Clear Outlook Counseling
Adult Client Information

Today's Date_______________

Name____

Date of Birth_____/_______/_______ SSN_______/_____/_______________ M_____ F_____

Race: White_____ **African-American**_____ **Hispanic**____ **American Indian**_____ **Multiracial** ____

Other_____

Marital Status: Single____ **Married**____ **Separated**____ **Divorced**____ **In long-term relationship**____

Address ____**Zip Code**_____________

City State

Daytime Phone __________________**Evening Phone**_________________________________

Message: Yes No Message: Yes No

Email____

*Electronic Confirmation of appointments can be sent to me at the email listed above Yes No

Employer:____**Occupation:**_____________________________

Work Phone____ **Message: Yes No**

Primary Insurance:__________________________________**Primary Card Holder**______________________

DOB:__________________ **SSN:**____________________**Relationship to Client:**______________________

Member ID:___________________________________ **Group #**______________________________________

Secondary Insurance:______________________________**Primary Card Holder**_____________________

DOB:__________________ **SSN:**____________________**Relationship to Client:**______________________

Member ID:___________________________________**Group #**______________________________________

Authorization and Release to bill insurance:

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the therapist in the name of Clear Outlook Counseling, LLC

____
Client Signature

____ ______________________________
Print Name Date

Reason for appointment:

____
____
____
____
____
____

Symptoms/Complaints at this time (or in the last 3 months)
Check all that apply:

___Abuse ___Anger ___Appetite Change ___Concentration ___Childhood ___Career Choices
___Decision making ___Depression ___Drug/Alcohol Use ___Energy Level ___Feeling Inferior ___Finances
___Friends ___Grief ___Headaches ___Legal Matters ___Loneliness ___Marriage ___Memory
___Nervousness ___Nightmares ___Parenting ___Physiological Health ___Relaxation ___Sexuality
___Shyness ___Self Harm ___Sleep ___Spirituality ___Stress ___Suicidal Thoughts ___Unhappiness
___Weight ___Work Environment ____ Other

Receiving other Mental Health Services: Yes____ No____
If yes, explain:____
____
____

People who live in your home:

Name	Relationship	Age

Medical History

Do you have any medical conditions at this time? Yes_____ No_____
If yes, explain:____
____
____

Primary Care Physician___________________________________ Phone____________________
List Prescription Medications:

Name	Dosage	Reason

CONSENT FOR TREATMENT

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, and Couples 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) 201-5440, and you will be directed to leave a voicemail. We utilizes a voicemail system through Google Voice that is password protected. The voicemail may be sent to the clinician's office phone and as an attachment, to the clinician's email, which may or may not be encrypted, depending on that clinician's set up. Please note that there is the possibility that a message may be intercepted with unencrypted email. I have read, understand, and agree to the terms above concerning use of email to retrieve voicemails and password protection. ________ (initial)

· 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. Your therapist will discuss any additional fee with you before it is charged.

· 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. As mandated reporters we are obligated to report suspected child or elder abuse, imminent 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 Clear Outlook Counseling, LLC to provide such outpatient treatment that is determined to be medically necessary or otherwise appropriate. These services may include diagnostic assessment and individual or group counseling/therapy.

I have read and understand the Consent for Treatment.

Signature of Client/ Parent/Legal Guardian

____ __________________________________

Print Name of Signer | Date

____ __________________________________

Relationship to Client | Date

____ __________________________________

You may revoke your consent for treatment in writing at any time and all treatment will be discontinued at that time.

Financial Agreement

Insurance: (Please check the appropriate statement)

____I do have insurance that provides coverage for mental health and/or alcohol/drug treatment services. I agree to pay all deductibles, and/or co-insurance associated to the services I receive.

____I do not have insurance 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 that may provide coverage for mental health services, my insurance NOT be billed for privacy reasons. I acknowledge that with my request that I am financially responsible.

· 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. Your therapist will discuss any additional fee with you before it is charged.

MEDICARE PAYMENT

I, the undersigned, certify that any information given by me in applying for payment under Title XVII of the Social Security Act is complete, accurate, and current. As a Medicare Beneficiary, I have the right to receive Medicare covered services. I acknowledge that I have the right to be involved in any decisions about my treatment and services and who will pay for them.

WAIVER OF LIABILITY FOR NON-APPROVED SERVICES

Ohio law requires us 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 Clear Outlook Counseling, LLC for any services provided to the client. It is my responsibility to notify my therapist of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined. The undersigned acknowledges that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

I acknowledge that I am financially responsible for all charges associated with mental health services provided by Clear Outlook Counseling, LLC 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.

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 I will be charged 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 I will be charged for the scheduled appointment. I agree to pay any late cancellation, missed appointment charges or telephone charges incurred.

_________(initial)

Returned Check Fee: I agree to pay a returned check fee of up to $35.00.

Delinquent Account: I understand that COC may turn my account over to a collection agency if I do not pay in a timely manner. COC 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: Payments can be made on the website using Paypal. Payments should be made before or at the beginning of the session.

____

Client/Guardian Signature

____ ___________________________

Print Name Date

WELCOME

The practitioner's at the Clear Outlook Counseling, LLC are happy that you have decided to come in and find out if we can be of service to you.

Ohio Counseling Law requires us to provide you with the following information regarding your rights and responsibilities as a client here, and the limits of confidentiality. If you have any questions, feel free to discuss them Stephanie Skinner, LPCC-S (513-201-5440).

CLIENT RIGHTS

Clients have the following rights:

A. to be fully informed about a counselor's qualifications, training and experience (please see disclosure form for your counselor).
B. to understand any issue related to treatment or the therapy process.
C. to have the counselor available at the appointment time agreed upon in advance.
D. to discontinue counseling at any time. Should you decide to discontinue, your counselor will request a termination session to discuss progress or areas of continuing concern.
E. to request a change of counselor. Should you feel that you need to change counselors, feel free to discuss that issue with your present counselor.

CLIENT RESPONSIBILITIES

Clients bear the following responsibilities.

A. to arrive for counseling sessions on time, so the hour (45-50 minutes) set aside can be utilized maximally.
B. to cancel appointments 24 hours in advance, so that the counselor can plan an alternative use of his or her time.
C. If an appointment is cancelled less than 24 hours in advance (other than because of illness or family emergencies) you will be expected to pay $50.00 for the missed appointment.
D. You can pay your fee check, credit card, health saving account, or cash. If a person owes for over 3 sessions the client must work out a payment schedule in order to continue sessions.
E. Due to high bank costs, if a client has a check returned we would require cash payment for all future appointments.

LIMITS OF CONFIDENTIALITY

Every effort is made to treat your confidential information in a professional manner in keeping with ethical standards and laws regarding privacy. Please be advised however that there are certain circumstances under which confidential information may be divulged without your express permission.

A. All therapists are required to provide information specified by a subpoena issued by a court of Law; and the results of treatment or tests must be revealed to a court when a client has been ordered into treatment by the court.
B. A therapist may take steps to protect a client or others from imminent danger, when a client threatens physical injury to self or others.
C. A therapist must report disclosures of physical or sexual abuse of a minor to the local children's protective service.
D. A therapist must report disclosures of elder abuse or domestic violence to Adult Protective Services.
E. A therapist must report disclosures of physical or sexual abuse of individuals with disabilities to Child or Adult Protective Services.
F. Your signature below serves as acknowledgment of receipt of our **Notice of Privacy** and **Grievance Procedure (which is located on the website: clearoutlookcounseling.com or a paper copy provided upon request)**

Client's Signature____ Date_______________

Counselor's Signature_______________________________________ Date_______________

Clear Outlook Counseling, LLC
732 Lila Ave
Milford, OH 45150
513-201-5440

TELEHEALTH THERAPY CONSENT FORM

(REQUIRED IN THE EVENT TELEHEALTH IS NECESSARY)

Definition of Services:

I,____, hereby consent to engage in teletherapy with ______________________________. Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of Ohio.

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with the licensed clinician.

4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or

assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may psychotherapy, and that despite my efforts and the efforts of my clinician, my condition may not improve, and in some cases may even get worse.

8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my clinician will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I have read, understand and agree to the information provided above regarding telehealth:

Client's Signature: ________________________________ Date____________

Therapist's Signature: __________________________ Date____________