

AMIGO FAMILY COUNSELING, LLC

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NEW CLIENT WELCOME STATEMENT

Dr. Amigo and the staff at Amigo Family Counseling, LLC (AFC) would like to review some important information with you regarding our procedures and mutual responsibilities.

OFFICE HOURS

Amigo Family Counseling, LLC is open Monday through Friday, 11:00 am to 8:00 pm. Saturday appointments depend upon therapist availability. Appointments with Dr. Amigo are arranged by AFC administrative staff. All other appointments should be scheduled directly with your therapist or service provider. Our phone number is **614-310-1234**.

All incoming phone calls are received and routed by an automated voice mail attendant. For all **general** inquiries you may leave a message on extension "0" for the Front Desk. Confidential staff voice mailboxes are available 24 hours a day.

EMERGENCIES

Because we are not a 24-hour emergency facility, please contact these Emergency Centers should the need arise:

OSU Medical Center 1-614-293-8333

Netcare: 1-614-276-2273

North Central M.H. 1-614-299-6600

Suicide Prevention of Franklin County: 1-614-221-5448

SERVICES AND FEES

Most sessions are 45 or 60 minutes. Sessions of shorter or longer duration depend upon therapist availability. We will attempt to start and finish sessions in a timely manner. If your session does not begin on time, we ask for your understanding. Rarely would your therapist be unable to meet for the full time agreed to.

Note that once the required insurance information leaves our office, we have no control over who has access to it or how that information is used. For reasons of privacy, you may decide to pay out-of-pocket and not file with your insurance plan. If you choose to file with your insurance, we ask that you pay your co-payment or required percentage at the time of each session. We suggest that you keep track of such things as your deductible, required pre-certifications and/or the number of authorized sessions. Important information regarding your mental health benefits are available directly from your insurance provider. **Confirmation of benefits is your responsibility and if AFC is unfamiliar with the benefit plan, you will pay full fee and credit will be applied once benefits are confirmed.** As a courtesy to our clients, our billing department will file claims to your primary insurance provider. We do not file to secondary insurance. If you have any insurance or billing questions, please call Carol at MedComm Billing Consultants, 614-761-1533.

LEGAL PROCEEDINGS

If your therapist is required to become involved in legal proceedings involving your therapy (or your child's therapy), you agree to pay for the therapist's time in preparing for such legal action, including, but not necessarily limited to traveling to and attending a deposition, hearing, or trial, including any time spent waiting to testify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of your involvement in such legal action.

355 E. Campus View Blvd., Suite 105, Columbus, OH 43235 ♦ Phone: 614-310-1234 ♦ Fax: 614-310-1237

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CANCELLATION POLICY

Occasionally you may need to cancel or change your scheduled appointment time because of illness or scheduling conflicts. However, unlike medical practices which often double or triple book, we reserve our clinical time exclusively for you. When you can't make your scheduled appointment, we require at least a 24-hour notice. For Group Therapy, notification by 12:00 pm noon that day is required. **If you cancel your scheduled appointment with less than the required notice, for whatever reason, it is a "Late Cancellation." Because your appointment time is reserved, late cancellations and missed appointments are charged 1/2 the scheduled session fee.**

BENEFITS AND RISKS

The services we offer can have benefits and risks. Since treatment 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, mental health services have also been shown to have many benefits. Treatment may often lead to better relationships, solutions to specific problems and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

CHILDREN AND COUNSELING

Sessions may involve just the child, parent(s) or the child and family, depending on your particular situation and therapist's clinical preference. If you have important weekly information to share with your child's therapist, please fill out the "**Parent Feedback Form**" located next to the front desk window and hand it to your therapist. This is especially helpful for children involved in group therapy.

WAITING ROOM

Please understand that all of us appreciate a quiet and peaceful waiting room. Therefore, adult clients and/or parents are not to leave their young children without parental supervision in the waiting room. Also please refrain from unnecessarily sharing personal confidential information at the front desk with AFC staff.

COMMUNICATION POLICY

We will use any of the contact information you have provided in the intake process or as part of our New Client Packet which you will complete today and/or that currently is available in your file. This includes home phone number(s), cell phone number(s), work phone number(s) and e-mail addresses.

Please note that we use our sole AFC e-mail address primarily for appointment notifications and for the exchange of appointment related information of AFC service event reminders. Be aware that not all AFC clinical staff choose to communicate via e-mail.

Therefore, please refrain from e-mailing us (AFC staff) personal health information (PHI) related to your therapy sessions, as e-mail is not completely secure or confidential. Be aware that all e-mails are retained in the logs of your and our Internet Service Providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet Service Provider.

You should also know that any e-mails we receive from you are seen and handled by designated AFC administrative staff and then delivered to the named recipient in paper form. Any e-mails we receive from you and any responses we send you become a part of your legal and clinical record. Therefore we prefer that clinical information (PHI) be discussed or addressed via e-mail as little as possible.

It is important to clarify that any and all e-mail correspondence from AFC is not encrypted. Additionally, unencrypted e-mails carry with them certain levels of risk, for example, the information in the e-mail could be read by an unintended third party. So as a covered entity, AFC cannot be responsible for any unauthorized access. Please read and sign the AFC Informed Consent Sheet on bottom of page 3.

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NEW CLIENT INFORMATION SHEET – ADULT

CLIENT INFORMATION

Name: Last _____ First _____ Middle _____
Address _____
City _____ State _____ Zip _____
Phone: Home _____ Work _____
Cell _____ OK to Call? (H) ____ (W) ____ (C) ____
E-Mail Address: _____ OK to carbon copy? _____
Age _____ Date of Birth _____ Gender: M _____ F _____
Single _____ Married _____ Divorced _____ Separated _____ Other, Specify: _____
Employer _____ Occupation _____
Address _____
City _____ State _____ Zip _____
Spouse's Name: _____ Employer: _____

EMERGENCY CONTACT PERSON

Full Name _____
Address _____ City, St., Zip _____
Phone: Home: _____ Work: _____
Cell _____ E-mail Address _____
Relationship to Client _____
Primary Insurance Company _____
Who referred you to Amigo Family Counseling? _____

OFFICE USE ONLY BELOW:

Therapist _____
DSM 1V _____
DSM 1V _____

Today's date _____
FA _____
CA _____
CLIENT COPAYMENT _____

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NEW CLIENT FINANCIAL AGREEMENT TO PAY FOR SERVICES

I, The Undersigned, request that AMIGO FAMILY COUNSELING (AFC) provide professional services to me

(Name of Client)

or to _____ as a Client, and I agree to

(Other)

pay Amigo Family Counseling's fees as stated on the "Welcome Statement" I received. I understand that I am required to give at least 24 hours notice prior to canceling any appointment. For missed appointments and late cancellations, I will be billed and responsible for 50% of the session fee, which is non-reimbursable by Insurance, and shall be paid at the time of my next appointment.

If at any time, I am dissatisfied with the services provided at Amigo Family Counseling, I agree to discuss my views, reasons and plans with my therapist, and if necessary with Dr. Amigo, the Director of AFC.

I agree that this Financial Agreement will remain in effect with Amigo Family Counseling as long as professional services are being provided for me, my minor children or the above named client for which I am assuming financial responsibility, until such time that I inform my therapist in person, by telephone or by certified mail, that I wish to discontinue my therapy. I agree to pay in full for all services provided for me, my minor children, or the above named client, until I have paid the balance in full.

I understand that I am responsible for any and all charges assessed for services provided by Amigo Family Counseling, although other persons or insurance companies may make payments on my or this client's account.

I hereby authorize my insurance benefits to be paid directly to Amigo Family Counseling whenever I have not already paid for services in full. I also authorize Amigo Family Counseling to release any information required to process any claims. I acknowledge that I am responsible for any non-covered services.

I agree to pay a \$25.00 service charge on all returned checks. Also, in the event that this account goes to Collections, I agree to pay a 20% collection fee added to the balance.

I have read this financial agreement and agree to cooperate with and abide by all of its provisions as indicated by my signature below.

Signature _____ Date: _____

Printed Name: _____

Relationship to Client: Self _____ Parent/Guardian _____ Other _____

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LIMITS OF CONFIDENTIALITY NOTICE FOR NEW CLIENTS

Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens harms to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports abuse of adult who is developmentally disabled.
6. The client reports sexual exploitation by a licensed professional.
7. Felony activities may be reported.

State law mandates that mental health professionals may need to report these situations to the appropriate persons and/or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of this state.

Having read and understood the above, I agree to these limits of confidentiality.

Name of Client or Guardian

Date

Signature of Client or Guardian

Date

Signature of Clinician

Date

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NEW CLIENT MEDICAL & SURGICAL BACKGROUND SHEET

Date: _____ Client Name: _____ Physician Name: _____

MEDICAL & SURGERY HISTORY: (Check (x) if answer is Yes)

A. Have you EVER had:

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Injuries to Back, etc. |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Hospitalizations * | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other Operations * | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Medication Sensitivities * | |

If you indicated Yes for any of the above that has an asterisk (*) next to it, please explain:

B. Have you RECENTLY had:

- | | |
|--|--|
| <input type="checkbox"/> Accidents | <input type="checkbox"/> Tightness in chest (particularly during exercise) |
| <input type="checkbox"/> Cough on Exertion | <input type="checkbox"/> Swollen, Stiff or Painful Joints |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Calf Pain or Cramps with Exercise |
| <input type="checkbox"/> Skin Changes | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Other Problems |

If you indicated Yes for ANY of the above, please explain:

C. Medication Name Dosage Reason:

D. If you have allergies to medications, please list all allergies and explain specifically:

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DSM Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: _____ Sex: Male Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

		None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	