Cincinnati & Commonwealth Counseling Service Inc.

DATE

Client Name: _____
LAST NAME FIRST NAME M.I.

Address: _____
STREET CITY STATE ZIP

Cell Phone # _____ Home Phone # _____

Date of Birth: ____/____/____ S.S. # _____ FEMALE ☐ MALE ☐
MM DD YYYY

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Child/Under 18 ☐ AGE _____

Employer: _____ Phone # _____

Address: _____
STREET CITY STATE ZIP

Responsible Party Other than Client: _____
LAST NAME FIRST NAME M.I.

Address: _____
STREET CITY STATE ZIP

Relationship to Client: _____

Cell Phone # _____ Home Phone # _____

Date of Birth: ____/____/____ S.S. # _____ FEMALE ☐ MALE ☐
MM DD YYYY

Employer: _____ Phone # _____

Address: _____
STREET CITY STATE ZIP

Spouse Name: _____
LAST NAME FIRST NAME M.I.

Address: _____
STREET CITY STATE ZIP

Relationship to Client: _____

Cell Phone # _____ Home Phone # _____

Date of Birth: ____/____/____ S.S. # _____ FEMALE ☐ MALE ☐
MM DD YYYY

Employer: _____ Phone # _____

Address: _____
STREET CITY STATE ZIP

CHILDREN'S NAMES	DATE OF BIRTH	AGE

Cincinnati & Commonwealth Counseling Service Inc.

INSURANCE INFORMATION: PRIMARY

Insurance Company

Insurance Company Contact Phone Number
(The phone # is usually located on the back of card.)

Member/Subscriber ID#

Policy Subscriber If Different From Client

Group #

Date of Birth: ____/____/____
MM DD YYYY

INSURANCE INFORMATION: SECONDARY (IF APPLICABLE)

Insurance Company

Insurance Company Contact Phone Number
(The phone # is usually located on the back of card.)

Member/Subscriber ID#

Policy Subscriber If Different From Client

Group #

Date of Birth: ____/____/____
MM DD YYYY

EMPLOYEE ASSISTANCE PROGRAM-EAP (IF APPLICABLE)

EAP Company

EAP Company Contact Phone Number

Approval/Client ID#

Number of Visits Approved

Client's Reason for Visit:

Previous Mental Health Treatment:

Substance Assessment:	**HISTORY**	**CURRENT**
Alcohol-	N=Never, O=Occasional, D=Daily	
Tobacco (Any Form)-	N=Never, O=Occasional, D=Daily	
Vaping/E-Cigarette-	N=Never, O=Occasional, D=Daily	
Prescription Medication-	N=Never, O=Occasional, D=Daily	
Illegal Drugs/Type-	N=Never, O=Occasional, D=Daily	

Cincinnati & Commonwealth Counseling Service Inc.

Client Conditions/Illness of Relevance: _____

_____

_____

Client Family Medical History of Relevance: _____

_____

_____

Client's Primary Care Physician:
PCP

_____
Physician

_____
Practice

_____
Address City State Zip

_____
Phone # Fax #

In order to provide continuity of care, may your Therapist contact your Primary Care Physician? YES ☐
The proper release form will need to be completed. NO ☐

_____ _____
CLIENT NAME **DATE**

RX=Prescription/OTC=Over the Counter

Medication-RX or OTC/Strength	**Doctor/Dosage**	**Purpose**

THE CLIENT/RESPONSIBLE PARTY HAS READ, COMPLETED, SIGNED & DATED THE CINCINNATI & COMMONWEALTH COUNSELING SERVICE INC. - "CCCS NEW CLIENT FORM"

_____
Client/Responsible Party – PRINTED

_____ _____
Client/Responsible Party – SIGNATURE DATE

THE SPOUSE/PARTNER HAS READ, COMPLETED, SIGNED & DATED THE CINCINNATI & COMMONWEALTH COUNSELING SERVICE INC. - "CCCS NEW CLIENT FORM"

_____
Spouse/Partner – PRINTED

_____ _____
Spouse/Partner – SIGNATURE DATE

Cincinnati & Commonwealth Counseling Service Inc.

RELEASE FORM NOTIFYING THE CLIENT'S PCP OF TREATMENT BY THE FACILITY SHOWN BELOW

CLIENT NAME: DOB:

A. TREATING BEHAVIORALHEALTH CLINICIAN & FACILITY INFORMATION

Cincinnati & Commonwealth Counseling Service Inc. Ph#: 513-922-1660 Fax#: 513-922-6230

Behavioral Health Clinician- Signature

Behavioral Health Clinician-Printed

Address: _____
STREET CITY STATE ZIP

B. CLIENT PCP-MEDICAL CLINICIAN OR OTHER BEHAVIORAL HEALTH CLINICIAN & FACILITY INFORMATION

Facility: _____ Ph#: _____ Fax#: _____

Signature-Title

Printed -Title

Address: _____
STREET CITY STATE ZIP

C. CLIENT CLINICAL INFORMATION

1. **The client is being treated for the following behavioral health problem(s):**
   - ☐ ADHD/Behavior D/O
   - ☐ Substance Abuse
   - ☐ Psychotic Disorder
   - ☐ Bipolar D/O
   - ☐ Depressive D/O
   - ☐ Anxiety D/O
   - ☐ Eating Disorder
   - ☐ Adjustment D/O
   - ☐ Personality D/O
   - ☐ OTHER: _____

2. **The client is taking the following prescribed psychotropic medication(s):**
   - ☐ Antidepressant-SSRI
   - ☐ Antidepressant-Tricyclic
   - ☐ Antidepressant-MAOI
   - ☐ Antidepressant-Wellbutrin
   - ☐ Lithium
   - ☐ Antipsychotic-Atypical
   - ☐ Antipsychotic-Typical
   - ☐ Clozaril
   - ☐ Stimulant
   - ☐ Anxiolytic
   - ☐ Anticonvulsant/Mood Stabilizer
   - ☐ Other (Indicate medication name):

3. **Expected length of treatment:** ☐ < 3 months ☐ 3-6 months ☐ 6-12 months ☐ > 1 year

4. **Coordination of care issues/other significant information impacting medical or behavioral health care:**

DATE MAILED OR FAXED TO PCP/CLINICIAN AT FACILITY SHOWN ABOVE: _____
(PLACE A COMPLETED COPY OF THIS FORM IN THE CLIENT'S MEDICAL RECORD)

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in Section B above. The reason for disclosure is to facilitate continuity of treatment. This consent will last **one year** from the date signed. I understand that I may revoke my consent at any time.

Client/Responsible Party Signature Date

Behavioral Health Clinician/Facility Representative Signature Date

I do not want to have information shared with:

- ☐ My PCP/medical practitioner.
- ☐ My other behavioral health practitioner(s)/provider(s).
- ☐ I am not currently receiving services from a PCP or other medical practitioner.
- ☐ I am not currently receiving services from any other behavioral health practitioner or provider.

For Client Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: The information disclosed to you are from records whose confidentiality is protected by federal law. Federal regulations (42) CPR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

Cincinnati & Commonwealth Counseling Service Inc.

CLIENT INFORMATION & CONSENT FOR TREATMENT

Client Information:

The Client's therapist is engaged in a private practice providing mental health and substance abuse services. The sessions can range anywhere between 45-55 minutes in length. The number of sessions or length of treatment depends upon many factors and can be discussed with your therapist.

Cincinnati & Commonwealth Counseling Service Inc. offers hours at three different locations:

Western Hills-Ohio
5520 Harrison Ave. Ste. D
Cincinnati, Ohio 45248

Florence-Kentucky
75 Cavalier Blvd. Ste. 325
Florence, Kentucky 41042

Website: cincinnaticounseling.org (Print New Client Forms)
E-Mail: counselingcinti@aol.com
Fax # 513-922-6230

All scheduling is handled in the Western Hills Location

Western Hills hours are Monday- Thursday 9:00 am – 7:00 pm
Friday 9:00 am – 3:00 pm

Please call 513-922-1660 to schedule an appointment.

IN CASE OF EMERGENCY, IF THE THERAPIST CANNOT BE REACHED, PLEASE CALL 911.

CONSENT FOR TREATMENT

Limits of Services and Assumption of Risk:

- Behavioral health and substance abuse treatment may show many benefits for clients. Treatment often leads to improved relationships, solutions for problems, and significant reduction in feelings of distress.
- Since treatment often involves discussing unpleasant aspects of your life, the client may experience feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness.
- The treatment and services that are provided can have benefits and risks. There is no guarantee of what the client experiences.

Confidentiality:

- There are some situations in which the therapist is legally obligated to take actions which are believed necessary in the attempt to protect others from harm. The client's treatment may need to be revealed. If the situation arises, the therapist will make every effort to discuss the situation with you before taking any action and will limit disclosure to what is necessary.
- If the therapist has reason to believe that a child or vulnerable adult (i.e. the elderly, disabled or incompetent) is at risk of being neglected or abused, the law requires the situation is reported to the appropriate agency.
- If the therapist has reason to believe that the client presents a clear and substantial danger or harm to themselves, or others, the therapist will take protective actions. The actions may include, contacting family members, seeking hospitalization for the client, notifying any potential victim(s) and notifying the police.
- Parent(s) or legal guardian(s) of non-emancipated minor (under 18 years of age) clients have the right to access the clients' records.
- Insurance company providers and other third-party payers are given information that they request regarding services to clients.

The client hereby voluntarily agrees to receive behavioral mental health and, or substance abuse care, treatment, or services. The client hereby authorizes the therapist to provide such care, treatment, or services as are considered necessary and advisable.
The client understands, agrees, and participates in the planning of care, treatment, or services. The client may stop such care, treatment, or services at any time. The client understands there are no guarantees that treatment will be successful.

The undersigned client acknowledges that I have read, dated, and understand the information contained herein the "CCCS Client Information & Consent to Treatment" form.

Client/Responsible Party Signature | Client/Responsible Party Printed | Date

Cincinnati & Commonwealth Counseling Service Inc.

Client Financial Policy

Thank you for choosing ***Cincinnati & Commonwealth Counseling Service Inc.,*** as your mental health care provider. We are committed to providing quality mental health services. Your clear understanding of our Client Financial Policy is important to our professional relationship. Please take time to carefully review the following information and return this form to the front desk with your signature and today's date.

We require that all clients complete our Client Financial Policy prior to seeing the therapist.
It is your responsibility to notify our office of any client information changes (i.e., insurance information, address, phone, etc.).

Insurance:

- It is the client's responsibility to provide our office with **current insurance information.** We will request a copy of the insurance card at the client's first visit.
- If current information is not obtained at the time of service, it will become the client's responsibility to pay the entire balance until current information is provided to our office.
- Your insurance policy is a contract between **you and your insurance company.** It is ultimately your responsibility to confirm a therapist's status as part of your network. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

Co-Pays:

- Co-payments are due at the time you check in at the front desk **PRIOR** to your being seen by our therapists.

Deductibles and Co-Insurance:

- Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be **paid at the time of service.**

EAP-Employee Assistance Program:

- Some companies offer an Employee Assistance Program. It is the responsibility of the client to supply the EAP Company which provides this service along with a contact phone number for the EAP Company. (It is often different from your regular provided insurance plan.) The client also is given an authorization code and number of visits approved by the company. **Some EAP companies associate the authorization code to a specific therapist; please make sure of your status.**
- The approved visits will be at no cost to the client. Once the EAP visits have been exhausted, the client's regular insurance company will be billed.

Un-paid/Outstanding Balances:

- If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. **We cannot bill a former spouse regardless of a divorce decree.**
- You may contact our office at 513-922-1660 to set up payment arrangements if necessary. Any overdue balances may be considered for further collection activity.

Late Cancellations & No Show Appointments:

- Please help us serve you better by keeping appointments. In the event you are unable to keep your appointment we require, at minimum, a **24 hour notice.**
- **Failure to provide a 24 hour notice, or a no show/missed appointment will be charged a $50.00 fee.**
  This charge is the responsibility of the client and is not covered by any insurance carrier.
- Cincinnati & Commonwealth Counseling Service., reserves the right not to reschedule a client who habitually receives no show/late cancellation appointment fees. Our therapists' time is valuable and we have reserved an hour of their time for you, numerous occurrences do not allow for another client to be scheduled in that time slot.

Returned Checks:

- The charge for a returned check is **$35.00** payable by cash, money order, or charge (no checks accepted). This will be applied to your account in addition to the insufficient funds amount.

Cincinnati & Commonwealth Counseling Service Inc.

Client Financial Policy-Continued

Testing, Forms, Letters,& Court Appearances:

- There will be additional fees for testing, letters, FLMA paperwork, disability forms and other reporting. **Payment is due at the time of the testing or when paperwork is completed.**
- Court appearances, whether subpoenaed or not, are charged from portal to portal at the regular hourly rate.
- **This charge is the responsibility of the client and is not covered by any insurance carrier.**

Like all businesses it is our intention to thoroughly explain our financial policies and set forth our expectations. Your assistance and cooperation is appreciated.
We are pleased to have the opportunity to meet your needs. You may contact our office with any questions or concerns at 513-922-1660.

I have read the ***Cincinnati & Commonwealth Counseling Service Inc., Client Financial Policy*** and acknowledge my responsibilities by affixing my signature below.

- **Failure to provide a 24 hour notice, or a no show/missed appointment will be charged a $50.00 fee.**

Client/Responsible Party – SIGNATURE _____ Client Date of Birth _____

Client/Responsible Party - PRINTED _____ Date _____

VOLUNTARY CARD INFORMATION

The signature below authorizes Cincinnati & Commonwealth Counseling Service Inc., to process deductibles or co-pays that need to be paid at the time of service. (The card information is to be kept in the clients' file for future payments.)

☐ DISCOVER ☐ MASTER CARD ☐ VISA

CARD #: _____

Expiration Date: _____ 3 Digit Security Code-(Back of the Card): _____

Card Holder- Signature _____ Card Holder- Printed _____ Date _____

THE CLIENT ACKNOWLEDGES THE OPPORTUNITY TO HAVE, AND TO READ THE CINCINNATI & COMMONWEALTH COUNSELING SERVICE INC. - "PRIVACY PRACTICE-HIPAA FORM"

Client/Responsible Party – SIGNATURE _____ DATE _____