Hope Restored
COUNSELING SERVICES LLC

600 W. Loveland Ave., Suite 2A
Loveland, OH 45140
Phone: (513)683-HOPE
Fax: (513)683-4108

General Information

Patient Information: Date:_____

Patient Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:(_____)_____-_____ Other Phone:(_____)_____-_____
May We Leave a Message [ ] YES [ ] NO May We Leave a Message [ ] YES [ ] NO

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

Email Address – If Minor, Parent/Guardian: _____

Gender: [ ] Male [ ] Female

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

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

Primary Care Physician:_____ Phone:_____

Insured'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.

Insured's Name: _____

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

Insured's place of employment: _____

If different from above:
Address:_____

City:_____ State:_____ Zip:_____

Home Phone:(_____)_____-_____ Employer: _____

In Case of Emergency, Contact:

Name:_____ Relationship:_____

Phone:_____

Insurance Authorization Number: _____ (If known)

Who referred you to our practice? _____ May we thank them: [ ] Yes [ ] No

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 psychological services 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 psychological services 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 psychological services. 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 psychological services 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

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 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.

For group therapy purposes, information related to other clients will not be shared with parents/guardians who are not the parents/guardians of the individual client. If information is learned about other clients during the course of the group therapy services it should not be shared with others, specifically other parents/guardians of group members, others connected to Hope Restored Counseling, and other who are not connected to Hope Restored Counseling.

By signing below, you are acknowledging and agreeing to the confidentiality policy.

_____ _____

Parent/Guardian Signature Date

_____ _____

Therapist/Witness Signature Date

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TREATMENT OF MINORS AUTHORIZATION FORM

I, _____, authorize that I am the guardian or parent of _____, seeking counseling services by _____, the therapist at Hope Restored Counseling Services. LLC located in Loveland, Ohio

_____ _____
Parent/Guardian Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Signature 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 card holder:

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: _____