



COUNSELING  
CONNECTIONS  
CENTER

# Registration

Client Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

SS# \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ 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: \_\_\_\_\_



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

## Child-Adolescent Information

Date \_\_\_\_\_

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.

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Name of person filling out this form \_\_\_\_\_

Relationship to this child \_\_\_\_\_

1. In your own words, what are the problems or difficulties this child is experiencing? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. When did these problems first begin? \_\_\_\_\_
3. What changes have you noticed recently in his / her behavior or moods? \_\_\_\_\_  
\_\_\_\_\_
4. What aches, pains or physical discomforts does this child have? \_\_\_\_\_  
\_\_\_\_\_
5. What has he / she been hospitalized for in the past? \_\_\_\_\_  
\_\_\_\_\_
6. What accidents has this child had? \_\_\_\_\_  
\_\_\_\_\_
7. Which schools has this child attended? \_\_\_\_\_  
\_\_\_\_\_
8. In which subjects does he / she earn his / her best grades? \_\_\_\_\_  
\_\_\_\_\_
9. In which subjects has he / she earned his / her lowest grades? \_\_\_\_\_  
\_\_\_\_\_
10. Is this child's schoolwork: Above Average \_\_\_\_\_ Average \_\_\_\_\_ Below Average \_\_\_\_\_
11. What are his / her favorite subjects? \_\_\_\_\_  
\_\_\_\_\_
12. What school problems does he / she have? \_\_\_\_\_



---

13. Please CIRCLE any of the following which are problems with this child.

- |                    |                           |                          |
|--------------------|---------------------------|--------------------------|
| 1. Stealing        | 11. Tiredness / Fatigue   | 20. Clumsiness           |
| 2. Lying           | 12. Eating Problems       | 21. Over-Activity        |
| 3. School Problems | 13. Sex Problems          | 22. Under-Activity       |
| 4. Running Away    | 14. Shyness               | 23. Easily Upset         |
| 5. Toilet Problems | 15. Extreme Fears         | 24. Self-critical        |
| 6. Temper Tantrums | 16. Over-Dependency       | 25. Destructiveness      |
| 7. Nail Biting     | 17. Jealousy / Resentment | 26. Depression / Sadness |
| 8. Sleep Problems  | 18. Cruelty               | 27. Guilt Feelings       |
| 9. Nervousness     | 19. Over-Sensitive        | 28. Alcohol / Drugs      |

Please tell us a little about each one you circled \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

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

---

---

---

---



COUNSELING  
CONNECTIONS  
CENTER

# Family/Home History Child/ Adolescent

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

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. Do you belong to a church? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name of the church \_\_\_\_\_

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

Important \_\_\_\_\_ Very important \_\_\_\_\_ Not very important \_\_\_\_\_ Not at all important \_\_\_\_\_

11. How important is religion to you?

Important \_\_\_\_\_ Very important \_\_\_\_\_ Not very important \_\_\_\_\_ Not at all important \_\_\_\_\_

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

---

---

---

---



COUNSELING  
CONNECTIONS  
CENTER

# New Client Information Child/Adolescent

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

Date \_\_\_\_\_

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. In which school subjects do you earn the best grades? \_\_\_\_\_  
\_\_\_\_\_

10. In which school subjects do you earned the lowest grades? \_\_\_\_\_  
\_\_\_\_\_

11. Is your schoolwork: Above Average \_\_\_\_\_ Average \_\_\_\_\_ Below Average \_\_\_\_\_

12. What are your favorite subjects? \_\_\_\_\_  
\_\_\_\_\_

13. What school problems do you have? \_\_\_\_\_  
\_\_\_\_\_

14. Has your behavior ever led to court-ordered treatment? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**\*\*\*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)





# 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