



6797 North High Street, Suite 350, Worthington, Ohio 43085
 614.888.9200 tel / 614.888.3239 fax

Male Female

First Name Middle Name Last Name

Street Address

City State Zip

Date of Birth Home Phone Work Phone Cell Phone

IF Parent/Guardian: First Name Last Name Relation to Client

NAME, PHONE NUMBER AND RELATIONSHIP OF EMERGENCY CONTACT

Appointment Notification

If you wish to receive an email confirmation regarding your appointments please complete the appropriate fields below.

Email address: _____

Signature of Authorization: _____ Date: _____

By providing my signature I consent and am aware that the email message I receive will contain the client's name listed above. I consent to receive email notifications regarding my appointment(s).

Feedback

We welcome your comments, complaints, and compliments in person, via phone, letter, or our online survey. If you wish to receive an email link to our client satisfaction survey please check here:

CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, LIMITS TO CONFIDENTIALITY

- I understand and consent to treatment at Directions Counseling Group and to the release of information for therapeutic, billing, supervision and other purposes in connection with my treatment, between and among Directions Counseling Group therapists, staff and service contractors who perform work on behalf of Directions Counseling Group, as well as with other medical providers that may have an interest in or may be helpful to me or/my child’s care. I understand that for a more detailed look at how my (my child’s) health information may be released and used under certain circumstances, that I may review the current Notice of Privacy Practices which is available to me in brochure form and online at: www.directionscounseling.com
- I understand that payment is due at time of service for all fees. In the event that charges are filed insurance carrier I am liable for all co-pays, deductibles, and any fees unpaid by insurance for any reason and am responsible for understanding my benefit plan. Additionally, I understand that Directions Counseling Group has no contractual obligation with my insurance company or me that would entitle or guarantee me reimbursement for expenses I incur for services at Directions Counseling Group.
- I understand that the counseling services I/my child receive are strictly confidential to the fullest extent allowable by state and federal law. Licensed therapists are mandated to report known or suspected abuse of a minor, elderly or disabled person; a client that is a danger to self or others; and certain court mandated situations. Limits to confidentiality are disclosed to me in the Notice of Privacy Practices available in brochure form and online at: www.directionscounseling.com

X _____ Date: _____
 Client Signature (Parent/Guardian if minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge my receipt of Directions Counseling Group, Inc.’s *Notice of Privacy Practices* (revised and effective November 8, 2005) available in our office and at: www.directionscounseling.com received by me on the date above:

X _____
 Printed Name of Client Signature of Client / Client’s Personal Representative

X _____
 Printed Name of Client’s Personal Representative Description of Representative’s Authority to Act on Behalf of the Client

REGARDING YOUR CHILD’S THERAPY

Directions Counseling Group policy requires the signature of both parents prior to treatment*

Our child therapists’ sole interests are in caring for children; therefore, we ask that the parent(s) and/or guardian(s) agree to not request, or to have any representative request, written documentation for the court or it’s legal representatives, from Directions Counseling Group or it’s associates.

X PRINT NAME OF CLIENT	
X PRINT Parent/Guardian #1 Name	X SIGN Parent/Guardian #1 Name
X PRINT Parent/Guardian #2 Name	X SIGN Parent/Guardian #2 Name

*If you desire an exception to this policy appropriate documentation must be provided, reviewed and approved by Directions Counseling Group prior to treatment, at your expense. Acceptable documentation authorizes one parent/guardian to obtain mental health services for the child/children. Examples of such documentation are a custodial agreement or divorce decree.

DISCLOSURE OF POLICIES AGREEMENT

PARENTS OF MINOR CLIENTS: It is very important that children have a sense of privacy in their counseling in order for them to be open and honest. A child's right to confidentiality will be honored within the limits of state law. Although parents generally have an unlimited right to information involving their children, the counselor will attempt to disclose information to parents based on the counselor's judgment of what is in the child's best interest from a therapeutic standpoint.

THERAPY CONSIDERATIONS: You should understand that there are various types of therapy that may be involved in your treatment and that there are some risks that may be involved, which could range from feeling uncomfortable to a more intense reaction. The purpose of therapy is to help you handle problems/situations in a constructive way. You should understand that you have the right to discontinue therapy at any time as well as the right to change therapists until you find one with whom you feel comfortable. You should also understand that your therapist can provide you with information on alternative ways to handle your issues, which may include a referral to another therapist who specializes in a specific area, or to an agency that may handle your care in the event that you are unable to fulfill your financial obligations to Directions Counseling Group.

CRISIS SITUATIONS: Directions Counseling Group is not a crisis intervention facility. If a life-threatening or other crisis situation arises, please take the following steps: (1) Call 911 or your local police, (2) Call Netcare at (614) 276-2273. (3) Call your counselor to make them aware of the situation.

INTAKE PROCESS: It is our ultimate goal that you get the help you are searching for. Directions Counseling Group employs numerous counselors to address the various needs of our clients. During our intake process we make every effort to schedule you with a counselor who is best suited to address your unique situation. If you feel uncomfortable directing your concerns to your counselor, please inform our intake staff and we will attempt to find another counselor for you or if necessary an outside referral.

RECORDS RELEASE: Requests for release of records are authorized by our counseling staff and/or the Executive Director. Record retrieval can take up to 2 weeks depending on storage location and administrative processing. Administrative staff will contact the party when the record is ready for pick-up. Costs will be determined by what is allowable under Ohio Revised Code 3701.741.

LEGAL PROCEEDINGS: I understand that my therapist may be required to become involved in legal proceedings involving my therapy (or my child's therapy). In that case, I agree to pay for the therapist's time in preparing for such legal action, including, but not necessarily limited to: traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of my involvement in such legal action.

COLLECTIONS: I understand that if I do not fulfill my financial responsibilities to make payments that I owe to Directions Counseling Group, that Directions Counseling Group may take appropriate collection action against me, up to and including taking legal action to collect amounts due from me. If that happens, I understand that the minimal amount of information necessary for such collection activity will be released and I consent to that release.

NO SHOW/CANCELLATION POLICY: The following fees are assessed for less than 24 hour cancellation and no-show to appointment: 1st no show or less than 24 hour cancellation: \$50.00; 2nd no show or less than 24 hour cancellation (at any time during treatment process): \$65.00; 3rd no show or less than 24 hour cancellation: Full fee. Please leave cancellation messages in general or scheduling voicemail box, NOT counselor's voicemail box.

FEES: All fees are due at time of service. The following list is not an exhaustive list of all services available. You may receive services from us that are not listed. Please consult with our staff to verify fees prior to receiving services from us. Initial Session \$165.00, 60 minutes; Follow-up Session \$135.00, 45-50 minutes; Follow-up Session with Senior Counselor \$150.00, 45-50 minutes; Marriage or Family Session \$145.00, 45-50 minutes; Marriage or Family Session with Senior Counselor \$160.00, 45-50 minutes; 80-90 minutes \$190.00; 30 minutes \$80.00. Returned check fee: \$40.00. Phone calls may be billed in 15 minute increments at the discretion of your therapist.

SLIDING FEES: Your fee may differ if a courtesy sliding-fee was previously arranged. All sliding fee arrangements are re-evaluated every six (6) months and may increase by up to \$10.00.

I have read and agree to the terms of the policies on this page. I have had the opportunity to ask questions about them; and agree to abide by and be bound by them.

PRINT CLIENT NAME

SIGNATURE (Client / Parent / Guardian / Responsible Party)

DATE

Client Medical History and Current Concerns

Client Name: _____

Height: Weight: Recent Weight Gain/Loss:

Number of Children: Allergies:

Date of Last Physical: Physician and phone:

Current Medical Problems:
ALL Current Medications (include dosage, prescribing doctor, and phone number):
Past Medical Problems (include prior mental health treatment and psychotropic medications):

Number of Pregnancies: Use of Alcohol x/week: Use of Caffeine x/week:

Use of Tobacco x/week: Exercise x/week:

What changes or benefits do you hope to obtain from counseling?

- 1.
- 2.
- 3.
- 4.
- 5.

Child Mood Checklist

Child's Name _____ Name of Person Completing Form _____

Date _____ Please check the box that best describes how often your child has been experiencing these symptoms within the last six months.

	Never or Rarely	Sometimes	Often	Very Often
Persistent sad or irritable mood	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lost of interest in activities once enjoyed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Significant change in appetite or body weight	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Difficulty sleeping or oversleeping	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Psychomotor agitation or retardation	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Loss of energy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Feelings of worthlessness or inappropriate guilt	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Difficulty concentrating	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Recurrent thoughts of death or suicide	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Frequent vague, non-specific physical complaints such as headaches, muscle aches, stomachaches or tiredness	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Frequent absences from school or poor performance in school	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Talk of or efforts to run away from home	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Outbursts (shouting, complaining, unexplained irritability, crying)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Being bored	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lack of interest in playing with friends	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Alcohol or substance abuse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Social isolation, poor communication	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Fear of death	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Extreme sensitivity to rejection or failure	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Increased irritability, anger, or hostility	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Reckless behavior	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Difficulty with relationships	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Severe changes in mood- either extremely irritable or overly silly and elated	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Overly-inflated self-esteem; grandiosity	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Increased energy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Decreased need for sleep – able to go with very little or no sleep for days without tiring	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Increased talking – talks too much, too fast; changes topics too quickly; cannot be interrupted	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Distractibility – attention moves constantly from one thing to the next	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Hypersexuality – increased sexual thoughts, feelings, or behaviors; use of explicit sexual language	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Increased goal-directed activity or physical agitation	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Disregard of risk – excessive involvement in risky behaviors or activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Excessive anxiety and worry, occurring more days than not about a number of events or activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Finds it difficult to control the worry	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Restlessness or feeling keyed up or on edge	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Being easily fatigued	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Difficulty concentrating or mind going blank	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Irritability	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Muscle tension	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Sleep disturbance (difficulty falling or staying asleep, restlessness, or unsatisfying sleep)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Loses temper	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Argues with adults	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Actively defies or refuses to comply with adults' requests or rules	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Deliberately annoys people	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Blames others for his or her mistakes or misbehavior	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Touchy or easily annoyed by others	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Angry and resentful	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Spiteful and vindictive	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Impairment in the use of nonverbal behaviors such as eye contact, facial expressions, body postures/gestures	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Failure to develop peer relationships appropriate to age	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lack of spontaneous seeking to share enjoyment, interests, or achievements with other people	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Lack of social or emotional reciprocity	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Preoccupation with an interest that is abnormally intense or focused	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Inflexible adherence to routines or rituals	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Repetitive motor mannerisms, e.g. hand or finger flapping or twisting	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Persistent preoccupation with parts of objects	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4