Counseling Solutions
8858 Commerce Loop Drive
Columbus, OH 43240
614-880-9800
Fax: 614-880-9802

Date _____
Therapist_____
Diagnosis_____

Name_____
Address_____
City, State, Zip_____
Home Phone_____Work_____Cell_____
Date of Birth_____
Marital Status_____Years Married_____Years Divorced_____ Divorced what year_____
Spouses Name_____
Spouses Date of Birth_____

Occupation_____Last Grade Completed_____
Employer_____Phone Number_____
Spouses Employer_____Phone Number_____
Primary Insurance_____
Primary Holder of Insurance_____Date of Birth_____
Group Name_____Group Number_____
ID Number_____Provider Phone Number_____
Co-Pay Amount_____

***__24 hours notice is required to cancel an appointment without being charged. Failure to do so will mean that you forfeit any pre-payment for a scheduled session and/or will make you accountable for payment in full for the canceled session.__**

Signature_____

Please make checks payable to: Counseling Solutions

Intake Assessment Form

Please provide the following information and answer the questions below. Please note; **Information you provide here is protected as confidential information.** Please Fill out this form and bring it to your first session.

Today's Date: _____

GENERAL INFORMATION

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth date: _____/_____/_____ Age: _____ Gender [ ] Male [ ] Female

Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message ☐Yes ☐No

Cell/Other Phone: ( ) May we leave a message ☐Yes ☐No

E-mail: _____
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____
Race: _____

Cultural Considerations: _____

Religion: _____

Education

High School: _____

(Where) (Last grade completed) (Graduated? Y or N)

Post High School Education:

Explain:

_____

_____

Is or was school performance a concern for you?

If yes, explain:

_____

_____

Marital Status

[ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Never

Years Married: _____ Years Divorced: _____

Are you currently in a romantic relationship? _____

If yes, for how long? _____

On a scale of 1-10 how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?_____

_____

_____

Children:

Name	Age	Sex	Occupation or Grade	Living with Client	Biological, Adopted, or Step

Your Brothers and Sisters:

Name	Age	Biological, Adopted, Or Step

Other Household Members

Name	Age	Relationship to Client

Describe your relationship with:

Parents: _____

Siblings: _____

Extended Family Members: _____

Husband/Wife/Significant Other:

_____

Your Children: _____

Health History

Primary Physician: _____

Primary Physicians Address: _____

Primary Physicians Phone: _____Date of Last Exam_____

Please List Allergies if Any_____

Have you previously received any type of mental health services (Psychotherapy, Psychiatric services, ECT.)?
Yes_____
No_____
If yes, when and where?

_____

_____

List any support groups you have attended in the past or presently:

_____

_____

Was support group attendance helpful?

_____

_____

Are you currently taking any prescription medications?
Yes_____
No_____
Please list:

_____

_____

Have you ever been prescribed psychiatric medication?
Yes_____
No_____
Please list:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

*How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific problems you are currently experiencing:_____

_____

*How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

_____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?

_____

_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression?

Yes_____ No_____

If yes, approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

If yes, when did you begin to experience this?

_____

_____

Are you currently experiencing any chronic pain?

If yes, please describe:

_____

_____

Are any physical characteristics or body image a concern? Explain:

_____

_____

Is sexual functioning an area of concern for you? Explain:

_____

_____

Substance Use

Do you drink alcohol more than once a week? Yes_____ No_____

If yes, how often? _____

Is alcohol an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

How often do you engage in recreational drug use?

Daily____ Weekly____ Monthly _____ Never____

Is recreational drug use an area of concern for you? Yes_____ No_____

If yes, explain:

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle ECT.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Abuse History

Have you experienced physical, sexual or emotional abuse? Yes___ No___

If yes, explain_____

Legal History

Do you have a history of any legal charges? Yes_____ No_____

If yes, explain_____

Are you currently on probation or parole? Yes_____ No_____

If yes, explain_____

Is treatment court ordered? Yes_____ No_____

Employment

Are you currently employed? Yes____ No_____

If yes, what is your current employment situation?

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

Additional Information

What do you consider to be some of your strengths?

_____

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

_____

What would you like to accomplish out of your time in therapy?_____

_____

_____

_____

Is there anything else you feel we should know, or that you are concerned about?

_____

_____

_____

_____

X_____

Signature of Person Completing Form

Informed Consent and Office Policies

Counseling Solutions
8858 Commerce Loop Dr.
Columbus, Ohio 43240
Phone (614) 880-9800

CONFIDENTIALITY: Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- **Duty to Warn and Protect**
  When a client discloses intentions or a plan to harm another person, or when information is obtained from clients or from collateral sources that others may be at danger, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

- **Abuse of Children and Vulnerable Adults**
  If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

- **Court Order**
  Mental Health Practitioners are required to provide information in response to court orders and subpoenas.

- **Insurance Providers** (when applicable)
  Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. Only the minimum necessary information will be communicated to the carrier. By signing this contract you are consenting to a release of information about your case to your health plan. Your practitioner has no control or knowledge over what insurance companies do with the information or who has access to this information.

- **Technology**
  Cell phone usage can be intercepted by third-parties. This form or communication is used to help you with services and with coordination of services outside of your scheduled session. Your mental health practitioner is not responsible for any interception by third parties during these calls. Similarly, confidentiality cannot be assured when using the internet and in un-encrypted email messages. Should Counseling Solutions be contacted by you through the internet, this constitutes implied reciprocal use of electronic mail.

- **Other Participants**
  Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The practitioner will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the practitioner from others involved in your treatment therefore, clients under 18 cannot be assured of unconditional confidentiality from their parents. Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

- **Staff**
  A client of any clinician is considered a client of the agency. Your case may be discussed and reviewed by other clinicians and staff. All Counseling Solutions staff are held to the strictest level of confidentiality standards.

I have reviewed, understand, and agree to the stated policies regarding confidentiality. **_____Initials**

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

I have reviewed, understand, and agree to the stated policies regarding cancellation. **_____Initials**

EMERGENCIES

If known ahead of time, you must discuss any expectations you have for emergency treatment with your therapist and agree to develop and follow a step-by-step crisis plan. You may telephone your practitioner in an emergency. Your practitioner is not always immediately available by phone and may not be available in the late evening. If unavailable, your call will be returned as soon as possible. If your practitioner is unavailable, or if your crisis needs immediate attention, please proceed to the nearest hospital emergency room or call Netcare at (614) 276-2273; the Suicide Prevention Hotline at 1-800-Suicide (1-800-784-2433), or 911.

Our general philosophy regarding emergencies is that clients are assumed to be self-responsible (i.e. autonomous, functioning, not in need of day to day supervision). In addition, as private practice clinicians we cannot assume responsibility for client's day to day functioning as can institutions nor can we be available for 24-hour per day crisis care.

I have reviewed, understand, and agree to the stated policies regarding emergencies. **_____Initials**

PRACTITIONER FEES:

Payment for service is made at the end of each session at the agreed upon fee determined by practitioner and client. If utilizing your health insurance, fees will be determined by the practitioner's contracted rate with the insurance company and co-pays will be collected at the end of each session.

- Individual Sessions $175.00 per session
- Couple or Family Sessions $175.00 per session
- Group Sessions $ 80.00 per group session
- Appointments not cancelled with 24 hour notice or Missed Appointments $175.00 per session or what has been determined between you and the practitioner.
- An additional 5% charge will apply to all credit card transactions

I have reviewed, understand, and agree to the stated policies regarding practitioner fees. **_____Initials**

I have read this informed consent completely and have raised any questions I might have about it with my practitioner. I have received full and satisfactory response and agree to comply with all items freely and without reservations.

_____	_____	_____
Signature of Client	Print Name	Date
_____	_____	_____
Signature of Parent/Legal Representative	Print Name	Date
_____	_____	_____
Practitioners Signature	Print Name	Date

Counseling Solutions, LLC
8858 Commerce Loop Dr. Columbus, Ohio 43240
(P) 614-880-9800 (F) 614-880-9802
www.counselingsolutions.info

Notice of Privacy Practices
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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy and security of PHI and to provide you with notice of our legal duties and privacy and security practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website or in our office or by sending a copy to you in the mail upon request.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may discuss your situation and/or disclose PHI to any other consultant only with your consent, such as your primary care physician. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain a written authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy. Note, psychotherapy notes may not be required to be released for eligibility or underwriting purposes.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your consent. Examples of payment-related activities are: making a determination of eligibility of coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services or our lawyer) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI or we have otherwise obtained your consent to release the information. For training and teaching purposes PHI will be disclosed only with your consent.
Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make

disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy and/or Security Rule.

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization or consent only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

Required or allowed by law, such as (including but are not necessarily limited to): the reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department), or abuse involving the elderly or the developmentally disabled/mentally retarded.

- If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from you or your personal or legally-appointed representative, or upon receipt of a court order. The privilege does not apply when you are being evaluated for a third party and you have provided an authorization to release the information to the third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or to other persons as permitted by law, including you.
- To defend against an action filed by you against us.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked, unless we have already relied on it.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Bill Mason, Counseling Solutions, LLC, 8820 Commerce Loop Dr., Columbus, Ohio 43240.

- Right of Access to Inspect and Copy. You have the right to inspect and copy PHI that are part of treatment records that we have created.
- Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period. We are not required to report disclosures made for treatment, payment, or health care operations unless they involve electronic records.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have a right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Bill Mason, Executive Director, Counseling Solutions, 8858 Commerce Loop Dr., Columbus, Ohio 43240, 614-880-9800. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

We will not retaliate against you for filing a complaint.

If you need additional information regarding this Notice of Privacy Practices, please contact:

Bill Mason, Executive Director
8858 Commerce Loop Dr.
Columbus, Ohio 43240
614-880-9800
614-880-9802 Fax

Counseling Solutions, LLC

8858 Commerce Loop Dr. Columbus, Ohio 43240

(P) 614-880-9800 (F) 614-880-9802

www.counselingsolutions.info

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I _____, acknowledge that I

received a copy of the Notice of Privacy Practices for Counseling Solutions, LLC.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledge of Receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (please specify)

_____

_____