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: ____________

Patient Social Security #: ______________ Date of Birth: _____-_____-_____
Gender Assigned at Birth: [ ] Male [ ] Female

Primary Care Physician: ____________________ Phone: ____________

Parents' Marital Status: [ ] Married [ ] Single [ ] Divorced
[ ] Separated [ ] Widowed [ ] NA (children)
Mom's Name: ____________________
Dad's Name: ____________________
Parents/Guardians' Email address: ______________________________
Home Phone: ( )__________________ Cell: ( )______________ (Mom)
Cell: ( )______________ (Dad)
Which is the best number to Call: [ ] Home [ ] Cell, Mom/Dad
Where May We Leave a Message: [ ] Home [ ] Cell, Mom/ Dad
Preferred Contact: [ ] Home [ ] Cell, Mom/Dad Email [ ]

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: ____________________

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

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

_______________________________________ _______________________________

Client Signature (if age 13 or older) Date

_______________________________________ _______________________________

Therapist Signature Date

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.**

<u>Purpose and Background</u>:
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.

<u>Confidentiality</u>:
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.

<u>Legal Proceedings</u>:
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.

<u>HIPPA</u>:
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.

<u>Contact Information</u>:
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

Consent To Bill Third Party Payer

Use of Insurance:
As a part of receiving psychological services 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:

Court Related Fee	$500.00 (for first 4 hrs or less, $500 for next 4 hrs or less)
Psychotherapy Session (45-50 min)	$175.00
Case Management (per 15 minute)	$ 35.00
Missed Appointment/Late Cancellation	$ 80.00
Phone Calls -lasting more than 15 mins	$ 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	$ 30.00 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.

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 $80.00 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 off-set 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

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 **$80 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 an 8 week period, a subsequent appointment time cannot be guaranteed**.

______________________________________ ________________________

Signature of client/responsible party Date

Hope Restored Counseling Services LLC

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

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: ________________________________Date:__________

CHILD INTAKE

Date of Birth:______________ Age:____________ Name: ______________________________

General

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

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

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

____

____

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?

☐ No ☐ Yes

____

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

☐ No ☐ Yes

____

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

☐ No ☐ Yes

____

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

☐ No ☐ Yes

____

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 Music/Art

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

Math History English Reading Spelling Science Social Studies Music/Art

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/OVI ☐ 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

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: ____