COUNSELING CONNECTIONS CENTER

Registration

Client Name_____DOB_____Date_____

Address_____

SS#_____ Single___ Married___ Widowed____ Seperated____ Divorced____

Male_____ Female_____

Home Phone_____ Email_____ Cell Phone_____

Where can we leave reminder calls? Home____ Cell____ Email_____ Work____ Text _____
(IMPORTANT: If texting is selected, identify service provider eg: Verizon, Boost etc…)

Clients Employer _____Employer Phone_____

Address_____Occupation_____

Who is responsible for this account _____DOB_____

Address_____email_____

SS# _____Relationship to client _____Phone #_____

Please complete this section for the person who carries the insurance and provide a copy of the card:
If Secondary insurance exists please provide a copy of the card to the office.

Primary Insurance _____ ID#_____GR#_____

Name of Insured_____ Employer_____

Address_____DOB_____

SS#_____ Phone #_____Relationship to Client_____

Emergency Contact_____Relationship_____Phone_____

Address_____ EMAIL _____

Can we mail statements and other correspondence to your home? _____ Yes _____ No

If No, Where would you like them mailed? _____

Any special instructions for communications: _____

COUNSELING CONNECTIONS CENTER

Center Policies

Welcome to Counseling Connections Center, LLC. The following information is provided so that you have a clear understanding of the process of clinical counseling and of our office policies. Please read this information carefully because it will help you utilize these services effectively. We would be pleased to answer any questions you may have regarding treatment, confidentiality, or center policies.

Ethical and Professional Standards

The professional staff of the Counseling Connections Center agrees to abide by the code of ethics of the American Counseling Association as set forth in the laws and regulations governing the practice of Counseling and Social Work. We will make every effort to protect the welfare of those who seek services. If you are ever unhappy with the services provided, we ask that you communicate with us so that we can remedy the situation or provide appropriate referral assistance.

Ohio law requires that issues discussed during counseling be kept confidential. Information that you reveal will not be discussed with others without your written consent. Your records will not be sent or shown to others without your written permission.

There are several exceptions to the confidentiality laws. They are: 1) if there is a threat of potential harm to self (suicide) or others (homicide); 2) if there is suspected child/elder abuse or neglect; 3) subpoena of records by the Court. If any of the above should occur, you will be informed of the need to share the information.

Length of Treatment

For many problems, short term counseling will be all that is necessary. However, when multiple problems are identified, counseling may extend over a longer period of time. We will discuss the duration of counseling after the initial session and as necessary during the treatment. It is the ethical responsibility of the counselor to end the counseling relationship when it is reasonably clear that the client is not receiving benefit from treatment.

Appointments

All visits are by appointment only. If you must miss an appointment we require at least 24 hour notice. If you give less than 24 hours notice or you do not show up for an appointment, it will be at the discretion of the counselor whether or not you will be charged a no show fee of $40.00.

There are times when we are unable to answer our phone. Please leave a message on our confidential voicemail.

Counseling Fees

Counseling sessions typically last 45-50 minutes. The initial session may be longer as we collect background information and complete registration information. The initial session fee is $120.00 and each subsequent session is $100.00.

If you have health insurance, please bring your insurance card for us to copy for our records. Even though part of your counseling expenses may be covered, we require your copay at the time of service. If your plan does not have a set copay, we require $30.00 at the time of service. If we are out of your network, we expect payment in full and you may be reimbursed by your insurance company. A sliding scale may be utilized on a case by case basis.

Fees may be paid by check, cash, HSA, or credit cards. Statements will be provided upon request.

Court Involvement

By signing this form, you are hereby agreeing not to call your counselor in regard to testifying in any court proceeding or deposition. Your counselor is not treating or evaluating any disorder relevant to a civil or criminal proceeding. If the signer waives the counselor/client privilege and calls or subpoenas the counselor to testify at any court proceeding, there will be a $150.00 charge per hour for travel time, appearance and report writing. The signer hereby agrees to pay Counseling Connections Center $150.00 before any information revealed or discussed during any counseling session will be disclosed for any purpose other than medical necessity.

Counseling Connections Center is staffed for counseling sessions by appointment only. We are not a 24 hour emergency or crisis center. If you need crisis or emergency services, please call:

*Firelands Counseling and Recovery Services at 800-826-1306, or
*Police at 911, or
*Go directly to the nearest emergency department.

Client or Guardian Signature:_____Date:_____

Counselor Signature:_____Date:_____

COUNSELING CONNECTIONS CENTER

Family/Home History Adult

Name of Person Completing Form_____ **Date**_____

1. STARTING WITH THE CLIENT please list all persons living in the home:

Name:	Age:	M/F	Relationship:	Occupation:	Last Grade Completed In School:

2. Please list all members of the client's family (parents, siblings, and children) who do not live with the client:

Name:	Age:	M/F	Relationship:	Occupation:	Last Grade Completed In School:

3. What problems exist in the home? _____

_____

_____

4. When are these problems worse? _____

_____

5. When are these problems better? _____

_____

6. Which family member seems easiest to get along with and why? _____

_____

7. Which family member is the most difficult to get along with and why? _____

_____

8. Who disciplines the children in the home and how? _____

_____

_____

9. Please list any current marriages in your family (including yours)

_____married_____on (date)_____

_____married_____on (date)_____

_____married_____on (date)_____

_____married_____on (date)_____

10. Please list any previous marriages in your family (including yours)

_____was married to_____from_____to_____

_____was married to_____from_____to_____

_____was married to_____from_____to_____

_____was married to_____from_____to_____

11. Do you belong to a church? Yes_____ No_____

If yes, name of the church_____

12. How important is religion in the family's life?

Important_____ Very important_____ Not very important_____ Not at all important_____

13. How important is religion to you?

Important_____ Very important_____ Not very important_____ Not at all important_____

14. Please tell us any other significant or interesting information about you that we may not have asked.

_____

_____

_____

COUNSELING CONNECTIONS CENTER

New Client Information Adult

Welcome to the Counseling Connections Center. We wish to be of service to you. To help us get started, kindly fill out the following confidential questionnaire. Thank you.

Name_____Age_____Date of Birth_____

1. In your own words, what difficulties bring you here? _____

2. Please circle any concerns you or your family have at this time:

Abuse	**Divorce**	**Marriage**	**Relationships**
Alcohol	**Drugs**	**Motivation**	**Shyness**
Anger	**Eating**	**Parenting**	**Sleeping**
Anxiety	**Energy Level**	**Peer Problems**	**Suicidal Thoughts**
Boredom	**Family**	**Physical Health**	**Tension**
Career	**Fears**	**Pregnancy**	**Study Skills**
Communication	**Friends**	**Problem Solving**	**School Problems**
Confusion	**Grief**	**Procrastination**	**Time Management**
Dating	**Identity**	**Religion**	**Other_____**
Depression	**Loneliness**	**Sex**	**Other_____**

3. Have you tried before to get help for this? Yes_____ No_____

4. When did these problems first begin? _____

5. What solutions have you tried on your own?_____

6. **What important things have happened to you / your family in the last six months? _____**

   _____

7. **Have you received any prior counseling, psychological or psychiatric services? Yes_____ No_____**

   If yes, when_____where_____

8. **Are you currently receiving counseling, psychological or psychiatric services? Yes_____ No_____**

9. **How did you hear about the Counseling Connections Center?**

   Friend ____Physician _____Pastor ____ Insurance Company/E.A.P. _____Teacher _____Website_____

   Yellow Pages _____Other (Please specify) _____

10. **Please place a check mark next to any of the following experienced by you and/or your parents, grandparents or siblings.**

	Self	Parents	Grandparents	Siblings	Comment
Learning Problems:					
Substance Abuse:					
Mental Illness:					

11. **Has your behavior ever led to court-ordered treatment? Yes_____ No_____ If Yes, explain_____**

    _____

    _____

COUNSELING CONNECTIONS CENTER

Personal Health

*****NOTE: CHILD to complete if able or with assistance.**

Date:_____

Name:_____

1. **Family Physician:** _____ **Your Height:** _____ **Your Weight:**_____
2. **Date of your last medical examination:** _____
3. **Any current medical conditions being treated?** _____
4. **Do you currently have any aches or pains?** _____
5. **Please circle any medically related concerns you currently have at this time:**

Vision Problems	Muscle Pain
Headaches	Sleep concerns
Hearing Problems	Exercise
Dizziness	Alcohol consumption
Trouble Breathing	Smoking
Chest Pain/Pressure	Sex
Stomach upset	Bad dreams/nightmares
Diarrhea/Constipation	Back/Neck pain
Appetite Concerns	Tiredness/Exhaustion
Balanced Diet	Nervousness

6. **What prescribed medicines are you currently taking?** _____

_____

7. **What serious illnesses / operations have you had?** _____

_____

8. **Are you on a special diet?** Yes_____ No_____

9. **Do you have any physical limitations?** Yes_____ No_____

If so, explain: _____

10. **Do you drink alcohol?** Yes_____ No_____

At what age did you start drinking alcohol? _____

How frequently do you drink alcohol now? _____

How many alcoholic drinks do you have on an average week? _____

11. **What street drugs have you used?** _____

_____

How old were you when you used them? _____

Are you using street drugs now? Yes_____ No_____

If yes, what street drugs? _____

FOR WOMEN ONLY

My menstrual cycle is regular: Yes_____ No_____

I have premenstrual problems: Yes_____ No_____

I take birth control pills: Yes_____ No_____

I am having change of life problems: Yes_____ No_____

COUNSELING CONNECTIONS CENTER

Receipt of Policies and Consent to use and Disclose Personal Health Information

This form is an agreement between you, _____ and the Counseling Connections Center. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.
(Child)

You have received a copy of the Center Policies statement. If you have any questions about counseling or office policies please ask.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you, or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to these others. You are also acknowledging that you have read, understand and agree to all the forgoing provisions of your counseling at the Counseling Connections Center stated in the Center Policies. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read the Notice of Privacy Practices before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices or our Center Policies. If we do change it, you can get a copy by calling us at 419-447-8111, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

By signing this form I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts the assignment below.

I also authorize payment of medical benefits to the treating physician or supplier for services provided on my behalf.

I will comply with the office procedures as stated in the Center Policies statement.

_____ _____
Signature of client/parent/legal representative Date

_____ _____
Printed name of client/parent/legal representative Relationship to the client

Date of NPP_____ Witness_____ (copy given to the client/parent/legal representative)

COUNSELING CONNECTIONS CENTER

Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information about:

Printed Name _____ Date of Birth _____

I authorize _____ of the **Counseling Connections Center** to use or disclose the following information: _____

_____.

Dates of care included: From _____ to _____

To this person or organization: _____

Address: _____

This information will be used/disclosed for the following purpose: _____ at the request of the individual, or

_____

This authorization expires on: (date or condition for expiration) _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulation at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer for **Counseling Connections Center at 300 Melmore Street, Tiffin Ohio 44883.**

I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it. I acknowledge that I do have the right to receive a copy of this form after I sign it.

_____ _____
Signature of client/parent/legal representative Date

_____ _____
Printed Name of client/parent/legal representative Relationship to the Client

_____ _____
Signature of Witness Date

This authorization to Use and Disclose Protected Health Information may be revoked by the client / parent / legal representative at any time except to the extent that action has already been taken. I hereby revoke this Authorization to Use and Disclose Protected Health Information.

_____ _____
Signature of client/parent/legal representative Date