Melissa Strombeck, IMFT & Associates

Melissa Strombeck, IMFT
Stephen Fortson, Ed.D, PCC-S
Katie Dorsten, IMFT, CTP-C
Margaret Shea-Bianchi, PCC
Eric Henderson, PCC-S
37 Iron Gate Park Drive, Centerville, OH 45459
www.melissastrombeckimft.com

Client Information and Office Policy Statement

1. New Client

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any question you have regarding any of these policies.

2. Goals

The major goal is improving your quality of life including identifying and coping more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

- Increasing personal awareness
- Increasing personal responsibility and acceptance to make changes necessary to attain your goals
- Identifying personal treatment goals

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with the recommended treatment(s). Probabilities of these will be discussed as part of your treatment planning.

You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

3. Appointments, Counselor Availability and After Hours Emergencies

Appointments are usually scheduled for 45 or 50 minutes. Clients are generally seen weekly or more/less frequently as acuity dictates and you and our therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. Counselors check voicemail messages during normal business hours. Messages left outside of normal hours of operation will be picked up the next business day. In the event of an emergency, dial 911, call Crisis Care at (937)224-4646, or go to your nearest emergency room.

4. Confidentiality

Issues discussed in therapy are important and generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly or disabled person, 2) when a therapist believes you are in danger of hurting yourself or another person or you are unable to care for yourself, 3) if you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal authorities, 4) if you therapist is ordered by a judge to release information as part of a legal involvement in company litigation, etc., 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected records may become exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or to family members.

5. Record Keeping

A clinical chart is maintained describing our condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are locked and kept on site. Request for medical records will be subject to medical records copying fees in accordance with Ohio Revised Code 3701.741.

6. Fees and Appointments

Appointments are approximately 45-50 minutes in length and generally take place on a weekly basis.

Fee schedule

Initial Assessment	$140.00
Individual Session	$90.00
Couples Session	$140.00
Family Session	$140.00

7. Document Review and Writing, and Telephone Services

Document review and writing as well as services provided via telephone/Skype/Facetime are not covered by your insurance. Telephone calls lasting more than 15 minutes and document review/writing services will be billed directly to you at $100.00/hour. Services will be billed in 15 minute increments.

8. Court Appearance or Testimony

Court appearance or testimony is billed at an hourly rate of $190.00, portal to portal, plus mileage and expenses. Court preparation time as well as time spent consulting with attorneys will also be billed. A copying and filing preparation charge will be billed for records or other materials subpoenaed. The individual requesting this activity will be billed separately from regular charges and payment is due in full upon receipt of statement. A prepaid deposit may be required before this service is rendered.

9. Payment

Payment is due at the time of session unless other arrangements have been made. Your therapist will file your insurance claim, but you are responsible for deductibles, co-insurance and co-payments. It is your responsibility to familiarize yourself with your insurance benefits. We ask that you pay your deductible, co-pay or out-of-pocket fee at the time of service by cash, check or Visa/MC/Discover.

10. Late Cancellations/No Shows and Missed Appointments

We request 48 hours' notice if you need to reschedule or cancel an appointment. The first time you no-show or late-cancel an appointment, you will not be charged. The second time, you will be billed for half the cost of a session without insurance (insurance companies do not reimburse for missed sessions). The third time and after that you no-show or late-cancel an appointment, you will be billed for the total out-of-pocket cost of the session.

11. Child Care Release

Melissa Strombeck, IMFT & Associates does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.

12. Complaints

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist or any office policy, please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier, or contact the Counselor, Social Worker and Marriage & Family Therapist Board of Ohio at (614)466-0912.

13. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you. Melissa Strombeck, IMFT & Associates reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by Melissa Strombeck, IMFT & Associates of your therapeutic needs, Melissa Strombeck, IMFT & Associates ability to address those needs, or other circumstances that lead Melissa Strombeck, IMFT & Associates to conclude in its sole and absolute discretion that your counseling needs would be better served at another counseling facility. Under such circumstances, Melissa Strombeck, IMFT & Associates will suggest an appropriate counselor(s) or counseling agency.

Consent for Treatment

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

Print Name:_____ Date:_____

Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient:_____ Print Name:_____

Registration

I am seeking: ◯ Individual Counseling ◯ Couples Counseling ◯ Family Counseling

I am: ◯ Single ◯ Married ◯ Divorced

Note: Only one set of paperwork is needed per course of therapy.

Client Information

Date of Birth:_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home #:_____ Cell #:_____

Work #:_____ Other #:_____

Email:_____

On which number may we leave a **confidential message?**: ◯ Home ◯ Cell ◯ Work ◯ Other

Are text messages ok?: ◯ Yes ◯ No

How did you hear about Melissa Strombeck, IMFT & Associates? _____

Insurance

Will you be using insurance to help pay for treatment?: ◯ Yes ◯ No

Insurance Carrier:_____

Policy Number:_____ Group Number:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____

Are you the subscriber of this policy?: ◯ Yes ◯ No

If no, who is?:_____ Relation to you:_____

Subscriber Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Subscriber Date of Birth:_____

Employer:_____

Address:_____

City:_____ State:_____ Zip:_____

I am: ◯ Self-employed ◯ Unemployed ◯ Retired

How many people live in your household? _____

Symptom Checklist

How often have you been bothered by these symptoms in the past few weeks?

Please use the following guidelines for answer each question,
0 - Not at all bothered
1 - Slightly bothered
2 - Occasionally bothered
3 - Moderately bothered
4 - Frequently bothered
5 - Constantly bothered
6 - Severely bothered

1	Pain in my shoulders	0 1 2 3 4 5 6
2	Headaches	0 1 2 3 4 5 6
3	Neck and chest pain	0 1 2 3 4 5 6
4	Not knowing where I am	0 1 2 3 4 5 6
5	Troubling thoughts that repeat themselves	0 1 2 3 4 5 6
6	Feeling dizzy	0 1 2 3 4 5 6
7	Dry mouth	0 1 2 3 4 5 6
8	Feeling restless	0 1 2 3 4 5 6
9	Less interest in things I used to enjoy	0 1 2 3 4 5 6
10	Feeling nervous	0 1 2 3 4 5 6
11	Problems from alcohol or taking drugs	0 1 2 3 4 5 6
12	A need to count unimportant items	0 1 2 3 4 5 6
13	Feeling sick to my stomach	0 1 2 3 4 5 6
14	My mind is going blank	0 1 2 3 4 5 6
15	Feeling guilty about alcohol or drug use	0 1 2 3 4 5 6
16	Increase in sleep walking	0 1 2 3 4 5 6
17	Try too hard to help others	0 1 2 3 4 5 6
18	Back pain	0 1 2 3 4 5 6
19	Needing to block out impulsive thoughts	0 1 2 3 4 5 6

20	Sudden fear of dying	0 1 2 3 4 5 6
21	Drinking or using drugs too often	0 1 2 3 4 5 6
22	Problems reading my own handwriting	0 1 2 3 4 5 6
23	Feeling helpless	0 1 2 3 4 5 6
24	Nightmares about something bad that happened to me	0 1 2 3 4 5 6
25	Talking in my sleep more than usual	0 1 2 3 4 5 6
26	Fears of going outside alone	0 1 2 3 4 5 6
27	Feeling like I'm having a heart attack	0 1 2 3 4 5 6
28	Having to repeat certain things I do to avoid getting nervous	0 1 2 3 4 5 6
29	Feeling sensitive about my faults	0 1 2 3 4 5 6
30	Crying a lot	0 1 2 3 4 5 6
31	Trouble thinking of the names of family members or close friends	0 1 2 3 4 5 6
32	Shortness of breath	0 1 2 3 4 5 6
33	Feeling anxious	0 1 2 3 4 5 6
34	Flashbacks of something bad that happened to me	0 1 2 3 4 5 6
35	Needing to use drugs or alcohol to get high	0 1 2 3 4 5 6

History

Reason for starting therapy:_____

Problem areas: circle all that apply

Family	Work/School	Anger	Behavior	Depression
Relationships	Anxiety	Alcohol/Drugs	Eating	Other_____

What do you hope to accomplish in therapy?_____

_____

Physical health problems: Current_____

Past_____

Weight_____Height_____Weight change in past 6 months?_____

Appetite change?_____ Food or drug allergies_____

How would you describe the nutritional value and balance of your diet?

_____

Is there anything else you would like me to know before we begin your treatment?

_____

_____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name:_____

Patient Address:_____

Patient Phone Number:_____

In the course of providing service to you, we create, received and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your confidential information for purposes of payment may include the submission of your personal information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, determination of benefits and payment; or our submission of your personal information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at our office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform mental health treatment. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the use and disclosures made for purposes of treatment, payment or mental health treatment, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY CONFIDENTIAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Patient Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient:_____ Print Name:_____

RELEASE OF INFORMATION
(For use in Family and/or Couples' work)

Name:_____ Date:_____

I authorize the clinician assigned to me at Melissa Strombeck, IMFT & Associates, to release information regarding my psychotherapy treatment to:

Agency or Person:_____

Telephone Number:_____

Email/Fax:_____

Address:_____

This information shall be limited to:_____

_____

This authorization shall be in force and effect until _____, at which time this authorization expires.

_____ _____

Client signature Date