DaySpring Counseling

Child Client Information Form

Parent(s)I Guardian(s): To make our first session easier and more time efficient, please complete on information form for each minor who will be attending counseling.

Child's Name____________________ Age________ D. 0. B.________

Grade____ Child's School ____________________

Parent(s) Name(s) ____________________

Address____________________

City____________________ State________ Zip____________

Home Phone (______) ________-________ Work Phone(______)________–__________

Cell Phone (________) ________--________

S.S.# ________– _____-__________ (if applicable)

In case of an emergency contact____________________

Emergency contact phone (_____) ______--______ Relationship to child ____________

Name of Child's Doctor____________________Phone (_____) ______--________

Doctors Address____________________ City____________ State____ Zip_____

Please tell us about the family your child is growing up in.

Father's Name____________________ Occupation________________

Mother's Name____________________ Occupation________________

Adopted? ☐ Yes ☐ No

Please list the name of your child's brothers and sisters and their current ages:

____________________ ____________________

____________________ ____________________

Are parents divorced? ☐ Yes ☐ No

-If yes, how old was the child when this happened? ______________

Is either parent deceased? ☐ Yes ☐ No

-if yes, which parent(s) is deceased? ____________________________

-How old was the child when this happened? __________________

Name of step parent__________________ Child's age when remarried? _____

Name of step parent__________________ Child's age when remarded? _____

Name and ages pf step/half brothers, step/half sisters:

____
____
____
____
____
____
____

Please tell us about any health problems your child has experienced in the past 12 months or any ongoing health problems:

____
____
____
____

Please give us the names of any medications and their dosages that your child regularly takes:

Medications : **Prescribed by**:

____ ________________________________
____ ________________________________
____ ________________________________

Abuse History:

☐ Physical ☐ Emotional ☐ Sexual

Have your child been in counseling before? ☐ Yes ☐ No

If so, how long ago? ______________ With whom? _______________________

Please describe briefly any problematic behaviors or areas of concern related to your child.

____
____
____
____

What are your child's interests and hobbies?

____
____
____

What do you believe your child does well?

____
____
____

What is your child's most difficult behavior for you to manage?

____
____
____

Please list the names and addresses of other professionals consulted:

1. ____
2. ____
3. ____
4. ____

Please use the space below to write any additional comments you wish to make regarding your child.

____
____
____
____
____
____
____
____
____

Parent(s) Signature: **Date:**

______________________________ ____________________

______________________________ ____________________

DaySpring Counseling

SUMMARY OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) & Your Privacy Rights

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent.

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about your case, although every effort is made to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. If you are comfortable with this practice, your therapist will not tell you about these consultations unless he or she feels that it is important to your work together. Your therapist will note all consultations in your Clinical Record. Similarly, you should be aware that we practice as a group with other mental health professionals and employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Every mental health professional in DaySpring Counseling, LLC. is bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy, and have agreed in writing not to release any information outside of the practice without the permission of a professional staff member.
- We also have contracts with business associates, such as our billing service, our accountant, etc. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the privilege law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. In addition, if a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If you file a complaint or lawsuit against a therapist, he or she may disclose relevant information about you in order to defend him or herself. If you file a worker's compensation claim, you must sign a release so that we may release the information, records or reports relevant to the claim.

There are situations in which we are legally obligated to take actions that we believe are necessary to attempt to protect others from harm. If this happens in your case, we may have to reveal some information about your treatment. These situations are very unusual in our practice:

- If we know or have reason to suspect that a child under 18 years of age (or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age) has suffered or faces a threat of suffering any physical or mental wound, injury, disability, including abuse or neglect, the law requires that we file a report with the appropriate government agency, usually the Public Children Services Agency.
- If we have reasonable cause to believe that an elderly adult is being abused, neglected, or exploited, or is in a condition that is the result of abuse, neglect, or exploitation, the law requires that we report such belief to the county Department of Job and Family Services.
- In addition, if we know or have reasonable cause to believe that a client has been the victim of domestic violence, we must note that knowledge or belief and the basis for it in the client records.
- If we believe that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else, and we believe that disclosure of certain information may serve to protect that individual, then we must disclose that information to appropriate public authorities, and/or the potential victim, and/or professionals, and/or the family of the client.
- If such a situation arises in your case, we will make every effort to fully discuss it with you before taking any action and we will limit the disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with your

therapist. The laws governing confidentiality can be quite complex and we do not have legal training. It is best to seek formal legal advice.

PROFESSIONAL RECORDS

The laws and standards of our professions require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. We do recommend that you initially review them in your therapist's presence, or have them forwarded to another mental health professional. If your request for access to your records is refused, you have a right of review, which can be discussed with you upon request. You should be aware that some therapists keep Protected Health Information about you in two sets of professional records.

YOUR RIGHTS AND THE RIGHTS OF MINORS AND PARENTS

HIPAA provides you with rights which include: requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement/Notice form. In addition, parents and clients under 14 years of age who are not emancipated should be aware that the law allows parents to examine their child's treatment records unless the child's therapist decides that such access would injure the child. Children between 14 and 18 may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement.
While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment.

INSURANCE REIMBURSEMENT

In order for you to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. We will bill your insurance company and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your
insurance policy covers and if pre-certification is needed. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. Some managed-care plans will not allow your therapist to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis, and sometimes we are required to provide treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report submitted, if you request it.

HIPAA NOTICE

This serves as an acknowledgement that you have received notification regarding HIPAA from DaySpring Counseling, LLC.

______________________________ ______________________________

Client Signature Date Client Name (Please Print)

DaySpring Counseling

CONSENT FOR SERVICES

I understand and agree to the following:

Dayspring Counseling does not practice nor maintain support for crisis intervention therefore is not available for 24hr/7-day per week consultation via phone or in person. Any situation that might be considered a medical, emotional and/or mental health emergency should be handled at the nearest medical emergency room in your area or by contacting 911.

The law protects the privacy and confidentiality of communications between a client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA. However, there are three exceptions in which we are required legally and ethically to break this confidence and contact the appropriate person(s) and/or authorities. They are as follows;

1) Information that indicates you are likely to harm yourself or another person.
2) Information that indicates neglect or harm to a minor or those unable to protect themselves.
3) A legal situation in which case notes are subpoenaed to court regarding your involvement in counseling and/or if we are required to testify.

A counseling hour lasts for 50 minutes and may be scheduled on a weekly, bi-weekly, monthly or other specified basis. Termination or quitting counseling is your personal right at any time.

All DaySpring counselors are licensed in the State of Ohio as Professional Counselors and are qualified to diagnose and treat mental and emotional disorders as well as provide individual, group, family and couples therapy.

I have read and understand what I can expect from counseling treatment offered. I hereby consent for DaySpring Counseling, LLC. to provide professional diagnostic assessment, counseling services and/or testing for myself or for my child.

____

Client or parent/guardian signature Date

____

Other signature if couples or marital counseling Date

____

Provider & credentials Date

DAYSPRING COUNSELING INSURANCE AUTHORIZATION FORM

PATIENT INFORMATION

Patient name: Social Security Number:
Street Address: Date of Birth: Marital status: S M W SEP D
City/State: Zip: Telephone Number:
Email:

•PATIENT EMPLOYER INFORMATION

Employer name: Telephone Number
Employer street address: City/State: Zip:
Patient's occupation:

INSURED PERSON (IF NOT PATIENT)

Name: Telephone Number: Date of Birth:
Street address: City/State Zip: S.S.#

•INSURED PERSON EMPLOYER INFORMATION

Employer:
Employer street address City/State: Zip:

•INSURANCE

#1 Primary insurance company name:
Primary insurance company address:
ID Number: Plan: Group:
Subscriber's name: Relationship to patient:
Subscriber's employer: Type of Insurance: HMO PPO MC TRADITIONAL

#2 Secondary insurance company name:
Secondary insurance company address:
ID Number: Plan: Group:
Subscriber's name: Relationship:
Subscriber's employer: Type of Insurance: HMO PPO MC TRADITIONAL

•AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize DaySpring Counseling, LLC. to apply for benefits on my behalf for covered services rendered or supervised by DaySpring Counseling, LLC. I authorize payment of medical benefits from my insurance company be made directly to DaySpring Counseling. I authorize the release of any medical information necessary to process this claim. I certify that the information that I have reported with regard to my insurance coverage is correct. Either my insurance company or I may revoke this authorization at any time in writing.

Signature: ______________________________ Date: ____________________

PLEASE PROVIDE OUR OFFICE STAFF WITH YOUR INSURANCE CARD SO A COPY MAY BE MADE.

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FINANCIAL CONSENT and FEES

I agree to pay DaySpring Counseling, LLC. for all psychotherapy services rendered and attest that I have been informed of said charges. I have been provided a copy of HIPAA & Your Privacy Rights and understand that every effort will be made to safeguard my health information.

If psychotherapy services are covered by private insurance, benefits due to me under existing policies are hereby assigned to the above named provider. I permit a copy of the signature on this release to serve as a lifetime authorization. A copy of this form may be used in place of the original.

I understand that specific diagnostic and treatment information may be required by third party payers and I authorize the release of all necessary requested medical information to process all claims.

I understand that I (or the person signed as financially responsible) am personally responsible for the costs of psychotherapy services including but not limited to; unmet deductible, co-payment, co-insurance, and any fees or portions of fees not paid by my insurance carrier. Payment for services is expected at the time services are rendered and I accept responsibility of payment for services.

Failure to keep payments current or to arrange and maintain a payment plan for services will result in collection action for the balance due and/or termination of counseling services. I consent to a periodic review of my file by the director of DaySpring Counseling, LLC. and/or my counselor's supervisor on an as needed basis.

I authorize DaySpring Counseling to apply for insurance benefits and for all payments to be rendered for covered services rendered by one of the following counselors: Melissa Yoak, LPCC, Deborah Sands, LPCC, Nora Cord, LPCC, Michael Johnson, LPCC, Jennifer Vasquez, LPC or Thomas Butler, LPCC.

_____________________________________ _______________
Client or parent/guardian signature Date

_____________________________________ _______________
Responsible Party Signature Date

_____________________________________ _______________
Service provider/credentials Date

Please check one of the following:

___ **Insurance**
$135 submitted for first session (diagnostic)
$110 submitted for every 50-60 minute session (individual or conjoint/family)

____ **Self-Pay/No Insurance**
$135 submitted for first session (diagnostic)
$110 submitted for every 50-60 minute session (individual or conjoint/family)

_____ **Sliding Scale**
$______ for all sessions

**This information is required by the Counselor, Social Worker, and Marriage and Family Therapist Board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state.*
OHIO COUNSELOR, SOCIAL WORKER, AND MARRIAGE AND FAMILY THERAPIST BOARD
50 West Broad Street, Suite 1075 Columbus, OH 43215 (614) 466.0912

DaySpring Counseling

CANCELLATION AND NO-SHOW POLICY

DaySpring Counseling requires a 24-hour notice should a client need to cancel an appointment.
By neglecting to do so, DaySpring Counseling reserves the right to charge $60.00 per missed session (which is not covered by insurance). Exceptions are made based on emergency situations such as lack of transportation, illness, etc. This fee must be collected before a subsequent appointment can be scheduled.

DaySpring Counseling reserves the right to terminate counseling services due to multiple late cancellations and/or no-shows, or failure to make payments for missed sessions.

For clients' convenience, there is a 24-hour voice mail service (330-645-9975) in which messages related to cancellations may be left.

____

Client Signature or Parent/guardian Date

____

Provider Date

CREDIT CARD AUTHORIZATION:

Most of our clients now opt to leave a credit card on file at our office in order to process copayments and/or balances due for services. Please fill out the form below should you choose to take advantage of this convenient payment method.

DaySpring Counseling
Credit Card Authorization

Client ______________________________ **Date** ________________

Card Number ______________________________ **Expiration** ____________

Amount __________ **Cardholder Zip Code** ________________

Keep this information on file: **Yes** ______ **No** ______

Card Holder Signature ____

The card holder's signature authorizes DaySpring Counseling to utilize their credit card information to charge for counseling services rendered.