

A Sound Mind Counseling Service, LLC

**203 East Galbraith Road
Cincinnati, OH 45216**

**8050 Beckett Center Drive, Ste 120
West Chester, OH 45069**

Phone (513) 948-0023 Fax (513) 948-0087

Date _____

Patients Name _____
Last First Middle Age Date of Birth

Address _____ Home Phone (____) _____
#Street City State Zip Code

_____ Work Phone (____) _____ EXT _____
Place of Employment

Cell Phone (____) _____ Social Security Number ____/____/____ Sex _____

Marital Status: **Single Widowed Married Divorced/Separated** Email address _____

Insurance Information

Insured Name _____ Patient Relationship to Insured _____

Address _____ Home phone _____ Date of Birth ____/____/____

City, State, Zip _____ Sex _____ Social Security Number ____/____/____

Place of Employment _____ Work phone (____) _____

Name of Insurance Company: _____ Policy I.D. _____ Group # _____

Address _____ City, State, Zip _____ Phone # _____

Authorization number: _____ Effective date: ____/____/____ Co-Payment _____

Reason for appointment: _____

If any of the following questions pertain to you please answer:

1. Are there any court dates that you are aware of? _____ Date: _____

2. Name the attorneys involved: _____ Phone # _____

Payment is expected at the time of your session unless other arrangements have been made. If you have insurance please answer the questions below:

Please read the following information and sign where appropriate

I understand that I am financially responsible for all services to me, including the balance remaining after the payment of the insurance benefit.

I give consent to have my child _____ treated by: _____ Date _____

Assignment of benefits: I authorize payment of medical benefits to physicians: _____

Client Signature: _____ Date: _____

I heard about this service from: ____ Christian Blue Pages ____ Church ____ news paper
____ psychology today ____ Friend ____ magazine
____ Insurance Company ____ Radio

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated herein.**

_____ is authorized to release protected health information related to the evaluation and
(Provider Name-Please Print)

treatment of _____ / _____ / _____
(Member Name) (Member ID#) (Date of Birth – MM/DD/YYYY)

PCP Name: _____ PCP Phone: _____

PCP Address: _____
(Street) (City) (State) (Zip Code)

BH Provider Name: _____ BH Provider Phone: 513-948-0023

BH Provider Address: 203 E. Galbraith Road Cincinnati, OH 45216
(Street) (City/State/Zip Code)

Other Name: _____ Other Phone: _____

Other Address: _____
(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Face sheet | <input type="checkbox"/> History & physical | <input type="checkbox"/> Laboratory/diagnostic testing results | <input type="checkbox"/> School information |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Medication records | <input type="checkbox"/> Behavioral health/psychological consult | <input type="checkbox"/> Psychological eval/testing results |
| <input type="checkbox"/> ER record report | <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Psychosocial assessment | <input type="checkbox"/> Other |
| <input type="checkbox"/> Substance abuse treatment record | <input type="checkbox"/> Summary of treatment records & contact dates | | |

_____ **I hereby refuse to give authorization for any release of information**

(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

CONFIDENTIALITY

I understand these are the exceptions to confidentiality:

- (a) I _____ understand that by signing this document I state I will not kill my self or kill anyone else. If I am feeling suicidal I will call **9-1-1** first.
- (b) Abusing a child or any elderly person.
- (c) I understand that my confidentiality may be breached if I enter into a group (due to lack of control for what others may say in the group).
- (d) I know that managed care, peer reviews and court orders for records/depositions also are an exception to confidentiality.
- (e) Any supervision by students or consultations does not fall under the confidentiality law.
- (f) All support staff doing filling and billing have access to the record. For fee collection purposes, there is no confidentiality.

Again, I understand these are the exceptions to confidentiality. I also agreed to call 9-1-1 or go to a hospital if I feel suicidal or homicidal.

NAME

DATE

Past Psychiatric History:

Psychoeducational - Have you ever had testing performed?

Where _____ When _____

By Whom _____

Have you ever been in therapy before?

With Whom _____

For what concern _____

Have you ever been hospitalized? Yes No

Year _____ For how long? _____

What was the reason for the hospitalization? _____

Family History:

Does your family have a history of mental illness? Yes No

Who?

What medication(s) is the family member taking?

Development History:

Please list everyone whom you grew up with in your home. Please report what type of relationship you had with each member.

Medical History:

Do you have any medical illness?

Please list all:

Have you had any major surgeries?

Please list them all:

List all current Medications you are taking:

Please list all Medication Allergies that you have:

Who is your Primary Care Physician?

Location: _____

Substance Abuse:

How many cigarettes do you smoke?

Daily _____ Weekly _____

How much alcohol do you consume?

A day _____ A Week _____

What type of illegal drugs do you use? _____

Daily _____ Weekly _____

Have you ever been in a drug and alcohol center?

When? _____ Where? _____

Legal History: Do you have any court dates? (*Please list*) _____

Who lives in your home with you please provide names, ages, and relationship to you?

Where do you work and for how long? _____

Are you currently in school? _____ *Where?* _____

Do you have a Associates B.A. M.A. M.ED Ph.D.

Activities/Relationships

What do you do for fun? _____

Are you presently in a relationship?

With Whom? _____ *For how long?* _____

Have you ever been? Physically Sexually Abused Mentally Abused

By Whom? _____

How old were you? _____

Would like to address these issues in therapy? Yes No

What are your spiritual beliefs? _____

A Sound Mind Counseling Service, LLC

Office Policies

Patients are seen by appointment only. Open on most Saturday's.

After Office Hours

If you have a true life threatening emergency, please call **9-1-1** or go immediately to the nearest emergency room.

If you have an urgent problem after hours, you can call the after hours emergency number at **513-484-5798**. Please leave a brief message along with the telephone number to where you can be reached and please take the call block off your phone.

If your problem can wait till the next business day, you can leave a message on the office answering machine and your call will be returned the next business day.

Cancellations

If it necessary to change or cancel an appointment, you must give a 24 hour notice. For all same day cancellation there will be a **\$40.00 fee no exceptions. All Saturday cancellations and no shows, there will be an \$65.00 charge.**

Phone sessions

All phone sessions must be scheduled in advance and are **\$50.00** for a 1/2 hour.

Fees and Payments

All patients are required to pay their co-pays prior to their session. If you do not have your co-payment you will be asked to reschedule your appointment.

A **\$40.00 fee** will be charged for any returned check. Self pay patients are required to pay the office charges prior to their session in cash. Some patients may be responsible for a portion of their bill that insurance does not cover or any deductibles that need to be met, please contact your insurance company before you come. It is the responsibility of the patient to supply their insurance and demographic information at the time of each visit. This includes new insurance cards, new addresses or new phone numbers.

There is a **\$1.00 charge per page** to transfer records to another physician to cover the cost of copying.

Work/School Excuses

If you need a work or school excuse you will be required to be seen by Shantel Thomas before any notes will be given.

All letters will be typed on Wednesday or Thursday and can be picked up on Friday's; a **\$5.00 fee will be applied.**

Billing Problems

Please leave a message with **Gezele**, for any billing problems. She will return your phone call within two business days. Please leave a daytime number and evening phone where you can be reached and the best time to call.

Written reports

All written reports will be billed at \$35.00 per half hour.

Court appearances

Court appearances will be billed at \$250.00 for the first hour then \$150.00 per hour thereafter. The first two hours must be paid in advance and are nonrefundable if the court appearance is cancelled in less than 72 hours.

Signature

Date

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www.asoundmindcounseling.com

Consent to Treat Minor

Name of minor to be seen _____

I agree to avail the above-named minor child into a counseling relationship with the understanding of the following conditions:

- 1) I understand that the minor's counseling records are kept confidential, except where disclosure is required by law (e.g., child abuse/elder abuse reporting requirements ,serious threat of harm to *self* or others) or the minor has signed the appropriate release of information forms.
- 2) Counseling will cover emotional, physical and spiritual aspects of my life and may sometimes be distressing and difficult.
- 3) I have the right to discontinue therapy at any time with minor's consent. I understand terminating counseling is best decided after consulting with minor and minor's therapist.
- 4.) Barring emergencies, I understand I must cancel and/or reschedule minor's appointments by notifying the office **at least 24 hours** prior to the scheduled appointment hour. There -will be a **charge** if appointment is cancelled within 24 hours of appointment time. If you do not call and do not show up for your appointment, the **\$40 charge or (\$65.00 Charge for Saturday)** will apply. You may leave a message on our voice mail, which will accurately record the date and time of your call.
- 5) In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable A Sound Mind Counseling Service, LLC any and all claims, demands, actions or causes of action of whatsoever kind and nature related to the counseling process.

I have read and understood the preceding information and agree to the policies of A Sound Mind Counseling Service, LLC as stated. I understand that these comments are prerequisite to minor's receiving and continuing counseling through, A Sound Mind Counseling Service, LLC.

Parent's Signature _____ Date _____

Minor's Signature _____
Date _____

Therapist's signature _____ Date: _____

**A Sound Mind Counseling Service, LLC
Privacy Notice**

▶▶▶I acknowledge receipt of A Sound Mind Counseling Service
Notice of Privacy Practices. ◀◀◀

Signature

Date

Relationship: Self Parent Guardian Other _____
Specify