Nina Kucyk Psy.D, PCC-S \_\_\_\_\_\_ Jennifer Mizicko PCC, LSW \_\_\_\_\_\_ Theresa Carroll PCC-S \_\_\_\_\_\_\_

Jennifer Seda-Miller PCC-S \_\_\_\_\_\_ Will Maxon-Kann PCC-S \_\_\_\_\_\_\_ Nancy Castle PCC \_\_\_\_\_\_\_ Rebekah Watkins \_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Suffix \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF A MINOR**: Whom currently has custody\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Divorced: visitation schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\* Please Note: If joint custody, I am aware that both parents need to be informed of treatment. \_\_\_\_initial \_\_\_\_Co.**

Phone: Cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to text appointment reminders? \_\_\_\_\_\_\_\_

Work phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Permission to email: \_\_\_\_\_\_\_ Reminders

\_\_\_\_\_\_\_Billing Statements

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City / State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clients Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_

Gender: Male Female Trans\*\_\_\_\_\_\_\_\_\_\_\_\_ (preferred pronoun)

Marital Status: Employment Status (circle one)

Single\_\_\_\_\_\_ Student Retired

Married \_\_\_\_\_years \_\_\_\_\_months Employed Disabled

Divorced \_\_\_\_\_\_years \_\_\_\_\_months Unemployed Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Separated \_\_\_\_\_\_years \_\_\_\_\_months

Widowed \_\_\_\_\_\_years \_\_\_\_\_months Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family Members in the home:

Name Birth Date Age \_Relationship to Client\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

Person Financially Responsible

Self-Pay \_\_\_\_\_\_\_\_\_\_\_\_

Name under whose Insurance: \_\_\_\_\_\_\_\_ Self **OR**

Insured Name: First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_ Male \_\_\_\_\_\_\_ Female Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to client: \_\_\_\_\_\_\_\_\_ Spouse \_\_\_\_\_\_\_\_Child \_\_\_\_\_\_\_Parent \_\_\_\_\_\_\_Other

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City / State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Nbr \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copay \_$\_\_\_\_\_\_\_\_\_\_\_ **I acknowledge that copays are due at time of visit** \_\_\_\_\_\_\_\_ (initial)

**Emergency Contact**

Relationship to Client: \_\_\_\_\_\_ Parent \_\_\_\_\_\_\_ Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City / State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What concerns bring you to counseling?

What changes do you wish to see as a result of counseling?

**Court Involvement**: \_\_\_\_\_\_ No \_\_\_\_\_\_Yes (details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Legal Issues Pending: Is so please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Currently under doctor’s care? Yes No Date of last physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor (s) involved in your care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ Permission to release information(initial) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Issues (including allergies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication currently using (\_\_\_\_\_ None)

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Medication used in the past year NOT currently using (\_\_\_\_\_None)

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**PAST PSYCHIATRIC HISTORY**

Psychiatrist Involved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last seen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ permission to release information (initial or leave blank)

Wrap around services: Case Management \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Disability \_\_\_\_\_\_\_\_\_\_\_\_

Prior Outpatient Therapy: include previous practitioners, dates of treatment, previous treatment interventions and response to treatment (including responses to medications)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**NOTICE OF PRIVACY PRACTICES**

**Receipt and Acknowledgement of Notice**

Client Name (or Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the “The Notice of Privacy Practices”. I understand that if I have any questions regarding the Notice or mu privacy rights, I can contact the Therapist at 2401 Whipple Ave, NW, Canton Ohio 44708 or call 330-956-5681.

Signature of Client Date

Signature of Parent, Guardian or Personal Representative\* Date

\*If signing as a personal representative of the individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_ Client Refused to Acknowledge Receipt

Signature of Counselor Date

**STATEMENT OF FEES**

**RECEIPT, ACKNOWLEDGMENT OF NOTICE & AGREEMENT TO PAY FOR SERVICES**

Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Therapist charges a fee for providing services. Our standard fee is $150 for 60-90 minute session; $125 for 45-50 minute session; however mange care and insurance company contracts may have preset fees that we are required to accept. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. *We will fill out forms and provide you with whatever assistance we can tin helping you receive the benefits to which you are entitled;* **however, you (not your insurance company) are responsible for full payment of my fees.** It is very important that **YOU** find out exactly what mental health or substance abuse services your policy covers.

You should also be aware that most insurance companies require you to authorize us to provide them with clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of entire records (in rare cases). This information will become part of the insurance company’s files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands.

**Client Acknowledgment**

I hereby acknowledge that I am personally responsible for the fees charged for services received. I understand that insurance claims are submitted only as a service. I also understand the following:

* **Copayments are due at time of appointment**
* Arrangements may be made for payments toward any outstanding deductible amounts
* I must give **24 hour notice of cancellation to avoid being charged** a cancelation fee equal to the amount of insurance coverage or the agreed upon fee charge
* In the event of **“no call / no show”** I understand that I will be **charged a fee** equal to the amount of insurance coverage or the agreed upon fee charge
* Any needed or **requested report(s)** will be available for a **minimum of a $25 fee**

\_\_\_\_\_\_\_\_ I acknowledge that I have read and understood the Statement of Fees (initial)

\_\_\_\_\_\_\_\_ I acknowledge that I have signed and received a copy of the Statement of Fees (initial)

Signature of Client Date

Signature of Parent, Guardian, or Responsible Party Date

**CLIENT INFORMATION & ACKNOWLEDGMENT of INFORMED CONSCENT**

**to TREATMENT FORM**

***Your Therapist*** – The following therapists all are engaged in private practice providing mental health services housed at Total Health & Wellness

Nina Kucyk Psy.D, PCC-S: is a Licensed Independent Clinical Counselor – Supvr who holds a Doctorate in Psychology

Jennifer Mizicko LSW, PCC: is a Licensed Independent Clinical Counselor, Licensed Social Worker

Theresa Carroll PCC-S: is a Licensed Independent Clinical Counselor – Supvr

Will Maxon-Kann PCC-S: is a Licensed Independent Clinical Counselor – Supvr

Jennifer Seda-Miller: is a Licensed Independent Clinical Counselor – Supvr

Nancy Castle: is a Licensed Independent Clinical Counselor

***Mental Health & Substance Abuse Services***

The purpose of receiving mental health or substance abuse care services is to help you better understand your situation, change our behavior or move toward resolving your difficulties. The Therapist, using their knowledge of human development, behavior and trauma will make observations about situations as well as suggestion for new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur. You may being other family members to a therapy session(s) if you feel it would be beneficial, or if this is recommended by the Therapist.

The services I offer can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health and substance abuse are services have also been shown to have benefits for people. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in feelings of destress. But there are no guarantees of what you will experience.

***Appointments***

Appointments are made by calling 330-956-5681. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for missed appointment. Third party payers will NOT cover or reimburse for missed appointments. Appointments are 50-60 minutes in length, but may vary for clinical reasons. The number of appointments depends on many factors and will be discussed by the Therapist with you.

***Relationship***

Your relationship with the Therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the Therapist NOT have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The Therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you.

***Goals, Purposes and Techniques***

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the Therapist and to have input into setting goals of our therapy. As therapy progresses, these goals may change. You and the Therapist will jointly determine how to effect the changes you are seeking to make for yourself.

***Confidentiality***

The law protects the privacy of all communications between a client and a therapist. In most situations, the Therapist can only release information about your treatment to others if you sign a written authorization form.

There are some situations where we are permitted of required to disclose information either with or without your consent or authorization. For example:

* If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative’s) written authorization, or a court order. If you are involved in or contemplation litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
* If a government agency is requesting the information, we may be required to provide it
* If you file a complaint or lawsuit again me, I may disclose relevant information about you in order to defend the therapist.
* If you file a workers compensation claim, we must, upon appropriate request, provide a copy of your records or a report of your treatment.

There are some situations in which the therapist is legally obligated to take actions with she or he believes are necessary to attempt to protect others from harm, and we may have to reveal some information about a client’s treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

* If your therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agency
* If the therapist believes you present a clear and substantial danger or harm to yourself and/or others, he or she will take protective actions. There may include contacting family members, seeking hospitalization of you, notifying potential victim(s), and notifying the police

While this summary is designed to provide an overview of confidentiality and its limits. It is important that you read the “Notice of Privacy Practices” which was provided to you for more detailed explanations and discuss with the Therapist any questions or concerns you may have.

***Professional Records***

The laws and standards of our profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward these goals, your medical and social history, you treatment history, results of clinical tests (including raw test data), any past treatment records and I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record, if you request it in writing, except in unusual circumstances that involve danger of yourself and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee .25 per page. If we refuse hour request for access to your records, you have the right to review, which we will discuss upon request.

In addition, as your therapist, I may also keep a set of psychotherapy notes which are for my own use and designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except in rare legal circumstances.

***Minors***

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have.

***Authorization to Warn or Inform Third Parties***

In the event that the Therapist reasonably believes that I am in danger, physically or emotionally, to myself or another person, by signing this Client Information and Acknowledgment or Informed Consent to Treatment, I specifically consent for the Therapist to attempt to warn the person in danger and to attempt to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons listed below:

Name Relation Phone

Name Relation Phone

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization to warn or inform Third Parties shall expire upon the termination of my therapy with the Therapist.

I acknowledge that I have the right to revoke the above authorization to warn or inform third parties, **in writing**, at any time to the extent that the Therapist has not taken action in reliance on this authorization. I further acknowledge that ever if I revoke this authorization, the use and disclosure of my protected health information could still be permitted by law as indicated in the copy of the Notice of Privacy Practices of Therapist that I have received and reviewed.

**After Hours Emergencies**

You may leave a voice message (or text) at 330-620-8519 ONLY FOR EMERGENCIES and your therapist will be informed. If an **EMERGENCY call 330-452-6000**. You can also go directly to the nearest hospital emergency room or call 911 or your local crisis center. Emergencies are urgent issues requiring your immediate action.

***The Therapist’s Incapacity or Death***

I acknowledge that, in the event the Therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my files and records. By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I give my consent to allowing another licensed mental health or substance abuse professional selected by the Therapist to take possession of my files and records and provide me with copies upon request, or to deliver them to a therapist of my choice. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health or substance abuse professional.

***Consent to Treatment***

I, voluntarily, agree to receive mental health or substance abuse assessment, care, treatment, or services and authorities the Therapist to provide such care, treatment or series as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through the Therapist at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgment of Informed Consent to Treatment Form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name

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Client Signature Date

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Parent or Guardian Signature (for Minor Child) Date