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## Informed Consent for Receipt of Counseling Services (Child)

This form is to document that I, \_\_\_\_\_ give voluntary permission and consent for my child to receive psychological services from Hope Restored Counseling Services. My signature also verifies my right to give such permission.

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**Purpose and Background:**

The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of Ohio to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise. While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Hope Restored Counseling Services. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

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**Confidentiality:**

I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Supervision. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

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**HIPAA**

I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Hope Restored Counseling Services' "Notice of Privacy Practices", that were effective of as their start of business in June, 2008. I acknowledge I was offered this policy statement on the date indicated by my signature below.

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**Contact Information:**

The office address for Hope Restored Counseling Services is: 410 W. Loveland Ave. Suite A Loveland, OH 45140. I understand that for routine appointments and information I may call (513)683-4673. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible by my therapist. If I have an after-hours crisis or need assistance more quickly I can call my therapist at the crisis contact number provided in their regular voicemail box, however, I understand this number is for crises only. If I feel I need immediate psychiatric admission to a hospital for stabilization, I understand that I may be referred to the nearest hospital emergency room.

**I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.**

I release and hold harmless Hope Restored Counseling Services, and its staff and agents from any action or liability arising out of my participation in treatment.

\_\_\_\_\_  
Signature of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



420 W. Loveland Ave. Suite 105  
Loveland, OH 45140  
Phone: (513)683-HOPE  
Fax: (513) 683-4108

## Consent To Bill Third Party Payer

**Use of Insurance:**

As a part of receiving psychological services through Hope Restored Counseling Services, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will definitely mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and at times may constitute the release of treatment planning information.

**Charges for Services:**

Diagnostic Assessment	\$140.00
Court Related Fee	\$500.00 (for first 4 hours or less, \$500 for next 4 hours or less)
Psychotherapy Session (45-50 min)	\$125.00
Case Management (per 15 minute)	\$ 35.00
Missed Appointment/Late Cancellation	\$ 50.00

**Payment:**

I understand that payment is expected at time of service. If I wish to pay for services out of pocket, or for the purposes of making my co-payment, should I elect to use my insurance, I may make payments via cash or check. I understand all checks returned unpaid will be subject to a \$25.00 service fee, and if they remain unpaid for more than three months, may be turned over to a collection agency for the purpose of recovering lost funds.

**Use of Insurance and Authorization for Treatment:**

If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral or not following necessary guidelines set by my insurance company for accessing mental health benefits. I understand I will be charged \$50.00 for missed or cancelled appointments unless prior notification is given 24 hours prior to the time of the appointment, I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.

I, \_\_\_\_\_,

wish to use my medical insurance to off-set the cost of treatment, and in so doing give Hope Restored Counseling Services permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

do not wish to use any medical insurance benefit to cover services I receive through Hope Restored Counseling Services. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service.

\_\_\_\_\_  
Signature of Client/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



## Missed Appointment Policy

I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a “No Show” and will be billed to me at the rate of **\$50 per missed appointment**. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice. **In addition, if I miss more than two appointments in an 8 week period, a subsequent appointment time cannot be guaranteed.**

\_\_\_\_\_  
Signature of client/responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of witness

\_\_\_\_\_  
Date



9. Are disciplinary techniques used consistently and with good follow-through?  
 No  Yes

10. Are current disciplinary techniques effective at controlling undesirable behaviors?  
 No  Yes

11. Does your child respond to one parent or care-taker's disciplinary measures better than another?  
 No  Yes: If yes, who \_\_\_\_\_

12. Has your child experienced any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Parental Divorce   | <input type="checkbox"/> Parental Separation  | <input type="checkbox"/> Death of Parent             |
| <input type="checkbox"/> Death of Sibling   | <input type="checkbox"/> Death of Grandparent | <input type="checkbox"/> Death of Close Friend       |
| <input type="checkbox"/> Financial Problems | <input type="checkbox"/> Parental Alcoholism  | <input type="checkbox"/> Parental Drug Abuse         |
| <input type="checkbox"/> Domestic Violence  | <input type="checkbox"/> Physical Abuse       | <input type="checkbox"/> Verbal Abuse                |
| <input type="checkbox"/> Sexual Abuse       | <input type="checkbox"/> Family Bankruptcy    | <input type="checkbox"/> Prolonged Marital Discourse |

13. Has any member of your family ever been diagnosed with a mental illness or substance abuse problem including alcoholism/  
 No  Yes: If yes please provide further details.

14. Was your child born premature?  
 No  Yes

15. Birth Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

16. Approximate age when your child first began:  
\_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_ Toileting

### Medical History

17. Does your child have any immediate health problems (colds, injuries)?  
 No  Yes

18. Does your child have any chronic (long term) health problems (asthma, seizures, allergies, etc.)?  
 No  Yes

19. Has your child ever sustained any serious head injuries (unconscious, auto accident, fight, etc.)?  
 No  Yes

20. Does your child have any developmental disorders (mental retardation, learning disabilities, hearing disabilities, speech problems, etc.)?  
 No  Yes

21. Is your child currently under the care of a physician?

No

Yes: If yes, by whom and for what conditions?

Doctors Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Conditions being treated: \_\_\_\_\_

22. Is your child currently on any medication?

No

Yes

Medication

Dosage

Date Started

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

23. Please list all previous mental health medications:

Medication

Dosage

Date Started

Date Stopped

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

24. Please rate the nutritional value of your child's diet. Good \_\_\_ Fair\_\_\_ Poor\_\_\_

If fair or poor, please explain: \_\_\_\_\_

Check any of the following that apply.

Significant weight gain/loss in last 6 months

Problems chewing or swallowing

Food/drug allergies

Dieting

Overeating or eating too little

If any box is checked please explain: \_\_\_\_\_

25. Has your child had a recent vision check?

No

Yes: If yes, describe results: \_\_\_\_\_

26. Has your child had a recent hearing exam?

No

Yes: If yes, describe results: \_\_\_\_\_

### Educational History

27. What grade is your child currently in? \_\_\_\_\_

28. Where does your child attend school? \_\_\_\_\_

29. Circle any grade(s) failed. K 1 2 3 4 5 6 7 8 9 10 11 12 None

30. Circle any grades skipped. K 1 2 3 4 5 6 7 8 9 10 11 12 None

31. What grades does your child normally get in school? (Circle all that apply)

A B C D F

32. Have there been any tendencies toward improving or deteriorating school performance over the years?

No

Yes: If yes please provide further details.

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33. What are your child's strongest subjects in school? (Circle all that apply)

Math   History   English   Reading   Spelling   Science   Social Studies   N/A

34. What are your child's weakest subjects in school? (Circle all that apply)

Math   History   English   Reading   Spelling   Science   Social Studies   N/A

35. Has your child ever been:

Reprimanded at school:                       No                       Yes

Served detention:                               No                       Yes

Been suspended:                               No                       Yes

Been expelled:                                   No                       Yes

If yes to any, please explain: \_\_\_\_\_

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36. Has the school ever performed psychological or educational testing on your child?

No

Yes

If yes, describe results: \_\_\_\_\_

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### Social Development

37. Does your child have many friends?

No

Yes

38. Does your child make friends easily?

No

Yes

39. What are the most common activities that your child engages in? (bike riding, playing with friends, TV, etc.) \_\_\_\_\_

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### Behavioral Assessment

40. Has your child ever been in trouble with the law?

No

Yes: If yes, please explain.

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41. To your knowledge, does your child use tobacco?

No

Yes

42. To your knowledge, does your child drink alcohol?  
 No  Yes: If yes, how often, how much and for how long?

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When was the last time? \_\_\_\_\_ How many drinks? \_\_\_\_\_

43. What problems has your child suffered as a result of his/her drinking?  
 Arrest  DUI  Peer problems  
 Public intoxication  Financial problems  Arguments  
 None of the above

44. To your knowledge, has your child ever tried drugs?  
 No  Yes: If yes, what drug/s? \_\_\_\_\_

45. To your knowledge, does your child regularly use any drugs?  
 No  Yes: If yes, how often, how much and for how long?

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When was the last use? \_\_\_\_\_ What drug/s was used? \_\_\_\_\_

46. To your knowledge, is your child sexually active?  
 No  Yes

47. Does your child have concerns about his/her sexual orientation or sexual experiences?  
 No  Yes

48. Is your child pregnant or the parent of a child?  
 No  Yes

49. Who has legal custody of your child?  
 Both parents  Mother only  Father only  Other guardian

If other guardian, please indicate name: \_\_\_\_\_