AMS Counseling Services, LLC
15 W. Main St.
Madison, Ohio 44057
(440) 428-0118

PERSONAL HISTORY FORM

The purpose of this questionnaire is to obtain a more complete picture of your background and factors that may relate to your present concern. This information is confidential and cannot be released to any other person or agency without your written permission except when life or safety is seriously threatened or when required by law.

Please answer these routine questions as fully and accurately as you can.

CLIENT: _____

GUARDIAN NAME: (if applicable): _____

CLIENT DOB: _____

PRIMARY PHONE #: _____

ADDRESS: Street _____

City & Zip Code _____

EMAIL: _____

CLIENT SS # _____

GUARDIAN SS# (if applicable) _____

Gender and Preferred Pronouns: _____

Race/Ethnicity: _____

If necessary, may we contact you at home? Yes ____ No ____ Ph#: _____

Can we leave a message? Yes ____ No ____

If necessary, may we contact you at work? Yes ____ No ____ Ph#: _____

Can we leave a message? Yes ____ No ____

Who should we contact in event of an emergency?

Name: _____ Relationship: _____

Phone #: _____(type)_____ Phone #: _____(type)_____

Would you like to receive appointment reminders via text or email? Yes ___ No ____

Phone: _____ Email:_____

Name: _____
DOB: _____

HOUSEHOLD INFO: Please list the names and ages of all others living in your household. If you are a non-custodial parent, please indicate where and with whom your children are living.

Name	Age	DOB	Guardian/Place Residing

Briefly describe your reasons for being seen today: _____
_____
_____

Are you currently in a relationship? Yes ___ No ___

Do you currently feel safe at home? Yes ____ No ____

Is there a history of psychological, sexual, or physical abuse? Yes ___ No ___

Have you experienced/witnessed a domestic violence or a traumatic event: Yes ___ No ___
If yes, please list dates and events: _____
_____
_____

Have you had thoughts of harming yourself or others? Yes ____ No ____
List any previous suicide attempts: _____
_____

Has there been a change in your sleep pattern? Yes ___ No ___ More sleep _____ Less sleep _____

Have you had a weight change? ___Yes ___No If yes, how many lbs. gained _____ lost_____
time frame: _____

Have you ever seen a mental health professional before? Yes ____ No ____

Name of psychiatrist _____ Date of last appointment _____

Name of counselor _____ Date of last appointment _____

Have you ever been hospitalized for mental health or chemical dependency problems? Yes ___No ____
If yes, please list dates and reasons: _____
_____
_____

Briefly list any health problems including known allergies or medication allergies: _____
_____
_____
_____

Name: _____
DOB: _____

List all medications used by name, dosage and frequency: _____
_____
_____
_____

Marital history:

Name	Date married	Date separated/divorced/widowed
		S__ D__ W__
		S__ D__ W__
		S__ D__ W__
		S__ D__ W__

Children in order of birth

Name	DOB	Age	Sex	date of death (if applicable)
			M__ F__	
			M__ F__	
			M__ F__	
			M__ F__	
			M__ F__	

Family Background	living	Age	date of death (if applicable)
Father	Y__ N__		
Mother	Y__ N__		
Stepfather	Y__ N__		
Stepmother	Y__ N__		

Brothers/sisters – oldest to youngest

Name	DOB	Age	Sex	date of death (if applicable)
			M__ F__	
			M__ F__	
			M__ F__	
			M__ F__	
			M__ F__	

Is there a history of Mental Illness use in your family? Yes ___ No ___

Relationship to you: _____ diagnosis _____

Relationship to you: _____ diagnosis _____

Relationship to you: _____ diagnosis _____

Is there an incident of suicide in your family? Yes ___ No ___

Relationship to you: _____ date: _____

Relationship to you: _____ date: _____

Name: _____
DOB: _____

Social History:

Are you currently employed? Yes ___ No ___ Occupation _____

Last grade completed _____

Where you in the military? Yes ___ No ___ Branch _____

Religious affiliation: _____ Are you active in a Church Yes ___ No ___

Hobbies/Interests _____

_____

Legal History:

Have you ever been arrested? Yes ____ No____ When? _____

For what offense? _____

_____

Are you on probation? Yes ____ No ____ County of probation _____

Name & phone no. of probation officer: _____

Name & phone no. of attorney: _____

Do you currently use any alcohol or mood-altering drugs? Yes ____ No ____

Please describe which substance/s, how much you use & how often - daily/ weekly/varied:

_____

_____

Have you or anyone in your family ever thought that your usage could be a problem? Yes ___No ___

Have you ever felt that you should cut down on your use? Yes ___No ___

Have people ever criticized your drinking or drug use? Yes ___No ___

Have you ever felt bad or guilty about your drinking or drug use? Yes ___No ___

Have you ever drank or used drugs in the morning to steady your nerves or get rid of a hangover?

Yes ___ No ___

Is there a history of alcohol or drug use in your family? Yes ___ No ___

Relationship to you? _____ Sober Yes ___ No ___

Relationship to you? _____ Sober Yes ___ No ___

Relationship to you? _____ Sober Yes ___ No ___

Are you active in a program of recovery? Yes ___ No ___ Sobriety date _____

Do you have a gambling history? Yes ___No ___

Do you currently use tobacco? Yes ____ No _____

Are you interested in information on how to stop smoking? Yes ____ No ___

How did you learn about AMS Counseling Services? _____

Name: _____
DOB: _____

BURNS ANXIETY INVENTORY

Instructions: Choose the best answer for how the client has felt over the past week, including today. Mark the answer that best describes how much that symptom or problem has bothered the client.

0 = Not at all 1 = Somewhat 2 = Moderately 3 = A lot

Category 1: Anxious Feelings

1. Anxiety, nervousness, worry, or fear	0	1	2	3
2. Feeling that things around you are strange, unreal, or foggy	0	1	2	3
3. Feeling detached from all or part of your body	0	1	2	3
4. Sudden unexpected panic spells	0	1	2	3
5. Apprehension or sense of impending doom	0	1	2	3
6. Feeling tense, stressed, "uptight", or on edge	0	1	2	3

Category II: Anxious Thoughts

7. Difficulty concentrating	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to the next	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you're on the verge of losing control	0	1	2	3
11. Fears of cracking up or going crazy	0	1	2	3
12. Fears of fainting or passing out	0	1	2	3
13. Fears of physical illnesses or heart attacks or dying	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated, or abandoned	0	1	2	3
16. Fears of criticism or disapproval	0	1	2	3
17. Fears that something terrible is about to happen	0	1	2	3

Category III: Physical Symptoms

18. Skipping or racing or pounding of the heart (sometimes called palpitations)	0	1	2	3
19. Pain, pressure, or tightness in the chest	0	1	2	3
20. Tingling or numbness in the toes or fingers	0	1	2	3
21. Butterflies or discomfort in the stomach	0	1	2	3
22. Constipation or diarrhea	0	1	2	3
23. Restlessness or jumpiness	0	1	2	3
24. Tight, tense muscles	0	1	2	3
25. Sweating not brought on by heat	0	1	2	3
26. A lump in the throat	0	1	2	3
27. Trembling or shaking	0	1	2	3
28. Rubbery or "jelly" legs	0	1	2	3
29. Feeling dizzy, lightheaded, or off balance	0	1	2	3
30. Choking or smothering sensations or difficulty breathing	0	1	2	3
31. Headaches or pains in the neck or back	0	1	2	3
32. Hot flashes or cold chills	0	1	2	3
33. Feeling tired, weak, or easily exhausted	0	1	2	3

Name: _____

DOB: _____

Beck Depression Inventory
Circle the answer that best describes you

1. 0. I do not feel sad.
   1. I feel sad
   2. I am sad all the time and I can't snap out of it.
   3. I am so sad and unhappy that I can't stand it.

2. 0. I am not particularly discouraged about the future.
   1. I feel discouraged about the future.
   2. I feel I have nothing to look forward to.
   3. I feel the future is hopeless and that things cannot improve.

3. 0. I do not feel like a failure.
   1. I feel I have failed more than the average person.
   2. As I look back on my life, all I can see is a lot of failures.
   3. I feel I am a complete failure as a person.

4. 0. I get as much satisfaction out of things as I used to.
   1. I don't enjoy things the way I used to.
   2. I don't get real satisfaction out of anything anymore.
   3. I am dissatisfied or bored with everything.

5. 0. I don't feel particularly guilty
   1. I feel guilty a good part of the time.
   2. I feel quite guilty most of the time.
   3. I feel guilty all of the time.

6. 0. I don't feel I am being punished.
   1. I feel I may be punished.
   2. I expect to be punished.
   3. I feel I am being punished.

7. 0. I don't feel disappointed in myself.
   1. I am disappointed in myself.
   2. I am disgusted with myself.
   3. I hate myself.

8. 0. I don't feel I am any worse than anybody else.
   1. I am critical of myself for my weaknesses or mistakes.
   2. I blame myself all the time for my faults.
   3. I blame myself for everything bad that happens.

9. 0. I don't have any thoughts of killing myself.
   1. I have thoughts of killing myself, but I would not carry them out.
   2. I would like to kill myself.
   3. I would kill myself if I had the chance.

10. 0. I don't cry any more than usual.
    1. I cry more now than I used to.
    2. I cry all the time now.
    3. I used to be able to cry, but now I can't cry even though I want to.

11.
0. I am no more irritated by things than I ever was.
1. I am slightly more irritated now than usual.
2. I am quite annoyed or irritated a good deal of the time.
3. I feel irritated all the time.

12.
0. I have not lost interest in other people.
1. I am less interested in other people than I used to be.
2. I have lost most of my interest in other people.
3. I have lost all of my interest in other people.

13.
0. I make decisions about as well as I ever could.
1. I put off making decisions more than I used to.
2. I have greater difficulty in making decisions more than I used to.
3. I can't make decisions at all anymore.

14.
0. I don't feel that I look any worse than I used to.
1. I am worried that I am looking old or unattractive.
2. I feel there are permanent changes in my appearance that make me look unattractive
3. I believe that I look ugly.

15.
0. I can work about as well as before.
1. It takes an extra effort to get started at doing something.
2. I have to push myself very hard to do anything.
3. I can't do any work at all.

16.
0. I can sleep as well as usual.
1. I don't sleep as well as I used to.
2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3. I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0. I don't get more tired than usual.
1. I get tired more easily than I used to.
2. I get tired from doing almost anything.
3. I am too tired to do anything.

18.
0. My appetite is no worse than usual.
1. My appetite is not as good as it used to be.
2. My appetite is much worse now.
3. I have no appetite at all anymore.

19.
0. I haven't lost much weight, if any, lately.
1. I have lost more than five pounds.
2. I have lost more than ten pounds.
3. I have lost more than fifteen pounds.

20.
0. I am no more worried about my health than usual.
1. I am worried about physical problems like aches, pains, upset stomach, or constipation.
2. I am very worried about physical problems and it's hard to think of much else.
3. I am so worried about my physical problems that I cannot think of anything else.

21.
0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I have almost no interest in sex.
3. I have lost interest in sex completely.

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INFORMED CONSENT TO TREAT

Relationship

Your therapist's relationship with clients is a professional and therapeutic relationship. To preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of therapeutic relationships. Please do not attempt to "friend" your therapist or anyone else in the practice on Facebook or on any other social media site. You always have the right to terminate services with your therapist at any time and for any reason.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment your therapist recommends and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and your therapist will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. Your therapist will let you know if he or she feels that you are not a good fit or if you might obtain better help with someone else. Your therapist will always retain the right to terminate therapy with you. Some examples of when this may happen is if he or she feels you would be better served with another therapist, for rude or abusive behavior, for a pattern of missed or cancelled appointments, if he or she feels you are not complying with treatment requests, or if payments due remain unpaid. In the event that your therapist terminates services with you he or she will offer you referrals. You will automatically be considered terminated in the event that you do not schedule an appointment for a one-month period.

Confidentiality

Laws protect the privacy of all communications between a client and a therapist. In most situations your therapist can only release information about your treatment to others if you sign a written authorization. There are some situations where they are permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in court proceedings and a request is made for information concerning your treatment, your therapist cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order your therapist to disclose information.
- If a government agency is requesting the information, your therapist may be required to provide it.
- If you file a complaint or lawsuit against your therapist, he or she may disclose relevant information about you as part of a defense to your charges.
- If you file a worker's compensation claim, your therapist may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which your therapist is legally obligated to take actions that he or she believes is necessary to attempt to protect others from harm, and in such cases, they might have to reveal some information about your treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action, if they deem that to be appropriate under the circumstances and will limit disclosure to what is necessary. For instance:

- If your therapist has reason to believe that a child, a developmentally or physically disabled, an elderly adult or an

animal has been or is being neglected or abused, the law may require them to report that information to the appropriate state or local agency.

- If your therapist believes you present a clear and substantial danger of harm to yourself and/or others, he or she may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that the practice may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time your therapist may have the need to consult with his or her practice attorney regarding legal issues involving your care (this is an infrequent occurrence but does happen from time to time). The practice attorney is bound by confidentiality rules also. In addition, your therapist will reveal only the information that he or she needs to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that your therapist may practice with other mental health professionals, the practice may employ administrative staff, or your therapist may need to consult with outside medical professionals. In addition, your therapist may need to coordinate your care with your other healthcare providers. In most cases, protected information may need to be shared with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance. If your therapist or the practice does that only the information necessary for them to provide help to you, the client, will be released and you agree to allow them to do that. All the mental health and medical professions 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.

Also, the practice may have a contract with a collection agency. If that is the case, the practice will have a formal contract with this business, in which the business promises to maintain the confidentiality of the data except where release of certain information is allowed in the contract or is required by law. Only limited information, just enough to collect the amount you owe, will be disclosed by the practice in this situation.

In addition, the practice may have a contract with a billing service. As required by HIPAA, the practice will have a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except where release of the information is allowed in the contract or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with your therapist any questions or concerns that you have.

Legal Situations

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require your therapist's participation you will be expected to pay for all of their professional time, even if they are called to testify by another party. Your therapist will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. Your therapist's professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that they wait in court prior to or after they may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, your therapist charges $220.00 per hour for these services. You will also be responsible for any legal fees that they may incur in connection with the legal proceeding, which may include responding to subpoenas.

Name: _____
DOB: _____

Please be advised that as a treating therapist, your therapist cannot ethically provide any recommendations on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings.

Professional Records

The laws and standards of your therapist's profession require that your therapist keep Protected Health Information about you in your Clinical Record. Your Clinical Record may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that your therapist receives from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record if you request it in writing, unless your therapist determines for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law they may exercise the option of turning the records over to another mental health therapist designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, it is therefore recommended that you initially review them with your therapist or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, your therapist is allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so he or she will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, and if we store the information in an electronic format, your therapist will provide the information to you in an electronic format if you agree to accept the potential risks involved in sending the records that way.

Your therapist may also keep a set of psychotherapy notes which are for their own use, and which are designed to assist them in providing you with the best treatment. These notes are kept separate from your Clinical Record. Their release requires a separate authorization in addition to one for the Clinical Record. Your therapist will discuss with you whether they are maintaining psychotherapy notes on you.

Minors

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if your therapist feels that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that your therapist will have to turn them over to, unless otherwise required by federal law. Before giving your parents any information your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have. Except in unusual circumstances, your therapist likes to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent communicates in connection with the minor's therapy is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship, or other matters which are covered by court documents are involved before your therapist sees a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see a therapist on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of your therapist's intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Incapacity or Death of Therapist

If your therapist is incapacitated or dies, it will be necessary for another therapist to take possession of your file and records. By signing this form, you consent to allow another licensed mental health professional or another person who will be under an agreement to maintain the confidentiality of the records whom your therapist or the practice designates to

Name: _____
DOB: _____

take possession of your file and records, provide you with copies or to deliver them to a therapist of your choice. If you continue to receive treatment with a clinician in this practice, this informed consent form will continue to apply.

Disclosing Information to Family Members, Relatives, or Close Friends

By signing below, you agree to allow your therapist, if you are incapacitated, in an emergency, or are not available, to contact a family member, a relative, a close friend or any other person you identify, to disclose your personal health information that directly relates to that person's involvement in your healthcare. This information will be disclosed as necessary only if your therapist determines that it is your best interest based on his or her professional judgment. If you object to me doing this, please let me know during our first session together.

Email, Texting, and Electronic Communications

The therapists and this practice do not like to use e-mail, texting, or electronic communications unless you and your therapist both agree that is appropriate. If you decide you want to utilize any form of electronic communication, you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks.

You understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in your community.

By signing below, you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either your therapist and the practice to you or you to your therapist or the practice that involve scheduling and/or therapy.

If you do not want your therapist or the office to contact you at a certain address or phone number, please let your therapist know at your first meeting with him or her.

Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist I will be seeing at the practice to provide such care, treatment, or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third-party payer to obtain reimbursement unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive through a therapist at the practice at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor or a ward with a court approved guardian is the client I am signing on behalf of the minor or the ward as the authorized parent/guardian. (Information on minor rights will be shared with the minor, as appropriate.)

I also acknowledge that I have received a copy of the Notice of Privacy Practices for the practice listed at the top of this form.

_____	_____	_____
Client/Guardian Signature	**Office Staff Signature**	**Date**

Name: _____
DOB: _____

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trobinson@amscounselingservices.net

ELECTRONIC SERVICE DELIVERY INFORMED CONSENT

Electronic Service Delivery is defined as mental health therapy in any form offered or rendered primarily by electronic or technology assisted approaches when the mental health therapist and the client are not located in the same place during delivery of services. While working with your therapist you will always have the opportunity to ask any questions that you have about the therapy, electronic communications in general, and other issues involving your therapy. Your therapist will also assess your ability to handle computers and the internet, so that you and he or she may work in this way.

As a client receiving mental health services through electronic service delivery methods, you should understand:

1) This service is provided by technology (including but not limited to video, phone, text, and email) and may or may not involve direct, face to face, communication. There are benefits and limitations to these types of services. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information may not be direct, and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery. Your therapist will assess whether or not therapy through means of electronic service delivery is appropriate for addressing your issues and whether or not you have the knowledge and skills to use the technology involved.

2) As a therapist licensed in Ohio, your therapist may only deliver services to people located in Ohio, unless he or she obtains a license or is allowed to practice in the state where the person is located. If you plan on leaving Ohio for any length of time in the future, please let your therapist know as soon as possible so that you and he or she can make proper arrangements for future work or referrals, as appropriate. If you are going to be out of state during therapy, then your therapist will have to comply with the licensing laws of the state where you will be located. You agree to provide the street address where you will be receiving services and agree to update it if it changes.

3) If a need for direct, face to face services arises, it is your responsibility to contact providers in your area, or to contact this office for a face-to-face appointment. You understand that an opening may not be immediately available.

4) You may decline any electronic service delivery service at any time without jeopardizing your access to future care, services, and benefits.

5) These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet or through other electronic services that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. Your therapist and you will regularly reassess the appropriateness of continuing to

deliver services using technology. When using these services, you agree to accept the risks involved with the unencrypted exchange of information, if it is provided in that way.

6) Your therapist will need to verify your identity in a face-to-face meeting, which may be via video/audio electronically and then at subsequent sessions. At the initial session you and your therapist will address imposter concerns. You should be aware that misunderstandings are possible with telephone, text-based modalities (e.g., email), and real-time internet chat, since non-verbal cues are relatively lacking. Even with video chat software, since bandwidth may be limited and images may lack detail, misunderstandings may occur. Your therapist is an observer of human behavior. He or she will gather information from body language, vocal inflection, eye contact, and other non-verbal cues. Cultural differences and how they affect non-verbal cues may also be involved and your therapist will assess whether this type of therapy is appropriate for your cultural experiences, your environment and your therapeutic needs. If work is being done with families or groups with different levels of technological competence, power dynamics will be acknowledged. Please let your therapist know if you have any type of audio/visual or cognitive impairment prior to beginning therapy. If you have never engaged in online counseling, you need to have patience with the process and request clarification if you believe that you are not being understood by your therapist or you do not understand something that your therapist says. He or she will regularly review whether electronic service delivery meets the goals of therapy. Your therapist will also discuss with you how to handle disruptions in services and all methods of delivering services that are compliant with commonly accepted standards of technology safety and security at the time at which services are rendered.

7) In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

a) In emergency situations: If it is an imminent situation that requires face-to-face contact call 911 or go to the nearest emergency room. If it can be managed over the phone, you can call your therapist but if your therapist does not respond immediately or within a short period of time, you should contact local emergency services (for example, call 911 or go to your local hospital's emergency room, or call the National Suicide Prevention Hotline number -1-800-273-8255 or dial or text 988.) Also, other local hotline crisis phone numbers may be available to call, and you can check on the internet to find those.
b) Should service be disrupted: Try to regain contact using the same medium. If that does not work, attempt to make contact using text or e-mail. Your therapist will also make every effort to regain contact. If service is disrupted during a therapy session before the pre-agreed time frame has ended, you will have the opportunity to use the remaining time as soon as contact is made. If contact is not re-established within one hour, you will have the choice to end the session and be charged a pro-rated amount or allowed to schedule an additional session to use the remaining time.
c) For other communications: Your therapist and you may agree to communicate via a phone call, videoconferencing, e-mail, text, fax, or mailed letters.

(8) The potential benefits of online counseling include flexibility in scheduling and allowing you to engage in counseling outside of the office, which eliminates issues like transportation and other psycho-social barriers that might make it difficult for you to handle in a traditional office setting. The provision of online counseling may include risks related to the technology used, the distance between you and your therapist, and issues related to timeliness. For example, the potential risk of confidentiality may pertain to your accessing the internet from public locations. You should consider the visibility of your screen and being overheard when in public settings. It is recommended that you be in a private setting when

engaging in online counseling. You should also always use strong passwords to protect any information shared with your therapist. Never use a work computer for therapy as your employer may have access to the information shared in electronic communications. Be cautious when using a shared network with others.

(9) Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than it is in person. You are responsible for confidentiality in your own environment, including securing your hardware, internet access points, chat software, email, and passwords. Please develop passwords that are appropriate and strong and do not use autofill for usernames or passwords. Although your therapist will take steps to protect your information, he or she will have policies in effect to notify you of a breach of any of your confidential information which is required to be reported to you.

(10) Your therapist may utilize alternative means of communication in the following circumstances: if you do not respond to text, your therapist may call. If you do not respond to a call, your therapist may follow up with text or e-mail. If you do not respond to a call, text, or e-mail, your therapist may follow up with a mailed letter. In case of emergency (or concerns over your welfare), your therapist may contact your emergency contact if you have provided one.

(11) Your therapist will attempt to respond to communications and routine messages within 48 hours if he or she is available.

(12) It appears that most Ohio insurance companies are reimbursing for telehealth sessions. However, you should check with your insurance company to determine if they will reimburse you for electronic service delivery sessions. If insurance does not cover reimbursement, then you agree to pay the fee for the service.

(13) You need to take the following precautions to ensure that your communications are directed only to your therapist or other individuals: Ensure that you use the correct e-mail address, telephone number, Zoom or other link, or online name, fax number, and physical address to contact the appropriate individuals. Only leave voice messages after ensuring that the correct phone number was dialed, and the voicemail introduction identifies the correct individual.

(14) Your communications exchanged with your therapist, if capable of being put into written form, will be stored in the following manner: e-mails, texts, and other electronic communication relevant to treatment will be printed and kept in your file. Mailed letters and documents will also be kept in your file. Notes outlining electronic service delivery treatment sessions will be written and kept in your file. Your file will be kept in a locked file cabinet or stored electronically and will be accessible only by those who require or are allowed access and will be available to you or someone named by you for the length of time required under Ohio and federal law. Your therapist will not record sessions without first discussing it with you and obtaining your permission to do that. Please see your therapist's regular Informed Consent form for information on access to your records, including who will have access to them.

(15) The laws, ethics and professional standards that apply to in-person therapeutic services also apply to services delivered by electronic means. This document does not replace other agreements, contracts, or documentation of informed consent covering other issues. If you want licensing information on your therapist, you can find it at one of the licensing board websites. Psychology Board statutes, rules and other helpful information may be found at www.psychology.ohio.gov, the Counselor, Social Worker &

Name: _____
DOB: _____

Marriage and Family Therapist Board's website is found at www.cswmft.ohio.gov, and the Chemical Dependency Professionals Board's website is found at www.ocdp.ohio.gov.

Acknowledgment of Informed Consent to Treatment via Electronic Service Delivery Means

You voluntarily agree to receive mental health assessment, care, treatment, or services and authorize your therapist to provide such care, treatment, or services as are considered necessary and advisable via electronic service delivery means.

By signing this Electronic Service Delivery Informed Consent, you, the undersigned client, acknowledge that you have both read and understood all the terms and information contained herein and you agree to be bound by the provisions in this agreement. Ample opportunity has been offered to you to ask questions and seek clarification of anything unclear to you. If a minor or a ward is the client, you are signing on behalf of the minor or ward as the authorized parent/guardian. (Information on Minor rights will be shared with the minor)

You also acknowledge that you have received a copy of the regular Informed Consent and Notice of Privacy Practices for the practice listed at the top of this form.

_____	_____	_____
Client/Guardian Signature	**Office Staff Signature**	**Date**

Name: _____
DOB: _____

AMS Counseling Services
15 W. Main St.
Madison, Ohio 44057
(440) 428-0118

Welcome to our practice. Our purpose is to provide you with personal and professional psychotherapy, individually tailored to meet your needs. Our aim is to assist you in finding relief from distress, better insight, and functioning. Your length of service will be based on the level of care needed and completion of mutually agreed upon goals and objectives.

Medical Privacy Notice: In general, information shared with your therapist is confidential, (please refer to HIPPA Notice Privacy of Privacy Practices) except in cases involving abuse, life or death situations injury, or disability, and the purpose of preventing or controlling disease. If you were referred by an insurance company or managed care organization or professional, specific information may be shared for coordination of care. Due to logistical obstacles, initiation of or acceptance of any link to electronic communication will also be interpreted as informed consent at this time. Written notes regarding treatment, progress and outcome are kept for a minimum of seven (7) years and can be accessed upon request.

Billing information is routinely shared with insurance companies. Information required to collect delinquent bills will be shared with a collection agency. Accounts with no payment activity for 1 month are subject to a 3% late fee & all past due accounts will be considered delinquent beyond 60 days and turned over for collections.

All appointments are scheduled in advance, and it is expected that appointments will be kept or canceled no later than 24 hours in advance. All attempts are made to be considerate of your time; please do the same. Missed appointments are not covered by insurance companies and will be billed at the full session rate of $120. Appointments canceled less than 24 hours in advance are billed at the discretion of the therapist. All fees are due prior to returning for therapy.

FEES

Assessment $155 Individual Session $140 45 min. Session $120 30 min. Session $95

Group Session $80 Consultation $145 Court Appearance $ 220 hr. (includes drive time)

Unscheduled phone calls - $ 45.00 for each 15-minute increments

**Costs for records will be discussed when requested.

All clients must pay any deductibles and co-payments at the time of service. You are strongly encouraged to check with your benefits office or insurance carrier regarding any special authorization required for mental health services. Our fees will remain the same for telehealth services. Although we have contacted all insurance companies, it is still recommended that you contact your insurer about reimbursement for these services.

Regardless of the situation, you, not your insurance company, are responsible for all charges.

In the case of divorce, the parent with legal custody is responsible for all costs. We are required by law to confirm custody and guardianship. Copies of custody or guardianship documentation are required for us to provide services to a minor or ward.

Thank you for putting your trust in us. Please sign indicating that you have read and understand the above

_____ _____ _____ _____
Client/Guardian Signature Date Office Staff Signature Date

** Per Ohio Revised Code 3701.741

Name: _____
DOB: _____

AMS Counseling Services
15 W. Main St.
Madison, Ohio 44057
(440) 428-0118

Cancellation Policy

Welcome to our practice. We do our best to provide you with therapy tailored to meet your needs and accommodate your scheduling needs. Please keep in mind that you are reserving an hour of our time and request that you be considerate of our time as well.

We understand that there may be a need to cancel or reschedule on occasion and request that you contact the office a minimum of 24 hours in advance. Please also contact the office if you will be late for an appointment. It is your responsibility to remember the dates and times of your scheduled appointments. Understand that progress in therapy is adversely affected when appointments are consistently missed or shortened due to tardiness.

1. Any missed appointment without notification will be considered a no show/no call and will result in a fee of $120.00. A no show will constitute forfeiture of your protected time slot. This fee must be paid in full before another appointment can be scheduled. Your insurance is not responsible for no show fees.

2. Any appointment canceled less than 24 hours in advance will be considered a late cancellation and may result in a fee of $120.00. Consistent cancellations will be considered as your intent to terminate your therapy unless discussed with your therapist, prior to the cancellations. Two consecutive cancellations will constitute forfeiture of your protected time slot.

3. Consistent Tardiness may result in additional fees for your allotted time.

(Emergencies will be considered i.e., illness, extreme weather, death in the family). This fee must be paid in full before another appointment can be scheduled. Your insurance is not responsible for cancellation fees. Fees for late cancellations may be waived if the appointment can be rescheduled for the same week. (Per appointment availability).

Co-payments and deductibles are due at the time of service. Non-payment after two visits will result in suspension of therapy. Consistent non-payment may result in termination of therapy. All unpaid fees over 60 days past due will be turned over for collection.

Medicaid Addendum to Cancellation Policy

Due to Medicaid Rules, deHaas Family Counseling LLC is unable to charge the late cancellation or no-show fees that are attributed to all other clients, hence failure to contact the office within the requested time frame will result in automatic forfeiture of my protected time.
Should I wish to continue therapy, I have the option of contacting the office when I am available to inquire about open appointment times on that same day. I will not be awarded a protected time again until a pattern of regular attendance can be established.

Thank you for putting your trust in us. Please sign indicating that you have read and understand the above.

_____ _____ _____ _____
Client/Guardian Signature Date Office Staff Signature Date

INSURANCE INFORMATION

Did you call for Pre-Authorization? NO ___ YES ___ Pre-Auth Number: _____

MANY INSURANCE COMPANIES REQUIRE PRE-AUTHORIZATION FOR MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES. IF THIS IS REQUIRED BY YOUR INSURANCE CARRIER AND YOU DID NOT CALL, BE AWARE THAT YOU MAY BE PENALIZED WITH DENIAL OR REDUCED BENEFITS.

We must have **FULL INSURANCE INFORMATION COMPLETED BELOW.** It is up to the client to know his/her insurance coverage, including knowledge of co-payment amounts and yearly deductibles. We cannot verify this information for you. If payment of the bill has not been satisfied by the insurance company within 90 days, it is the responsibility of the client or guardian to pay the bill in full. All bills over 90 days past due will be turned over for collection. We will not wait for secondary insurance to pay the balance.
Co-payments and deductibles are always due at the time of service.

Clients Name _____ DOB: _____

Social Security Number_____

Client's relationship to insured: _____ Today's Date _____

Client's status: Single ___ Married ___ Widowed ___ Partnered ___ Other ___

Employed ___ Full-time student ____ Part-time student ____

PRIMARY INSURANCE COMPANY: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____

Insured's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insured's Social Security Number: _____ DOB: _____

Insured's Gender: Male _____ Female _____

Insured's Employer or School: _____

SECONDARY INSURANCE COMPANY: _____

Policy Number: _____ Group Number: _____

Insured's Name: _____

Insured's Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insured's Social Security Number: _____ DOB: _____

Insured's Gender: Male _____ Female _____

Insured's Employer or School: _____

Name: _____
DOB: _____

AUTHORIZATION AND CONSENT TO USE AND DISCLOSE MEDICAL INFORMATION

The- Privacy Notice of AMS Counseling Services, LLC refers to information about how we may use and disclose confidential information about you. The terms of our Notice may change from time to time. If we change our Notice, you may obtain a revised copy during your next visit. This notice is posted by the window in the waiting area.

By signing this Authorization, you agree to let us use and disclose confidential medical information about you in electronic and/or paper forms for treatment, payment, and health care operations. This includes information about physical and mental illness, substance abuse or HIV/AIDS, if applicable. Initiation of or acceptance of any link to electronic communication will be interpreted as informed consent. You are also consenting to the electronic and/or paper release of medical information about you to any insurer, third party payer, the Social Security Administration, or any agents or consultants who help this office get paid for your treatment and other health care operations.

Your authorization may be revoked, in writing, by you at any time. You will be responsible for any outstanding claims once written notice is received by this office.

Client/Guardian Signature: _____ Date: _____

Office Use Only:

Date notified of benefits: _____ By: _____

AMS Counseling Services, LLC
15 West Main St.
Madison, Ohio 44057
Phone 440-428-0118
Fax 440-417-0119
info@amscounselingservices.net

Physician Communication Form

Client Name: _____ DOB: _____

Primary Care Physician:
Name: _____
Address: _____
_____
Phone Number: _____
Fax Number: _____

By signing this Authorization, you agree to allow us to exchange confidential health information regarding your diagnosis and treatment with the named physician. This authorization can be revoked at any time except when action has been taken in reliance on the prior authorization.

I, _____, hereby authorize AMS Counseling Services, LLC
(Print client name)

Please check one:
____ To exchange any applicable information with my Primary Care Physician
____ Not to exchange any information about my care to my Primary Care Physician.

_____ _____
(Signature of Patient/Guardian) (Date)

To be completed by clinician _____

Date of assessment: _____
Presenting Problems/Diagnosis: _____
_____
Treatment plans/ Recommendations: _____
_____
Current/Reported Psychotropic Medications: _____
_____
_____

Clinician Signature: _____ Date_____