Brooke Kuntz, LISW-S

1820 Northwest Blvd Columbus, Ohio 43212

614-547-2413

DEMOGRAPHIC INFORMATION

CLIENT INFORMATION

Name: Last _____First _____Middle_____

_____

Preferred name:_____ Date of Birth:_____

Gender Identity *(preferred pronouns, etc.)*:_____

Sex: _____

Address: _____

City, State, Zip: _____

Phone: _____Email:_____

Permission to call & leave a detailed message?

- Yes
- No

Permission to text?

- Yes
- No

Permission to email?

- Yes
- No

Occupation and employment status:_____

Employer:_____

Relationship Status:

- Single
- Married
- Divorced
- In long-term relationship

- Separated
- Domestic Partnership
- Widowed
- Other:_____

If partnered, partner's name:_____
Name(s) of children and ages:_____

Relevant cultural information *(any information about identities you hold that you want your counselor to know about)*:_____
_____
_____
_____
_____

Referral:_____

EMERGENCY CONTACT PERSON
Full Name: _____
Relationship to Client:_____
Phone:_____

RESPONSIBLE PARTY INFORMATION *(Only complete if client is a minor)*
Name: Last_____First_____Middle_____
Relationship to client:_____
Address:_____City, State, Zip:_____
Phone:_____Email:_____
Date of Birth:_____

Name(s) Relationship to Client
_____
_____
_____
_____

I authorize the aforementioned individuals to (check all that apply)
___ schedule appointments
___cancel appointments
___change appointments
___inquire about appointment times/dates
___discuss/handle billing, insurance and payment issues

I understand that no information other than what is indicated above will be shared with the individuals indicated on this form.
Client Signature _____ Date_____ Custody Holder Signature for Minor _____ Date_____

INSURANCE INFORMATION
Primary Insurance Company:
Policy Holder's Name *(if different from client)*:_____
Policy Holder's Date of Birth:_____
Policy Holder's Phone Number:_____
Policy Holder's employer:_____
Policy Holder's Home Address:_____
_____
Insurance Company:_____
Policy/ID number:_____
Group number:_____
Claims address:_____
Claims Phone:_____

Credit Card Information:
Name on Card:_____
Card Type *(ex. Visa, Mastercard, etc.)*:_____
Number:_____Security Code:_____Exp. Date:_____
Billing address: _____
_____.

Seasons will bill your insurer directly for applicable services. Please remember that it is your responsibility to pay any deductible, co-pay or co-insurance amounts. For your convenience, we will keep your credit card information on file. We will then bill your credit card at the conclusion of each visit.

Client Information and Acknowledgment of Informed Consent to Treatment

Seasons Counseling Services, LLC (hereinafter "Seasons") provides counseling through Ohio licensed mental health therapists which are independently contracted with Seasons and are part of an Organized Health Care Arrangement between Seasons and Ohio Health Group programs. This Agreement applies to the therapist you will be seeing, and it will also describe the business practices of the therapists at Seasons. You will be seeing the therapist listed above.

Mental Health Services

The purpose of mental health services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. Using your therapist's knowledge of human development and behavior, he or she will make observations about situations and help you to develop new ways to approach them. It will be important for you to examine your own feelings, thoughts and behavior, and to try new approaches in order for change to occur.

The services offered can have risks as well as benefits. Treatment often involves discussing unpleasant issues, and you might experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health care 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.

The licensure and credentials held by this therapist provides him the authorization under law to diagnose and treat mental and emotional disorders and substance related disorders under the supervision of a clinical supervisor. For psychiatry/ medication management services, community-based resources, specialty practices, or higher levels of care, the counselor can provide referrals with evidence of necessity for such services, and with the person's permission. The counselor is not responsible for the accuracy or quality of services rendered

Appointments

Appointments are made by calling the phone number listed above. **Please call to cancel or reschedule at least 24 business hours in advance, or you will be charged $75.00 for the missed appointment unless your therapist determines an emergency was involved.** This means that appointments scheduled for Mondays need to be cancelled or rescheduled by the end of business on the Friday before the scheduled appointment. Third party payers will not cover or reimburse for missed appointments. Appointments are approximately 45-60 minutes in length, but session length may vary for clinical reasons. The number of appointments depends on many factors and your therapist will discuss this as part of your treatment planning.

Since there is no way a therapist can see another client when they have a late arrival, no reductions are provided when a client arrives late for an appointment. Some insurance companies will only pay for the actual time during which services are rendered. In that case you, the client, will be billed for the portion of the appointment time when no services could be rendered. Some governmental insurance or employee assistance programs do not allow billing for missed or partially missed appointments and if that is the case you will be billed in accordance with those programs' rules. Your therapist committed to being on time for your appointment, and hopes that you will attempt to do the same. If you are 15

minutes late, there is no guarantee that I will be able to fit in a full session. Please call a head if you see this as a possibility.

If you know you are going to have to cancel an appointment, contact your counselor by voicemail at 614-706-2228 x 721 or text to 614-547-2413 as soon as possible. If they do not answer, leave a message. Please let them know if you desire to reschedule your appointment; leave a message about dates and times that may work for you. They will return your call within a 24-48 hour period of time to schedule a new appointment time.

Your Rights

You have the right to competent and professional service. You have the right to be treated with respect and courtesy. You have a right to a therapeutic relationship without physical, sexual, verbal or other form of abuse or exploitation. You have the right to file a complaint. You have the right to review your clinical file and make a written request to have it released to a competent professional.

Your Responsibilities

At this level of care, individuals are expected to regularly meet and engage with the counselor during the diagnostic assessment, during the development of a treatment plan, and during the ongoing treatment of mental health needs. You are responsible to be an active, collaborative participant in your therapy process

Relationship

Your therapist's relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to "friend" your therapist or anyone else in the practice on Facebook or on any other social media site. You always have the right to terminate services with your therapist at any time and for any reason.

Goals, Purposes and Techniques

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment your therapist recommends and to have input into setting the goals of your therapy. As therapy progresses these goals may change. You and your therapist will jointly determine how to effect the changes you are seeking to make for yourself. You always have the opportunity to seek either another opinion or a different therapist. Your therapist will let you know if he or she feels that you are not a good fit or if you might obtain better help with someone else. Your therapist will always retain the right to terminate therapy with you. Some examples of when this may happen is in the event that he or she feels you would be better served with another therapist, for rude or abusive behavior, for a pattern of missed or cancelled appointments, if he or she feels you are not complying with treatment requests,

or if payments due remain unpaid. In the event that your therapist terminates services with you he or she will offer you referrals.

Confidentiality

Laws protect the privacy of all communications between a client and a therapist. In most situations your therapist can only release information about your treatment to others if you sign a written authorization. There are some situations where they are permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, your therapist cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order your therapist to disclose information;
- If a government agency is requesting the information, your therapist may be required to provide it;
- If you file a complaint or lawsuit against your therapist, he or she may disclose relevant information about you as part of a defense to your charges;
- If you file a worker's compensation claim, your therapist may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which your therapist is legally obligated to take actions that he or she believes is necessary to attempt to protect others from harm, and in such cases they might have to reveal some information about your treatment. If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action, if they deem that to be appropriate under the circumstances, and will limit disclosure to what is necessary. For instance:

- If your therapist has reason to believe that a child, a developmentally or physically disabled, an elderly adult or for some types of licensees an animal, is being neglected or abused, the law may require them to report that information to the appropriate state or local agency;
- If your therapist believes you present a clear and substantial danger of harm to yourself and/or others, he or she may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that the practice may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which

requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time your therapist may have the need to consult with his or her practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). The practice attorney is bound by confidentiality rules also. In addition, your therapist will reveal only the information that he or she needs to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that your therapist may practice with other mental health professionals and that the practice may employ administrative staff or your therapist may need to consult with outside medical professionals. In addition, your therapist may need to coordinate your care with your other healthcare providers. In most cases, protected information may need to be shared with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance. If your therapist or the practice does that only the information necessary in order for them to provide help to you, the client, will be released. All of the mental health and medical professions are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

Also, the practice may have a contract with a collection agency. If that is the case, the practice will have a formal contract with this business, in which the business promises to maintain the confidentiality of the data except where release of certain information is allowed in the contract or is required by law. Only limited information, just enough to collect the amount you owe, will be disclosed by the practice in this situation.

In addition, the practice may have a contract with a billing service or other third-party business tools. As required by HIPAA, the practice will have a formal business associate contract with these entities, in which they promise to maintain the confidentiality of this data except where release of the information is allowed in the contract or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with your therapist any questions or concerns that you have.

Legal Situations

If you or the client (if the client is a minor or a ward of a guardian) become involved in legal proceedings that require your therapist's participation you will be expected to pay for all of their professional time, even if they are called to testify by another party. Your therapist

will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. Your therapist's professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that they wait in court prior to or after they may be called to testify. Due to the time-consuming and often difficult nature of legal involvement, your therapist charges $200.00 per hour for these services along with a $50.00 charge for document preparation. You will also be responsible for any legal fees that they may incur in connection with the legal proceeding, which may include responding to subpoenas.

Please be advised that as a treating therapist, your therapist cannot ethically provide any recommendations on guardianship, custody, visitation, parenting capacity or abilities or what is in the best interest of the child(ren) if you or your child(ren) are involved in custody/divorce/guardianship proceedings.

Professional Records

The laws and standards of your therapist's profession require that your therapist keep Protected Health Information about you in your Clinical Record. Your Clinical Record may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that your therapist receives from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record if you request it in writing, unless your therapist determines for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event under Ohio law they may exercise the option of turning the records over to another mental health therapist designated by you, unless otherwise required by federal law. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, it is therefore recommended that you initially review them with your therapist or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, your therapist is allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so he or she will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, and if we store the information in an electronic format, your therapist will provide the information to you in an electronic format if you agree to accept the potential risks involved in sending the records that way.

Your therapist may also keep a set of psychotherapy notes which are for their own use and which are designed to assist them in providing you with the best treatment. These notes

are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except in rare legal circumstances. Their release requires a separate authorization in addition to one for the Clinical Record. Your therapist will discuss with you whether or not they are maintaining psychotherapy notes on you.

Fees, Payments, and Billing

Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that your therapist's services are paid for. Meeting this responsibility shows your commitment and maturity.

Seasons current regular fees are as follows. You will be given advance notice if these fees should change. Regular therapy services are $350.00 for the first diagnostic session, with following sessions at $300.00 for each 45-60 minute session. You will be asked to provide a credit card on file and after any insurance payments are received by Seasons, your credit card will be charged for any amounts that you owe. Other payment or fee arrangements must be worked out before the end of the first session. Insurance reimbursement levels may be affected by insurance company agreements, so for clients choosing to use their insurance final costs will be in accordance with the agreements Seasons has with in-network insurance companies.

Telephone consultations: Your therapist believes that telephone consultations may be suitable or even needed at times in therapy. If so, he or she will charge you their regular fee, prorated for the time needed. If your therapist needs to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with your therapist in advance so you and they can set a policy that is comfortable for both of you. Of course, there is no charge for calls about appointments or similar business issues. Insurance companies will typically not provide reimbursement for telephone consultations.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 10 minutes your therapist will tell you, because sessions that are extended beyond 10 minutes will be charged on a prorated basis. Insurance may not pay for the extended portion of a session.

Reports: Your therapist will not charge you for his or her time spent making routine reports to your insurance company, but will charge fees on a prorated basis for other types of written reports that you request.

It is important to note that the counselor does not fill out disability, FMLA or other paperwork related to worker's compensation. If you need the counselor to talk to your physician and collaborate on a report that he/she will be filling out please let him know.

If you think you may have trouble paying your bills on time, please discuss this with your therapist. Your therapist will also raise the matter with you so you can arrive at a solution. If your unpaid balance reaches $1,000.00, your therapist will notify you in writing. If it then remains unpaid, he or she may stop therapy with you if you and they cannot agree on a payment plan. Fees that continue unpaid after this may be turned over to small-claims court or a collection service and you agree to allow the practice to do that. If you challenge a credit card fee, then you allow the practice to respond to the credit card company. If the practice chooses to do that, they will report only enough information to collect fees due to your therapist.

Because your therapist is a licensed mental health therapist, many health insurance plans will help you pay for therapy and other services he or she offers. Because health insurance is written by many different companies, your therapist cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy" or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know.

If your health insurance will pay part of your therapist's fee, the practice will provide appropriate billing. However, please keep some things in mind: Your therapist had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you have to pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. You are responsible for paying the fees that are agreed upon. If you ask the practice to bill a separated spouse, a relative, or an insurance company and payment is not received on time, then you agree to pay this amount. In addition, the plan may have rules, limits, and procedures that should be discussed, and your therapist may not be on one of their panels.

The practice will provide information about you to your insurance company with your consent, and by signing below you agree that it may do that. By signing this form, you agree to assign any reimbursement you receive from your insurance company to the practice.

If you choose to not have your therapist send information to your insurance company, you must select this option before each session and then pay for the session in full and it will not be done through Seasons, but may be handled with your individual therapist. With this option no report of any information will be made to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

Minors

If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order or if your therapist feels that the release of your records to your parents might have an adverse effect on you, in which case under Ohio law they can name another mental health therapist that your therapist will have to turn them over to, unless otherwise required by federal law. Before giving your parents any information your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have. Except in unusual circumstances, your therapist likes to make both parents aware of and involved in the treatment. In addition, if one parent brings in a child and the therapy only involves the child, under Ohio law since generally both parents have access to the child's records unless that access is blocked by a court order, anything that either parent says in the sessions is available to both parents. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before your therapist sees a minor for treatment. Minors 14 years of age and older should be aware that they have an option to see a therapist on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of your therapist's intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Emergencies and After-Hours Care

Your therapist may be reached at the phone number listed at the beginning of this form. He or she will make every effort to return messages within 24 hours; however, he or she may not always be able to do that. Current clients will be notified during sessions of upcoming travel or vacation plans. If you have an emergency, you should go directly to a hospital emergency department or call 911. The National Suicide Prevention Lifeline number is 1-800-273-8255. Emergencies are urgent situations and require your immediate action. Netcare Access has a 24/7 emergency hotline for mental health issues in the Columbus area and it may be reached at: (614) 276-2273 (CARE).

Incapacity or Death of Therapist

In the event that your therapist is incapacitated or dies, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional or another person who will be under an agreement to maintain the confidentiality of the records whom your therapist or the practice designates to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice.

Disclosing Information to Family Members, Relatives, or Close Friends

_____ **Initial Here.** By initialing this section you agree to allow your therapist, if you are incapacitated, in an emergency situation, or are not available, to contact a family member, a relative, a close friend or any other person you identify, to disclose your

personal health information that directly relates to that person's involvement in your healthcare. This information will be disclosed as necessary only if your therapist determines that it is your best interest based on his or her professional judgment.

Email, Texting, and Electronic Communications

If you decide you want to utilize any form of electronic communication – email, texting, etc., you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks. Your counselor may be reached by phone at 614-707-2228 x 721. If the counselor does not answer please leave your name, return phone number, and a message—the counselor will return your phone call within a 24-48 hour period of time. Text messaging will be permitted for scheduling purposes only. The counselor may also be reached by email at brooke@seasonscounselingservices.com Emails will be answered within a 24-48 hour period of time.

If you wish to use unencrypted electronic communications, please place your initials in the space below:

_____ **Initial Here.** By initialing this section you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either your therapist and the practice to you or you to your therapist or the practice that involve scheduling and/or therapy. If you do not want your therapist or the office to contact you at a certain address or phone number, please let your therapist know at your first meeting with him or her.

Complaints or Concerns

Please bring any complaints or concerns directly to your therapist. Part of the therapeutic process is working through these types of concerns with your therapist. If you have concerns about your fit with your counselor, bring those up with them and they will address them or help you to seek alternative care options. If the complaint is not handled to your satisfaction, you can then also make a complaint with Dr. Andy Erkis at andy@seasonscounselingservices.com or with the Counselor, Social Worker, and Marriage and Family Therapist Board. They can be contacted at cswmft.info@cswb.state.oh.us or 614-728-7791 (this number is for complaints only). More information about the Board can be found online at http://www.cswmft.ohio.gov/.

If you are concerned that your therapist has violated your privacy rights, or you disagree with a decision your therapist has made about access to your records, you may contact your therapist, the State of OH Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

Acknowledgment of Informed Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist I will be seeing at the practice to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company or third party payer to obtain reimbursement, unless I direct otherwise.

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 a therapist at the practice at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor or a ward with a court approved guardian is the client I am signing on behalf of the minor or the ward as the authorized parent/guardian. (Information on minor rights will be shared with the minor, as appropriate.)

I also acknowledge that I have received a copy of the Notice of Privacy Practices for the practice listed at the top of this form.

Client Name(s) (please print) _____

_____

Client(s) Signature

_____ _____ Date

_____ _____ Date

Parent(s) or Guardian Signature (for minor child or children or disabled adults)

_____ _____ Date

_____ _____ Date