VALENTINO COUNSELING & CONSULTATION, LLC
New Client Information

Today's Date _____

Name: _____ Preferred Name: _____ DOB: _____

Address: _____

Best Contact Number: _____ (Circle One) Cell Work Home

Okay to leave message? Y N Email: _____

Preferred Method of Contact: Voice Mail Text Email Other: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Permission to contact in case of emergency? Y N

Race/Ethnicity: _____ Employment Status: _____

Employer: _____ School/Grade: _____

Pronouns: _____ Administrative Gender: _____ Sexual Orientation: _____

Spirituality/Denomination: _____ Marital Status: _____

Insurance Information

Insurance Carrier: _____ Subscriber Name: _____

Subscriber D.O.B. _____ Member I.D. _____

Group Number: _____ Provider Services Phone: _____

Person responsible for payment: _____ Relationship to client _____

Client History

Briefly describe why you are here today:

Please share a brief history of the presenting problem:

What mental health diagnoses have you received in the past, if any?

To the best of your knowledge, please briefly describe any trauma history:

Please list any medications you are currently taking, the amount, and why you are taking them:

Who currently prescribes your medication?

What medications have you taken in the past?

Have you been in therapy before? Please briefly describe your experience:

Are you currently seeing another therapist? If so, please list their name and the reason for treatment:

Medical history? (past surgeries, hospitalizations, etc.)

To the best of your knowledge, did you meet developmental milestones on time (i.e. fine and gross motor skills)? If not, please elaborate.

How often do you drink alcohol? How about past alcohol use?

Please describe any past or present drug use:

Highest Education completed:

List immediate family members and ages (parents, siblings, partners, children):

Family psychiatric history?

Any family concerns you would like me to know about?

Any past or current legal concerns you would like me to know about?

What do you feel are your strengths? Your limitations?

What else would you like me to know about you?

Financial Policy

Policy: Payment in full is expected at the time of service, unless prior arrangements have been made. If you are utilizing the self pay rates, you will owe $150 for your initial session, and $120 (55 minute session) or $110 (45 minute session) at the beginning of your appointment.

Insurance: If you are utilizing your insurance benefits, your copay or coinsurance will be collected at the beginning of each appointment. We will bill most insurance providers for you (including Medicaid), as well as most secondary insurance carriers, if applicable. If your insurance provider denies payment, you are responsible in full for any remaining balance. I have contracted rates with most insurance companies; please contact your insurance provider prior to your first appointment to verify in network coverage with me, and to identify your coverage benefits. If you have questions regarding your benefits throughout treatment, contact your insurance provider directly. If your insurance carrier denies your claims for more than 60 days, you will be responsible in full for the balance.

Missed Appointments: I require at least 24 hours notice if you'd like to cancel or reschedule your appointment. *Missed appointments or cancellations without 24 hours notice will result in a fee of $120*. Please note that insurance does not cover missed appointment fees. All missed appointment fees must be paid by your next session. I reserve the right to charge this fee to your credit card upon missed appointment or late cancellation. There will be no penalty to any client who requests a Telehealth appointment if attending an in-person appointment is not possible.

Credit Card on File: I require all clients to have a valid credit card on file for use of copays, outstanding fees, and missed appointment fees only. Credit Card numbers are kept on file via the Square website, which is secure.

Case Management and Legal Fees: If you require me to complete paperwork, provide a letter, or make phone calls on behalf of your treatment, you will be charged a case management fee, at my $120/hour session rate for any of those services that require more than 10 minutes of my time. Should you require my services with regard to any legal proceedings, that is also billed to you at $120/hour and is not a covered service by insurance.

By signing below, you indicate that you have read, understood, and agree to the financial policy as stated above.

_____ _____

Client signature (or parent/guardian signature, if applicable) Date

_____ _____

Clinician Signature and Credentials Date

Informed Consent and Services Agreement

Welcome to Valentino Counseling and Consultation! It is my goal to provide you with ethical services that meet your primary reasons and goals for seeking my services. Below you will find information about my practice and our work together, as well as your responsibilities as the client. By signing below, you are indicating that you have read, understand, and agree to the following statements:

Consent to treatment: You are entering into this therapist/client relationship fully understanding the risks and benefits to treatment. In addition, your personal information and confidentiality is protected by entering into this therapist/client relationship. It is important to understand that you may feel worse before you get better, as the process of therapy involves exploring and processing through difficult thoughts and feelings.

Diagnostic and follow up sessions: Your first session is a diagnostic assessment. Insurance carriers require a diagnosis in order for you to utilize your full benefits. I will share with you my clinical insight into the diagnosis you are given. If you do not want a diagnosis, you have the option to pay my self pay rates. The first session is meant to gather information from you so that I can form a clear understanding of your presenting issues as well as any relevant history. Follow up sessions include narrowing down treatment goals and utilizing evidence-based treatment methods to obtain those goals. We will work together to develop treatment goals that are most important to you.

Cancellation policy: You can schedule sessions one at a time, or up to 60 days in advance. I require 24 hours notice, given to me via email or telephone, if you'd like to cancel or reschedule your appointment. This allows me to provide that appointment time to another client in need of services. If you do not provide me with 24 hours notice, you will be charged a late cancellation/missed appointment fee at or before your next appointment with me. This policy excludes Medicaid clients.

Insurance: You may choose to use your insurance benefits for therapy services, in which case I will collect your insurance information from you at or before your first appointment, or when you obtain benefits. Call your insurance provider prior to your first appointment to ensure you fully understand your financial responsibilities. In order to utilize your insurance benefits, insurance providers require me to disclose your diagnosis. At times, insurance providers request additional information in order to approve ongoing clinical care. By signing below, you are providing your consent to release this information. I utilize a HIPAA compliant and secure electronic medical records system in order to process your claims and store personal information.
Please initial here to provide consent to release this information _____

Confidentiality: Any information shared with me during our sessions is kept confidential, except for those limitations outlined in the HIPAA "Notice of Privacy Practices" document that you have signed. Those circumstances include:

- Known or expected abuse, neglect or exploitation of a child under 18, a person with a disability or an elderly adult. I am required by law to report these situations to the proper authorities and comply with any required follow-up.
- Known or suspected risk of imminent serious harm to yourself or someone else. I must disclose that information to appropriate public authorities, the potential victim, and/or professional workers, and/or the family of the client.
- Your records are ordered by a court of law, or necessary for protecting myself in a lawsuit.

Medical Records: Your hard copy records are stored in a secure location in my office. Your online medical records are stored in a secure, HIPAA compliant electronic medical records system. You have the right to request access to your medical records, unless it is determined that the release of those records would cause harm to the client. Medical records may not be released to you or anyone else without your signed consent. Please be aware that I share my office with Milena Brumbaugh, LISW-S of Milena Elise Counseling & Consultation, LLC. If an unpredictable event or my death were to occur, Milena Brumbaugh, LISW-S will become responsible for all client records of Valentino Counseling & Consultation, LLC.

Consultation with other Therapists and/or My Attorney: I may consult about your case if needed with colleagues within the profession. Identifying information is absent and your confidentiality is protected. In addition, it may become necessary to discuss legal issues involving your case with my consulting attorney. By signing below, you consent to these consultations, which will be limited to the amount of information necessary for me to properly address the issues that may arise in therapy.

Release of Information: It may be helpful during your treatment for me to communicate with other helping professionals with whom you see. These may include, but are not limited to, your primary care physician, psychiatrist, medical specialists, and any other therapist with whom you have seen or currently see. If I believe it would be clinically appropriate, I will discuss this rationale with you and receive your consent utilizing a Release of Information document.
Please initial here if you provide your consent for me to contact your PCP _____

Technology and Communication: You have the option to communicate with me via telephone, text, and email. If you choose any of these avenues for communication, you acknowledge confidentiality limitations when utilizing technological services. I am not always available due to the nature of my work; if you need more immediate assistance due to safety concerns, please call 911, go to your nearest emergency room, or go to or call Netcare Access at (614) 276-2273.

Minors and Parents: If you are bringing your minor child for services, you have the right to access their information. However, in order to build therapeutic rapport and trust with your child, I will request your permission to only share with you information that pertains to their health or safety. If you would like me to inform you of any additional, specific information that arises during the course of treatment with your child, please inform me at the beginning of treatment.

Consumer's Bill of Rights

All consumers of services offered by licensed professionals of the State of Ohio Counselor, Social Worker & Marriage and Family Therapist Board (CSWMFT Board) have the legal right to:

- Receive competent professional services.
- Verify the credentials of licensed professionals and to know the names and titles of licensed professionals who provide service.
- Receive services that are respectful and sensitive to your cultural background.
- Clear explanations of the services being offered or provided and how much they cost.
- Refuse any services offered.
- Know what client records will be maintained and how to obtain copies; personally identifiable information normally cannot be revealed without the consumer's consent.
- File a complaint with the CSWMFT Board about a licensed professional or an unlicensed practitioner.
- Request and be provided reasonable accommodations to access professional services if you are a person with a disability.

You are encouraged to choose professionals who uphold the rights listed above and who also:

- Treat you with courtesy and respect.
- Explain your service options, including their consequences and any follow-up services which may be required or recommended.

For answers to questions about these rights and for more information about what services licensed professionals may provide, contact:

Counselor, Social Worker and Marriage and Family Therapist Board
77 S. High Street, 24th Floor, Room 2468 Columbus, Ohio 43215-6171
Tel: (614) 466-0912 Fax (614) 728-7790
Email: cswmft.info@cswb.state.oh.us

Professional Misconduct Complaints: Call 614-466-0912 and ask for the Investigation Department.

Your signature below indicates that you have read, understood, and agree to informed consent for services, the above stated policies and release of information to your PCP and insurance provider, HIPAA Notice of Privacy Practices, and the Client Bill of Rights.

_____	_____	_____
Client Name (printed)	Client Signature (or parent/guardian)	Date

_____	_____
Clinician Signature and Credentials	Date