Client Information

Please write clearly **Date _____**

Client Name_____

Address_____

City_____ State_____ Zip Code _____ Date of Birth_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Which number is best to reach you or leave messages? __work__home__cell

Person responsible for payment _____ (Relationship to client) _____

Insured's Employer _____ Birth date of the insured _____

Primary care physician _____ Phone _____

Emergency contact _____ Phone _____

Briefly describe your reason for seeking help:

List any MEDICATION you are now taking, the AMOUNT and WHY you are taking it:

List any allergies and/or medical conditions:

Are you currently seeing any other therapist? Indicate name and reason:

Have you ever received psychiatric help or counseling of any kind before? If so, please BRIEFLY describe:

Anything else you would like me to know about you:

How did you hear about me?

Optional:

Age _____ Gender _____ Sexual Orientation _____

Marital Status _____ Spiritual Beliefs _____ Race/Ethnicity _____

By signing this paper, you indicate the following:

- **You understand that payment is due at the time of service and agree to this contract of payment for services rendered.**
- **You agree to give AT LEAST 24 hours notice or you will be charged for the time that was reserved for you.**
- **Your signature allows us to communicate with your insurance company as needed for payment.**
- **You consent to be treated.**

Current Payment Agreement:

Diagnostic Evaluation: _____

Individual Psychotherapy: _____

Family Psychotherapy: _____

Missed Appointment (less than 24hrs notice): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Please remind us to make a copy of your insurance card

Informed Consent and Service Agreement

Welcome to my practice. It is my primary goal to perform ethical and supportive treatment to each of my clients. This form contains important information about my professional and clinical policies. Please read it carefully. Your signature indicates a mutual agreement between us.

Clinical Services: Clinical therapy includes benefits as well as risks. Risks include the experience of difficult and uncomfortable feelings. Please keep in mind that you may feel worse before you start to feel better. Benefits may include reduction in distress, improved interpersonal relationships, and greater individual management of stress. There are no guarantees about the outcome of therapy. I expect you will contribute and participate in sessions and follow-through with treatment recommendations to work toward treatment goals. If at any time either of us feels that we are not a "fit," we will have a discussion about treatment barriers and referrals will be discussed and evaluated.

Intake: Your initial session will consist of a clinical assessment and discussion/development of treatment goals. Treatment modalities that I use in practice will be discussed. If you choose to continue treatment, a follow-up session will scheduled to begin to work toward your goals.

Appointments: I provide individual, family, and couples sessions by appointment only. Session appointments are 45min-60min in length. Additional "intensive" sessions may be scheduled dependent on treatment needs, and the length of time may vary. You are responsible for attendance on time for your scheduled appointment. I require 24 hours' notice for cancelled appointments. If an appointment is cancelled with less than the required notice or if you do not show up for your appointment time, you will be charged a fee of $50 (excludes Medicaid clients). Each client is allotted one late cancel/no show per calendar year.

Professional Fees: My professional rate for an intake appointment is $150 and for a therapy session is $130. If you have insurance, I will bill your insurance provider for services. It is your responsibility to contact your insurance carrier prior to the first session to determine if you will owe a copayment or deductible for services. Fees will be collected at the time of service and can be made through cash, check, or credit/health savings cards. Statements for payments due are available and may be mailed if fees are due on your account. If payment is not received by 3 months past the date due, your account may be sent to a collection agency. In addition, I charge a prorated fee for services outside of individual/family sessions. My fee for the preparation of documents, attendance at requested meetings and communication with legal counsel is $100/hour. If involvement in a court case includes attendance at or testifying in a hearing, you will be required to pay for the professional time required.

Insurance: I am in-network for most major insurance carriers. Please be advised that most insurance companies require disclosure of your primary diagnosis for compensation of services. At times, insurance carriers may request additional information about your treatment to determine clinical necessity for care. By signing this agreement, you give consent for me to communicate requested information to your provider.

Medical Records: I am required to keep appropriate records of the services that I provide. Your case records are stored in a secure location in my office. Except in cases of potential harm, you have a right to your case record. You also have a right to the release of your record to other professional providers with a signed release of information and request. Please note there is a fee of $100/hour for the preparation and release of records. If there is an emergency and I am no longer able to provide you treatment, your records can be obtained from Lisa Hayes, LISW-S 614-398-1283.

Consultation: I work independently, but do discuss case consultation with my colleagues as needed. I obtain and provide supervision to the colleagues with whom I share this office. Current colleagues include Tammy Moore, LISW-S and Lisa Hayes, LISW-S.

Confidentiality: Your information will be kept confidential as outlined in the additional document that you have signed, entitled "HIPPA Notice of Privacy Practices."

Contacting me: I am available to clients by telephone and email. If you choose to communicate with me through email, you acknowledge that there are limits to what can be kept confidential over the Internet. I am often not immediately available by telephone or outside of business hours. I encourage the use of your support system and coping strategies to manage stress outside of scheduled appointment times. If at any time you feel that you cannot wait for a return phone call or keep yourself safe, please contact 1) Netcare Access at 614-276-2273, 2) call 911, or 3) attend your nearest emergency department.

Other Rights: If at any time you are unhappy with any aspect of your treatment, I hope that you will discuss your concerns with me. These concerns will be handled with care and respect. You may end your therapy or request outside referrals at any time. You have the right to safe, respectful, and considerate care, without discrimination as to race, ethnicity, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask me questions about your treatment and my specific training and expertise. You have the right to expect that I will provide ethical treatment and will not engage in inappropriate social or sexual relationships with any of my clients. If you feel that your concerns have not been adequately addressed, you may contact the State of Ohio Counselor, Social Worker and Marriage and Family Therapy Board at 77 S. High St, 24th Floor, Room 2468 Columbus, OH 43215; (614) 466-0912.

Client Rights: You have the right to:

- **Be treated with respect**
- **A safe environment free from sexual, physical, and emotional abuse**
- **Inclusion in your treatment goals and plans for treatment**
- **Ask questions about my polies, practice, and expertise**
- **Disclosure of all fees and costs**
- **Have your information kept confidential per HIPAA privacy practices**
- **Referrals for appropriate resources and treatment**
- **Inquire about your treatment progress**
- **Terminate treatment at any time**

CONSENT TO TREATMENT: Your signature below indicates that you have read the Informed Consent and Service Agreement as well as the HIPPA Notice of Privacy Practices and agree to their terms.

_____	_____	_____
Client Signature	**Client Name (Print)**	**Date**
_____	_____	_____
Witness Signature	**Name**	**Date**
_____	_____	_____
Authorized Representative	**Name**	**Date**

HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This information is effective as of January 1, 2016

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

All information released will be in accordance with state and federal laws and the ethics of the counseling profession.

This notice describes my policies related to the use and disclosure of client health care information.

For the purposes of treatment I use and disclose health information to provide, manage and coordinate care. This may include case consultation with identified colleagues Lisa Hayes, LISW-S and Tammy Moore, LISW-S.

To obtain payment I use and disclose health information to verify insurance coverage and to process claims and collect fees.

I use and disclose health information for healthcare operations such as reviews of treatment and business activities.

I will disclose client information to report child abuse, medical emergency and as required by law. This includes:

- **Report of suspected physical, sexual or emotional abuse of a minor to appropriate authorities**
- **Report homicidal ideation to the identified victim(s) and local police department**
- **Report suicidal intentions if treatment recommendations are not followed**

Client Signature _____ Date_____

Witness Signature _____ Date_____

Updated January, 2016 **(Page 1 of 1)**

FINANCIAL POLICY

Patient Name: _____
Date of Birth: _____ SSN: _____

BASIC POLICY: Payment in full is due at the time service is provided unless prior arrangements have been made. Co-payments are due at the time of service. If you are unprepared to pay your co-pay on the day of your visit a $5.00 service fee will be charged to your account.

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. If your insurance requires a referral or prior authorization it is your responsibility to assure that one is available to our office prior to or at the time of your service. Our office contracts with many insurance carriers; please contact your insurance prior to your appointment to verify you are receiving care from a participating provider. Co-payments, coinsurance and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private contract between you and your carrier, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If you have questions about your benefits or your insurance carrier's decision to pay or deny your claim, please contact your insurance carrier directly. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE/MEDICAID PATIENTS: We will bill Medicare/Medicaid for you. We will also bill secondary insurance carriers for you. All coinsurance amounts or deductibles not covered by an insurance plan are due and payable at the time service is rendered.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MISSED APPOINTMENTS: In fairness to other patients and to the counselor, we require at least 24 hours notice to cancel appointments. You may be charged a $50 fee for missed appointments.

COLLECTION OF FEES: If it becomes necessary to bill you more than once for your share of services, a $5.00 per month fee will be charged to your account until payment in full has been received. In the event that action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees as determined and awarded by the court. If this is referred for collection, I/We agree to pay collection fees up to 25% on the balance owing. If legal action is deemed necessary, I/We agree to pay reasonable attorney's fees and court costs in addition to the above costs.

MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made to for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Medicare Program and its agents any information needed to determine these benefits or the benefits payable to related services.

_____

Signature Printed Name Date

ASSESSMENT OF INSURANCE BENEFITS: Patients with insurance please read and sign below. I hereby assign all benefits for any services furnished to me to . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____

Signature Printed Name Date

I have read, understand and agree to the above financial policy for payment of professional fees.

The patient is ultimately responsible for payment of all professional fees.

_____

Signature Printed Name Date

_____

Witness Signature Printed Name Date

Authorization to Release/Obtain
Confidential Information

I,_____, date of birth _____/_____/_____ herby authorize and request that Suzanne Rutti, MSW, LISW-S may release to or contact the following individuals, groups or insurance for matters of my well-being and/or payment, any confidential information regarding the diagnosis and treatment of myself or my minor children.

Names to contact or release to: Phone # Address:

_____

_____

_____

_____

_____

Signature: _____ Date: _____
(Client)

Signature: _____ Date: _____
(Parent or Guardian)

Signature: _____ Date: _____
(Witness)

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name:_____ **Age:**____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Client Information

Please write clearly **Date _____**

Client Name_____

Address_____

City_____ State_____ Zip Code _____ Date of Birth_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Which number is best to reach you or leave messages? __work__home__cell

Person responsible for payment _____ (Relationship to client) _____

Insured's Employer _____ Birth date of the insured _____

Primary care physician _____ Phone _____

Emergency contact _____ Phone _____

Briefly describe your reason for seeking help:

List any MEDICATION you are now taking, the AMOUNT and WHY you are taking it:

List any allergies and/or medical conditions:

Are you currently seeing any other therapist? Indicate name and reason:

Have you ever received psychiatric help or counseling of any kind before? If so, please BRIEFLY describe:

Anything else you would like me to know about you:

How did you hear about me?

Optional:

Age _____ Gender _____ Sexual Orientation _____

Marital Status _____ Spiritual Beliefs _____ Race/Ethnicity _____

By signing this paper, you indicate the following:

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Current Payment Agreement:

Diagnostic Evaluation: _____

Individual Psychotherapy: _____

Family Psychotherapy: _____

Missed Appointment (less than 24hrs notice): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Please remind us to make a copy of your insurance card

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- **Inclusion in your treatment goals and plans for treatment**
- **Ask questions about my polies, practice, and expertise**
- **Disclosure of all fees and costs**
- **Have your information kept confidential per HIPAA privacy practices**
- **Referrals for appropriate resources and treatment**
- **Inquire about your treatment progress**
- **Terminate treatment at any time**

CONSENT TO TREATMENT: Your signature below indicates that you have read the Informed Consent and Service Agreement as well as the HIPPA Notice of Privacy Practices and agree to their terms.

_____	_____	_____
Client Signature	**Client Name (Print)**	**Date**
_____	_____	_____
Witness Signature	**Name**	**Date**
_____	_____	_____
Authorized Representative	**Name**	**Date**

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I use and disclose health information for healthcare operations such as reviews of treatment and business activities.

I will disclose client information to report child abuse, medical emergency and as required by law. This includes:

- **Report of suspected physical, sexual or emotional abuse of a minor to appropriate authorities**
- **Report homicidal ideation to the identified victim(s) and local police department**
- **Report suicidal intentions if treatment recommendations are not followed**

Client Signature _____ Date_____

Witness Signature _____ Date_____

Updated January, 2016 **(Page 1 of 1)**

FINANCIAL POLICY

Patient Name: _____
Date of Birth: _____ SSN: _____

BASIC POLICY: Payment in full is due at the time service is provided unless prior arrangements have been made. Co-payments are due at the time of service. If you are unprepared to pay your co-pay on the day of your visit a $5.00 service fee will be charged to your account.

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. If your insurance requires a referral or prior authorization it is your responsibility to assure that one is available to our office prior to or at the time of your service. Our office contracts with many insurance carriers; please contact your insurance prior to your appointment to verify you are receiving care from a participating provider. Co-payments, coinsurance and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private contract between you and your carrier, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If you have questions about your benefits or your insurance carrier's decision to pay or deny your claim, please contact your insurance carrier directly. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE/MEDICAID PATIENTS: We will bill Medicare/Medicaid for you. We will also bill secondary insurance carriers for you. All coinsurance amounts or deductibles not covered by an insurance plan are due and payable at the time service is rendered.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

MISSED APPOINTMENTS: In fairness to other patients and to the counselor, we require at least 24 hours notice to cancel appointments. You may be charged a $50 fee for missed appointments.

COLLECTION OF FEES: If it becomes necessary to bill you more than once for your share of services, a $5.00 per month fee will be charged to your account until payment in full has been received. In the event that action is brought hereof, the prevailing party shall be entitled to recover from the other party the court costs and attorney fees as determined and awarded by the court. If this is referred for collection, I/We agree to pay collection fees up to 25% on the balance owing. If legal action is deemed necessary, I/We agree to pay reasonable attorney's fees and court costs in addition to the above costs.

MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment of authorized Medicare benefits be made to for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Medicare Program and its agents any information needed to determine these benefits or the benefits payable to related services.

_____

Signature Printed Name Date

ASSESSMENT OF INSURANCE BENEFITS: Patients with insurance please read and sign below. I hereby assign all benefits for any services furnished to me to . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____

Signature Printed Name Date

I have read, understand and agree to the above financial policy for payment of professional fees.

The patient is ultimately responsible for payment of all professional fees.

_____

Signature Printed Name Date

_____

Witness Signature Printed Name Date

Authorization to Release/Obtain
Confidential Information

I,_____, date of birth _____/_____/_____ herby authorize and request that Suzanne Rutti, MSW, LISW-S may release to or contact the following individuals, groups or insurance for matters of my well-being and/or payment, any confidential information regarding the diagnosis and treatment of myself or my minor children.

Names to contact or release to: Phone # Address:

_____

_____

_____

_____

_____

Signature: _____ Date: _____
(Client)

Signature: _____ Date: _____
(Parent or Guardian)

Signature: _____ Date: _____
(Witness)

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	