THE COUNSELING SOURCE, INC.

10921 REED HARTMAN HIGHWAY, SUITE 133
CINCINNATI, OH 45242
Phone: (513) 984-9838 * FAX (513) 984-8075
800-618-0688 800-738-9854

FAX REFERRAL SHEET/ PHONE INTAKE FORM

REFERRAL DATE: _____

_____ **ROUTINE:** Appointment scheduled within 2 weeks
_____ **PRIORITY:** Appointment scheduled within 1 week, Serious symptomology displayed
_____ **URGENT*:** Appointment scheduled same day as referral, danger to self or others, treat as an emergency.
*If referral is urgent, call The Counseling Source office to notify in addition to sending fax referral.

CHILD/STUDENT NAME: _____ ☐ Male ☐ Female

ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

PHONE NUMBER OF CLIENT: _____SCHOOL:_____

CLIENT DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

LEGAL GUARDIAN/EMERGENCY CONTACT:_____

ADDRESS: ☐ Same as Client or _____

CITY: _____ STATE:_____ ZIP:_____

PHONE NUMBER(S): _____

PRIMARY INSURANCE: _____ PHONE NUMBER: _____

GROUP #:_____ ID#:_____

INSURER'S SOCIAL SECURITY #:_____ DATE OF BIRTH:_____

PRESENTING PROBLEM (check all that apply): ☐ suicidal thoughts/statements/attempts
☐ acting sexually inappropriate ☐ adjustment difficulties ☐ anger problems ☐ anxiety ☐ appetite problems
☐ being depressed ☐ being withdrawn ☐ changes in sleep patterns ☐ fears ☐ emotional outbursts
☐ impulsivity ☐ inattention ☐ memory problems ☐ mood swings ☐ problem behaviors
☐ psychotic thinking ☐ relationship problems ☐ thought distortion ☐ worries
☐ other:_____

NAME and TITLE OF PERSON MAKING REFERRAL:_____

PHONE NUMBER/CONTACT INFO:_____

FOR OFFICE USE ONLY:

Referral Received:_____

Primary Clinician:_____ Admit Date:_____
☐ Previously seen by TCS

CONSENT FOR EVALUATION/TREATMENT
FEE AGREEMENT AND INSURANCE AUTHORIZATION

THE COUNSELING SOURCE, INC.
10921 Reed Hartman Highway, Suite 133
Cincinnati, Ohio 45242
Phone: (513) 984-9838 or (800) 618-0688 Fax: (513) 984-8075 or (800) 738-9854

Client Name:_____

Address:_____

City:_____State:_____Zip Code:_____

Telephone: (_____)_____
Area Code

I, the above named individual (or legal representative of this individual) acknowledge and agree to the following:

General Consents/Acknowledgments:

1. I consent to receive mental health services as provided by The Counseling Source, Inc. These services will include Mental Health Assessment, and may include Psychiatric Diagnostic Interview, Pharmacologic Management Service, Behavioral Health Counseling and Therapy Service, Community Psychiatric Supportive Treatment Service, if recommended. All Services provided beyond the initial assessment and psychiatric diagnostic interview will be provided consistent with an Individual Service Plan developed with my input.
2. I acknowledge that I have been informed of the risks and benefits of treatment and my right to refuse or withdraw consent for treatment.
3. I authorize review of my records for quality assurance purposes.
4. I acknowledge that repeated cancellation of sessions without 24 hour prior notice may result in termination of services by The Counseling Source, Inc.
5. I authorize The Counseling Source, Inc. to contact and exchange information about my care with my physician and staff of referring agencies or facilities.

Client Rights Information:

I acknowledge that I have been provided with a copy of the Client Rights and Grievances Policy and Procedures.

Fee Agreement/Insurance Authorization:

1. I authorize The Counseling Source, Inc. to act as my agent in obtaining payment from all third party payers and authorize third party payers to make payment directly to The Counseling Source, Inc.
2. I acknowledge that my monthly income is _____, my family size is _____, and that based on current third party payment information, the portion of the charges for which I will be billed is as follows:

Client Name_____ Date_____

Estimated Charges

$_____per hour for Mental Health Assessment, **plus any deductibles and co-payments** (please check insurance policy/policies).

$_____per hour for Behavioral Health Counseling , **plus any deductibles and co-payments** (please check insurance policy/policies).

$_____per hour for Psychiatric Diagnostic Interview, **plus any deductibles and co-payments** (please check insurance policy/policies).

$_____per hour for Pharmacologic Management Service , **plus any deductibles and co-payments** (please check insurance policy/policies).

$_____per hour for Community Psychiatric Supportive Treatment Service, **plus any deductibles and co-payments** (please check insurance policy/policies).

Total number of hours required for Mental Health Assessment & Psychiatric Diagnostic Interview varies. Inquiries as to estimates of total evaluation time may be addressed to the clinician providing service

Counseling and Community Psychiatric Supportive Treatment Service may be provided in individual or group sessions. Treatment times, and thus costs, may vary.

3. I understand that in signing this document I authorize release of sufficient information to the local Mental Health Board that the Board can enroll me in MACSIS (Multi-Agency Community Services Information System) and determine my eligibility for publically funded services.
4. I am liable for the full cost of services, including any deductibles and co-payments not covered by third party payers. Third party payers (Medicare, Medicaid, private insurance, etc.) will be billed for any covered services, to the extent that I am eligible.
5. I authorize release of information from my clinical records as necessary to process claims for third party payers.
6. I authorize release of information to The Counseling Source to verify household income. This may include, but is not limited to, information from the Internal Revenue Service and my present and past employer(s).
7. I acknowledge that I am responsible for notifying The Counseling Source, Inc. of changes in my insurance coverage or financial status which may affect my billing for services.
8. I acknowledge that with prior warning The Counseling Source, Inc. may terminate services due to non-payment of my bill.

_____ _____

Signature of Guardian or Legal Representative Date

Name of Guardian/Legal Representative:_____Relationship:_____

Address: _____

City:_____State:_____Zip Code:_____

Telephone Number: _(_____)_____

I acknowledge that I have reviewed the above information with the client and/or guardian. I have presented orientation material to (client name) _____(SS#)_____and if the client/guardian had questions, I answered them to apparent satisfaction or helped obtain answers.

_____ _____

Signature of Representative of The Counseling Source Date

Client Race (all that apply): ☐ Asian ☐ Black/African American ☐ Alaskan Native ☐ Native American/American Indian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

Ethnicity (all that apply): ☐ Puerto Rico ☐ Mexican ☐ Cuban ☐ Other Hispanic ☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Return to TCS Clinician

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

The Counseling Source, Inc.
10921 Reed Hartman Hwy., Suite 133
Cincinnati, OH 45242

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information (PHI) about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have been informed of our use and disclosure of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you and that you understand the contents of our Notice and how it applies to you.

_____ _____

Date Signature of Client (or Personal Representative, if applicable)

_____

Client's Printed Name

Complete this section only if the above is not signed:

☐ Notice of Privacy Practices was provided to the client (or Personal Representative, if applicable)

☐ A good faith effort was made by the undersigned to obtain client's (or Personal Representative's, if applicable) on this notice but was unable to due to:_____

_____

_____

_____ _____

Date Signature of Clinician

THE COUNSELING SOURCE, INC.
10921 REED HARTMAN HWY., SUITE 133
CINCINNATI, OH 45242
513-984-9838 or 800-618-0688

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 carefully.

Our duty to Safeguard your Protected Health Information

Individually identifiable information about your past, present or future health or condition, the provision of health care to you, or payment of the health care is considered "Protected Health Information" ("PHI"). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

We are required to follow the privacy practices described in this Notice, though **we reserve the right to change our privacy practices and the terms of this Notice at any time.** You may request a copy of the new notice from The Counseling Source. It will also be posted at our office at 10921 Reed Hartman Hwy., Suite 133, Cincinnati, OH 45242.

How We May Use and Disclose Your Protected Health Information

We use and disclose PHI for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment or our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity in order for that entity to perform a function on our behalf, we must have in place an agreement from the outside entity that it will extend the same degree of privacy protection to your information that we must apply to your PHI. However, the law provides that we are permitted to make some uses/disclosures without your consent or authorization. The following offers more description and some examples of our potential uses/disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations. Generally, we may use or disclose your PHI as follows:

For Treatment: We may use health care information about you to provide you with behavioral health treatment or services. We may disclose information about you to doctors, nurses, counselors, social workers, psychologists and other health care professionals in training, or other agency personnel who are involved in taking care of you through the agency. If you are involved with multiple programs within our agency, different departments may also share health care information about you in order to coordinate the different things you need. We also may disclose health care information about you to people outside the agency who may be involved in your care, such as family members, caregivers or others who are involved in providing your health care. Your PHI may also be shared with outside entities relating to your treatment, such as the local community mental health board if they are involved in the provision or coordination of your care.

To Obtain Payment: We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to the Medicaid program, the Ohio Department of Mental Health, the local community mental health board (through the Multi-Agency Community Information Services Information System (MACSIS) and/or a private insurer to get paid for services that we delivered to you. We may release information to a collection agency for collection purposes.

For Health Care Operations: We may use/disclose your PHI in the course of operating our program. For example, we may use your PHI in evaluating the quality of services provided, or disclose your PHI to our accountant or attorney for audit purposes. Release of your PHI to the Multi-Agency Community Services Information System (MACSIS) and/or state agencies might also be necessary to determine your eligibility for publicly funded services.

Appointment Reminders: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home and/or phone your home.

Uses and Disclosures Requiring Authorization: For uses and disclosures beyond treatment, payment and operations purposes we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop

future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

Uses and Disclosures of PHI from Mental Health Records Not Requiring Consent or Authorization: The law provides that we may use/disclose your PHI from mental health records without consent or authorization in the following circumstances:

When Required by Law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

For Public Health Activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

For Health Oversight Activities: We may disclose PHI to protection and advocacy agencies or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.

Relating to Decedents: We may disclose PHI relating to a death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

For Research Purposes: In certain circumstances, and under supervision of an Institutional Review Board or a Privacy Board, we may disclose PHI to research staff in order to assist medical/psychiatric research.

To Avert Threat to Health or Safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For Specific Government Functions: We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

Uses and Disclosures Requiring You to have an Opportunity to Object: In the following situations, we may disclose a limited amount of your PHI if we inform you about the disclosure in advance and you do not object, as long as the disclosure is not otherwise prohibited by law.

To families, friends or others involved in our care: We may share with these people information directly related to their involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

Your Rights Regarding Your Protected Health Information: You have the following rights relating to your protected health information:

To Request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To Choose how we contact you: We may contact you via mail, phone or in person. You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

To Inspect and request a copy of your PHI: Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see you protected health information upon your written request. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have a right to choose what portions of your information you want copied and to have prior information on the cost of copying.

To Request Amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60

days of receiving your request. We may deny the request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in PHI.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; to you or your family; or pursuant to your written authorization. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or disclosures made before April 14, 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each 12 month period. There will be a charge for more frequent requests.

You have the right to receive this notice: You have the right to receive a paper copy of this Notice and/or an electronic copy by email upon request.

How to Complain about our Privacy Practices:

If you think we have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. <u>You also may file a written complaint with</u>:

Secretary of the U.S. Department of Health and Human Services
U.S. Department of Health and Human Services
Office for Civil Rights
Region V, 233 N. Michigan Ave., Suite 240
Chicago, IL 60601
phone 312-886-2359, fax 312-866-1807
TDD 312-353-5693

We will take no retaliatory action against you if you make such complaints.

<u>Contact Person for Information or to Submit a Complaint</u>:
If you have questions about this Notice or any complaints about our privacy practices, please contact:

Cynthia Bair, Ph.D., Privacy Officer
The Counseling Source, Inc.
10921 Reed Hartman Hwy, Suite 133
Cincinnati, OH 45242
(Phone) 513-984-9838 (Fax) 513-984-8075
(Email) cbair@thecounselingsource.com