TO CONTACT US:

Your therapist is:_____

Extension #:_____

CRISIS OR EMERGENY SITUATIONS:

When emergency circumstances occur, we recommend that you use one of the publicly funded Emergency Services, which are staffed on a 24 hour basis; or go to your nearest hospital emergency room.

CRISIS & EMERGENCY NUMBERS

**Call “988" for The Suicide and Crisis Lifeline**

| | |
|---|---|
| Good Samaritan Crisis Care | 224-4646 |
| Suicide Prevention Center | 229-7777 |
| Miami Co. Mental Health Center | 335-7148 |

MIDWEST BEHAVIORAL CARE, LTD.

(937) 454-0092

Dayton North

3821 Little York Road

Dayton, OH 45414

Dayton South

28 East Rahn Road

Suites 105, 107, 110

Kettering, OH 45429

Welcome to Midwest Behavioral Care

Midwest Behavioral Care is a multi-disciplinary group mental health practice with offices located throughout western Ohio. We provide clinical and educational, and mediation services for individuals, families, and businesses of all sizes.

MBC is owned by two licensed psychologists:
Stephen W. Pearce, Psy.D. and Debra K. Sowald, Psy.D.,LPCC. Other professionals include independently licensed psychologists, clinical social workers, and counselors possessing skills to meet the varied needs of our clients.

It is MBC's goal to provide you with the best service possible. Ask your therapist any questions you may have regarding your treatment. If you have any questions regarding insurance, billing, or authorization, please call the Administrative Office for assistance.

Financial Policy:

In order to keep your cost of healthcare services to an absolute minimum, we have adopted the following policy:

- Midwest Behavioral Care will bill for professional services based upon the amount of professional time utilized by the delivered service. Fees are based on the length of sessions. A standard session time is 50 minutes, allowing 10 minutes for required documentation.
- It is your responsibility to inform Midwest Behavioral Care of your primary insurance coverage. If your coverage changes, it is your responsibility to report this.
- The responsibility for payment for all services is yours, regardless of whether or not you have health insurance. All fees not reimbursed by insurance will be billed to you. Copayments are to be given to your therapist at the time of your session. Each session will be charged a separate co-payment fee, even if multiple sessions occur on the same day.
- A $5.00 fee will be added to your account if billing is required to collect a co-payment due.
- If your insurance policy has a deductible feature, it is your responsibility to pay the full fee of the session if a claim is denied because your deductible is due.
- If you have secondary insurance, it will be your responsibility to collect from this insurance company. MBC does not consider secondary insurance a responsible party for payment of services.
- If you are not covered by insurance, you are required to pay the full professional fee at the beginning of your appointment.

Call Midwest Behavioral Care's office (454-0092) at least 24 hours prior to cancelling or rescheduling your appointment. If you do not notify MBC, you will be charged the full session fee for each missed appointment.

**Midwest Behavioral Care, Ltd.**

Administrative Office 3821 Little York Road, Dayton, OH 45414 937-454-0092

## CLIENT INFORMATION AND TREATMENT AGREEMENT

Welcome to Midwest Behavioral Care, Ltd. (hereinafter abbreviated as MBC), a group mental health practice that provides a range and variety of services. Since you are a new client, it is important that we provide you with some information about your treatment, your rights, and our office policies. Please read the following form. The therapist working with you will be pleased to respond to any questions you may have regarding any of this information.

This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is included with this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on MBC unless a) we have taken action in reliance on it; b) there are obligations imposed on us by your health insurer in order to process or substantiate claims under your policy; or c) you have not satisfied any financial obligations you have incurred.

### PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client, and the particular problems you are experiencing. There are many different methods your therapist may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things you talk about, both while you are at sessions and when you are not.

Psychotherapy can have benefits and risks. Since therapy 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, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Your first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist should be able to offer you some first impressions of what your therapy work will include and a treatment plan

to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable with your therapist. Therapy can involve a large commitment of time, money, and energy, so you should use careful judgment about the therapist you select. If you have questions about the therapy procedures, discuss them with your therapist whenever they arise. If your doubts persist, we will be happy to assist you to secure an appropriate consultation with another mental health professional for a second opinion.

**APPOINTMENTS**

Appointments are often scheduled for 45- or 60- minute sessions on a once per week basis. However, ongoing therapy is a negotiated process between you and the therapist, and frequency of sessions is partially the decision of the client. Both you and your therapist should periodically evaluate and discuss the progress and the process of therapy, and renegotiate the need and frequency of further appointments. You have the right to terminate therapy at any time. A termination session may be suggested in order to discuss progress made or areas of concern, and to allow the therapist to make any recommendations deemed necessary.

There will be no digital or other recording of treatment sessions, without the express consent of all parties present.

**LENGTH OF TREATMENT**

For many problems, short-term treatment (between one and twelve sessions) is possible. This is particularly the case when one basic problem is identified and is the focus of treatment. When there are several concerns, or when the issues have lasted over a long period of time or over a variety of life areas, a longer term treatment is likely. It may be possible for your therapist to estimate duration or treatment after initial assessment procedures are completed.

**CLIENT RIGHTS AND PARTICIPATION IN THE TREATMENT PLANNING PROCESS**

It is our expectation that you and your therapist will participate as equal and active contributors to your treatment. At all times, you have the right to a full explanation from your therapist about the following aspects of treatment:

1) Methods and techniques used or proposed in your treatment
2) Known or predictable consequences of refusing the suggested treatment
3) Known or predictable side effects from the proposed treatment
4) Reasonable expectations for the duration and outcome of treatment
5) The training and qualifications of your therapist

Always remain aware that you are expected to actively participate in decision making about your treatment. You have the right to refuse or terminate any treatment for any reason at any time. You also have the right to seek additional clinical opinion from other providers, at your own expense.

**CONFLICTS**

If at any time you are displeased with your services, it is important that you talk it over with us. Some clients do this in writing if they feel unable or afraid to do so verbally. You do have the right to change therapists. We will make every attempt to respond to your concerns or resolve any conflicts. If you need help finding other

psychological care, we will do our best to help you find someone. Please try to resolve conflicts with us **before** contacting another mental health service provider; mental health professionals consensually agree that involvement with more than one therapist **at one time** may be harmful for clients, and is unethical for therapists. However, the foregoing circumstances do not in any way detract from your right to refuse treatment, or to seek second opinions from other professionals.

**PSYCHOLOGICAL TESTING**

Your therapist may suggest psychological testing as a brief and efficient method of gaining information about important aspects of your personality and/or current psychological status. Fees for psychological assessment are based upon the number and nature of tests given. If you therapist recommends testing, they will discuss the fees at the time testing is recommended. Your therapist will discuss the results with you after testing is completed.

**CONTACTING YOUR THERAPIST**

The best way to contact us is to leave a message using our voicemail system. To contact our clerical staff, call 454-0092 and dial "0" at the prompt between 9:00 and 5:00 on weekdays. To leave a message for your therapist, call 454-0092 and then dial your therapist's extension. Your therapist's name is _____ and their extension is _____. When trying to reach us, please leave your name and one or more numbers and times when we can return your call. Also, leave the name of the specific person you want the message to go to. We will attempt to get back with you as soon as we can after we receive your message. On some occasions, due to your busy schedule and ours, this may be one or two working days. We ask for your understanding in this matter. IF a call is urgent, call our clerical staff and tell them of the urgency of your call; they will then attempt to make immediate contact with your therapist, if at all possible.

**EMERGENCIES**

We provide services by appointment only. Your therapist may not be available during emergency conditions. On those occasions, or when you need a guaranteed, very rapid, or immediate response to your call, we recommend that you use of the publicly funded Emergency Services, which are staffed on a 24-hour basis:

**Call "988" for The Suicide and Crisis Lifeline**

| | |
|---|---|
| Good Samaritan Crisis Care | 224-4646 |
| Suicide Prevention Center | 229-7777 |
| Miami County Mental Health Center Hotline | 335-7148 |

If you believe you are imminently in danger of harming yourself or someone else, call the police or a reliable friend to transport you to the nearest hospital Emergency Room for immediate care.

**LIMITS ON CONFIDENTIALITY**

In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that

require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we will make every effort to avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. Consultations will be noted in your Clinical Record (which is called PHI in our form entitled: Notice of Our Policies and Practices to Protect the Privacy of Your Health Information).
- MBC utilizes many mental health professionals and several administrative staff. In most cases, we may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- MBC also has contracts with attorneys and other collection specialists. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where MBC is permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, we cannot provide any information without your (or your personal or legal representative's) written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.
- If a client files a worker's compensation claim, the client must execute a release so that we may release the information, records or reports relevant to the claim.
- If a court of law issues a subpoena or court order, we may, despite efforts to claim Privilege, be ordered by the court to provide the information specified by the court order.

There are some situations in which therapists are legally obligated to take actions, which are necessary to attempt to protect others from harm and may require revealing some information about a client's treatment. These situations are unusual in our practice, but do occur.

- If a therapist knows or has reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, the law requires filing a report with the appropriate government agency, usually the Public Children Services Agency. Once such a report is filed, MBC may be required to provide additional information.

- If a therapist has reasonable cause to believe that an adult over age 59 and living independently and who is physically or mentally impaired is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, the law requires reporting such belief to the county Department of Job and Family Services. Once such a report is filed, MBC may be required to provide additional information.
- If a therapist knows or has reasonable cause to believe that a client has been the victim of domestic violence, they must note that knowledge or belief and the basis for it in the client's records.
- If a therapist believes that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else and believes that disclosure of certain information may serve to protect that individual, then they must disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client.
- Counselors and Social Workers are required to report to police if they know that a felony has been or is about to be committed. (This is <u>not</u> required of Psychologists)

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.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with your therapist. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

**PROFESSIONAL RECORDS**

You should be aware that, pursuant to HIPAA, MBC may keep Protected Health Information (PHI) about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended 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, we charge a copying fee of $3.11 per page for the first ten pages, 65 cents per page for pages 11 through 50, and 26 cents per page for pages in excess of fifty, plus $19.17 fee for records search, plus postage. If we refuse your request for access to your Clinical Record, you have a right to review, which your therapist or a representative of the practice will discuss with you upon request.

In addition, MBC therapists may also keep a set of Psychotherapy Notes. These Notes are for the therapist's own use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations during sessions, your therapist's analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to your therapist that is not required to be

included in your Clinical Record. These Psychotherapy Notes are kept separate from you Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless your therapist determines that such disclosure would have an adverse effect on you.

MBC is required by federal law to regularly monitor providers' accurate completion of therapy billing and charting, to comply with Medicare laws and supervision laws. Clinical/Medical records may be reviewed by insurance companies and internal compliance officers, in accordance with HIPAA law. The Privacy Rule allows covered health care providers to share protected health information for treatment purposes without patient authorization, as long as they use reasonable safeguards when doing so. These treatment communications may occur orally or in writing by phone, fax, e-mail, or otherwise.

**CLIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that your therapist amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about the policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and Midwest's privacy policies and procedures. Your therapist or a representative of the practice will be happy to discuss any of these rights with you.

**MINORS & PARENTS**

Clients under 14 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless the therapist decides that such access would injure the child or the parents and the therapist agree otherwise. Children between 14 and 18 may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30 day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment.

For children 14 and over, it is a common therapist practice to request an agreement between the client and his/her parents allowing the therapist to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions, as well as a verbal summary of their child's treatment when it is complete. Your child's therapist will discuss such an arrangement with you personally in the event that they wish for the therapy to proceed in this manner.

Under Ohio law, a non-residential parent is entitled to the same access as a residential parent to the child's records, including psychotherapy records; this is true unless the court has determined by way of a court order that it is not in the best interest of the child for the non-residential parent to have access to that information.

**PROFESSIONAL FEES**

The fee for a 45 minute diagnostic session (your first appointment) is $150.00. All subsequent services are billed at $100.00 per 45 minute session or 45 minutes of service, or $130.00 for 1 hour of service. Services for which clients are billed at this usual rate include psychotherapy; administering, scoring, interpreting and report writing for psychological tests; letters; consultations; travel time for out of the office services; telephone counseling and lengthy telephone calls (generally calls that last more than 5-10 minutes, to be billed at the discretion of the therapists); and other services of a professional nature. Correspondence, psychological testing, report writing, forensic services, and travel must be paid for in advance of the service. Group therapy will be billed at a rate to be determined by the nature of the group and the length of the group sessions, but group fees are always less than the $100.00 per 45 minute rate. Mediation services are $150.00 per hour, and must be reserved prepaid in blocks of 3 hours or greater.

**Payment is due at the time of service**. Other financial arrangements can sometimes be negotiated at the client's request, which should be done at the initial session. **For clients who have insurance co-payments: In some cases, you may be able to pay only your co-payment at the time of service. If this is the case, be certain to pay the co-payment at the time of the session. You may be assessed a $5.00 rebilling fee for each session at which you fail to pay your co-payment.**

At your request and for a $5.00 fee, our billing staff can provide a monthly statement showing the activity on your account for that month. We will also bill your primary insurance company on approximately a bi-weekly basis. However, if the insurance billing becomes very time consuming (i.e. if your insurance company makes extraordinary demands for information) we reserve the right to bill you an additional charge for that time. We do not take any responsibility for interacting with secondary insurance companies. If you have more than one insurance, we will bill the first insurance company, but not the second. If you wish to file for secondary insurance benefits yourself, MBC will prepare insurance billing forms for you to submit for a fee of $5.00 per form at your request.

When your account is in arrears, you will be billed for the amounts you owe by our clerical staff. If you do not pay this bill promptly, future bills for the same outstanding fees will be sent. A rebilling fee of $10.00 will be assessed for each bill after the first. **Please pay your fees consistently and on time.**

If your account is in arrears, interest at a rate of 2% per month may be added to your balance. This may continue for each month that payment is in arrears. There will be a $30.00 charge for returned checks.

If you fail or refuse to make payment, as agreed or negotiated, we reserve the right to obtain the services of a collection agency or attorney. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. **Please note: You are responsible for all collection expenses and attorney fees required as a result of non-payment of your full account balance**. This can include late fees, interest, attorney fees, court fees, and garnishment fees, if applicable.

**We reserve the right to discharge clients for repeated or prolonged failure to pay for services.**

**COURT APPEARANCES**

If you become involved in legal proceedings that require the participation of your therapist, you will be expected to pay for all of their professional time, including preparation and transportation time and costs, even if the therapist is called to testify by another party. There is a minimum fee of 3 hours of time at the rate of $200.00 per hour for court appearances, $250.00 per hour for out-of-county appearances. **This minimum charge must be paid in advance of the scheduled court appearance.** If full payment has not been received prior to 48 hours before the court hearing, your therapist may refuse to appear. **Should the court date be canceled, thefee is non-refundable**. If the court proceedings are rescheduled, the same payment requirement will apply. If the time involved exceeds 3 hours, you will be billed for each additional hour at $200.00 per hour ($250.00 per hour if out of county). Court, Preparation, and Travel Time are each billed at this fee. Depositions will be billed at the same rates and requirements.

**CANCELLATIONS AND MISSED APPOINTMENTS**

When you schedule an appointment with a therapist, that therapist reserves the appointed time for you. We therefore consider appointments to be an important commitment on the part of both the client and the therapist. If you find it unavoidable to cancel a scheduled appointment, we ask that you do so as soon as you become aware that you will not be able to attend. Except in an emergency, or in case of severe illness, missed appointments will be billed at the usual rate ($100.00 for most sessions, $150.00 for intake sessions). **Insurance companies do not reimburse for late cancellations or missed appointments. You will be expected to pay in full for the missed session at the time of the next appointment.**

If you are late for a scheduled appointment, our policy is that the therapist will wait for 20 minutes. If you are not in attendance by then, your therapist may not be able to see you and you will need to reschedule. You will be billed for the session fee (again, typically $100.00).

In the event that you arrive for your appointment intoxicated or under the influence of illegal drugs, your therapist may refuse to see you at that time. However, you will be billed for that session. The judgment of whether you are intoxicated/under the influence is at the discretion of the therapist.

**INSURANCE REIMBURSEMENT**

**It is your responsibility to investigate your insurance coverage before entering into a treatment contract with us.** You are responsible for all charges incurred, regardless of the amount paid by your insurance company, unless other arrangements have been made between our organization and your insurance company or managed care organization. It is also important for you to know that insurance companies do not pay for telephone consultations, consultations with school personnel and other professionals, court appearances, written reports or correspondence, missed appointments, and some other services. Sometimes insurance will not pay for services if the condition being treated has been treated in the past. Finally, some insurance companies do not cover psychological/mental health services at all.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorizations before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out

specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can sometimes be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that professionals provide it with information relevant to the services that are provided to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical client record. In such situations, MBC will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, MBC has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. MBC will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that MBC can provide requested information to your carrier.

Once you have all of the information about your insurance coverage, you can discuss with your therapist what can be expected to be accomplished with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. **It is important to remember that you always have the right to pay for all services yourself to avoid the problems described above** (unless prohibited by contract).

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I _____ have read and understand the above information and policies and agree to abide by those policies. Specifically, I will pay $_____ at each session. Insurance forms to primary insurance company will be submitted by MBC. I authorize the staff at MBC to release any information necessary for third-party claim submissions and/or payment for services. Any exceptions to this agreement are noted below. This agreement will remain in effect until renegotiated in writing between me and MBC.

IF YOU HAVE ANY QUESTIONS ABOUT OUR PRIVACY, PROFESSIONAL, OR FINANCIAL POLICIES, PLEASE ASK US ABOUT THEM BEFORE SIGNING BELOW. PLEASE SIGN TWO COPIES. RETURN ONE COPY TO THE OFFICE AND RETAIN ONE COPY FOR YOUR OWN INFORMATION. THANK YOU.

_____ _____

Signature of client and/or Responsible Party (parent or guardian if a minor) Date

_____ _____

Signature of spouse and/or Co-responsible Party Date

# Midwest Behavioral Care, Ltd.

Administrative Office

Administrative Office: 3821 Little York Road
Dayton, Ohio 45414
Phone: (937) 454-0092
Fax: (937) 264-1101

## CLIENT IDENTIFICATION FORM

| | | | |
|---|---|---|---|
| Name | | | |
| Address | | | |
| City | State | Zip Code | |
| Home phone | Work phone | Cell Phone | |
| Is it okay to leave a message at the above numbers? Y N | If no, please let us know which number(s) are not okay. | | |
| Date of Birth | Social Security number | | |
| Sex | Driver's License number | Marital Status | |
| Employer | Employer address | | |
| Physician's name | Physician's address | | |
| In case of emergency, whom may we contact not living with you | | | |
| Address | Home phone | Work phone | |
| Have you been seen at Midwest Behavioral Care previously? | | | |

## PERSON RESPONSIBLE FOR PAYMENT (if different from client)

| | | | |
|---|---|---|---|
| Full legal name *(first)* | *(middle)* | *(last)* | |
| Address | | | |
| City | State | Zip Code | |
| Alternative mailing address | | | |
| City | State | Zip Code | |
| Home phone | Work phone | Extension | |
| Alternative phone number you can be reached at | | | |
| Social Security number | Driver's License number | | |
| Employer | Employer address | | |

**PRIMARY INSURED (if different from client)**

| | | |
|---|---|---|
| Insured's name | | |
| Address | | |
| City | State | Zip Code |
| Home phone | Work phone | Extension |
| Date of Birth | Social Security number | Sex |
| Relationship to Patient | | |
| Employer | | |

**INFORMATION ABOUT INSURANCE COMPANY**

| | | |
|---|---|---|
| Insurance Company | | |
| Claims Address | | |
| City | State | Zip Code |
| Mental Health Member Services Phone Number | | |
| Policy ID# | Group # | Co-payment *($ or %)* |

**Therapist Use Only. Do Not Complete.**

Therapist_____ Diagnosis Code_____ Office Location_____

CPT-IV Code_____ Referred by_____

**Midwest Behavioral Care, Ltd.**
Administrative Office 3821 Little York Road, Dayton, OH 45414

**AUTHORIZATION TO RELEASE PHI FROM MBC FOR INSURANCE BILLING**

Client Name _____ S.S. # _____ Birth Date _____

| | |
|---|---|
| __x__ Assessment and Diagnostic Impression | __x__ Treatment Plan and/or Outcome |
| __x__ Medications Used and Response to the Medication | __x__ Treatment Plan and/or Outcome |
| __x__ Assessment of Client's Substance Use/Abuse and Stage of Recovery | __x__ Client Identifying Information |
| __x__ Recommendations for Follow-Up | __x__ Indicators of Progress |
| __x__ Psychosocial History | __x__ Psychological Evaluation |
| __x__ Admission Summary | __x__ Discharge Summary |

_____Other_____

This information should only be released to the Following Insurers and/or their Designees:
_____
_____

I am permitting Midwest to release this information for the purpose of utilizing my medical benefits to help with payment on my account for professional services rendered by the professional staff of Midwest Behavioral Care, Ltd.

This authorization shall remain in effect until all claims have been settled.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, your revocation will not be effective to the extent that Midwest has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Also, revocation of this consent will render the signee and/or guardians responsible for payment in full on this account.

I understand that Midwest generally may not conditional psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I release Midwest Behavioral Care, Ltd. and its personnel from any legal liability resulting from the release of this information wit the understanding that Midwest Behavioral Care, Ltd. personnel will exercise reasonable professional safeguards regarding this information.

I have read and understand this document.

Signed this _____ day of _____. 20_____.

Signature of Client(s) _____

Signature of Parent or Guardian, if applicable_____.

Signature of Witness_____

A TRUE PHOTOCOPY HEREOF MAY BE CONSIDERED AS AN ORIGINAL.

# Authorization to Disclose Protected Health Information Primary Care Physician

Communication between behavioral health providers and you primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plans, progress, and medication if necessary.

I, _____, _____, _____/_____/_____,
(Patient Name-Please Print) (Patient Identification Number) (Patient Date of Birth –MM/DD/YYYY)

authorize _____, to release protected health information related to my evaluation and treatment to:
(Provider Name- Please Print)

**PCP Name**:_____ **PCP Phone**:_____

**PCP Address**:_____ _____ _____ _____
(Street) (City) (State) (Zip Code)

**Information to be completed by Behavioral Health Provider**

I saw _____ on _____ for _____
(Patient Name – Please Print) (Date) (Reason / Diagnosis)

**Summary**:_____

_____

**Treatment recommendations**: _____

_____

If you have any questions or would like to discuss this case in greater detail, please call me at: _____
(Phone Number)

_____ _____ _____
(Provider Signature) (Provider Printed Name) (Licensure)

**Patient Rights**

You can end this authorization (permission to use or disclose information) any time by contacting:
**(937) 454-0092**
If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
You do not have to agree to this request to use or disclose your information.

**Patient Authorization**

The undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

PATIENT PLEASE CHECK ONE

_____ To release any applicable mental health / substance abuse information to my primary care physician

_____I DO NOT give my authorization to release any information to my primary care physician

_____ _____ _____ _____
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

Signed by Authorized Representative, describe relationship to patient:_____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREATMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

Information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client ID #_____

Contract Number:
Patient:
Claim Number:
Date of Service:

Dear:

Before we can process your claim, we need to know if you, your spouse or your dependents are currently covered by another health insurance company. Therefore, complete the form below and return this letter to us in the enclosed envelope **within 14 days to avoid unnecessary denial of this claim.** To protect your privacy and properly update your membership file, we regret that we cannot accept this information by phone. Thank you

1. Do you or any member of your family have health care insurance with another company?

_____ Yes – Family coverage _____ Yes – Single coverage _____ No
Spouse's birthdate _____

2. If spouse's coverage has terminated, please provide cancellation date. _____

3. Do you or any member of your family have Medicare Part A coverage? _____ Yes _____ No
Medicare part B coverage? _____ Yes _____ No

4. Is the patient a dependent child whose natural parents are divorced or separated? _____ Yes _____ No
If "Yes", give the name of the parent ordered by the court to maintain health care as "Name of Insured" in the section below and attach a copy of the court order.

*If you answered "Yes" to any of these questions, please fill out the following regarding the other insurance:*

Name of Insured _____ Birthdate _____ Social Security Number _____
Employer, Union or Sponsoring Organization of Insured _____
Effective Date _____ Cancelled Date _____ Employment Status _____ Active _____ Retired
Employer's Street Address _____
Employer's City, State, Zip Code _____
Insurance Company Name _____ Policy Number _____
Insurance Company's Street Address _____
Insurance Company's City, State, Zip Code _____
Insurance Company's Phone Number _____

I hereby certify the above statements are true and correct to the best of my knowledge, and authorize any insurance company, employer, or hospital to release all information with respect to myself and any of my dependents which may affect the benefits under this or any other plan providing benefits or services.

_____ _____
Your Signature Date

**Midwest Behavioral Care, Ltd.**
Administrative Office 3821 Little York Road Dayton, OH 45414(937) 454-0092

## Notice of Our Policies and Practices to Protect the Privacy of Your Health Information

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

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Midwest may *use* or *disclose* your *protected health information* (*PHI*), *for treatment, payment*, *and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*

-*Treatment* is when your therapist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would occur if your therapist consults with another health care provider, such as your family physician.

-*Payment* is when Midwest is reimbursed for your healthcare. Examples of disclosures related to payment include, for example, when Midwest discloses your PHI to your health insurer in order to obtain reimbursement for your health care or to determine eligibility or coverage.

-*Health Care Operations* are activities that relate to the performance and operation of the overall practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within Midwest's practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure"* applies to activities outside of Midwest's practice group, such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

Midwest may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when Midwest is asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes that your therapist may have made about conversations occurring during a private, group, joint, or family counseling session, which your therapist may have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. Finally, we will obtain authorization from you before using or disclosing PHI in any way not described in this Notice.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) Midwest has already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Midwest may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If, in a professional capacity, your therapist knows or suspects that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, your therapist is required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, s/he is required by law to immediately report such belief to the County Department of Job and Family Services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, if the therapist providing treatment is licensed in Ohio as a Psychologist; the psychologist will not release this information without written authorization from you or your personal or legally-appointed representative, or a court order. The foregoing Psychologist/Client Privilege does NOT apply to other non-medical mental health service providers; you should ask the therapist assigned to you about their status in this regard, if court involvement seems likely to occur. Also, privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If your therapist believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, s/he may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to your therapist an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and s/he believes that you have the intent and ability to carry out the threat, then s/he is required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law

enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).

- **Worker's Compensation:** If you file a worker's compensation claim, Midwest may be required to give your mental health information to relevant parties and officials.

- **When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law**. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Midwest Behavioral Care's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Midwest is not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a mental health professional. Upon your written request, Midwest will send your bills to another address.)

- *Right to Inspect and Copy*– You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in Midwest's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your therapist or Midwest's Director of Clinical Services may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, your therapist will discuss with you the details of the request process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Midwest may deny your request. On your request, your therapist will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, your therapist will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from Midwest upon request, even if you have agreed to receive the notice electronically.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket* – You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for services.

- *Right to be Notified if There is a Breach of Your Unsecured PHI* – You have a right to be notified if: a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; b) that PHI has not been encrypted to government standards; and c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Midwest Behavioral Care's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

- If we revise our policies and procedures, we will provide notice thereof to all clients who are currently maintaining active accounts with Midwest, via U.S. mail.

V. Complaints

If you are concerned that Midwest has violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact Stephen Pearce, Psy.D., our Privacy Officer, at 454-0092, ext. 115.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

Midwest reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide active clients with a revised notice in person or by U.S. mail, within 30 days of the effective date of policy changes.

**Midwest Behavioral Care, Ltd.**
Administrative Office 3821 Little York Road, Dayton, OH 45414 (937) 454-0092

# MBC Information Concerning and Acknowledgment of Informed Consent to Communicate Via Email or Text

Email or Text: Your Clinical File will include either an annotation of or a copy of all email or text communications sent to or received by the Provider in connection with your therapy. There are limitations and risks in connection with the use of email or text communications, including but not limited to privacy, confidentiality, and related limitations and risks.

Consent: By my signature below:

a. I hereby give my informed consent to communicate with my MBC Provider, via email or text;

b. I understand that I have the right to refuse or withdraw the informed consent given above. I have the right to revoke this Informed Consent Form, in writing, at any time, by sending such written notification to the above office address. I understand that my revocation will not be effective to the extent that action has already been taken in reliance on the Informed Consent;

c. I acknowledge that I have read and understood all information contained herein and that I have been given an opportunity to ask questions concerning this document;

d. I acknowledge that I have been given a signed copy of this document.

Signature of Client: _____ Date: _____

Signature of Responsible Party (if client is a minor) _____

Client Information:

Name of Client: _____

Address: _____

Date of Birth: _____ Phone: _____

Email: _____

**Midwest Behavioral Care, Ltd.**
Administrative Office 3821 Little York Road, Dayton, OH 45414 (937) 454-0092

# Consent to Participate in Telehealth Visits

### What is telehealth?

Telehealth is away to visit with healthcare providers, in this case your therapist, through the use of an electronic device such as a computer, smartphone, tablet, iPad, or Chromebook. It has become a much more common practice in Healthcare since the inception of the Coronavirus SARS2.

### Are there advantages to the use of telehealth for me?

- You don't have to go to a clinic or office to see your provider.
- You won't risk getting sick from other people.
- The service is available to you in the comfort of a place of your choosing.

### Are there potential disadvantages or risks of telehealth for me?

- You and your provider won't be in the same room, so it may feel different from an office visit.
- Your provider may not be able to attend to all your cues, especially nonverbal ones, as in person, and so may be less accurate in reading your emotional cues.
- In rare cases, it is possible your provider may decide you still need an office visit.
- Technical problems may interfere on occasion with the start of your session, or during the course of the session itself. **If this should occur, please have your telephone available and waiting, and your therapist will call you.** Together, the two of you can decide whether to re-attempt using the virtual program or simply continue the session telephonically.
- Because communication is occurring over an electronic medium, it is not possible for us to guarantee that a third party cannot somehow cut into the signal and follow along with the call. However, there are things that you can do, and that we will do, to try to minimize those risks: We agree to:
    1) Contact you from a secure internet connection, not public Wi-Fi.
    2) Only contact you from a private space, where no other people can hear.

3) Whenever possible, use encrypted software for video calls, so that the calls cannot be hacked into. (Ask your therapist if their software is encrypted.)

We suggest that you also protect yourself by using a secure internet connection and locating yourself in a space where you can have privacy from interruption and from being overheard by others.

- In the event of a mental health or other emergency, since you will not be in the therapist's office, there will need to be a contingency for providing emergency care. For this reason, each time there is a telehealth session, it is the client's duty to provide the therapist with:
    1) A telephone number where you, the client, can be immediately reached,
    2) The physical location where you are located during the session (in case we need to contact police, fire, or EMT services), and
    3) The name and telephone number of a person who can reach you quickly should an emergency occur.

**What if I want an office visit, not a telehealth visit?**

If being physically in the presence of your therapist is very important to you, and your therapist is not presently offering in person visits, you are free to choose to transfer to a therapist who is providing those services.

**What if I try telehealth and don't like it?**

You can stop using telehealth at any time, even during a telehealth visit. Be aware, however, that there may be risks to prematurely ending therapy. It is advised that you talk with your therapist before terminating therapy for any reason, so that you and the therapist can make a plan to cover any such risks, such as referral to another therapist who is doing office visits instead of teletherapy visits.

**What other things do you want me to know?**

1) We agree that we will not record your sessions electronically, and will only record information from your sessions in your file. You retain full rights to confidentiality of the information you share during telehealth sessions. We also ask you to agree never to record our sessions.
2) Your therapist has selected the electronic platform used for video sessions, and will teach you how to use it for your sessions. You will need to use either a smartphone or a device with a webcam for these sessions.

3) It is very important that you be on time for your sessions. In the event that you cannot be at a session, it is essential that you let your therapist know, well in advance, that you will not be in attendance.
4) We advise that you confirm that your insurance company will pay for telehealth sessions; if they do not, you will be responsible for the cost of the services.
5) If you are a minor, your parents must also consent to your use of telehealth sessions.
6) It is assumed that where telehealth services are in use, the therapist and client also are likely to be in communication by other electronic methods as well, including telephone, text, and/or email. By agreeing to telehealth services, you are also agreeing to be contacted on occasion by these other means as well.

If you sign this document, you agree that:

- We talked about the information in this document.
- Your questions have been answered.
- You want a telehealth visit.

---

Your name (please print) Date

---

Your signature Date

---

Parent or Guardian Name (if required) Date

_____

Parent or Guardian Signature (if required)

_____

Midwest Representative Name and Signature Date

Client's ID# _____

**Midwest Behavioral Care, Ltd.**
Administrative Office

Administrative Office: 3821 Little York Road
Dayton, Ohio 45414
Phone: (937) 454-0092
Fax: (937) 264-1101

## CONSENT TO TREAT A CHILD/ADOLESCENT

**Part I:** In order for us to treat a minor child (under 18 years of age) we must have the written consent of the child's parent(s) or legal guardian(s). Please indicate your consent for us to treat your child by signing the following statement:

I, _____, state that I have the legal right to authorize Midwest Behavioral Care and/or its staff to provide mental health services to _____ (DOB: _____) and do herewith authorize said services.

_____
Signature Date

_____
Signature Date

**Part II:** As a rule, parents or legal guardians have a right to complete access to all information concerning the adolescent or child involved in therapy with us. However, our experience suggests that in order for many child and/or adolescent clients to feel comfortable in therapy, it is beneficial to offer them the opportunity to talk with the therapist and to know that what they tell the therapist will not get back to their parents (except in cases of imminent danger to the client or others, or where the therapist considers the information to be so serious that the parents' ultimate responsibility for the client's welfare dictates that the parents be kept informed).

We ask that you consider this issue in the therapy with your child. If you are willing to agree to this informal waiver of your right to full disclosure, we ask that you do the following:

a) indicate your agreement by signing the form below, and
b) tell your child that you have agreed to allow him/her to talk with us with a spirit of privacy, and that you will not insist that we relate all that your child tells us back to you.

_____
Signature Date

_____
Signature Date

**Midwest Behavioral Care, Ltd.**
Administrative Office

Administrative Office: 3821 Little York Road
Dayton, Ohio 45414
Phone: (937) 454-0092
Fax: (937) 264-1101

**CHILD/ADOLESCENT BACKGROUND FORM**
**(Parent or guardian must complete by first session)**

Child's name:_____ Date:_____
Age:_____ Date of Birth:_____ Sex:_____ Home Phone:_____
Cell Phone:_____ Parent/Guardian work #:_____

List child's relatives including those by previous and subsequent marriages and any deceased siblings (with date of death).

| **Name** | **Age** | **Relationship** | **Grade or Occupation** | **Living in Household** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If not presently with the child, please give name and whereabouts of biological parent(s):
_____
_____

Legal Custodian of child, if other than natural parent(s):_____
If child adopted?_____ If yes, what age was child when adopted?_____

Parents' Marital Status: (Check as many as apply)
___ Married to each other ___Separated
___ Divorced ___ Widowed
___ Mother remarried ___ Father remarried
___ Never married to each other; living: ___ Separately; ___ Together
If the child's parents are divorced, who has legal custody?_____
What are the visitation arrangements?_____
_____
Are there any problems with this?_____What kind?_____
How do the parents feel about this child?_____
_____

Name of person filling out this form: _____
Who referred you to us?_____
Address of referral source:_____
May we contact referral to thank them? ❑ YES ❑ NO

## CHILD'S CURRENT PROBLEMS AND THEIR HISTORY

Describe the child's current problem(s) (medical, behavioral, emotional):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check any of the following which are problems with this child:

___ Depressed
___ Anxious
___ Nervous habits
___ Easily upset
___ Panic Attacks
___ Guilt feelings
___ Tiredness & fatigue
___ Sleep problems
___ Shyness
___ Nail biting
___ Self-destructive
___ Extreme fears
___ Self-critical
___ Obsessions & compulsion
___ Eating problems
___ Irritable
___ Feelings of worthlessness
___ Delusions (believing things which are not true)
___ Hallucinations (hearing voices/seeing things that are not there)

___ Hyperactivity
___ Poor attention
___ Poor concentration
___ Memory problems
___ Clumsiness
___ School problems
___ Difficulty following instructions
___ Day-dreaming too much
___ Speech problems
___ Toilet problems
___ Jealousy
___ Disorientation
___ Elevated mood
___ Oppositional
___ Impulsive
___ Medical Illness

___ Stealing
___ Cruelty
___ Fire setting
___ Running away
___ Temper tantrums
___ Destructiveness
___ Physical aggression
___ Drug or alcohol abuse
___ Sexually active
___ Vandalism
___ Verbal aggression
___ Resentment
___ Overly sensitive
___ Trauma History
___ Physical
___ Sexual
___ Emotional
___ Perpetrator

**Risk Assessment:** **(underline all that apply)**

| | | | | | |
|---|---|---|---|---|---|
| **Suicidality** | Not Present | Ideation | Plan | Means | Prior Attempt |
| **Homicidality** | Not Present | Ideation | Plan | Means | Prior Attempt |

| **Current Impairment:** | **Impairment Level (circle level)** | | | | |
|---|---|---|---|---|---|
| **Categories** | **No Impairment** | **Mild Impairment** | **Moderate Impairment** | **Marked Impairment** | **Extreme Impairment** |
| Relationship/Family | 1 | 2 | 3 | 4 | 5 |
| Job/School/Performance | 1 | 2 | 3 | 4 | 5 |
| Friendship/Peer Relationships | 1 | 2 | 3 | 4 | 5 |
| Hobbies/Interests/Play Activities | 1 | 2 | 3 | 4 | 5 |
| Physical Health | 1 | 2 | 3 | 4 | 5 |
| Legal Status (Arrest, Probation) | 1 | 2 | 3 | 4 | 5 |
| Activities of Daily Living (personal hygiene, bathing, etc.) | 1 | 2 | 3 | 4 | 5 |
| Eating Habits | 1 | 2 | 3 | 4 | 5 |
| Sleeping Habits | 1 | 2 | 3 | 4 | 5 |
| Ability to Concentrate | 1 | 2 | 3 | 4 | 5 |
| Ability to Control His/Her Temper | 1 | 2 | 3 | 4 | 5 |

When did the current problems start or when were they first noticed?_____

_____

Is the child aware of the problem(s)?_____ If yes, how is this awareness expressed:_____

_____

Has the possibility of evaluation been discussed with the child?_____

If yes, what was the child's reaction?_____

List all professionals and agencies which have been involved in the current problem(s), dates of contact, and whether it was beneficial:

_____ Date:_____ Beneficial?_____

_____ Date:_____ Beneficial?_____

_____ Date:_____ Beneficial?_____

Has the child had medical, behavioral, or emotional problems other than the current one(s)?

_____ No _____ Yes. If yes, please specify and list agencies involved and dates of contact.

_____ Date:_____ Beneficial?_____

_____ Date:_____ Beneficial?_____

Who disciplines the children, and how? (Be specific) _____

_____

_____

How does your child respond to discipline?_____

_____

What are the child's strong points or favorable characteristics?_____

_____

_____

What games or particular interest does this child enjoy?_____

_____

_____

What kinds of things might serve as rewards for this child?_____

_____

_____

What religion does this child's family endorse?_____

How involved is the child with a religious system?_____

_____ Are the child's religious beliefs important to him/her?_____

## Substance Use and Dependency

How often does your child currently use the following substances? (Place a check in the column to indicate current use; *if your child past use was different, indicate this by writing "past" in the appropriate column next to each substance.*)

| | Daily | 3-5x/week | 1-2x/week | 2-3/month | 1/month | seldom | never |
|---|---|---|---|---|---|---|---|
| Beer | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Wine | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Distilled Alc. | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Marijuana | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Cocaine | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Crack | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Barbiturates | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Amphetamines | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Tranquilizers | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Analgesics | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Heroin | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Tobacco | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Caffeine | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Other (List) | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
| Other (List) | ___ | ___ | ___ | ___ | ___ | ___ | ___ |

Has your child had problems as a result of his/her substance use?_____ Describe _____

_____

_____

Has anyone in your child's family ever had problems with substance abuse or dependency?_____
Who, and what substances?_____

_____

Has anyone in your family been involved in treatment for substance use or dependency? _____
Who, and what treatment?_____

_____

Has anyone in your family been involved with a 12-step group (AA, Al-Anon, etc.)?_____
Are they now?_____ What group(s)?_____

## TREATMENT GOALS

List the benefits you hope your child to derive from counseling/therapy. This is most important. Please be specific.

1) _____
2) _____
3) _____

Do you think this child would be helped more by:

___ Counseling with parents
___ Counseling with the child individually
___ Family Counseling including parents and child
___ Systematic Skills to change specific problem behaviors
___ Other: _____
___ Psychological Testing
___ Group therapy
___ Medication

## CHILD'S EDUCATION

School your child is presently attending?_____
Address:_____
Phone:_____ Grade:_____ Principal:_____
Teachers:_____
How does your child do in school, in terms of grades, ability, and behavior?_____
_____
Has your child repeated any grades?_____ If yes, provide what grade and the reason for repeating the grade:_____
Has your child required special help in any of the schools attended?_____
Dates_____ School _____ Nature of help_____ Beneficial?_____
Dates_____ School _____ Nature of help_____ Beneficial?_____
Child's behavior problems in school:_____
_____
_____
What psychological or achievement test has this child had previously?_____
_____
What were the results or scores?_____
_____

## CHILD'S DEVELOPMENT

Please list any problems encountered during the pregnancy and/or delivery and the first weeks of life:_____
_____
Was the child administered oxygen at birth?_____

## EARLY DEVELOPMENT

Was your child an easy-to-care-for infant?_____ If not, please explain:__
_____
Was your child an easy-to-care-for toddler?_____ If not, please explain___
_____
Please list any problems encountered in the first three years of life:_____
_____
If your child has started puberty, has the onset appeared to cause any difficulties?_____ If yes, please give details_____
Has your child ever behaved or talked in a way that was not sexually appropriate for a boy/girl or his/her age?_____ If yes, give details:_____
_____

## CHILD'S HEALTH

Name of family physician _____
Address:_____
Does your child have any allergies?_____ If yes, please give details:_____
_____
Has your child ever had a fever above 105 degrees?_____ If yes, please give child's age at the time and the cause:_____
Has the child had any significant accidents or injuries (including broken bones)?_____
If yes, give details_____
Has your child ever lost consciousness?_____ If yes, give details:_____
_____
Has your child ever been hospitalized?_____ If yes, give details_____
_____

Has your child had any operations?_____ If yes, give details_____
_____
Has your child ever had seizures (convulsions)_____ If yes, give details_____
_____
Has your child received medications in the past for emotional, physical, learning, or behavioral problems?_____ If yes, please give the following details:
Problem:_____
Age when first prescribed:_____
Medication:_____ Daily Dose:_____
Times per day:_____ Taken since: (date)_____
Who prescribed the medication(s)?_____
Is it helping?_____ Side effects?_____

Is the child presently taking any other medications?_____ If yes, problem:_____
_____
Age when first prescribed?_____
Medication:_____ Daily Dose:_____
Times per day:_____ Taken since (date)_____
Who prescribed the medication(s)?_____
Is it helping?_____ Side Effects?_____

Please describe any occurrences of birth defects, mental retardation, nerve disease (cerebral palsy, epilepsy) and psychiatric condition in the immediate family and the child's blood relatives:
_____
_____

## SIGNIFICANT EVENTS

**Have any of the following events occurred in your family? If so, please describe:**

| Event | Year | Describe |
|---|---|---|
| _____ move to a new place | _____ | _____ |
| _____ significant separation from a parent | _____ | _____ |
| _____ loss of someone very close | _____ | _____ |
| _____ frightening experiences | _____ | _____ |
| _____ change of school | _____ | _____ |
| _____ serious illness or injury in family | _____ | _____ |
| _____ death in family | _____ | _____ |
| _____ change in family's financial status | _____ | _____ |
| _____ separation or divorce | _____ | _____ |
| _____ brother or sister leaving home | _____ | _____ |
| _____ marriage of sibling | _____ | _____ |
| _____ emotional difficulties | _____ | _____ |
| _____ legal problems | _____ | _____ |
| _____ other (specify) | _____ | _____ |

## MARITAL HISTORY OF PARENTS

How would you describe your marital relationship?_____
_____
Have you sought outside help with regards to marital problems?_____
If yes, please give details_____
_____
Have any extended family members had problems with substance abuse (drugs, alcohol)?_____
If yes, please give details_____
Have any extended family members been involved in incest (sexual interaction between a parent and child or between the children)?_____ If yes, please give details:_____
_____
Has any family member been sexually, physically, or emotionally abused?_____ If yes, please give details:_____
Please describe any problems that occurred while the child's father was growing up:_____
_____
Please describe any problems that occurred while the child's adoptive, step, or foster parent(s) or guardians were growing up:_____
_____

**Midwest Behavioral Care, Ltd.**
Administrative Office

Administrative Office: 3821 Little York Road
Dayton, Ohio 45414
Phone: (937) 454-0092
Fax: (937) 264-1101

## ADOLESCENT HISTORY FORM
## (To be completed by child)

Date_____

So that we can help you, please fill out the following information. This information will be treated in a professional manner.

NAME_____ AGE_____ SEX_____
BIRTHDATE_____ PHONE NUMBER_____
In your own words, what problems or difficulties bring you here at this time?_____
_____
_____
_____
_____
_____
Have you tried to get any previous help for this?_____ What kind?_____
_____ When? _____ Where? _____ Was this helpful?____
_____ How? _____
What procedures have you tried on your own?_____
When did these problems first begin? _____
What important things have happened to you or your family in the last six months?_____
_____
What sudden changes have you noticed recently in your behavior and moods or in family members?_____
_____
_____

## BIO-MEDICAL HISTORY

What aches, pains, or physical discomforts do you have these days?_____
_____
What have you been hospitalized for in the past?_____
_____
What serious illnesses have you had during your life?_____
_____
What accidents have you had?_____
How long have you been drinking alcohol?_____ How frequently do you drink alcohol?_____ How much alcohol do you drink?_____

What drugs have you used?_____ Reason_____
_____ How long? _____
What is the name and address of the physician you usually see?_____
_____
When was your latest medical examination?_____
What medicines are you taking these days?_____
What is the name and address of the person to notify in case of emergency?_____
_____
Who referred you to us?_____

## SCHOOL HISTORY

Which schools have you attended since entering school?_____
_____
What grade are you in now?_____ At what school?_____
In what three subjects do you earn your best grades?_____
_____
In what three subjects do you earn your lowest grades?_____
_____
What grades did you repeat?_____
Is your schoolwork: Above Average_____ Average _____ Below Average_____
What are your favorite subjects? _____
What special school problems do you have? _____
_____
How do you get along with your teachers as compared to your parents?_____
_____
What psychological or achievement tests have you had previously?_____
_____ What were the
results or scores?_____

## SOCIAL HISTORY

How old were you when you began dating?_____
How often do you date? _____
What do you like to do on a date? _____
What problems do you have with persons of the opposite sex? _____
_____
How serious do you feel these problems are? _____
How many friends do you have? _____
What people have you felt close to in your life? _____
_____
Tell us how you learned about sexual intercourse, when, and from whom. _____
_____
_____
_____

## HOME HISTORY

What problems do you have at home? _____
When are these problems worse? _____ When are they better? _____
Please fill in the names, ages, etc. of your family:

| NAME | AGE | LEVEL OF EDUCATION | OCCUPATION | WHERE EMPLOYED | WORK SCHEDULE |
|---|---|---|---|---|---|
| Father: | | | | | |
| Mother: | | | | | |
| Brothers: | | | | | |
| | | | | | |
| | | | | | |
| Sisters: | | | | | |
| | | | | | |
| | | | | | |

Others living in your home:

_____
_____

(If any of the above are adopted, please indicate this)

Which family member seems easiest to get along with and why?_____
_____
Which family member is the most difficult and why?_____
_____
Who disciplines the children and how? _____
_____
_____
How long have your parents been married to each other?_____ Has either parent been married before?_____ For how long? _____
What marriage problems have there been between your parents?_____
_____
_____
How do your parents feel about you?_____
_____
_____
What medical/physical problems have there been in your family or in relatives? _____
_____
_____
What emotional troubles, nervous breakdowns, convulsive disorders, etc. have there been in your family or in relatives? _____
_____
_____
What troubles has your family had with the law?_____
_____
What religion does your family belong to? _____
Who lives in the house with you? _____ How many bedrooms are there? _____ What are the sleeping arrangements? _
_____
What sort of a neighborhood do you live in? _____
_____

## GENERAL

Do you think you would be helped more by:

a. Directions to change specific behaviors.
b. Talking about your problems individually
c. Counseling with your parents
d. Counseling with your teachers
e. Psychological testing
f. Receiving medicine
g. Group therapy
h. Other (Explain)

ADDITONAL INFORMATION: Please list all psychologists, physicians, speech therapists, clinics, etc. which you have had contact with. Also, please tell us any other significant or interesting information about you that we may not have asked about.