CLIENT DEMOGRAPHIC FORM Date_____

Last Name _____First Name_____ Age_____

Mailing Address _____

City_____, State _____Zip_____

Home Phone_____Work Phone_____

Cell/Other Phone_____ Email:_____

Marital: M S W D Gender M F

IN ORDER TO FOLLOW UP WITH YOU DURING AND AFTER SERVICES, CHECK EACH APPLICABLE BOX

WORK: HOME: OTHER or CELL:

Permission to call you_____Permission to call you_____Permission to call you. #_____

Permission to leave message _____Permission to leave message _____Permission to leave message_____

MAIL: Permission to use Mailing Address: Y N Special Instructions_____

Clients Social Security # _____Client's Date of Birth _____

How would you like to pay for your sessions?

Self Pay:_____ Insurance:_____(complete information below)

Insurance ID #:_____ Insurance Group #:_____

Insurance Company_____Co-pay Amount: $_____

Insurance Mailing Address:_____State_____Zip_____

Insurance Phone_____Does your insurance require pre-authorization? Yes No

Authorization # if EAP::_____ # of Sessions Approved for EAP: _____

Benefit Holder's SS#_____

Name of Benefit Holder_____Birth Date:_____

Benefit Holder's Relationship to Client _____

Benefit Holder's Employer_____

Who referred you to me?_____

Client Symptom Self Evaluation

Completed by Client

*Please Print Legibly – Information Remains **Strictly** Confidential*

Your Name:_____ **Date**:_____

WHAT CONCERNS DO YOU HAVE?_____

_____

_____

Symptoms (please mark all that apply):

Emotional:

- □ Feeling of extreme happiness
- □ Feeling of extreme sadness
- □ Feeling stressed
- □ Feeling nervous or anxious
- □ Feeling fearful
- □ Excessive worry
- □ Indecisiveness
- □ Depression
- □ Easily irritated
- □ Paranoid thoughts
- □ Self-esteem problem
- □ Feeling guilty
- □ Sudden feelings of panic
- □ Perfectionism
- □ Change in sleeping habits
- □ Procrastination
- □ Crying spells
- □ Problems with anger
- □ Exaggerated startle response
- □ Lack of enjoyment of usual activities
- □ Increased use of alcohol / drugs
- □ Avoiding things
- □ Trouble performing your job
- □ Poor interpersonal skills
- □ Reckless behavior
- □ Trouble concentrating
- □ Not getting along with friends / family
- □ Hearing voices
- □ Fear of situations where escape is difficult
- □ Obsessions or compulsions
- □ Thoughts about hurting yourself
- □ Thoughts about hurting others
- □ Thoughts about killing yourself
- □ Thoughts about killing others
- □ Suicide attempts
- □ Acting violently
- □ Intrusive thoughts

Physical:

- □ Lack of energy
- □ Dry mouth
- □ Memory problems
- □ Chronic weakness
- □ Chronic pain
- □ Muscle tension / aches
- □ Numbness
- □ Sweating / clammy hands
- □ Nerve problems
- □ Trembling / twitching
- □ Hot flashes
- □ Dizziness
- □ Frequent urination
- □ Stomach or bowel problem
- □ Weight changes
- □ Change in eating habits
- □ Self-starvation
- □ Chest pain
- □ Shortness of breath
- □ Heart symptoms
- □ Trouble swallowing
- □ Change in sexual interest

HOW LONG HAVE YOU HAD THE SYMPTOMS CHECKED ABOVE? ***(APPROXIMATE DATE SYMPTOMS BEGAN)*** _____

_____

_____

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

___Attendance ___Absences Mon/Fri.'s ___Tardiness ___Decrease in productivity
___Erratic Behavior ___Conflict with Supervisors ___Discipline ___None
___Conflicts with Fellow Employees

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL:_____

_____

_____

On a Scale of 1-5, how would your rate your distress? (l is low, 5 is severe distress)_____

Medical Condition You Have: (If yes check)

___Diabetes	___ High Blood Pressure	___Heart Disease
___Blood Problems	___Bone/Joint Problems	___Brain Problems
___Skin/Hair/Nail Problems	___Liver Disease	___Respiratory Problems (Breathing)
___Genital	___Kidney/Bladder	___Cancer
___Allergies	___Eyes	___Autoimmune
___Chronic Pain	___Gastrointestinal	___Head Injury

Other health problems not listed above:_____

_____

Sleep Problems:_____

Appetite Problems: _____

Past Health Problems (include difficulties with developmental milestones under age 18) _____

_____

Medication currently using: If NONE, write your initials here_____

Medication	Dosage	Time Taken	Prescribing Doctor	Reason Prescribing

Medication Allergies: If **NONE**, initial here_____If yes what:_____

_____

PAST TREATMENT INTERVENTIONS:

Date	Medical & Surgical	Provider/Program/Hospital
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Conditions that Run in Your Family: (If yes check)

___Diabetes	___ High Blood Pressure	___Heart Disease
___Blood Problems	___Bone/Joint Problems	___Brain Problems
___Skin/Hair/Nail Problems	___Liver Disease	___Respiratory Problems (Breathing)
___Genital	___Kidney/Bladder	___Cancer
___Allergies	___Eyes	___Autoimmune
___Chronic Pain	___Gastrointestinal	

HEALTH HABITS INFORMATION:
For the following questions please base your answers on **the past month** (approximately).

Y N Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
Y N Have you been dieting to lose weight?
Y N Have you smoked cigarettes on a daily basis?
Y N Have you experienced any increased feelings of sadness or hopelessness?
Y N Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol? (Circle your answer):

A) I do not drink at all
B) About once a month.
C) Two to three times a month.
D) One to three times a week.
E) Once a day or more.

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

Y N In the past **year** have you used any illicit or non-prescription drugs?
Y N During the past **month** have you participated in leisure/social/spiritual activities?

Have you ever had a DUI? _____No _____Yes: Details: _____

Y N "In the past year, have you ever drunk or used drugs more than you meant to?" Or "have you spent more time drinking or using than you intended to?"
Y N "Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?"
Y N "Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?"
Y N "Has anyone objected to your drinking or drug use?"
Y N "Have you ever found yourself preoccupied with wanting to use alcohol or drugs?"
Y N "Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?"

FAMILY RELATIONSHIPS (Members of the family you are/were close to)

Name	**Relationship**	**Age (or Year of Death)**	**Quality of Relationship: Excellent, Good, Fair, Bad**	**Lives with you:**
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

Partner's First Name	**Indicate:** Married (M) Live together (LT)	**Length of Relationship**	**Reason ended**

WORK HISTORY: (Start with most recent)

Place	**Position**	**From**	**To**	**Reason ended**

PERSONAL & FAMILY HISTORY:

Were you or any family member physically abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member sexually abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member emotionally abused? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member had a problem with drugs or alcohol? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member ever tried to commit suicide? YES NO (circle)

If yes: Self - family (circle one or both)

Is there any history of anxiety, depression or mental illness in your family? YES NO (circle)

If yes: Self - family (circle one or both)

COMMENTS:

Payment Authorization Form

Patient: _____ Responsible Party*_____

Billing Address: _____ CC #: _____

_____ Expiration Date: _____

_____ Validation Code: _____ HSA (Y/N) _____

***Parent/Legal Guardian is responsible for Minors and non-minor Children. If parents are divorced, Mason Family Counseling will not act as a mediator in settling claim/payment issues. <u>The parent that brings the child in for treatment is responsible for payment</u>. Legally, we are not able to bill ex-spouses, regardless of divorce decree. If you leave us this payment authorization form or pre-pay the ESTIMATED amount you will be able to <u>drop your child off</u> for treatment. If you do not, you will be required to <u>sign your Child in</u> and pay the ESTIMATED due or they will not be seen. <u>PLEASE do not put your child in a difficult situation!</u>**

It is Mason Family Counseling (MFC) **obligation** and **responsibility** to the insurance companies that we are contracted with to collect all office fees for therapy visits at the time of service, which includes **co-pays and deductibles**. If your insurance company has given you other payment information, we will need this in writing.

Please be informed that if you have not met your deductible at the time of service, your insurance will not pay and will apply the fees to your responsibility until your deductible is met. Please complete the following Insurance information:

Your Deductible: $ _____ **Deductible Accumulation to Date**: $_____

Your Co-Pay/Co-Insurance: $_____ **Visit Limit**: _____ **Visit Accumulation**: _____

We check this information at each visit and we will let you know what we ESTIMATE your payment to be. This information is based on information we receive from your insurance company. Please note that it is <u>ultimately your responsibility</u> to review your insurance coverage and benefits prior to and during treatment. You may be responsible for amounts not indicated above if the Explanation of Benefits we receive from your insurance company indicates and additional amount that is your responsibility.

We will be utilizing your credit card within 24 hours of the day of each visit to collect the ESTIMATED amounts due including by not limited to:

- Co-pays, Co-Insurance and Deductibles due
- Any Self-Pay rates if not going through insurance
- Patient portions applied by insurance and not quoted above following any processed claim.
- Any No-Show/Last-Minute cancellations fees due in accordance with our 24-hour Cancellation Policy.

This will not compromise your ability to dispute charges or question your insurance company's determination of payment. For any questions about your statements, charges or if you believe you are due a refund, please do not hesitate to contact our billing department at 513-229-7900.

By signing below, I understand and agree that I am responsible for any collectible payments as due. I authorize MFC to apply estimated charges to the credit card as I accumulate charges from services rendered and as claims are processed. I understand the no prior contact will be made before these charges are made. I also understand that MFC will only send me a statement or detailed invoice of the charges made upon my request.

_____ _____ _____

Financially Responsible Party (Print) Signature of Financially Responsible Party Date

_____

To Be filled in at by our office at your first office Visit:

Unit your deductible is met; we have calculated your patient portion for every visit to be an ESTIMATED $_____.

After your deductible is met we have calculated your patient portion for every visit to be an ESTIMATED $_____.

If no deductible, we have calculated your Co-Pay/Co-Insurance to be an ESTIMATED: $_____

Initials: _____ Date: _____

PERMISSION TO TREAT/FEE AGREEMENT

THIS CONSENT TO TREAT/FEE AGREEMENT dated below BETWEEN:_____ (Responsible Party) AND Laura Vail Sage, Inc, DBA: Mason Family Counseling, 5134 Cedar Village Dr, Mason, OH 45040.

BACKGROUND:

The Responsible Party (RP) is of the opinion that the Service Provider has the necessary qualifications, experience and abilities to provide services in connection with the Client and hereby gives permission to treat same Client (If not RP_____)

The Service Provider is agreeable to providing such services to the Client, on the terms and conditions as set out in this Agreement.

IN CONSIDERATION OF the matters described above and of the mutual benefits and obligations set forth in this Agreement, the receipt and sufficiency of which consideration is hereby acknowledged, the parties to this Agreement agree as follows:

Engagement: The Client hereby agrees to engage the Service Provider to provide the Client with services consisting of Individual, Group or Family Counseling/Therapy, and such other services as the Client and the Service Provider may agree upon from time to time.

Term of Agreement: The term of this Agreement will begin on the date of this Agreement and will remain in full force and effect until completion of the Services.

Performance: Both parties agree to do everything necessary to ensure that the terms of this Agreement take effect.

Compensation: ***Co-payments are due at the beginning of each session. A five dollar service charge is added to the account for each session where the co-pay is not paid at time of service. Denied insurance claims are due 10 days after date on client bill***. Out of pocket costs are $65 for the first session and $65 for subsequent sessions.

Late Penalties: The following penalties will be imposed on the RP for failing to pay the Service Provider in a timely fashion. ***A service fee of 2% of the balance per month will be charged for unpaid charges over 60 days old.***

No Show/Late Cancellation Penalties: The appointment time is reserved for the client only. Therefore a charge will be imposed if the client fails to show for a scheduled appointment or does not cancel 24 hours in advance. ***The charge for the first time is $30.00, the second time $60.00 and the third time $90.00.*** Late cancellations for emergencies can be discussed.

Other Expenses: The Service Provider will be reimbursed for the following expenses incurred by the Service Provider in connection with providing the Services: ***Paperwork completed outside of session: $25.00 per 15 minute increment including Written Report for any purpose, Returned Checks: $25.00 per occurrence. Phone calls over 2 minutes: $25.00 per fifteen minute increments*** (Note: phone sessions are not usually covered by your insurance***). Court Appearance or Conferences with 3rd parties will be charged at $150 – $180 per hour*** (mileage will not be charged if under 50 miles and hourly billing will begin at the time the provider leaves the office. If mileage is charged it will be at the Federal reimbursement rate)**.**

Confidentiality: The Service Provider acknowledges that a material term of the Agreement with the Client is to keep confidential information belonging to the Client confidential and protect its release to the public. The Service Provider agrees not to divulge, reveal, report or use, for any purpose, any confidential information which the Service Provider has obtained or which was disclosed to the Service Provider by the Client or RP, except as outlined in a., b., or c., below. The obligation to protect the confidentiality of the Client's confidential information will survive the termination of this Agreement and will continue indefinitely.

The Service Provider may disclose the minimum necessary confidential information:

a. To a ***third party insurance provider*** where the Client or RP presents an insurance card/company as a reimbursement source.

b. To the extent ***required by law*** or by the request or requirement of any judicial, legislative, administrative or other governmental body. However, the Service Provider will first give notice to the Client or RP of any possible or prospective order (or proceeding pursuant to which any order may result), and the Client or RP will have been afforded a reasonable opportunity to prevent or limit any disclosure.

c. ***In the event*** Client or RP ***accounts have gone unpaid for 90 days***, the Service Provider may release a copy of this agreement, Client or RP contact information and a copy(s) of any billing sent to the client to a third party collection service. No other confidential information will be released.

Modification of Agreement: Any amendment or modification of this Agreement or additional obligation assumed by either party in connection with this Agreement will only be binding if evidenced in writing signed by each party or an authorized representative of each party.

Governing Law: It is the intention of the parties to this Agreement that this Agreement and the performance under this Agreement, and all suits and special proceedings under this Agreement, be construed in accordance with and governed, to the exclusion of the law of any other forum, by the laws of the State of Ohio, without regard to the jurisdiction in which any action or special proceeding may be instituted.

BY THE CLIENT/PARENT/GUARDIAN SIGNATURE BELOW, the client/parent/guardian has duly executed this Fee Agreement/Consent to treat with Laura Vail Sage, Inc.

_____ _____

Client/Parent/Guardian Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. **Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclosed PHI to any other consultant only with your authorization, such as your primary care physician.**

For Payment. **We may use and disclosed PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility of coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.**

For Health Care Operations. **We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes PHI will be disclosed only with your authorization.**

Required by Law. **Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.**

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required or allowed by law, such as, included, but are not necessarily limited to: the reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department), or abuse involving the elderly or the developmentally disabled/mentally retarded.
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or to other persons as permitted by law, including you.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked, unless we have already relied on it.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Laura Vail Sage, LISW – 5134 Cedar Village Drive, Mason, OH 45040.

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although e are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have a right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Laura Vail Sage, LISW, at 5134 Cedar Village Drive, Mason, OH 45040 or with Region V, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601. Voice Ph. (312)886-2359; Fax (312) 886-1807; TDD (312) 353-5693.

We will not retaliate against you for filing a complaint.

The effective date of this notice is November 20, 2005.

Mason Family Counseling
5134 Cedar Village Drive
Mason, OH 45040
Phone (513)229-7900
Fax (513)229-0202

NOTICE OF PRIVACY PRACTICES

Mason Family Counseling

I, _____ (Print your name)
hereby acknowledge that I have received the Notice of Privacy Practices from Mason Family Counseling.

_____ _____
Signature of Client or Client's Guardian Date

If client and/or guardian refuse to sign, please note this here:

_____ _____
Counselor Signature Date

Registration Information
OFFICE POLICY

1. Your appointment time is reserved for you; I do not double book appointments. Therefore, I have to charge if you fail to show for that appointment or do not cancel twenty-four hours in advance. The charge is $30.00 the first time, $60.00 the second time and $90.00 thereafter. Late cancellations for emergencies can be discussed.
2. Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I may not be able to complete this work if given to me at the end of a session and the charge for paperwork outside of sessions is $25.00 per 15 minutes. I prefer that all such work be done in your session so that you are fully aware and participate in what is written.
3. Sessions are 45 minutes long except for the first session, which may be a bit longer. Please help me monitor the time so that I do not keep you or another client waiting.
4. Your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations and then help me track the number of sessions allowed or you may be responsible for payment.
5. If you need to have a report written by me for any purpose a charge of $100.00 per hour, pro-rated to the time your report takes, will be charged and is not reimbursable by insurance. This fee must be paid before the report can be released to you or to any other party.
6. I have a twenty-four hour message service. If you leave a message for me, I am notified shortly of your call. If you are in an emergency situation and do not hear from me immediately then you must call the 24 hour crisis hotline at 281-2273, your primary care physician, your insurance company, or go to the emergency room so that you are safe and can receive the care you need.
7. Termination of treatment: if you miss three scheduled appointments in a row or are not seen for more than three months, then you will no longer be considered an "active" client in my practice. For legal purposes this policy must be defined. If you wish to return for treatment, simply call me and you case will become active again at the time of your first appointment. Please remember to check your insurance authorization needs prior to your first appointment.
8. Please inform me immediately of any change in insurance coverage, personal address or phone numbers as well as employment changes. Failure to update information regarding insurance coverage could result in your sessions not being reimbursed by your insurance company and you would be responsible for the charges.
9. Please make your co-payment by cash or check at each session. There is a $25.00 charge for any returned checks.
10. Phone calls are welcome but those lasting over 2 minutes may be charged for at a rate of $25.00 per quarter hour (15 minutes). Please be aware that your insurance may not pay for phone therapy.
11. If after termination of therapy, you have a balance due and have not begun paying on it within 30 days, the account will be charged a service fee of 2% of the balance per month. If regular payment is not occurring, your account may be turned over to collection.

CLIENT RIGHTS

- Clients have the right to be treated with dignity and respect.
- Clients have the right to impartial services and access to treatment, regardless of race, religion, gender, ethnicity, age, disability or source of payment.
- Clients will be assured that all information is kept confidential.
- Information will not be released without their prior consent, except in an emergency, or as required by law.
- Clients have the right to be treated by staff/providers who communicate, or arrange for communication in a language and format they understand.
- Clients have the right to be provided with a complete, easily understood explanation of their condition and
- treatment.
- Clients have the right to be informed of all treatment options regardless of the cost of benefit coverage.
- Clients have the right to receive information about services and their role in the treatment process.
- Clients have the right to receive information on availability of providers and the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on policies, services and their rights and responsibilities offered by their insurance company(s).

- Clients will be informed of the complaint, grievance and appeal processes should a dispute arise over treatment and/or claims.
- Clients will be afforded all of his/her rights and privileges guaranteed by state and federal laws.
- Clients have the right to be informed of their rights and responsibilities in the treatment process.
- Clients have the right to participate with providers in decision-making regarding their treatment planning.

Limitation in rights:
The main limitation is in the area of confidentiality. In the following situations, confidentiality does not apply:
(1) An order by the Court, (2) in the case of suspected child, elder or domestic abuse, and (3) for you own welfare (suicide) or that of others (homicide) in serious and imminent life-threatening situations.

For those clients using their insurance to pay for therapy, a consultation with your attending/primary care physician and your insurance company may be needed. Disclosure of your diagnosis, review of your treatment sessions and a review of your treatment plan may be required to access your insurance benefits. You may chose not to authorize the release of this information, however this may prevent you from using your insurance benefits. ***Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use these benefits.***

THE PROCESS OF COUNSELING/THERAPY:

1. Possible benefits derived from therapy include:
   a. Better ways to deal with social, familial and occupational relationships.
   b. Better personal adjustment and contentment.
   c. Better ability to cope with problems and stress.
   d. Better productivity.
2. It is important to note that professional ethic do not permit a guarantee that you will receive these benefits. It is believed that a better life is possible for most people and that an individual's investment and commitment in therapy can determine the outcome.
3. Therapy may also involve some feelings of discomfort. These feelings can occur when you begin to work on changing your beliefs and/or behaviors. This discomfort is viewed as a stepping-stone to a more effective and satisfying life.

I fully understand the above agreement and I freely agree to the above conditions:

_____ _____

Client Signature Date

My Clinician conforms to the Counselor and Social Worker Board or Psychology Board that regulates the practice of professional counseling and therapy and requires this information be given to clients.

State of Ohio Counselor & Social Work Board
50 W. Broad St. Suite 1075
Columbus, OH 43215-5919
Phone 614-466-6462

Ohio Chemical Dependency Professionals Board
Huntington Plaza37 W. Broad Street, Suite 785
Columbus, Ohio 43215
Phone (614) 387-1110 Fax (614) 387-1109

State Board of Psychology
Vern Riffe Center for Government and the Arts
77 S. High Street Suite 1830
Columbus, OH 43215-6108
Phone (614) 466-8808 | fax (614) 728-7081
Toll Free (877) 779-7446

****Informed Consent For Distance Therapy**

I hereby consent to engaging in telemedicine with Laura Vail Sage, Inc as part of my psychotherapy. Ms. Sage is licensed as a LISW, LICDC in Ohio and holds a DCC. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to a health care practitioner located in Ohio or outside of Ohio.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services have certain benefits and limitations. Care may not be as complete as face-to-face service if using chat or email. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

4. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law. However, Laura Vail Sage, Inc is the legal owner of all written or recorded information.

If I have a life threatening clinical emergency I will dial 911 immediately or go to my nearest emergency room. If my crisis is not life threatening and my psychotherapist is unavailable I will contact: http://www.befrienders.org/ or the National Suicide Hotline at 800-784-2433 for assistance.

If for some reason there is a technology problem and our session does not start on-time or is interrupted I will use an alternative contact given to me by my psychotherapist.

I understand that the time I have scheduled with my psychotherapist is reserved only for me and in compensation for the exclusive reservation of the psychotherapist's professional time; I will pay in advance for our session and will not obtain a refund if I fail to be available at the appointed time without 24 hours prior notice.

If I would like more information on my psychotherapists license, ethics or of the rules and regulations governing the above licenses, I can find information at:

- http://www.cswmft.ohio.gov/
- http://ocdp.ohio.gov/licensing.stm
- http://www.naswdc.org/pubs/code/default.asp

My signature below indicates that I have read and understood the information provided above.

_____ _____

Name Date

This notice must be signed and received by Laura Vail Sage, prior to the commencement of treatment.