

RIVER VALLEY COUNSELING, LLC

CHILD/ADOLESCENT INTAKE PACKET

Counselor seeing: _____

CLIENT INFORMATION

Client Name _____ **DL#** _____

Street Address _____ PO Box _____

City/State/Zip _____

Home Phone # _____ **Can we leave a message at this number?** Yes No

Daytime Phone # _____ **Can we contact you here?** Yes No

Cell Phone # _____ **Can we leave a message on this phone?** Yes No

Client Date of Birth _____ Social Security # _____

Parent/Responsible Party Name (if client is minor) _____

Parent/Responsible Party Social Security # _____ Date of Birth _____

Primary Care Physician _____

Emergency Contact Name(required): _____ **Phone #:** _____

Address (required): _____

Insurance Information (Copy of Insurance Card and Driver's License is Required)

• **This section is required to be filled out in full** •

1) **Primary** Insurance Company _____ Ins Co Phone # _____

Employer of Subscriber _____

Name of Subscriber _____ Date of Birth _____

Subscribers Social Security # _____ Relationship to Client _____

Address of Subscriber (if different from Client) _____

2) **Secondary** Insurance Company _____ Ins. Co Phone # _____

Employer Name (with address) _____

Name of Subscriber _____ Date of Birth _____

Subscribers Social Security # _____ Relationship to Client _____

Address of Subscriber (if different from Client) _____

IF THERE IS A THIRD INS. PLEASE NOTIFY RECEPTIONIST TO GIVE YOU ATTACHMENT

CLIENT AGREEMENT

The above information is current and correct to the best of my knowledge.

I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy.

This agreement also grants authorization to RVC to release such information as may be necessary for completion of my insurance claim with payment of benefits to RVC for services rendered.

Client/Guardian Name (please print)

Client/Guardian Signature

Date

Witness

Date

Revised 01/2011

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ Relationship: _____ Today's Date: _____

Identifying Information

Child's Name: _____ **Date of Birth:** _____ **Age:** _____
Gender: Male Female **Race:** _____ **Height:** _____ **Weight:** _____
Hair Color: _____ **Eye Color:** _____

Behavioral Health

Why is the child coming to counseling?

What do issues or circumstances do you believe contribute to the child's problems?

How long has this problem persisted? _____

Under what conditions do the problems usually get worse?

Under what conditions do the problems usually improve?

Has the child previously been involved in counseling? No Yes **If yes, describe the reasons for counseling, who provided the counseling and the outcome.**

Counselor _____

Reason:

Outcome:

List your Child's greatest strengths:

List your child's greatest weaknesses:

List your child's main difficulties at home:

List your child's main difficulties at school:

Has the child previously been in counseling?

Psychiatric Hospitalizations: None Past Current

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)
Behavioral Health Symptom Checklist		
<i>Please indicate the degree your child has experienced any of the following symptoms in the last 4 weeks.</i>		
0 = Never	1 = Occasionally	2 = Regularly
3 = Frequently		
_____	1. Trembling, or feeling shaky	
_____	2. Shortness of breath or smothering sensation	
_____	3. Racing heart, heart palpitations or chest pain (circle which)	
_____	4. Moist palms or excessive sweating	
_____	5. Dizziness, lightheadedness, unsteady or faint (circle which)	
_____	6. <u>Nausea, diarrhea, or other abdominal distress (circle which)</u>	
_____	7. Frequent headaches or other muscle aches	
_____	8. Startle easily	
_____	9. Irritability (loses temper easily)	
_____	10. Worrying a lot	
_____	11. Trouble swallowing, "lump in throat", or choking sensation	
_____	12. Fearful of or embarrassed by being watched or being the focus of attention	
_____	13. Avoid talking to strangers	
_____	14. <u>Fear of embarrassment</u>	
_____	15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable	
_____	16. <u>High levels of anxiety in the presence of an object or situation</u>	
_____	17. Regular and disturbing thoughts about a past traumatic experience	
_____	18. Regular and disturbing dreams about a past traumatic experience	
_____	19. <u>Avoidance of thoughts feelings, or conversations associated with a traumatic experience</u>	
_____	20. Excessive hand washing or fear of germs	
_____	21. Excessive checking (i.e., doors, locks, stove)	
_____	22. <u>Excessive need for order or neatness or counting ritual(s)</u>	
_____	23. Unusual and persistent sad feelings	
_____	24. Diminished interest or participation in enjoyable or important activities	
_____	25. Difficulty concentrating or poor memory (circle which)	
_____	26. Tire easily or low energy level	
_____	27. Thoughts of suicide	
_____	28. Increased or decreased sleep (circle which): avg. hrs per night _____	
_____	29. <u>Feelings of hopelessness</u>	
_____	30. Persistent and abnormally elevated mood	
_____	31. Over inflated feelings of self-worth	
_____	32. Decreased need for sleep	
_____	33. Rapid or racing thoughts	
_____	34. Excessive involvement in pleasurable activities	
_____	35. <u>Excessive and/or reckless spending</u>	
_____	36. See or hear things that others around you are unable to perceive	
_____	37. <u>Hold ideas or beliefs that are not shared by others</u>	
_____	38. Self induced vomiting	
_____	39. Excessive exercise	
_____	40. Use of laxatives or diuretics to lose weight	
_____	41. <u>Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)</u>	
_____	42. Careless mistakes in school work, work, or other activities	
_____	43. Can only pay attention for short periods at school/work/home	
_____	44. Failure to complete schoolwork, chores, duties	
_____	45. Hyperactive: fidgets, squirms, talks excessively	
_____	46. Acts without thinking of consequences	

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If current or past use is indicated to any of the above items compete the following questions?

Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection

Has the child ever received inpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Has the child ever received outpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Is the child currently pregnant ? No Yes Is the child an IV drug user? No Yes

Family History

Parent's marital status: Married Divorced Separated Never Married Widowed

If the parents are not married, the child's age when divorce, separation or parents death occurred? _____

What is the relationship between the child and his/her custodial parent(s) Check all that apply:

- Parents married, together Single Parent, Mother Single Parent Father Parents Unmarried
 Mother & Stepfather Father & Stepmother Adoptive Family
 Other _____

Living Situation: Parent's Home Foster Home Relative's Home Homeless Group Home
 Residential Other _____

Household members Names (if client lives in more than one household list household 1 – 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education
Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Mother's age: _____ If deceased, how old was the child when she passed away? _____

Father's age: _____ If deceased, how old was the child when he passed away? _____

Number of Brothers _____ Their ages: _____

Number of Sisters _____ Their ages: _____

Where is the child in birth order (i.e. 1st born, 2nd born etc.) of his/her siblings? _____

Briefly describe the child's relationship with his/her siblings.

Briefly describe the style of parenting, including types of discipline, used in the household.

Describe the reasons your child is disciplined.

Parent's Employment

Mother's Current Employment Status Employed Unemployed Job/Occupation: _____

Name of employer: _____ Date Last Worked _____ Satisfied with Job Yes No

Father's Current Employment Status Employed Unemployed Job/Occupation: _____

Name of employer: _____ Date Last Worked _____ Satisfied with Job Yes No

Family Financial History:

Amount of Monthly Income _____ Source(s) of income: _____

Loss of Income due to: _____

Financial Problems No Yes If yes, explain: _____

Developmental History

List any drugs/medications used by the mother or family at the time of conception or by the mother during pregnancy

Indicate important physical development issues including developmental milestones including sensory/motor, motor, cognitive, mental retardation or autism

List the ages when the following developmental milestones occurred:

	<u>Age</u>	<u>Comments</u>
Walking	_____	_____
Talking	_____	_____
Toilet Trained	_____	_____

Rate your child's development, compared to others the same age in the following areas

Social Development	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Physical Development	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Language	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Intellectual Ability	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Emotional Expression	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average

For each type of development that you rated as *Below Average*, describe your current *Specific* areas of concern.

Medical History

Physician Name: _____

Address: _____
Street & Number City State Zip

Date of most recent physical exam: _____ **By Whom:** _____ **Phone:** _____

Results: _____

Immunizations Check the immunizations for the following diseases:

Chicken Pox Diphtheria German Measles Measles Mumps

<input type="checkbox"/> Polio <input type="checkbox"/> Small Pox <input type="checkbox"/> Tetanus			
Drug Allergies:			
List any major illness and/or operations			
Has the child had any medical hospitalizations in the last three years <input type="checkbox"/> No <input type="checkbox"/> Yes, if yes, complete below:			
Hospital	City	Date	Reason
List any <i>current</i> physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):			
List any <i>past</i> physical concerns:			
Has the child ever had head trauma that resulted in loss of consciousness and/or required medical treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<i>What medications is client now taking? List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.</i>			
Prescription/Over the Counter Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes		Out of Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown	
Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown	
Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown		Current Medication: _____ Total Daily Dosage: _____ Reason: _____ Compliance <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Partial <input type="checkbox"/> Unknown	
Does the client/family think medications help the client get better? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			
Does your child use caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes from (coffee, tea, soda) _____		Daily Use _____	
Does your child use tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes from (cigarettes, snuff, snus) _____		Daily Use _____	
On the average, how many hours of sleep does your child receive nightly? _____			
After going to bed, how long does it take your child to fall asleep? _____			
If falling asleep is a problem, how long has it been a problem? _____			
Does your child regularly awaken in the night?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your child regularly have bad dreams or nightmares?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does your child experience bad dreams and is unable to awaken during them?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
Describe your child's appetite? <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Average Appetite <input type="checkbox"/> Large Appetite			
Has the child's weight changed in the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, by how much? _____ <input type="checkbox"/> weight gain <input type="checkbox"/> loss			
Has client had any of the following symptoms in the past 60 days? Please check.			
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Coughing	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Seizures
<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Tingling in Arms/Leg
<input type="checkbox"/> Confusion	<input type="checkbox"/> Falling	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tremors
<input type="checkbox"/> Consciousness Loss	<input type="checkbox"/> Gait Unsteadiness	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Vision Changes
<input type="checkbox"/> Constipation	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Pulse Irregularity	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Other: _____			

Health History Questionnaire

Has the client or any of the relatives (related by blood) had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the client (parent, brother, sister, aunt/uncle, cousin, children, etc.) in the comment section.

Problem	Client			Family History	Relationship to the Client
	Now	Past	Never		
AIDS					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					
Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Suicide					
Thyroid					
Tuberculosis					

If the client has had any of the above , please write the problem, what treatment was received, and when

Problem & Treatment received:	When
Problem & Treatment received:	When

RIVER VALLEY COUNSELING, LLC

**131 N. Ewing St., Unit B
Lancaster, OH 43130
(740) 689-6700**

**647 Hill Rd North, Unit B
Pickerington, OH 43147
614-833-6900**

Acknowledgement of Supervisory Relationship

The therapists at River Valley Counseling, LLC, participate as a group in supervisory sessions, working together and under the supervision of Dr. Angeline Stergiou and Dr. Stuart Oppenheimer.

You are entitled to request that your therapist NOT reveal confidential information either to another therapist or to a particular supervising psychiatrist. In such cases, the therapist will obtain necessary supervision from an alternative psychiatrist.

I understand that failure to sign Supervisory Relationship could mean that my insurance may deny payment, and I will be responsible for the entire balance.

I wish to request an exception. (Please write it here) _____
_____.

Your signature on this form indicates you approve of your therapist's supervisory relationship

Signature: _____ Date: _____

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or less than 24-hour notice on cancellations will result in a \$35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late to appointments could also result in charges that would be equal to the time you kept your therapist waiting. **Insurance will not be billed for this. * Note to Parents – if you are financially responsible for your child, it is your responsibility to make sure you know when your child's appointments are and it is your responsibility to pay this fee if the appointment is missed. Continued non-compliance in keeping your appointments can result in dismissal from the practice.**

I HAVE READ THE OFFICE POLICY AND RECEIVED A COPY. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.

Client/Legal Guardian Signature Date

Witness Date

**RIVER VALLEY COUNSELING, LLC
CONSENT FOR TREATMENT AND INFORMATION SHEET**

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last 45-50 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you.

There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.

Once any charge has remained on your account for 120 days, the entire outstanding balance will be forwarded to a collection agency. Any fees and/or interest added by the collection agency will be charged to you in addition to the outstanding balance which you owed River Valley Counseling.

We place a high value on the confidentiality of your records. Records will be held confidential except as required by law, or as released by your written authorization. In a small number of situations, therapists are legally required to reveal information; for example, if you reveal information that indicated a clear danger of injury to yourself or others. Records may, on occasion, be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Every effort is made to answer calls during our regular office hours. If we are unable to answer or the office is closed at the time of your call, please leave a message, and we will return your call as soon as we can.

Entering psychotherapy requires a commitment of time, energy and resources, and often also requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND CONSENT FOR TREATMENT.

Signature

Printed Name of Client

Date

IF MINOR CLIENT, PARENT/GUARDIAN ATTESTS TO HAVING LEGAL CUSTODY AND CONSENTS TO FEES AND TREATMENT BY THIS SIGNATURE.

Parent Signature

Date

Revised December, 2011

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FEE SCHEDULE
All Counselors

Initial Session	\$160
Office Visit 45-60 Min	\$120
Office Visit 20-30 Min	\$ 80
Family Counseling	\$130

I have read and understand the Financial Policy and office procedures at River Valley Counseling, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.rivervalleycounseling.org.

Client Name (please print)

Date

Client Signature

If the client is a minor, the Guardian must sign below:

Guardian Name (please print)

Date

Guardian Signature

Date

Witness

Effective June1, 2008

RIVER VALLEY COUNSELING, LLC

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Receipt of Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that on _____ I received, or viewed from the website, the Notice of Privacy Practices of River Valley Counseling, LLC, which sets forth the ways in which my personal health information may be used or disclosed by River Valley Counseling, LLC, and outlines my rights with respect to such information.

Please list anyone to whom we may release medical information and/or speak with in regard to appointments along with their relationship to you:

_____	_____
_____	_____
_____	_____
_____	_____

Would you like for us to leave information regarding scheduling and appointments on your answering machine?

_____ YES _____ NO

Signature _____

Date _____

January, 2011

OFFICE POLICIES

FEES

Fees are based on the type of service provided and length of time.

Initial Session	\$160
Office visit 45-50 min, Individual	\$120
Office visit 20-30 min, Individual	\$ 80
Office visit 45-50 min, family	\$130

PHONE CONSULTATIONS

Telephone consultations lasting 10 minutes or longer will be billed in 15 minute intervals based on the per hour rate of the counselor charge. **As a rule, insurance will not cover this fee.**

PAYMENT FOR COURT TESTIMONY

If the clinician is required to testify for any reason in court pertaining to treatment, you will be responsible for paying the fee for the amount of time spent in court, giving depositions, other court related business and travel time to and from the setting at the usual and customary rate of your counselor's time. **As a rule, insurance does not cover this expense.**

MEETINGS OUTSIDE THIS FACILITY

Any meetings that are requested outside of River Valley Counseling, LLC, i.e. school, Job and Family Services, other therapist's offices and home visits will be charged the usual and customary rate. **Insurance does not cover this cost.**

CORRESPONDENCE FEES

Correspondence to non-medical contacts and/or written reports which require considerable preparation that is not necessary for treatment (i.e. letters to attorneys, courts, parents, etc.) will be billed in 15 minute intervals based on the usual and customary rate. This will be your responsibility since insurance will not pay for this service.

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a 24-hour notice or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or less than 24-hour notice on cancellations will result in a \$35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late to appointments could also result in charges that would be equal to the time you kept your therapist waiting. Insurance will not be billed for this. * Note to Parents – if you are financially responsible for your child, it is your responsibility to make sure you know when your child's appointments are and it is your responsibility to pay this fee if the appointment is missed. Continued non-compliance in keeping your appointments can result in dismissal from the practice.

RETURNED CHECK FEE

If the bank for any reason returns a check, you will be billed an additional processing fee of \$25.00 in addition to the amount owed. No checks will be accepted in our office thereafter. Credit/debit cards and Cash only will be accepted.

INSURANCE CLAIM PROCESSING

The office will bill insurance and managed care companies for you on a routine basis. Co-pays are expected at each visit. For insurance plans, you are expected to pay your deductible (if not met) and/or any portion of the fee, which will not be covered by insurance. Please make at least a partial payment at each session. You will be responsible for contacting your insurance plan prior to starting services to learn whether you have mental health coverage, limits, deductibles, and to obtain necessary authorizations.

OVERDUE ACCOUNTS

If more than ninety (90) days have lapsed since a charge has been incurred and no payment has been received on the account within the last 30 days, we reserve the right to turn the account over to a collection agency. If this happens neither you, nor anyone in your immediate family, will be able to schedule appointments here until the account is paid in full. If you are having financial difficulties, please contact the billing office to make arrangements. We will be glad to work with you. Continued non-compliance in keeping your account current can result in dismissal from the practice.

River Valley Counseling, LLC

Notice of Privacy Practices

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

The terms of this Notice of Privacy Practices apply to River Valley Counseling, located at 131 N. Ewing Street, Unit B, Lancaster, Ohio, and 647 Hill Rd. North, Unit B, Pickerington, OH 43147.

The members of this health care arrangement work and practice at the location listed above. All members will share personal health information of our patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices by submitting a request to the Privacy Officer of River Valley Counseling, LLC.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures For Treatment. We will make uses and disclosures of your health information as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you.

Uses and Disclosures For Payment. We will make uses and disclosures of your personal health information as necessary for the payment purposes of those health professionals that have treated you or provided services to you. For instance, we may forward information regarding your medical procedures and treatment to our insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval.

We may also disclose limited health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain portions of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services. We may contact you to provide appointment reminders and/or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or alternative locations. For instance, if you wish appointment reminders not to be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Privacy Officer.

Health Products and Services. We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of all patients that receive a particular drug and will need to review a series of medical records. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Confidentiality of Alcohol and Drug Abuse Patient Records. The confidentiality of alcohol and drug abuse patient records maintained by this facility is protected by federal law and regulations. Generally, the facility may not say to a person outside the program that you attend a drug or alcohol program, or disclose any information identifying you as an alcohol or drug abuser unless: (1) you consent in writing; (2) the disclosure is allowed by a court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Federal law and regulations do not protect any information about a crime committed by you at either our facility or against any person who works for the facility or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate or local authorities.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- We may release your personal health information for any purpose required by law;
- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your personal health information as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- We may release your personal health information your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- We may release your personal health information if required to do so by subpoena or discovery request; in some cases you will have notice of such release;
- We may release your personal health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- We may release your personal health information to coroners and/or funeral directors consistent with law;
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- We may release your personal health information if in limited instances we suspect a serious threat to health or safety;
- We may release your health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities; and
- We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

Ohio law requires that we obtain consent from you before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. Requests for access may be made verbally or in writing to our office and require an authorization for release of information signed by you or your legal representative. If you request a copy of the information, we will charge you as follows:

Copies: \$15.00

Chart reviews must be scheduled and will be charged at \$10.00

There is no charge for the copying and release of your health information when it is released to another health care provider for continuity of care.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reason for the amendment/correction request. If an amendment or correction to your request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the Medical Office Specialist at your physician's office.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Medical Office Specialist at your physician's office. The first accounting in any 12-month period is free; you will be charged a fee of \$15.00 for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations. A restriction request form can be obtained from the Medical Office Specialist at your physician's office. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, an agreed-to restriction to sending such termination notice to our office.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Office at River Valley Counseling, LLC. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgment of Receipt of Notice. You will be asked to sign an acknowledgment form that you received this Notice of Privacy Practices.

FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the Privacy Office at River Valley Counseling, LLC. As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE

This Notice of Privacy Practices is effective April 14, 2003.