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 tetify, responding to a subpoena, in addition to any legal fees my therapist may incur as part of your involvement in such legal action.

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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 – CHILD

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________
Fulltime Student? Yes / No Grade: ______________ School Name: _____________________________________

RESPONSIBLE PARTY INFORMATION **(Note: If parents are separated or divorced, the parent bringing the child is considered the responsible party.)**

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 ____________________________________
If married, Spouse's Name: ___________________________________ Employer: _____________________________

EMERGENCY CONTACT PERSON

Name: Last______________________________________ First ______________________________ Middle ________
Address____
City____ State ___________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 _______________________ **Today's date**_____________________
DSM 1V _______________________ **FA** ______________________________
DSM 1V _______________________ **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. Has your child EVER had:

( ) High Blood Pressure
( ) Diabetes
( ) Stomach Ulcers
( ) Gout
( ) Heart Attack
( ) Arthritis
( ) Allergies
( ) Varicose Veins
( ) Heart Surgery
( ) Hospitalizations *
( ) Lung Disease
( ) Other Operations *
( ) Cardiac Catheterization
( ) Medication Sensitivities *
( ) Injuries to Back, etc.
( ) Kidney Disease
( ) Heart Murmur
( ) Epilepsy
( ) Overweight
( ) Asthma

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

B. Has your child RECENTLY had:

( ) Accidents
( ) Cough on Exertion
( ) Difficulty Sleeping
( ) Skin Changes
( ) Heart Palpitations
( ) Back Pain
( ) Nervousness
( ) Tightness in chest (particularly during exercise)
( ) Swollen, Stiff or Painful Joints
( ) Calf Pain or Cramps with Exercise
( ) Chest Pains
( ) Shortness of Breath
( ) Fatigue
( ) 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-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6—17

Child's Name: ______________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**___________

Relationship with the child: ____

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11—17

Name: ________________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**___________

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.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**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.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			