# New Client Information Form

Today's Date: _____

## PERSONAL INFORMATION

First Name:_____ Middle Initial:_____ Last Name: _____

Street Address:_____City:_____State: _____

Zip: _____ Date of Birth: ___/___/___ Birth Sex:☐Male ☐ Female ☐ Married ☐ Single ☐ Other

Soc. Sec. Number_____ Gender Identity:☐Male ☐Female ☐Transgender MTF ☐Transgender FTM
☐Gender Queer ☐Other _____ ☐Choose not to disclose

Race: _____ Sexual Orientation: ☐Heterosexual ☐Homosexual ☐Bisexual ☐Other _____
☐Unknown ☐Choose not to disclose

Home Phone: (___)_____ May we leave a voice mail message: Yes No

Work Phone: (___)_____ May we leave a voice mail message: ☐ Yes ☐ No

Cell Phone: (___)_____ May we leave a voice mail message: ☐ Yes ☐ No

Email:_____May we send you appointment notifications via email? ☐ Yes ☐ No
Please be aware that there are risks associated with unencrypted e-mail (please ask if you need further clarification). By providing my signature I consent and am aware that the email message I receive will contain the name listed above.

Signature of Authorization:_____Date: _____

## EMERGENCY CONTACT

Name:_____Relationship:_____Phone Number: (_____) _____

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given an opportunity to access Open Arms Counseling, LLC's ***Notice of Privacy Practices*** online http://www.oacounseling.net/forms.html or received a copy in person. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Clinical Director at 614-625-7183.

X_____
PRINT Name of Client PRINT Name of Client's Personal Representative

X_____
SIGNATURE of Client / Client's Personal Representative Description of Representative's Authority to Act on Behalf of the Client

❑ Patient/Client Refuses to Acknowledge Receipt _____ _____
Signature of Staff Member Date

# New Adult Client Information Form

## CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, LIMITS TO CONFIDENTIALITY

- I understand and consent to treatment at Open Arms Counseling, LLC and to the release of information for therapeutic, billing, supervision and other purposes in connection with my treatment, between and among Open Arms Counseling, LLC's therapists, staff and service contractors who perform work on behalf of Open Arms Counseling, LLC, as well as with other medical providers that may have an interest in or may be helpful to me or/my child's care. I understand that for a more detailed look at how my (my child's) health information may be released and used under certain circumstances, I may review the current Notice of Privacy Practices which is available to me upon request and online at http://www.oacounseling.net/forms.html.

- I understand that payment will be collected by an administrative staff member or clinician prior to the start of the session. In the rare circumstance of payment not being collected at the time of service, the full payment for services to date must be collected at the time of the next appointment.

- I understand that Open Arms Counseling, LLC has no contractual obligation with my insurance company or me that would entitle or guarantee me reimbursement for expenses I incur for services at Open Arms Counseling, LLC. I understand that I may request a receipt of payment that I may turn into my insurance company for possible reimbursement based upon my policy's out-of-network benefits; however, I am responsible for understanding my benefit plan and liable for payment at the time of service.

- I understand that the counseling services I/my child receive are strictly confidential to the fullest extent allowable by state and federal law. Licensed therapists are mandated to report known or suspected abuse of a minor, elderly or disabled person; a client that is a danger to self or others; and certain court mandated situations. Limits to confidentiality are disclosed to me in the Notice of Privacy Practices available to me upon request and online at http://www.oacounseling.net/forms.html.

X_____ X_____ Date: _____

Print Client Name Signature

## SOCIAL MEDIA POLICY

Open Arms Counseling, LLC, Inc., uses a variety of Social Media outlets allowing us to share practice information, news and event updates with other social media users. Please read our Social Media Policy located at our office or online at http://www.oacounseling.net/forms.html to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet.

This is to acknowledge I have been presented with Open Arms Counseling, LLC, Inc.'s ***Social Media Policy.***

X_____

PRINTED Name of Client SIGNATURE of Client / Client's Personal Representative Date

X_____

PRINTED Name of Client's Personal Representative Description of Representative's Authority to Act on Behalf of the Client

Open Arms COUNSELING

# Welcome
# New Client Paperwork

## DISCLOSURE OF POLICIES AGREEMENT

THERAPY CONSIDERATIONS: You should understand that there are various types of therapy that may be involved in your treatment and that there are some risks that may be involved, which could range from feeling uncomfortable to a more intense reaction. The purpose of therapy is to help you handle problems/situations in a constructive way. You should understand that you have the right to discontinue therapy at any time as well as the right to change therapists until you find one with whom you feel comfortable. You should also understand that your therapist can provide you with information on alternative ways to handle your issues, which may include a referral to another therapist who specializes in a specific area, or to an agency that may handle your care in the event that you are unable to fulfill your financial obligations to Open Arms Counseling, LLC.

CRISIS SITUATIONS: Open Arms Counseling, LLC is not a crisis intervention facility. If a life-threatening or other crisis situation arises, please take the following steps: (1) Call 911 or your local police, (2) Call Netcare at (614) 276-2273. (3) Call your counselor to make them aware of the situation.

INTAKE PROCESS: It is our ultimate goal that you get the help you are searching for. Open Arms Counseling, LLC employs numerous counselors to address the various needs of our clients. During our intake process we make every effort to schedule you with a counselor who is best suited to address your unique situation. If you feel uncomfortable directing your concerns to your counselor, please inform our Clinical Director and we will attempt to find another counselor for you or if necessary an outside referral.

RECORDS RELEASE: Requests for release of records are authorized by our counseling staff and/or the Executive Director. Record retrieval can take up to 2 weeks depending on storage location and administrative processing. Administrative staff will contact the party when the record is ready for pick-up. Costs will be determined by what is allowable under Ohio Revised Code 3701.741.

LEGAL PROCEEDINGS: I understand that my therapist may be required to become involved in legal proceedings involving my therapy (or my child's therapy). In that case, I 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 my involvement in such legal action.

COLLECTIONS: I understand that if I do not fulfill my financial responsibilities to make payments that I owe to Open Arms Counseling, LLC, that Open Arms Counseling, LLC may take appropriate collection action against me, up to and including taking legal action to collect amounts due from me. If that happens, I understand that the minimal amount of information necessary for such collection activity will be released and I consent to that release.

NO-SHOW/CANCELLATION POLICY: The following fees are assessed for a no-show or a cancellation with less than 24 hours' notice of an appointment: 1st no-show or less than 24 hour cancellation: $45; 2nd no-show or less than 24 hour cancellation (at any time during treatment process): $45; 3rd no-show or less than 24 hour cancellation: $45. Please leave cancellation messages in general voicemail box, NOT counselor's voicemail box.

**Client's acknowledgement (initials):** _____

FEES: All fees are due at time of service. The following list is not an exhaustive list of all services available. You may receive services from us that are not listed. Please consult with our staff to verify fees prior to receiving services from us. LPCC-S Intake $130.00; Assessment $100.00; 60 minute $105.00; 45 minute $80.00; 30 minute $60.00. LPC Intake $130.00; Assessment $100.00; 60 minute $105.00; 45 minute $80.00: 30 minute $60.00. CT Intake $30.00; Assessment $30.00; 60 minute $30.00; 45 minute $30.00; 30 minute $30.00 Returned check fee - $40.00.

**Client's acknowledgement (initials):** _____

I have read and agree to the terms of the policies on this page. I have had the opportunity to ask questions about them; and agree to abide by and Be bound by them.

_____
PRINT CLIENT NAME

_____ _____
SIGNATURE (Client / Parent / Guardian / Responsible Party) DATE

# New Adult Client

## MEDICAL HISTORY AND CURRENT CONCERNS

Today's date: _____

Client Name: _____ ○ Male ○ Female

Birthdate: _____ Age: _____ Height: _____ Weight: _____ Recent Weight Gain/Loss: _____

Physician: _____ Phone: _____ Last Physical: _____

Exercise: ○ No ○ Daily ○ weekly: _____ times/week Pregnancies: _____ Number of children: _____

**Do you have/have you had:**

- ○ Epilepsy
- ○ Cardiac/heart issues
- ○ Thyroid disease
- ○ Sleep disorder
- ○ Stroke
- ○ Parkinsons
- ○ Hepatitis
- ○ Dementia
- ○ Multiple Sclerosis
- ○ Endocrine issues/Hypoglycemia
- ○ Diabetes
- ○ Headaches
- ○ Asthma
- ○ High blood pressure
- ○ Emphysema
- ○ Cold intolerance
- ○ Autoimmune disease
- ○ Allergies
- ○ Head trauma/concussion
- ○ Cancer, type: _____
- ○ Other: _____

○ Medication allergies (specify): _____

| **Drug Use:** | None | Past | Current | | None | Past | Current |
|---|---|---|---|---|---|---|---|
| Alcohol | ○ | ○ | ○ | Cocaine | ○ | ○ | ○ |
| Marijuana | ○ | ○ | ○ | Heroin | ○ | ○ | ○ |
| Stimulants | ○ | ○ | ○ | Steroids | ○ | ○ | ○ |
| Hallucinogens | ○ | ○ | ○ | Other | ○ | ○ | ○ |
| Inhalants | ○ | ○ | ○ | | | | |

Drug of choice: _____ Quit on: _____

Caffeine: ○ No ○ Yes amount/day: _____ source: _____

| Current Prescriptions | Dosage | Frequency | Prescribed for | Using since | Prescribed by |
|---|---|---|---|---|---|
| | | | | / / | |
| | | | | | |
| | | | | / / | |
| | | | | / / | |

| OTC Medications | Symptom | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# DSM-5 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, select 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 been bothered by the following problems? | **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? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 2. Feeling down, depressed, or hopeless? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 5. Starting lots more projects than usual or doing more risky things than usual? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 7. Feeling panic or being frightened? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 8. Avoiding situations that make you anxious? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 10. Feeling that your illnesses are not being taken seriously enough? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| VI. | 11. Thoughts of actually hurting yourself? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| VII. | 12. Hearing things other people couldn't hear, such as voices even when no one was around? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 17. Feeling driven to perform certain behaviors or mental acts over and over again? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| XII. | 19. Not knowing who you really are or what you want out of life? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 20. Not feeling close to other people or enjoying your relationships with them? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | ☐ | ☐ | ☐ | ☐ | ☐ | |
| | 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)]? | ☐ | ☐ | ☐ | ☐ | ☐ | |

Open Arms
COUNSELING

☐ I have insurance that I wish to use (Please fill out insurance information below)

☐ I will not be utilizing insurance at this time (skip to Office Billing Policy)

**INSURANCE INFORMATION:**

Policy Holder Name: _____

Relationship to client: _____

Policy Holder Date of Birth: _____ / _____ / _____

Policy Holder SSN: _____-____-_____

Primary Insurance: _____

Primary Insurance ID Number _____

Secondary Insurance_____

Secondary Insurance ID Number: _____

Home Address: _____

Phone: _____-_____-_____

Employer: _____

Employer Phone: _____-_____-_____

E-Mail: _____

**OFFICE BILLING POLICY:**

1. Clients must pay their account IN FULL at the time of service unless a payment plan is set up with our office manager.
2. Our office accepts, Visa, MasterCard, Discover, American Express, cash, and personal Checks.

Client Name_____

Client Signature_____ Date: _____

Parent/Guardian Name_____

Parent/Guardian Signature_____ Date: _____