WELCOME

Welcome to Clermont Mental Health. Ohio Counseling Law requires us to provide you with the following information regarding your rights and responsibilities as a client here, and the limits of confidentiality. If you have any questions, feel free to discuss them Mandy Friedman MS LPC 513-843-3166 or Crystal Hubbell MS LPCC-s 513-770-1705.

CLIENT RIGHTS

Clients have the following rights:

A. to be fully informed about a counselor's qualifications, training and experience.

B. to understand any issue related to treatment or the therapy process.

C. to have the counselor available at the appointment time agreed upon in advance.

D. to discontinue counseling at any time. Should you decide to discontinue, your counselor will request a termination session to discuss progress or areas of continuing concern.

E. to request a change of counselor. Should you feel that you need to change counselors, feel free to discuss that issue with your present counselor or with Mandy Friedman or Crystal Hubbell (see contact information above).

CLIENT RESPONSIBILITIES

Clients understand the following:

A. Clients should arrive for counseling sessions on time.

B. Clients must cancel appointments at least 24 hours in advance. If an appointment is cancelled less than 24 hours in advance (other than illness or family emergencies) clients will be charged a cancellation fee of $50.

C. Session fees are due at time of service.

D. Clients may pay fees via check, credit card, HSA, or cash. If a balance is owed for more than three sessions, client must arrange a payment schedule in order to continue sessions.

E. If a client's check is returned we will require cash payment for all future appointments.

F. Borrowed materials must be returned or client will be charged for replacement.

G. Client will be charged fees for counselor's time spent outside of session for special requests. This includes phone calls, additional paperwork or assessments and court appearances.

LIMITS OF CONFIDENTIALITY

Every effort is made to treat your confidential information in a professional manner in keeping with ethical standards and laws regarding privacy. Please be advised however that there are certain circumstances under which confidential information may be divulged without your express permission.

A. All therapists are required to provide information specified by a subpoena issued by a court of Law; and the results of treatment or tests must be revealed to a court when a client has been ordered into treatment by the court.

B. A therapist may take steps to protect a client or others from imminent danger, when a client threatens physical injury to self or others.

C. A therapist must report disclosures of physical or sexual abuse of a minor to the local children's protective service.

D. A therapist must report disclosures of elder abuse or domestic violence to Adult Protective Services.

E. A therapist must report disclosures of physical or sexual abuse of individuals with disabilities to Child or Adult Protective Services.

F. Privacy cannot be guaranteed for correspondence via text or email.

G. If clients have relationships with other clients of this practice, it is the responsibility of the client to disclose that information to the therapist. Due to geographic proximity, it is common for our clients to

somehow know each other. If a client informs their counselor of a conflict of interest, the client may choose to sign a waiver of acknowledgement. This applies to multiple family members and acquaintances.
H. Your signature below serves as acknowledgment of receipt of our **Notice of Privacy, Grievance Procedure and Informed Consent (which is located on the website: www.clermontmentalhealth.care or a paper copy provided upon request)**

Client's Signature_____ Date_____

Counselor's Signature_____ Date_____

CONTACT INFORMATION			
Name:			
	First *Middle*	*Last*	*Date of Birth*
Address:			
	Street Address *City*	*State*	*Zip*
Home Phone:		May We Leave A Message?	□ Yes □ No
Mobile Phone:		May We Leave A Message and Text?	□ Yes □ No
Email Address:		May We Send A Message?	□ Yes □ No
Emergency Contact:			
	Name/Relationship	*Phone:*	
What brings you in for counseling?			
Insurance	Company Name _____ ID # _____ Group Number _____		

PERSONAL/FAMILY HISTORY		
Marital Status: _____ Single _____ Married In a Relationship with _____		
Names/Ages of Individuals that live with you		
Name	Relationship	Age

Occupation: _____ How many years _____

Education: _____

MEDICAL HISTORY

Do you have any medical conditions at this time? ☐ Yes ☐ No		
If Yes, Please Explain: _____		
Primary Care Physician _____ Phone _____		
Are you currently taking any prescription medications? ☐ Yes ☐ No		
Name:	Dosage:	Reason:
Name:	Dosage:	Reason:
Name:	Dosage:	Reason:
How often do you drink alcohol?	Type:	Times Per Week:
Do you use any other drugs?	☐ Yes ☐ No If Yes, List:	

COUNSELING/PRIOR TREATMENT HISTORY

	WHEN	REACTION TO OVERALL EXPERIENCE
Counseling/psychiatric		
Suicidal thoughts/attempts		
Drug/alcohol treatment		
Hospitalizations		
Involvement with self-help groups		

Please check behaviors and symptoms that you experience:

	Aggression		Fatigue		Mood shifts
	Anger		Gambling		Panic attacks
	Anxiety		Hallucinations		Phobias/fears
	Avoiding people		Heart palpitations		Recurring thoughts
	Cyber addiction		High blood pressure		Sexual addictions
	Depression		Hopelessness		Sexual difficulties
	Disorientation		Impulsivity		Sick often
	Distractibility		Irritability		Sleeping problems
	Eating disorder		Judgment errors		Suicidal thoughts
	Elevated mood		Memory problems		Worrying

Is there anything else that you would like for me to know: