Spirit of Peace Clinical Counseling

WELCOME

LICENSED PROFESSIONAL CLINCIAL COUNSELORS, PROFESSIONAL COUNSELORS, AND SOCIAL WORKERS

We are pleased that you have considered coming to Spirit of Peace for therapy. Counseling is a very personal shared interaction and should not be entered into lightly. We present this information in an effort to make you familiar with our procedures in advance.

OFFICE HOURS

Our clinicians are seen by appointment only. Counseling hours and days may vary, depending upon the clinician's and the counselee's needs. Evenings and Saturdays are available for some clinicians. Our administrative hours are Monday through Friday, 9:00 a.m. to 5:00 p.m., during which time our clinicians/intake coordinators return all calls. Messages can be left anytime on our voice mail, 614-442-7650 or email info.sopcc@gmail.com. All appointments, including at Satellite locations, are made through contact with the individual clinician.

SERVICES AND FEE SCHEDULE

Our fees for a LPCC, LPC, LISW, LSW, or Intern are $175.00 for the first session and subsequent sessions of 30 minutes are $75.00, 45 minutes are $125.00, and 60 minutes are $150.00. Session length will be determined at the first session with your clinician taking into consideration your insurance benefits or financial situation. The fee includes additional time for the clinician to make notes, fill out assessment forms, make telephone calls and referrals when needed, and to plan for the future sessions. Every effort will be made to begin and end promptly, but our commitment to respond to priority needs, such as psychological emergencies, may require you to be flexible and understanding.

If you are considering using insurance for reimbursement, you should discuss this option with your clinician prior to your first visit. Some insurance policies cover some percentage of outpatient counseling, however, you are ultimately responsible to pay any balance that your insurance company may not cover. Reduced fee counseling is available to help make the cost of counseling affordable, for those who qualify out of need. **It is our intent that all who seek counseling are assisted in finding a way to make that help affordable.**

WHAT YOU CAN EXPECT DURING YOUR FIRST SESSION

Your first visit to SOPCC is a time for you to begin to know us and how we operate, and for us to get to know you and your concerns. During your first session, you can expect the counselor to:

1. Inquire about concerns.
2. Inquire about your background.
3. Review our policies and procedures.
4. Answer your questions.

HELPFUL HINTS FOR YOUR FIRST SESSION

1. Bring your current, valid insurance card with you so we can make a copy of it.
2. Bring the forms that your counselor asked you to fill out in advance, that they either mailed to you or requested you download from our website.
3. If applicable be prepared to pay for the session in full or a co-pay or deductible.
4. Make a list of ideas you want to talk about.
5. Make a list of questions that you have.
6. Remind yourself that asking questions during the session is a valuable thing to do.

CHILDREN

Because we care about the safety and well being of your family, we ask that you provide supervision for your children in the reception area if you bring them along with you to the counseling office. It is preferable that during parent's sessions and psychological testing that other arrangements are made for childcare. If other arrangements are not possible, please do not leave your children unattended while meeting with your therapist. Bring a relative or friend with you to care for them.

CONFIDENTIALITY AND LIMITS OF CONFIDENTIALITY

Our entire staff adheres to professional standards regarding confidentiality. *Statutes require and/or permit us to notify specified others in situations of expected homicide, suicide, and child or elder abuse or neglect.*

Spirit of Peace Clinical Counseling

CLIENT'S RIGHTS

The services, programs, and facilities of Spirit of Peace Clinical Counseling are provided in a non-discriminatory basis, as required by the Civil Rights Act of 1964. All residents of Franklin and surrounding counties are eligible for services without discrimination on account of race, creed, color, religion, sex, national origin, age, handicap, or ancestry. Participants in the services offered by SOPCC are entitled to rights and grievance procedures as required by Ohio Revised Code 5119.61 for SOPCC and as provided for by Ohio Department of Mental Health Rule #5122: 2-1-02.

For Your Understanding

1. This information is provided at the intake or the very next appointment.
2. Clinicians will provide an oral explanation of the rights of most interest to you.
3. A copy of the Client's Rights Policy and Grievance Procedure is posted in the waiting area of the SOPCC office.
4. A complete copy of Client's Rights Policy and Grievance Procedure is provided to you herein.

Client's Rights

Each client has the following rights:

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy;
2. The right to service in a humane setting which is the least restrictive feasible as defined in the treatment plan;
3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;
4. The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent to or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client;
5. The right to a current, written, individualized service plan that addresses one's own mental health, social and economic needs and that specifies the provision of appropriate and adequate services, as available, either directly or by referral;
6. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan;
7. The right to freedom from unnecessary or excessive medication;
8. The right to freedom from unnecessary restraint or seclusion;
9. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments, or therapies, or regardless of relapse from earlier treatment in that or other service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written into the clients' current service plan;
10. The right to be informed of and refuse any unusual or hazardous treatment procedures.
11. The right to be advised of and refuse observation of techniques such as one-way vision mirrors, tape recorders, television, movies, or photographs;
12. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense;
13. The right to confidentiality of communications and of all personally identifying information with the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or parents or legal guardian of a minor client or court appointed guardian of the person of an adult client in accordance with rule 5122.2-3-11 of the administrative code;
14. The right to have access to one's own treatment plan unless access to particular, identified items of information is specifically restricted for the individual client for clear treatment reason in the client's treatment plan. Clear treatment reasons shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is imminent risk. The person restricting the information shall explain to the client factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policy and procedures for viewing or obtaining copies of personal records;
15. The right to be informed in advance of the reason's for discontinuance of service provision, and to be involved in planning for the consequences of that event'
16. The right to receive an explanation of the reasons for denial of service;
17. The right not to be discriminated against in the provision of service on the basis of religion, color, creed, sex, national origin, age, life-style, race physical or mental handicap, or developmental disability.
18. The right to know the cost of services;
19. The right to be fully informed of all rights;
20. The right to exercise any and all rights without reprisal in any form including continued uncompromised access to service.
21. The right to file a grievance; and
22. The right to have oral and written instructions, for filing a grievance.

CLIENTS RIGHTS OFFICER

Clients Rights Officer is available to assist clients with all aspects of client rights and the grievance procedure.
This information is required by the Ohio Counselor, Social Worker, Marriage and Family Therapist Board which regulates all licensed counselors. Counselor and Social Worker, Marriage and Family Therapist Board: 50 W. Broad St., Ste. 1075, Columbus, OH 43215-5919 *614-0912

Spirit of Peace Clinical Counseling

Privacy Officer: Michele Melaragno
1170 Old Henderson Rd. Suite 100
Columbus, OH 43220
614-442-7650 ext.3
info.sopcc@gmail.com

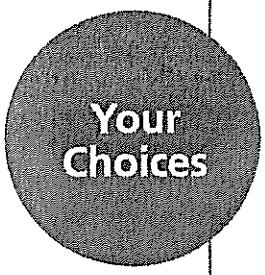
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ ***See page 2*** *for more information on these rights and how to exercise them*



You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ ***See page 3*** *for more information on these choices and how to exercise them*

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

** We do not store client case files electronically.*

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 23, 2013

This Notice of Privacy Practices applies to the following organizations.

This Notice applies to Practice Management Solutions employees who operate our payment services.
Fax: 614-771-1798
Phone: 614-771-1778

Larry Castle – Ext 201	*larry@pmsibas.com*
Katie Boggs – Ext 202	*kate@pmsibas.com*

Spirit of Peace Clinical Counseling - Michele Melaragno
614-442-7650 ext. 3

Spirit of Peace Clinical Counseling
Main Office: 1170 Old Henderson Road
Columbus, OH 43220
Tele: 614-442-7650 FAX: 614-442-7656

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge my receipt of SOPCC's *Notice of Privacy Practices* (effective April 1, 2003) received by me on the date stated below:

Date of Signature of Client or Personal Representative of Client

Signature of Client or Personal Representative of Client

Print Client's Name

Client's Address

Print Name of Personal Representative

Description of Personal Representative's Authority to Act for the Client (if applicable)

Spirit of Peace Clinical Counseling
Main Office: 1170 Old Henderson Road
Columbus, OH 43220
Tele: 614-442-7650 Fax: 614-442-7656

AUTHORIZATION FOR CREDIT/DEBIT CARD PAYMENTS FOR SERVICES

I, _____ authorize Spirit of Peace Clinical Counseling (SOPCC) and/or its billing services group, Practice Management Solutions (PMS), to charge my credit/debit card for services rendered to myself and/or the clients listed below. In providing us with your credit/debit card, you are giving SOPCC and PMS permission to automatically charge your card on file for the following fees and balance(s) for you and/or other clients listed on this form at the time of service.

Co-pay/Co-insurance/Deductible: The amount defined by the client's insurance company for behavioral health services that are due at the time services are rendered.

Self-Pay Fees: The clinician's fee for service when insurance and/or employee assistance programs do not apply.

No Show and Late Cancellation Fees: The fee listed in the clinician's Disclosure Statement for **non-emergency** appointment no-shows or cancellations without 24 hour notice.

Outstanding Balance: If the client's insurance provider has paid their portion of the bill and there is still an outstanding balance owed, Spirit of Peace Clinical Counseling will send a balance statement to the client/guarantor/responsible party's address on file by regular mail and/or provide the client with a statement in session. If we do not receive a response or payment in full within **30 days** of the statement date, any balance owed will be charged to this credit/debit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question the insurance company's determination of payment.

I authorize SOPCC and/or PMS to charge the above fees and outstanding balance(s) to my credit/debit card: **Visa** ____ **MasterCard** _____ **Discover** ____ **American Express** ____

Credit Card# _____ Exp. Date: _____/_____/_____

Security Code: _____ Card Holder's Name (please print):_____

Signature: _____ Date: _____/_____/_____

If you wish to leave this credit/debit card on file for other clients, please print the name(s) below:

Client Name: _____ Date of Birth: ____/_____/_____

Client Name: _____ Date of Birth: ____/_____/_____

Client Name: _____ Date of Birth: ____/_____/_____

Spirit of Peace Clinical Counseling

CLIENT INFORMATION FORM

(please complete all the information requested on this form)

********* Please Print *********

First Appointment: _____ Today's Date: _____

CLIENT INFORMATION:

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ 9 Digit-Zip Code: _____-_____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

Ok to leave message at: _____ Email: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Employer: _____ Student: _____

In the event of an emergency SOPCC may contact: _____

Relationship: _____ at phone number ( )_____

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):
(Do not complete this section if the Responsible Party information is the same as the client information)

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____ City:_____ State: ____ Zip Code: _____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

Ok to leave message at: _____

PRIMARY INSURANCE INFORMATION: (This section is necessary for Spirit of Peace Clinical Counseling to receive payment from your Insurance/EAP for the counseling provided. *You must complete this section and present a copy of your insurance card for insurance to be billed*)

Insurance Company: _____

Phone Number: ( )_____

INSURED PERSONAL INFORMATION (Subscriber):

Relationship to Client: _____ Employer: _____

I.D. #: _____ Group #: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: ____ 9 Digit-Zip Code: _____-____

Home Phone: ( )_____ Birth Date: _____

Cell Phone: ( )_____ Sex: Male _____ Female _____

Work Phone: ( )_____ Social Security #: _____

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to SOPCC. I understand that I am responsible for paying my deductible or co-pay (where applicable).

Signature _____ Date _____

I authorize SOPCC to release information to Practice Management Solutions for the purposes of billing.

Signature _____ Date _____

PLEASE NOTE: We do not bill secondary insurance. If you choose to submit on your own, you must use the Explanation of Benefits statement sent by the primary insurance company to your address.

This section must be completed by the Clinician BEFORE paperwork is processed

Clinician: _____ **Location:** _____

Estimated amount due at time of service (co-pay and/or deductible): $ _____

Reduced fee (non-insurance only): $ _____ **Write off: $** _____

Diagnosis 1: _____ **Diagnosis 2:** _____

Miscellaneous Information: _____

_____

Spirit of Peace Clinical Counseling

CLINICAL HISTORY REPORT

DEMOGRAPHICS

Date:

Client Name: _____ Client Number: _____

Client Address: _____ (9 Digit Zip Code)_____-_____

Parent(s)/Guardian(s) Name(s): _____

Telephone Number(s): Okay to leave a message?

Home #: _____ Yes No Date of Birth: ____/____/____

Work #: _____ Yes No Age: _____

Cell #: _____ Yes No Gender: _____

Email: _____

PRESENTING PROBLEMS

Duration (Months)

1. _____ _____
2. _____ _____
3. _____ _____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time
Mild = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and /or day-to-day functioning
Severe = Profound impact on quality of life

	None	Mild	Mod	Sev		None	Mild	Mod	Sev		None	Mild	Mod	Sev
depressed mood	☐	☐	☐	☐	binging/purging	☐	☐	☐	☐	guilt	☐	☐	☐	☐
appetite disturbance	☐	☐	☐	☐	laxative/diuretic abuse	☐	☐	☐	☐	elevated mood	☐	☐	☐	☐
sleep disturbance	☐	☐	☐	☐	anorexia	☐	☐	☐	☐	hyperactivity	☐	☐	☐	☐
elimination disturbance	☐	☐	☐	☐	paranoid ideation	☐	☐	☐	☐	dissociative states	☐	☐	☐	☐
fatigue/low energy	☐	☐	☐	☐	circumstantial symptoms	☐	☐	☐	☐	somatic complaints	☐	☐	☐	☐
psychomotor retardation	☐	☐	☐	☐	loose associations	☐	☐	☐	☐	self-mutilation	☐	☐	☐	☐
poor concentration	☐	☐	☐	☐	delusions	☐	☐	☐	☐	significant weight gain/loss	☐	☐	☐	☐
poor grooming	☐	☐	☐	☐	hallucinations	☐	☐	☐	☐	related medical condition	☐	☐	☐	☐
mood swings	☐	☐	☐	☐	aggressive behaviors	☐	☐	☐	☐	emotional trauma victim	☐	☐	☐	☐
agitation	☐	☐	☐	☐	conduct problems	☐	☐	☐	☐	physical trauma victim	☐	☐	☐	☐
emotionality	☐	☐	☐	☐	oppositional behavior	☐	☐	☐	☐	sexual trauma victim	☐	☐	☐	☐
irritability	☐	☐	☐	☐	sexual dysfunction	☐	☐	☐	☐	emotional trauma perpetrator	☐	☐	☐	☐
generalized anxiety	☐	☐	☐	☐	grief	☐	☐	☐	☐	physical trauma perpetrator	☐	☐	☐	☐
panic attacks	☐	☐	☐	☐	hopelessness	☐	☐	☐	☐	sexual trauma perpetrator	☐	☐	☐	☐
phobias	☐	☐	☐	☐	social isolation	☐	☐	☐	☐	substance abuse	☐	☐	☐	☐
obsessions/compulsions	☐	☐	☐	☐	worthlessness	☐	☐	☐	☐	other (specify)	☐	☐	☐	☐

GOALS FOR COUNSELING

1. _____
2. _____
3. _____

DEVELOPMENTAL HISTORY (required information under age 18)

Delayed Development or Long Term effects from events: check normal or check description and describe effect

Prenatal/Perinatal Events:	☐ Normal	☐ Description	_____
Physical:	☐ Normal	☐ Description	_____
Psychological:	☐ Normal	☐ Description	_____
Social:	☐ Normal	☐ Description	_____
Intellectual:	☐ Normal	☐ Description	_____
Academic/Educational:	☐ Normal	☐ Description	_____
Sexual Abuse History	☐ Normal	☐ Description	_____
Physical Abuse History	☐ Normal	☐ Description	_____
Trauma Related History	☐ Normal	☐ Description	_____

FAMILY HISTORY

FAMILY OF ORIGIN: (check all that apply)

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	☐	☐	☐
father	☐	☐	☐
stepmother	☐	☐	☐
stepfather	☐	☐	☐
brother(s)	☐	☐	☐
sister(s)	☐	☐	☐
other (specify) _____	☐	☐	☐

Parents current marital status:

- ☐ married to each other
- ☐ separated for _____ years
- ☐ divorced for _____ years
- ☐ mother remarried _____ times
- ☐ father remarried _____ times
- ☐ mother involved with someone
- ☐ father involved with someone
- ☐ mother deceased for _____ years

Age of client at mother's death ____

- ☐ father deceased for _____ years

Age of client at father's death ____

Describe parents:

	Father	Mother
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:

- ☐ outstanding home environment
- ☐ normal home environment
- ☐ chaotic home environment
- ☐ witnessed physical/verbal/sexual abuse toward others
- ☐ experienced physical/verbal/sexual abuse from others

Age of emancipation from home: _____ Circumstances: _____

Special circumstances in childhood: _____

Has any family member: (check and describe all that apply)

☐ received outpatient psychotherapy? Who/Why: _____

☐ received inpatient treatment for a psychiatric, emotional or substance use disorder? Who/Why: _____

☐ had a history of alcohol/substance abuse? Who/What: _____

IMMEDIATE FAMILY:

Marital status:

- ☐ single, never married
- ☐ engaged _____ months
- ☐ married for _____ years
- ☐ divorced for _____ years
- ☐ separated for _____ years
- ☐ divorce in process ____ months
- ☐ live-in for _____ years
- ☐ prior marriages (partner)

Relationship satisfaction:

- ☐ very satisfied with relationship
- ☐ satisfied with relationship
- ☐ somewhat satisfied w relationship
- ☐ dissatisfied with relationship
- ☐ very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to Client

Intimate relationship:

- ☐ never been in a serious relationship
- ☐ not currently in relationship
- ☐ currently in a serious relationship

List children not living in the same household as client: Name/Age/Sex/Frequency of contact

Client Number: _____

FAMILY HISTORY (continued)

Describe any past or current significant issues in intimate relationships: _____

_____

_____

Describe any past or current significant issues in other immediate family relationships: _____

_____

_____

MEDICAL HISTORY

Describe current physical health: ☐ Good ☐ Fair ☐ Poor Name of primary care physician: _____

Address/Telephone of Family Physician/PCP: _____

Date last seen: _____ ☐ release obtained ☐ release refused by client

Current Medications/Dosages: (prescription/over the counter/herbal supplements): _____

_____

Allergies to Medications: _____

Name and Contact Information of Psychiatrist (if applicable): _____

_____

Date last seen: _____ ☐ release obtained ☐ release refused by client

Serious or long term effects of Illnesses, Surgeries, Injuries, and/or Hospitalizations:

Date_____ Age____ Reason/Effects_____

Date_____ Age____ Reason/Effects_____

Date_____ Age____ Reason/Effects_____

Date_____ Age____ Reason/Effects_____

Date_____ Age____ Reason/Effects_____

MENTAL HEALTH HISTORY

Prior outpatient psychotherapy? ☐ No ☐ Yes

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ ☐ release obtained ☐ release refused by client

Provider Name : _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ ☐ release obtained ☐ release refused by client

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder? ☐ No ☐ Yes

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ ☐ release obtained ☐ release refused by client

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ ☐ release obtained ☐ release refused by client

Current Treatment? ☐ No ☐ Yes

Provider Name: _____ Dates seen: _____

Address/Telephone: _____

Reason: _____ ☐ release obtained ☐ release refused by client

Client Number: _____

SUBSTANCE ASSESSMENT (over age 12)

History of Use:

Past Alcohol: ☐ No ☐ Yes Description: Frequency: _____ Amount: _____

Past Drugs: ☐ No ☐ Yes Description: Frequency: _____ Amount: _____

Description:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Use:

Alcohol: ☐ No ☐ Yes Description: Frequency: _____ Amount: _____

Drugs: ☐ No ☐ Yes Description: Frequency: _____ Amount: _____

Description

_____ _____ _____

_____ _____ _____

_____ _____ _____

Alcohol/Drug Treatment:

Inpatient: ☐ No ☐ Yes When/Where: _____

_____

Outpatient: ☐ No ☐ Yes When/Where: _____

_____

Tobacco Use:

☐ No ☐ Yes Description: Frequency: _____ Amount: _____ How long/when started: _____

SOCIO-ECONOMIC HISTORY

Current Supportive Relationships: check and describe all that apply

Siblings: _____

Parents: _____

Friendships: _____

Sexual Orientation: ☐ heterosexual ☐ homosexual ☐ bisexual

Cultural/Spiritual/Recreational History:

Cultural identity (e.g. ethnicity, religion): _____

Any cultural or religious issues that contribute to current problems: _____

_____

Currently active in community/church/recreational activites? ☐ No ☐ Yes Description: _____

_____

Formerly active in community/church/recreational activites? ☐ No ☐ Yes Description: _____

_____

Currently engaged in hobbies? ☐ No ☐ Yes Description: _____

Importance of Faith in Counseling: _____

Living Situation:	☐ housing adequate	☐ housing overcrowded	☐ dependent on others for housing ☐ homeless
	☐ housing dangerous/deteriorating	☐ living companions dysfunctional	
Employment:	☐ employed and satisfied	☐ employed but dissatisfied	☐ unemployed
	☐ coworker conflicts	☐ supervisor conflicts	☐ disabled _____
	☐ student	☐ unstable work history	
Education:	☐ grades 1 – 8	☐ some college	☐ vocational or tech degree
	☐ grades 9 - 12	☐ college graduate	
	☐ high school graduate	☐ post graduate degree	
Financial Situation:	☐ no current financial problems	☐ impulsive spending	☐ relationship conflicts over finances
	☐ large indebtedness	☐ poverty or below poverty income	
Military History:	☐ never in military	☐ served in military – no incident	☐ served in military – <u>with</u> incident, describe
			_____
Legal History:	☐ no legal problems	☐ now on probation/parole	☐ jail/prison _____ time(s), total time served _____
	☐ arrest(s) not substance related	☐ arrest(s) substance related	☐ description of last legal difficulty:
	☐ court ordered this treatment		_____

Client Number: _____

Spirit of Peace Clinical Counseling

QUESTIONS TO ASK YOUR INSURANCE COMPANY

Health insurance policies are an agreement between you and your insurance company. To help you understand what coverage you can expect in relationship to outpatient psychotherapy (counseling), simply call your insurance company regarding outpatient behavioral healthcare and ask the following questions. Although not every area of treatment is covered on this form, it should clarify most questions, and be useful in submitting claims.

1. *Date I called my insurance company* _____
2. *Name of the Person who gave me the information* _____
3. *Is my therapist in network? YES NO*

If the answer to #3 is NO, skip to #7.

If the answer to #3 is YES, answer the following set of questions and skip #7- #9.

4. *Does my policy require pre-certification or pre-authorization for treatment? YES NO*

   (If NO, proceed to #5.)

   If YES, how many visits will be pre-certified? _____

   What are the effective dates of the authorization? _____

   What is the authorization number? _____

5. *Does my policy require a referral from a physician? YES NO*

   Have I received the referral from my physician? YES NO

6. *What are my in-network benefits?:*

   Do I have a deductible? YES NO

   Are there separate deductibles for medical and mental health? YES NO

   Has my deductible been met? YES NO If NO what amount is left to be fulfilled? _____

   On what date does my deductible begin? _____

   How many visits do I have per year? _____

   Is this per calendar year or contract year? _____

   How much/what percentage do I have to pay at the time of service (co-pay)? _____

   Any other benefits or limits that I should know about? _____

   _____

Complete the following questions ONLY if your therapist is not in network:

7. *Do I have to choose a mental health provider within my network? YES NO*

   If YES, contact SOPCC for a referral to a therapist in your network: ***614-442-7650.***

8. *If NO, do I have out-of-network benefits? YES NO*

   If NO, contact SOPCC for a referral to a clinician that can work with you.

9. *If YES, what are my out-of-network benefits?* _____

   _____