest □ DUI □ Peer problems
□ Public intoxication □ Financial problems □ Arguments
□ None of the above

44. To your knowledge, has your child ever tried drugs?

□ No □ Yes: If yes, what drug/s? _____

45. To your knowledge, does your child regularly us any drugs?

□ No □ Yes: If yes, how often, how much and for how long?

_____

_____

When was the last use? _____ What drug/s was used? _____

46. To your knowledge, is your child sexually active?

□ No □ Yes

47. Does your child have concerns about his/her sexual orientation or sexual experiences?

□ No □ Yes: If yes, please elaborate:

_____

_____

48. Is your child pregnant or the parent of a child?

□ No □ Yes

49. Who has legal custody of your child?

□ Both parents □ Mother only □ Father only □ Other guardian

If other guardian, please indicate name: _____

50. <u>History of Harm to Self or Others</u>:

Do your child currently have any urges/thoughts of hurting him/herself? 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:

_____

_____

_____

_____

_____