

**Today’s Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MINOR’S INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_F\_\_\_ DOB\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_\_\_

Custody details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_

**INSURANCE COVERAGE (for minor)**

**Primary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Member ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Member ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization & Release to Bill Insurance or EAP:**

I authorize release of any information concerning my child’s health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance or EAP benefits. I also hereby authorize payment of insurance or EAP benefits otherwise payable by me directly to the therapist.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print Client’s Name

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s Signature Relationship to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Please Print Responsible Party’s Name Date

**Parent/Guardian 1**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_F\_\_\_ DOB\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Age\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

SSN\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Day)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Message? Yes No (Evening) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message? Yes No

Electronic Confirmation of appointments can be sent to me at: **EMAIL** listed above\* I would like to have access to the secure email option with ClearView Counseling: YES \_\_\_\_\_\_ NO\_\_\_\_\_\_

Please list the people who live in Parent/Guardian 1’s home:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Age Relationship Name Age Relationship   
  
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name Age Relationship Name Age Relationship

**Parent/Guardian 2**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M\_\_\_F\_\_\_ DOB\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Age\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

SSN\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Day)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Message? Yes No (Evening) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message? Yes No

Electronic Confirmation of appointments can be sent to me at: **EMAIL** listed above Yes\_\_\_ No \_\_\_

\* I would like to have access to the secure email option with ClearView Counseling: YES \_\_\_\_\_\_ NO\_\_\_\_\_\_

Please list the people who live in Parent/Guardian 2’s home:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Age Relationship Name Age Relationship

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**(Minor’s) Primary Care Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Signed release for permission to contact on file? Yes No

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Physical Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immunizations Up to Date? Yes\_\_\_ No\_\_\_

**(Minor’s) Current Medications:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Dose Purpose

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Name Dose Purpose

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Reason for Appointment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Symptoms/Areas of Concern**, check all that apply:

\_\_\_Abuse \_\_\_Energy Level \_\_\_Nervousness/Anxiety \_\_\_Shyness

\_\_\_Anger \_\_\_Feeling Inferior \_\_\_Nightmares \_\_\_Sleep

\_\_\_Appetite Change \_\_\_Friends \_\_\_Physiological Health \_\_\_Spirituality

\_\_\_Authority Figures \_\_\_Finances \_\_\_Relationship Issues \_\_\_Stress

\_\_\_Career Choices \_\_\_Gastrointestinal Distress \_\_\_Relaxation \_\_\_Suicidal Thoughts

\_\_\_Concentration \_\_\_Grief \_\_\_School \_\_\_Time Management

\_\_\_Decision Making \_\_\_Headaches \_\_\_Self Harm \_\_\_Unhappiness

\_\_\_Depression \_\_\_Loneliness \_\_\_Sexuality \_\_\_Weight

\_\_\_Drug/Alcohol Use \_\_\_Memory

Receiving any other Mental health services? If yes, please explain  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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To the best of your knowledge, is there any history of physical, sexual or emotional abuse? If yes, please specify.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How would you describe your child’s approach to new situations?

\_\_\_\_Positive, Jumps right in

\_\_\_\_Cautious, slow to warm up

\_\_\_\_Withdrawn, tends to not participate

How would you generally describe your child’s overall mood?

\_\_\_\_Positive, happy, laughing, upbeat, hopeful

\_\_\_\_Negative, depressed, cranky, angry, hostile

\_\_\_\_Mixed, but more positive than negative

\_\_\_\_Mixed, but more negative than positive

Is there anything else you think we need to know about your child/adolescent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Consent for Treatment

Thank you for choosing to work with us as you address some of the important issues in your life. We intend to provide you with excellent care and ethical services that make the best use of your valuable time, while honoring the challenges that have brought you here. You may ask to receive a copy of this for your records.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXPLANATION OF SERVICES**

* We see clients Monday through Saturday.
* We share this suite with our colleagues, and we provide ongoing supervision for each other.
* We provide Individual, Family, Couple, and Group Counseling and are happy to discuss these options with you.
* If you need to reach us when we are not in the office you may call our main number (513) 860-1100, and you will be directed about how to reach your therapist.
* We make the assumption that you can change and grow, and that some of this change can occur within a relatively short period of time. We strive to do brief and effective treatment.
* Our fee is $130.00 per hour for a regular 45-55-minute session and $150.00 for the initial session. Payment is expected at the time of service. You are responsible for the charges. If you are paying through your insurance, you are responsible for your co-pay at time of service and for any amount left unpaid by your insurance.
* Additional fees will be charged for letters, appearance in court, reports, and extended phone calls. These things are not covered by insurance. Please see the additional services fee agreement. Your therapist will discuss any additional fee with you. Payment is expected prior to receipt of additional service.
* We view the therapeutic relationship as a partnership that is principally dedicated to your growth and to finding solutions. Part of our job is to remind you of your own strengths and abilities while you go about the business of creating more of the type of life that you want.
* As with nearly any type of treatment, there is the chance that it may not be helpful. The “fit” between client and therapist is important to good treatment outcome. In the beginning of treatment, you may feel worse before you feel better. Therefore, we want to hear from you throughout our work together about how we are doing – so that we can make any needed adjustments to help you more effectively.
* Information discussed within the therapy setting is held confidential and will not be shared without written permission except under limited situations, which under reasonable circumstances, would be discussed with you before disclosure is made. These situations include revelations of unreported child or elder abuse, immanent suicide or harm to others, or reports of exploitation by a therapist.

**CONSENT TO TREATMENT**

The undersigned, client/client’s legal guardian, voluntarily consent to outpatient treatment for mental health, co-occurring, and/or substance use and authorize ClearView Counseling Services (CV) to provide such outpatient treatment that is determined to be medically necessary or otherwise appropriate. These services may include individual or group counseling/therapy, Diagnostic Assessment, Psychological Testing.

**WAIVER OF LIABILITY FOR NON-APPROVED SERVICES**

Ohio law requires CV to inform the undersigned that if your insurance company did not give prior approval for therapy services and you chose to have services provided, you are required to pay for the services. My signature acknowledges I have read and understand the above. If my insurance company denies payment, I agree to be personally and fully responsible for the payment of all services incurred. These services include both formal and informal letters, appearances in court, reports, and extended phone calls.

**CLIENT FINANCIAL RESPONSIBILITY AGREEMENT**

In consideration of services received or to be received, the undersigned requests that payment of authorized insurance benefits, including Medicare, if the client is a Medicare beneficiary, be made on the client’s behalf to CV for any services provided to the client. It is my responsibility to notify CV of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined by CV. The undersigned acknowledges that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

ClearView Counseling Services appreciates your trust in choosing us to provide mental health care services to you, or someone for whom you have responsibility. Our client and family-centered treatment philosophy requires that we communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with these policies.

I acknowledge that I am financially responsible for all charges associated with mental health services provided by CV to me (or the client named above). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

**Insurance or EAP: (Please check the appropriate statement)**

\_\_\_\_I do have insurance or EAP services that provides coverage for mental health and/or alcohol/drug treatment services. I am requesting that CV bill my insurance or EAP provider. I agree to pay all deductibles, and/or co-insurance associated to the services I receive at CV.

\_\_\_\_ I do not have insurance or EAP services that provides coverage for mental health and/or alcohol/drug treatment services.

\_\_\_\_ I request that whether or not I (or the client named below) have insurance or EAP services that may provide coverage for mental health services, CV **NOT** bill my insurance or EAP company for privacy reasons. I acknowledge that with my request that CV not bill my insurer I create a personal financial obligation on my part.

**LATE CANCELLATIONS, MISSED APPOINTMENTS or TELEPHONIC SERVICES**

I understand that I am required to provide at least 24 hours notice if I (or the client named above) am unable to keep a scheduled appointment. In the event that I do not provide 24 hours advance notice, I acknowledge that CV has the right to charge me for the scheduled appointment. If I fail to cancel a scheduled appointment, and do not come at my (or the client’s) scheduled appointment time, I understand that CV will charge me for the scheduled appointment. I agree to pay CV any late cancellation, missed appointment charges or telephone charges incurred. **\_\_\_\_\_\_\_\_\_(initial)**

**Returned Check Fee**: CV may, in its discretion, charge a fee for any check returned by my financial institution, regardless of reason. In such event, I agree to pay CV a returned check fee of up to $25.00.

**Delinquent Account**: I understand that CV may turn my account over to a collection agency if I do not pay in a timely manner. CV has a separate collection policy, which will be provided to me if I ask for it. I also understand that if my account is sent to a collection agency a 35% surcharge will be applied to the balance.

**Credit Card Payments**: I understand that CV may charge my credit card for any charges discussed in this agreement.

**HIPAA Consent:** When we send you an email or you send us an email the information sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted through the internet. Once email is received by you, someone may be able to access your email account and read it.

* I understand the risks of unencrypted email and do hereby give permission to ClearView to send me personal health information via unencrypted email. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ initial **OR**
* I do not wish to receive personal health information via email. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ initial.

**OTHER INFORMATION**

* I, the undersigned, acknowledge responsibility for myself and my actions and liability arising or resulting from my actions/omissions while I am being treated at CV. I, the undersigned, acknowledge that CV is not responsible to me or my property for the actions/omissions or any liability arising from the actions/omissions of any other clients at CV.
* I, the undersigned, understand that at any time I may elect to participate in other services or refuse any services, treatment or therapy upon full explanation of the expected consequences of such refusal.
* I have seen a copy of the Notice of Privacy Practices (HIPAA) which include the client rights and grievance policy \_\_\_\_\_\_\_\_\_\_**(Initial)**
* I have seen the Additional Service Fee Schedule. **\_\_\_\_\_\_\_\_\_ (initial)**
* I have completed the credit card authorization form. \_\_\_\_\_\_\_\_\_**(initial)**
* I have read and understand the Consent for Treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/ Parent/Legal Guardian Print Name of Signer

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Printed Name of Witness

**NOTICE OF PRIVACY PRACTICES**

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Our commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, will be available on our website (downloadable version), and you may request a copy of our most current Notice at any time. This mandate is effective as of April 14, 2003. If you have questions about this Notice, please contact your counselor.

**We may use and disclose your PHI in the following ways:**

* **Treatment**: Our practice may use your PHI to treat you. For example, the people who work for our practice may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. We may also disclose your PHI to other health care providers for purposes related to your treatment. Finally, our practice may use and disclose your PHI to inform you of potential treatment options or alternatives, or of health-related benefits or services that may be of interest to you.
* **Payment:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.
* **Disclosures About Victims of Abuse, Neglect or Domestic Violence:** We may disclose PHI to notify the appropriate government authority as required or expressly authorized by law or when the patient agrees if we believe a patient has been the victim of abuse, neglect or domestic violence. CV honors the New mandated Reporting Requirement- Animal Abuse. By law, if a licensee suspects animal abuse, a report may be made to a law enforcement officer, humane society agent, or animal control professional.
* **As Required By Law:** We will disclose PHI when required to do so by federal, state or local law.
* **To Avert a Serious Threat to Health and Safety:** Consistent with Ohio law, we may use and disclose certain PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. In addition, we may use and disclose PHI if we believe that the use or disclosure is necessary for law enforcement to identify or apprehend an individual who has escaped from a correctional institution or from custody.

**Your rights regarding your PHI:**

* **Confidential communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to your counselor specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
* **Requesting restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to your counselor. Your request must describe in a clear and concise fashion:
  + The information you wish restricted,
  + Whether you are requesting to limit our practice’s use, disclosure or both,
  + To whom you want the limits to apply.
* **Inspection and copies:** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to counselor in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
* **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your counselor. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
* **Accounting of disclosures:** All of our clients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to your counselor. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
* **Right to a paper copy of this notice:** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a paper copy of this notice, contact your counselor.
* **Right to file a complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Compliance Officer, Tracy Mert. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
* **Right to provide an authorization for other uses and disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact your counselor.

 **Service Fee Schedule:**

1. **Subpoena** for court: $400/ hour or $1600 (minimum) to cover the four- hour usual and customary charge, to be paid in full prior to court date appearance. This fee involves: clinician need to clear schedule, preparation time involved, transportation, waiting time, and attendance to legal proceeding. If proceedings are longer than 4 hours, $400 will be added per each additional hour of time. All payments are due 48 hours prior to scheduled court appearance and no later than noon on Thursday if the court proceedings are scheduled for Monday. A therapist may reserve the right to terminate the therapeutic relationship, and refer out to other mental health providers especially when clinician has indicated that s/he does not attend court and/or is subpoenaed when asked not to.
2. **Report/ Letter/ Assessment-** Remit customary $150/ hour, towards time spent doing research and writing of document, to be paid for prior to obtaining report.
3. **Phone calls/ Email Correspondence-** Remit $150/ hour, $75/ half hour, or $38/ fifteen min, spent on the phone or involved in email collaboration/ consultation with clinician, paid for prior to call, with begin time and end time already determined.
4. **Out of Office Meetings-** (To include: team mtgs, IEP mtgs, hospital meetings, meetings with attorneys or MDs, and/ or other types of CPST mtgs, and so on)- Remit $150/ hour, to be paid for prior to appointment. Time spent transporting to and from the indicated location may hold additional costs and are to be determined by the clinician.