SOLUTIONS COUNSELING, LLC

APPLICATION FOR SERVICES

IDENTIFICATION DATA:

Name:_____ Sex: ☐Male ☐Female

Address:_____
Street City State ZIP code

Home Phone:_____ Cell Phone:_____

Best Number To Reach You At: Home / Cell

Age:_____ Birth Date:_____ Social Security #:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Other: _____

Education- Highest Grade Completed: _____ College Degree(s):_____

	How Long?	Occupation:
_____ Present Employer	_____	_____
_____ Previous Employer	_____	_____

FAMILY HISTORY:

	Age	Living?	Occupation
_____ Spouse	___	_____	_____
_____ Mother	___	_____	_____
_____ Father	___	_____	_____

Number of Children: _____ Ages: _____ Number Living: _____

Number of Siblings: _____ Ages: _____ Number Living: _____

Others Living in Household:_____

Relationship:_____

Notify in case of Emergency:_____ _____
Name Phone

INSURANCE INFORMATION:

_____ _____ _____
Primary Insurance Coverage Policyholder's Name Policyholder's Date of Birth

RESPONSIBILITY FOR PAYMENT: I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or to a member of my family.

Date: _____ Signature: _____

HEALTH DATA:

Do you have any current medical problems? (Please describe) _____

_____

Is it being treated? ☐ Yes ☐ No If yes, by whom?_____

Primary Care Physician Name: _____

What medication(s) are you taking? _____

_____

Have you ever had a drug allergy or sensitivity? ☐ Yes ☐ No If yes, to which drug(s)?_____

_____

Have you ever seen any of the following for help with a problem? (excluding this visit?)

☐ Psychiatrist ☐ Psychologist ☐ Social Worker ☐ Counselor ☐ Minister ☐ Chemical Dependency Counselor

For what?_____

_____ When?_____

Have you ever been hospitalized for psychiatric or chemical dependency services? ☐ Yes ☐ No

If yes, where and when? _____

_____

CHEMICAL USE HISTORY:

Do you drink alcohol? ☐Yes ☐No If yes, what do you drink? ☐Beer ☐Wine ☐Hard Liquor

How often do you drink? ☐Daily ☐3-5 times per week ☐1-2 times per week ☐Less frequently

Do you sometimes drink more than you had planned? ☐Yes ☐No

Have family or friends ever expressed concern about your drinking? ☐Yes ☐No
Have you ever been arrested for alcohol related charges? DUI, Public Intoxication, D+D, etc. ☐Yes ☐No
Have you ever been treated for drinking? (Gone to AA) ☐Yes ☐No
Ever had episodes where you were unable to remember periods when you were drinking? ☐Yes ☐No

_____

What Has Been Your Experience With The Following?

		Use Currently (within 1 year)	Have Used In Past	Have Never Used
Tranquilizers	(Valium, Librium, Tranxene, Azene Miltown, Equanil, Xanax, Centrax)	☐	☐	☐
Pain Pills	(Darvon, Codeine, Percordan, Demerol, Dilaudid, Heroin, Talwin)	☐	☐	☐
Diet Pills	(Amphetamines, Speed, Dexedrine, Ritalin, White Crosses, Zip)	☐	☐	☐
Sleeping Pills	(Doriden, Placidyl, Dalmane, Seconal, Tuinal Nembutal, Amytal, Phenobarbital, Noctec, Somnos)	☐	☐	☐
Hallucinogens	(Marijuana, Hashish, THC, LSD, MDA, PCP, Mescaline, Psilocybin, Angel Dust, Mushrooms)	☐	☐	☐
Volatiles	(Aerosols, Paint Thinner, Glue, Lacquer Amyl or Butyl Nitrite"Poppers", Gasoline)	☐	☐	☐
Others—List	_____	☐	☐	☐

Has family or friends ever expressed concern over your use of drugs?	□Yes	□No
Have you ever been arrested for any offense involving drugs?	□Yes	□No
Have you ever been treated for chemical dependency?	□Yes	□No
Have you ever overdosed on drugs (accidental or purposeful)?	□Yes	□No

PRESENTING CONCERN: (Please provide a brief statement as to why you are seeking services.)

Thank You For Completing This Application.

Solutions Counseling, LLC
Health Insurance Information Form

Primary Insurance Provider _____ Policy/ID Number _____

Insured's Name _____ Insured's Date of Birth _____ Employer _____

Patient/Client Seeking Services _____ Client's Date of Birth _____ Is patient employed full time? ☐ **YES** ☐ **NO**

Is the Insured's address the same as the client's? (If no, please fill in the line below) ☐**YES** ☐**NO**

Street _____ City _____ State _____ Zip _____

Do you have a secondary Insurer? ☐ **NO** ☐ **YES** (If so please fill in below.)

Secondary Insurance Provider _____ Policy/ID Number _____

Insured's Name _____ Insured's Date of Birth _____ Employer (If different from above) _____

Release of Information:

I, _____, by signing below, do authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits and/or insurance benefits to either myself or to Solutions Counseling, LLC.

Patient or Authorized Person _____ Date _____

SOLUTIONS COUNSELING, LLC

CLIENT INFORMATION AND ACKNOWLEDGEMENT OF INFORMED CONSENT TO TREATMENT

Thank you for choosing Solutions Counseling, LLC. Our goal is to provide you with effective, time sensitive, compassionate counseling services. We understand that the issues you bring to us are very important to you. Please be assured that your concerns are of utmost importance to us. Please review the information that follows and sign at the conclusion of this document. Your signature indicates this information has been provided to you and you have been given the opportunity to ask any questions about the information that follows.

General Practice Information:

Solutions Counseling, LLC, is a **limited liability company** in the State of Ohio. The sole member/owner of Solutions Counseling, LLC, is Dwayne E. Smith, Ph.D. Andy Solovey, LISW-S and Beth Latella, LPCC-S, serve as independent contractors on behalf of Solutions Counseling, LLC.

Please note that the **professional disclosure statement** for your clinician is prominently displayed in the office where your clinician provides services. Please review this document which is required by your clinician's licensing agency. Please let the involved clinician know if you would like to have a copy of the professional disclosure statement.

The **fee for services** at Solutions Counseling, LLC, is $140 for the first session and $120 for most sessions thereafter. There are fees for other services, such as non-routine report writing or phone consultations and these services are not normally covered by insurance. Please feel free to request a copy of our Fee Structure Policy if you would like additional details. Please note that all clients are responsible for fees incurred. Many clients do utilize insurance coverage to cover part or all of the fees incurred. However, this does not dismiss the client of the ultimate responsibility for the payment of fees incurred. We agree to follow protocol with insurance and managed care companies with whom we have contracts. With companies with whom we do not have contracts, we do not accept responsibility for following their protocols. When we are asked to complete forms or follow protocols for these companies, clients may be billed for the time invested in this work.

Cancellation fee: Any sessions that are to be canceled need to be canceled with 24 hours notice.

If 24 hours notice is not provided, a $40 fee is assessed. A client can cancel a session at any time, day or night, by calling 614-588-0303 and leaving a message.

Fees for insufficient funds checks: There is a $35 charge for any checks that are returned because of insufficient funds. It is requested that when a client is made aware that a check has been returned for insufficient funds, please contact Solutions Counseling, LLC, to arrange for payment of this fee as well as for reimbursement for the original amount of the check.

Limits on Confidentiality:

Our goal is always to provide effective and compassionate counseling services within a confidential and trusting setting. However, it is important that it is understood that there are some limits to our ability to maintain client confidentiality. For instance, if your counselor has reason to believe that a child under 18 years of age, or a vulnerable adult (i.e., mentally retarded) is being neglected or abused, the law requires that the situation be reported to the appropriate state or county agency (i.e., the public children services agency). Once a report is filed, we may be required to provide additional information.

If we believe that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else and we believe that disclosure of certain information may serve to protect that individual, then we must disclose that information to appropriate public authorities and/or the potential victim, and/or professional workers, and/or the family of the client. Additionally, if a court orders us to provide a full or partial client record, we must comply with the jurisdiction of the court.

(CONTINUED ON BACK)

Contacting Us:
Due to our work schedules, we are frequently not immediately available by telephone. Please feel free to leave a message on our confidential office voice mail at 614-588-0303, if we do not answer. If you experience a mental health emergency, we recommend you call 911 for assistance or go to the nearest hospital emergency room for assistance. In Franklin County, you can contact NetCare Emergency Services at 614-276-2273.

The Experience of Receiving Counseling
Experiencing mental health counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have many benefits. Counseling often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. If you are finding the counseling experience is causing you emotional distress, or it does not seem useful, or if you are finding the experience to not be helpful toward accomplishing your treatment goals, please bring this to the attention of your counselor. Again, our goal is always to provide effective and compassionate counseling services within a confidential and trusting setting.

Consent to Treatment
I voluntarily agree to receive mental health counseling services and authorize Solutions Counseling, LLC, to provide such care, treatment, or services as are considered necessary and advisable (to me or my minor child).

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 Solutions Counseling, LLC, at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgment of Informed Consent to Treatment form, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____
Signature (of client or guardian of a minor child) Date

NOTICE OF PRIVACY PRACTICES

SOLUTIONS COUNSELING, LLC
252 BRADENTON AVE.
DUBLIN, OH 43017

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.

This Notice is effective as of November 1, 2008. rev. 3/1/2018

We are required by law to maintain the privacy of protected health information (PHI), and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms at anytime. Any changes will be effective for all protected heath information that we maintain. The revised Notice will be posted in the waiting room. You may request the revised Notice at anytime.

We have a designated Privacy Officer to answer your questions about our Privacy Practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer will also take your complaints and give you information about how to file a complaint.

Our Privacy Officer is Dr. Dwayne Smith. You can contact the Privacy Officer at 614-588-0303.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and healthcare operations:

We may use the information in your record to provide treatment to you. We may disclose information in your record to help you get healthcare services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use of disclose information from your record to obtain payment for services your receive. For example we may submit your diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow “healthcare operations.” these operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordination care with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

Your Rights:

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or other healthcare operations. However, we do not have to agree to these restrictions.

You have the right to receive confidential communications from us. For example, if you want tot receive bills and other information at an alternative address, please notify us.

You have a right to inspect the information in your record and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be submitted in writing.

If you feel the PHI we have about you is incorrect or incomplete, you have the right to ask us to amend the information, although we are not required to agree to the amendment.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your PHI). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record, unless you give written authorization. You may revoke this authorization in writing at anytime, but this will not affect any use or disclosure before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are required to make without your permission:

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. We must also disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

Use or disclosure of your protected health information that we are allowed to make without your permission:

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations we muse our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must reported suspected child abuse and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce likelihood of harm to yourself or others.

We may use of disclose information from your record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public.

We may report births and deaths the the public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or a coroner. We may disclose information to funeral directors to allow them to carry out their duties upon your death. We may disclose information from your record to facilitate organ, eye, or tissue donation and transplantation.

We may assist in health oversight activities, such as investigations of possible healthcare fraud.

We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

Under certain conditions, we may disclose disclose information for specialized government purpose, such as the military, national security and intelligence, or protection of the president.

Your provider (or office staff) may contact you to provide appointment reminder as a courtesy. However, you are responsible for remembering your appointment.

Privacy Practices Pertaining to Substance Abuse Records:

The confidentiality of protected health information related to alcohol and drug abuse is protected by federal law and regulations. Violations of the applicable federal law and regulations is a crime, and may be reported to appropriate authorities.

We may not disclose any information about you unless you authorize the disclosure in writing, except as specified below.

We may disclose information about you if a court orders the disclosure.

We may disclose information about you in a medical emergency, to permit you to receive a needed treatment.

We may disclose information about you for purposes of a program evaluation, audits, or research.

We may disclose information about you if you commit a crime on our premises or against any person who works for us, or if you threaten to commit such a crime.

We are required to disclose information if we suspect child abuse or neglect.

Except as stated in this notice, you have the same rights and protections with respect to your health information as described in our general Notice of Privacy Practices.

I hereby acknowledge that I have received and have been given an opportunity to read this copy of the Solutions Counseling, LLC, Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can speak with my counselor or I can contact Dr. Dwayne Smith at 252 Bradenton Ave, Dublin, Ohio 43017 or 614-588-0303.

_____ _____

Signature of Client (or Parent/ Guardian) Date