

DATE: \_\_\_\_\_

Welcome! Thank you for entrusting us with your counseling needs. Please take a moment to complete the information below so we may serve you better. If client is a minor, please fill out the information for the minor child.

**CLIENT INFORMATION**

\_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

\_\_\_\_\_  
STREET ADDRESS PO BOX CITY STATE ZIP CODE

\_\_\_\_\_  
HOME PHONE WORK PHONE CELL PHONE

E-MAIL: \_\_\_\_\_

IT IS OK TO LEAVE A MESSAGE ON MY:  HOME PHONE  WORK PHONE  CELL PHONE  
 PLEASE DO NOT LEAVE ANY MESSAGES FOR ME

SEX: M  F  \_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER

CURRENT MARITAL STATUS:  SINGLE  MARRIED  SEPARATED  DIVORCED  WIDOWED

SPOUSE'S NAME: \_\_\_\_\_

CLIENT'S EMPLOYER OR SCHOOL: \_\_\_\_\_

HOW DID YOU HEAR ABOUT ME?  PROFESSIONAL REFERRAL  FRIEND  FAMILY  CHURCH/PASTOR  INTERNET  OTHER

**IN CASE OF EMERGENCY, PLEASE CONTACT:**

\_\_\_\_\_  
FIRST AND LAST NAME PHONE # OTHER PHONE #

\_\_\_\_\_  
RELATIONSHIP TO CLIENT

**PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE):**

\_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

\_\_\_\_\_  
STREET ADDRESS PO BOX CITY STATE ZIP CODE

\_\_\_\_\_  
HOME PHONE WORK PHONE CELL PHONE

\_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER EMPLOYER

DATE: \_\_\_\_\_

**SESSION FEE AGREEMENT**

My counselor has agreed to see me for a fee of: \$90.00 per session (50 minutes). If I am unable to keep my appointment, I will give my counselor a 24-hour notice, so others may be seen. I understand that I may be charged the full session fee of \$90.00 for any sessions cancelled within 24-hours of my scheduled appointment. I also understand that I will be charged an additional \$35.00 for all returned checks. I have read and understand this agreement and have had the opportunity to ask questions about it. I agree to pay at time of service the amount listed above for therapy sessions, in addition to other charges in connection with my treatment. If my financial circumstances change, I will promptly notify my counselor.

\_\_\_\_\_  
CLIENT/PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**CONSENT FOR TREATMENT**

I understand that my counselor provides professional clinical therapy that is informed and guided by a distinctively Christian worldview, based upon the teachings of Christ, the Apostles, and the Holy Scriptures. I hereby give my consent to receive professional services based upon this perspective. At any time during the course of treatment, I have the right to terminate counseling and request a referral to another professional or agency.

I understand and consent to treatment with my counselor and to the release of information for therapeutic, billing, supervision, and other purposes in connection with my treatment, as well as with other medical providers or parties that may have an interest in, or may be helpful to, my (my child's) care. I understand that for a more detailed view of how my (my child's) information may be released and used under certain circumstances, that I may review the current *Notice of Privacy Practices*, which is available to me in printed form.

\_\_\_\_\_  
CLIENT/PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of Westerville Counseling Group's *Notice of Privacy Practices*.

\_\_\_\_\_  
CLIENT/PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

Thank You!  
☪

## **WESTERVILLE COUNSELING GROUP POLICIES**

**PHONE CALLS:** You are welcome to contact your counselor between sessions. However, lengthy calls may be billed in 15-minute increments at the discretion of your counselor. During a crisis or emergency, if you can't reach your counselor, please call 911 or Netcare at 614-276-2273.

**PARENTS OF MINOR CLIENTS:** It is important that children and adolescents have a sense of privacy in their therapy in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgment of what is in the child's best interest from a therapeutic standpoint. Proof of Guardianship must be provided to your child's counselor prior to treatment. A *Consent for Treatment of a Minor* form must also be signed by the child's parent(s) or legal guardian(s) prior to treatment.

**LIMITS OF CONFIDENTIALITY:** As a mandated reporter, state law requires your counselor to report any allegations or suspicions of abuse or neglect of a child and any allegations or suspicions of abuse, neglect, or exploitation of any adult or developmentally disabled person. Your counselor is also obligated to seek immediate crisis intervention in the event that a client reports any threat (whether real or perceived) of imminent danger of physical harm to oneself or another person. Should you or a loved one experience thoughts of suicide, or if a suicide attempt is made, please call 911 or Netcare at 614-276-2273 and notify your counselor immediately.

**CONFIDENTIALITY FOR COUPLES/FAMILIES/GROUPS:** Please discuss with your counselor how you wish to handle spouse phone calls, scheduling, or individual sessions and limits of confidentiality where couples, families and groups are involved.

**THERAPY CONSIDERATIONS:** As with any type of therapy, there are some inherent risks involved in your treatment, which could range from mild feelings of discomfort to more intense reactions. The purpose of the therapy is to help you handle problems and situations in a constructive way. You have the right to discontinue therapy at any time, or to change counselors. Your counselor can provide you with information on alternative ways to handle your concerns, which may include a referral to another counselor who specializes in a specific area, or to an agency that may handle your care in the event that you are unable to continue with your present counselor.

**CRISIS SITUATIONS:** This counseling site is not a crisis intervention facility. If a life-threatening or other crisis situation arises, please take the following steps: 1) CALL 911 OR YOUR LOCAL POLICE; 2) CALL NETCARE AT 614-276-2273; 3) CALL YOUR COUNSELOR TO MAKE HIM/HER AWARE OF YOUR SITUATION.

**PAYMENTS:** At this time, we do not accept insurance, but are happy to provide you with a receipt that you may submit to your insurance company for possible reimbursement. We accept cash or checks only. Payment is due at the time of service, prior to your session. Any exception to this must be arranged with your counselor in advance. Please note there is a \$35.00 fee for all returned checks. Outstanding balances are the responsibility of the client, and may be cause for termination of services or referral to another agency which can accommodate your financial situation or need.

**SESSION FEES:** Regular session fees are as follows: Individual Therapy (50 minutes) - \$90.00; Individual Therapy (75 minutes) - \$125.00; Marriage & Family Therapy (50 minutes) - \$90.00; Marriage & Family Therapy (75 minutes) - \$125.00; Group Therapy (60 minutes) - \$40 + materials fee; Group Therapy (90 minutes) - \$60 + materials fee.

**SCHOLARSHIPS:** We offer a limited number of counseling scholarships throughout the year for anyone demonstrating financial hardship or need. Proof of income may be required. We reserve the right to determine the number of sessions and/or scholarships offered in order that we may serve more clients. Scholarships are offered on a first-come, first-served basis.

**NO SHOW/CANCELLATION POLICY:** 1<sup>st</sup> No Show/Less than 24-Hour Cancellation - \$25.00. 2<sup>nd</sup> No Show (at any time during treatment) - \$45.00. 3<sup>rd</sup> No Show - \$90.00.

**ACCESS TO RECORDS:** You may review your record at any time at no charge. Copies of your record can be provided for a small fee, as set by the State of Ohio, to cover the cost of copies. Any request for release of client file information must be submitted in writing to: Robert Rubinow, 33 E. Schrock Rd., Suite 23, Westerville, Ohio 43081.

**RELEASE OF INFORMATION:** You agree that we may release your information to other medical providers, our attorney, our accountants, and for all other treatment, payment, and healthcare operations. We will share only the information we deem necessary to ensure continuity of services. Your consent for the release of information for treatment, payment, or health care operations shall be effective for a period ending four years after therapy has terminated.

**LEGAL PROCEEDINGS:** If your/your child's counselor is called upon to become involved in legal proceedings pertaining to therapy, you agree to pay for the counselor's time, as listed in the fee schedule, in preparing for such legal action, including, but not necessarily limited to, travel to and from, and attendance at a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees your counselor may incur as part of your involvement in such legal action. All testimony, information, assessments, or communications exchanged with the court shall remain professionally objective and independent of the relationship between counselor and client.

**ENDING THERAPY:** It is very important that your therapy have an appropriate ending. If you decide to stop coming for sessions, please inform your counselor. It is healthy to review what has been accomplished and what may still need to be accomplished. Please know that you are always welcome to return at any time.

**FEEDBACK/COMPLAINTS:** We strive to maintain the highest ethical standards of care and practice, and always look for ways to enhance our services. We welcome any questions, comments, or concerns related to the policies, content, or delivery of our counseling services. We will make every effort to resolve your concerns in a timely manner, and encourage you to first talk them over with your counselor. If the problem or concern is still unresolved, you have the right to contact the State of Ohio Counselor, Social Worker & Marriage and Family Therapist Board, either in writing at 50 West Broad Street, Suite 1075, Columbus, OH 43215, or by phone at 614-466-0912. You may also visit the Board Website at [www.cswmft.ohio.gov](http://www.cswmft.ohio.gov) to register a complaint.

**I HAVE READ AND AGREE TO THE TERMS OF THE POLICIES ABOVE, AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THEM.**

CLIENT'S OR CLIENT'S PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_