Clinician-Patient Consent to Treat and Financial Responsibility

Please read and *sign two copies*. Keep one for your records

Integrative Counseling Solutions, LLC is a business facility where a number of mental health professionals practice along with their supervisors. **Your contract for services is with your therapist and Integrative Counseling Solutions, LLC. Due to licensing requirements, your clinician may need to seek supervision or collaboration with other clinicians and scheduling staff. No identifiable information is released outside of this practice unless directly related to billing/insurance purposes. An additional consent to share information is required and may be requested should you want your clinician to share information with a 3rd party.**

WELCOME

Welcome to Integrative Counseling Solutions, LLC. We are happy you have decided to begin services with us and hope that we can answer any questions you may have. Let us know how we can help.

Ohio Counseling Law requires us to provide you with the following information regarding your rights, responsibilities and the limits of confidentiality. If you have any questions, feel free to discuss them Crystal A. Hubbell, LPCC-S; Ohio E. 1100061 (513-770-1705).

Rights and Risks:

- You may ask questions about any aspect of the counseling process.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.
- Therapy may include talking about emotionally provoking subjects and scenarios.

Confidentiality:

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- I am required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others.
- The court may subpoena counseling records.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.
- You may want to discuss further limits or exceptions of confidentiality.

Appointments:

- All office visits are by appointment and may be scheduled through the office manager or your counselor directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 53 minutes. Some insurance Co allow for only 45min slots.
- Late cancellation (less than 24 hours before) *and/or* no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get voice mail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations (see charges next page)

Privacy:

- Privacy cannot be guaranteed for correspondence via text or email. For our safety, security cameras are active in our office lobby/hallways as well as the entrances and common areas of the building.

Fees:

- The client portion (co-pay) of fees is expected at the time of service.
- Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires preauthorization to receive services, it is your responsibility and needs to be handled prior to your first visit.
- Insured clients are expected to take care of their fees as services are rendered. Our office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for

negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account. ***Failure to pay your part may jeopardize your benefits. Copays are not negotiable.***

- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Accounts become delinquent after thirty (30) days. ***Accounts 90 days in arrears will be terminated***.
- Any change in my financial situation I will discuss with my therapist. In the event you find it necessary to change mental health providers and require records to be sent from **Integrative Counseling Solutions, LLC** your account will need to be paid in full.

I have read, understand and agree to the above policies. I have been offered a copy of these policies to take with me if desired. I hereby authorize **Integrative Counseling Solutions, LLC** and my therapist to release any information acquired in the course of my therapy to my insurance company (if client is a minor, parent or guardian sign**). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred.** I understand that a re-billing fee/financial charge complying with Ohio State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I have read and/or received a copy of this consent.

If your insurance does not pay, you are responsible for the following prices.

Initial Intake Interview $145.00

Session Fee (53min) $125.00

Non or Late Cancellation $85.00

Bounced Check Fee $45.00

Telephonic service $40 per 15 min (not covered by insurance) Payment due before calls.

Letters, emails and reports are charged at $2.50 per minute. Payment due before next scheduled session

Your signature below serves as acknowledgment of receipt of Consent to treat**.**

Some of our therapist are supervised and while your information is still protected (names are not used) these supervisors help advise, direct and work closely with these clinicians to give you the best care possible.

____ **Sam Golden**	____ **Ashley Kilgore**	**Melanie Palmer IMFT-S**
____ **Kelli Knipper**	____ **Cassie Varady**	**Crystal Hubbell, LPCC-S**
____ **Kelli Davis**	____ **Lynsey Gleim**	**Brian Davis, LPCC-S**
____ **Dylan Swearingen**	____ **Kate Reichman**	
____ **Mary Gibson**		

Print Client Name(s): _____ **Date**:_____

Legal Guardian Signature: _____ **Date**:_____

Therapist Signature: _____ **Date**:_____

Emergencies:

The **best phone number** for all offices is **513-770-1705**. If you receive the voice mail, please leave a message for your personal counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation, and your therapist cannot be reached you may **call the 24-hour Mental Health Crisis Line: tel: 1-800-273-8255, *or* go immediately to your local hospital emergency room.**

Integrative Counseling Solutions

Permission to Send Email

It may occasionally be useful or necessary to send you information by email. It is your right to be informed about the risks of communicating by email that will be used to disclose provider/client information.

Email messages sent to you are <u>not guaranteed</u> to be secure, HIPAA compliant, encrypted, private, or confidential.

If there is an emergency or urgent situation, call 911 or go to the nearest emergency room for treatment.

If you believe that this would compromise your privacy or safety, you have the right to deny permission and request an alternate form of communication, such as phone contact. If your circumstances change, you can revoke permission to receive email at any time.

You acknowledge and understand the importance of this permission form and accept full responsibility for information communicated through email.

You agree that Integrative Counseling Solutions LLC and individuals associated with the office not responsible from any, and all claims and liabilities arising from the information through email.

Permission for the staff of Integrative Counseling Solutions, LLC to send written communication to my ***Email***. I understand that I may withdraw this permission at any time and will need to sign a new permission form at that time to update file.

Circle one: Approve / Deny

_____ _____
Signature Date

Print Name: _____

Email: _____

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Child Intake Form

Please provide the following information about your child:

Childs Full Name:_____

Nick Name:_____

Birth Date: _____ Today's Date _____

Address_____

City_____ State_____ Zip_____

Insurance Name_____

Insurance ID:_____ Group No._____

Parent or Guardian Name_____

Address_____

City_____State_____Zip_____

Home phone_____Cell phone_____

Email_____

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he /she do that other people like?

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Please provide the following information about your child:

Family History:
The name of the child's biological parents:

Mother:_____ Father:_____

Who has legal guardianship of your child?

Who does your child currently live with?

Names	**Ages**	**Relationship to child**

Who are your child's significant others NOT living with your child?

Names	**Ages**	**Relationship to child**

Please describe any past counseling that either your child or any family member has had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _____ If yes, Please describe:

Education History:
What school does your child attend?

Address:

Phone:_____ Teachers Name:_____

Current Grade:_____

What does your child's teacher say about him/her?

Other schools attended (including Pre-school)

Has your child ever repeated a grade? If so which one(s)

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

Fighting	lack of friends	drug/alcohol	detention
Suspension	learning disabilities	poor attendance	poor grades
Gang influence	incomplete homework	behavior problems	

Medical History:

What is the name of your child's medical doctor?_____

Address: _____ Phone:_____

Date of your child's last medical examination:_____

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, Please describe them:

Has your child experienced any of the following medical problems?

A serious accident Hospitalization Surgery Asthma

A head injury High fever Convulsions/seizures

Eye/ear problems Meningitis Hearing problems

Allergies Loss of consciousness Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?