HYDE PARK
COUNSELING PROFESSIONALS

CLIENT INFORMATION SHEET

Date _____

Last Name _____ First _____ Middle _____

Is the client a Minor? No ❑ Yes ❑ *if yes:* Parent/Guardian Name _____

Address _____ City _____State _____ Zip _____

Birthdate _____/_____/_____ Sex ___ M ____ F Marital Status _____ SS# _____-_____-_____

Email _____ Employer _____
PLEASE PRINT CLEARLY

Home Phone _____ May we leave a message Yes ❑ No ❑

Cell Phone _____ May we leave a message Yes ❑ No ❑

Work Phone _____ May we leave a message Yes ❑ No ❑

Emergency Contact _____ Relationship _____ Phone _____

Primary Care Physician Name _____ Phone_____

PRACTICE TERMS

_____ I understand I could be charged additional fees for completing documents, letters, and phone consulting

_____ I attest that the above information is correct to the best of my knowledge

_____ I understand that I am responsible for all amounts due that are not covered by my insurance

_____ I attest that I have read the HIPAA form outline.

Assignment and release I hereby assign my insurance benefits to be paid directly to Hyde Park Counseling Professionals. I am financially responsible for any and all non-covered services. I also authorize Hyde Park Counseling Professionals to release any information requested.

_____ _____

Client Signature/Authorize Parent/Guardian Date

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CLIENT SERVICE CONTRACT AND NOTICE OF PRIVACY PRACTICES THIS DOCUMENT APPLIES TO IN OFFICE COUNSELING/INTERNET COUNSELING/TELEPHONE COUNSELING

Date _____

Client Name_____ Last 4 Digits Of SS#_____

*IF YOU ARE IN CRISIS PLEASE DO NOT COMPLETE THIS DOCUMENT CALL 911 IMMEDIATELY/GO TO NEAREST EMERGENCY ROOM

This document describes some details about your professional relationship with Hyde Park Counseling Professionals. Please review the document **thoroughly** and initial on the designated line after each section to indicate you have reviewed the section and agree to it. Upon completion of your review of the entire document please sign your full name in the designated area on the last page.

AUTHORIZATION FOR OUTPATIENT TREATMENT OF AMINOR CHILD
INTERNET COUNSLEING IS NOT PERMITTED FOR ANY MINOR CHILDREN
Your signature indicates that you are, either the **PARENT or GUARDIAN** of "**NAMED MINOR CHILD**" _____ and hereby authorize a therapist affiliated with Hyde Park Counseling Professionals to administer counseling diagnostic and therapeutic treatments that may be considered advisable or necessary in his/her judgment. No guarantee or assurance is made as to the results that may be obtained.

CLIENT INITIALS_____

REPORTING ABUSE
The child reporting laws of the STATE OF OHIO require that any suspected abuse or neglect of any minor child under the age of 18, to be reported to the appropriate authorities, i.e. local police, Department of Children & Family Services. Child neglect may include, but is not limited to, inappropriate forms of punishment, physical and/or emotion neglect, abandonment or sexual molestation.

CLIENT INITIALS_____

EMERGENCY MEDICAL SERVICES: CALL 911/GO TO NEAREST EMERGENCY FACILITY
I do NOT provide emergency medical and/or psychological care and therefore, should the need for such treatment and/or become necessary, you must call 9-1-1 prior to ever calling me. More specifically, if you, at some point during outpatient counseling start to feel as though you might hurt yourself or take your own life, you hereby agree/and understand that I will call 9-1-1 to report your status. You will remain in my care until emergency authorities arrive to determine if the need for emergency treatment and/or transfer to a hospital may be necessary and appropriate. Signature on this document indicates your consent to such emergency treatment and/or transfer to a hospital and indemnifies me from any loss resulting from such emergency treatment and/or transfer. Your signature also indicates that you agree to assume sole responsibility for any and all charges incurred for such treatment.

CLIENT INITIALS_____

CONFIDENTIALITY:
I make every reasonable effort to safeguard the personal information, which you may share with me. The Notice of Privacy Practices provides information about how I may use and disclose protected health information about you. Signature on this document acknowledges compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

In accordance with Ohio law, my communication between you and I is "**confidential**" if it is not intended to be disclosed to third persons other than those personas present to further you interest in the consultation, examination or interview, those persons necessary for the transmission of the communication, and those persons who are participating in your diagnosis and treatment under my direction.
Under Federal Law, Protected Health Information (PHI) is the information I create and obtain in providing my services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment and applying to your insurance plan for future care or treatment. It also includes billing documents for those services.

There are, however, several important instances when the privilege may be waived by you and Hyde Park Counseling Professional's therapist.

When I am a party defendant to a civil, criminal or disciplinary action arising from a complaint filed by you, in which case the waiver shall be limited to that action;

When there is a clear and immediate probability of physical harm to you, to other individuals or to society and I communicate the information only to the potential victim, appropriate family member, law enforcement or other appropriate authorities;

When you agree to the waiver, in writing, or, when more than one person in your family is receiving therapy, when each family member agrees to the waiver, in writing. If you consent, we are permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Appropriate written authorization will be obtained from you before we release your PHI for purposes of treatment, payment and health care operations.

EXAMPLE OF USE OF YOUR HEALTH INFORMATION FOR HEALTH CARE OPTIONS:

A. I may have Business Associates such as billing services, bookkeepers, etc. who may have access to your PHI when they are preparing our routine financial statements or entering payments from insurance companies.

Additionally, there are several important instances when there is no privilege (which means No confidentiality of communications) between you and Hyde Park Counseling Professionals. Those instances are as follows:

1. For communications relevant to an issue in proceeding to compel hospitalization of you for mental illness, if I, in the course of diagnosis or treatment, have reasonable cause to believe you are in need of hospitalization;
2. For communication made in the course of a court-ordered examination of your mental or emotional condition;
3. For communications relevant to an issue of your mental or emotional condition in any proceeding in which you rely upon the condition as an element of your claim or defense or, after your death, in any proceeding in which any party relies upon the condition as an element of the part's claim or defense.
4. For any communication involving the perpetrator in any situation involving Known or suspected child abuse, abandonment, or neglect, regardless of the Source of the information requiring the report.
5. For any situation involving known or suspected abuse, neglect, or exploitation of the vulnerable adult (i.e., elderly person);
6. For preventing or controlling disease, injury or disability, as required by law, I may disclose your PHI to the public health or legal authorities
7. For health oversight activities, Federal Law allows me to release your protected health information to appropriate health oversight agencies.
8. For specialized government functions, as authorized by law, such as to Armed Forces personnel, for national security purposes, or to the public assistance program personnel.
9. For assistance in disaster relief efforts, as authorized by low.
10. For allowing funeral directors or coroners to carry out their duties, as authorized by law.

CLIENT INITIALS_____

By signing this form, you indicate the following:

1. That you consent to my use and disclosure of protected health information about you for treatment, payment and healthcare operations.
2. That you have the right to revoke this consent and may in fact do so by submitting a Written signed request from you to me.
3. That this is my "Notice of Privacy Practices" and that you have had the opportunity to "Review this Notice of Privacy Practice."
4. That I reserve the right to change the "Notice of Privacy Practice Policies" at any time.
5. That you have the right to restrict the uses of your information but that I not have to agree to those restrictions.
6. That you may revoke this consent in writing at any time and all future disclosures will then cease, however such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.
7. That you may condition treatment upon the execution of this consent.
8. That counseling will cover emotional, physical aspects of my life and may be distressing and difficult.

OUR RESPONSIBILITIES

Maintain the privacy of your PHI as required by Law.

1. Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you.
2. Abide by the terms of this contract.
3. Notify you, if we cannot accommodate a requested restriction or request.
4. Accommodate your reasonable requests regarding methods to communicate health information about you.

CLIENT INITIALS_____

By signing below, you acknowledge that you have received a copy of the Client Services Contract and Notice of Privacy Practices and that you have read and fully understand all the terms and conditions contained herein. Further, by signing below you are indicating your agreement to all of the terms and conditions contained here.

SIGNATURE_____ DATE_____

PRINTED NAME_____

SIGNATURE OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE OF CLIENT

ACTING ON BEHALF OF CLIENT_____ DATE_____

HYDE PARK
COUNSELING PROFESSIONALS

2651 Observatory Ave. Suite 20B Cincinnati, Ohio 45208
513-310-8408 Fax 513-898-1618

VIRTUAL/TELE MENTAL HEALTH COUNSELING INFORMED CONSENT

I _____, (name of client) hereby consent to participate in virtual mental health with _____ (name of provider) as part of my psychotherapy. I understand that virtual mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to virtual mental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risk and consequences associated with virtual mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to virtual mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that virtual mental health services are not appropriate and a higher level of care is required.
6. I understand that during a virtual mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____
Signature of Client/Parent/Legal Guardian Date

_____ _____
Signature of Therapist Date