

Pickerington Area Counseling Service
Fee Agreement

Client Name: _____

ID# (office use): _____

Terms and Conditions:

- I understand that if I am unable to keep my appointment, I must give 24 hours notice. I further understand that I will be charged a fee for the scheduled service. Failed appointment fees: Counseling: \$50, Psychiatric Evaluation: \$100, Psychiatric Follow-Up: \$50, Psychological Evaluation: \$100. Note: This fee may be reduced based on sliding-scale fee percentage (if applicable), with a minimum charge of \$10. *There are no fee reductions for psychological evaluation failed appointments.*
I further understand that two consecutive failed appointments or a pattern of failed/cancelled appointments may result in termination of services.
- *For those who qualify:* I understand that my fee will be determined by the agency sliding fee scale, which is based upon my gross annual family income and the number of dependents in my home. I understand that if I am not a resident of Fairfield county, I do not qualify for a sliding fee discount. I further understand that in order to receive a discount, I must supply verification of income within 30 days of the date of this agreement.
- The agreed upon fee percentage will not change without a new, signed fee agreement. If the client is eligible for Title XX funding, the fee percentage will be re-determined on or about 6 months from the date this form is signed. Other clients may have their fee percentage re-determined on or about one year from the date this form is signed. At any time, I may be requested to provide income verification for the purposes of re-determining the fee percentage.
- I understand that payment/co-payment is required at the time of service.
- I understand that future appointments will not be scheduled if I have an outstanding balance, or if I do not provide payment or co-payment at the time of a session.
- I understand that there will be a \$25.00 charge to my account for any returned checks.
- I understand that information contained in my chart may not be released to anyone without my written consent, with these exceptions: if the law mandates disclosure; if I am determined to be at risk of harm to myself or someone else; and for the purpose of therapist supervision and consultation, within ethical guidelines of their profession.
- I authorize the release of any medical or other information necessary to process claims to my insurance company (or Medicaid, or Medicare).
- If court testimony or deposition is required, I will be charged the full cost of services for the staff member's time away from the office.
- I recognize that ongoing communication is an essential tool of my treatment. Therefore, I understand that if I do not maintain contact (no face-to-face contact, no phone contact, no written contact) with my clinician for 60 days, my chart will be closed. If my chart is closed, I may re-open it at any time by contact the office to schedule a re-open/intake appointment. (Exception: Some clients will be scheduled to see the doctor every 2-4 months)
- Title XX clients will be charged based on their sliding fee eligibility for all services when Title XX funds have been exhausted.
- I will bring my Medicaid or insurance card to each appointment.
- My fee percentage will be 100%, unless I request a sliding fee scale. Note: Clients who live outside of Fairfield County or are covered by managed care insurance are not eligible. for a sliding fee. Please bring income verification to the office if you are requesting a sliding fee. (Office use: if fee percentage different from 100%, enter here: _____)
- If my insurance pays part of the full service cost, I will be responsible for my percentage of the unpaid balance, or the agreed upon co-payment amount.
- I understand that there are varying charges for each service, and if any additional services are required, I will be responsible for the fees charged for those services.

I further agree:

- To report any change in insurance, Medicaid, or Medicare status.
- To report any changes in household/family income to the billing office (only applicable if fee percentage is less than 100%).
- To bring any insurance payments that I receive directly to Pickerington Area Counseling Service.

I understand that my failure to comply with the terms and conditions of this agreement may result in a termination of service.

I understand that my signature gives my consent for treatment and my approval of the fee agreement.

Signature of: Client Guardian

Date

Witness (may be family member/friend)

Date

Pickerington Area Counseling Service does not discriminate in employment or services because of race, religion, creed, color, national origin, sex, or political affiliation.

Revised 01/18/12

PICKERINGTON AREA COUNSELING SERVICES
437 HILL ROAD
PICKERINGTON, OHIO 43147
INFORMED CONSENT FOR TREATMENT

CLIENT NAME _____ DOB _____ ID# _____

ACKNOWLEDGMENT OF CONSENT FOR TREATMENT

- 1) I agree to receive Mental Health and / or Alcohol and other Drug treatment as offered by Pickerington Area Counseling Services for:
 Myself My child The person for whom I am legal guardian

Myself, being a minor 14 years of age or older → *Pickerington Area Counseling Services Practice Manager prior-approval is required before first appointment is scheduled. Treatment will not exceed thirty (30) days or six (6) sessions, whichever occurs sooner. Treatment does not include Pharmacotherapy.*
Clinical Director Signature _____ Date _____

- 2) I give consent for the use of my Protected Health Information for treatment, payment and health care operations as described in the Notice of Privacy Practices.
3) I acknowledge this consent is voluntary.
4) I further acknowledge that I may revoke, in writing, this consent at any time; except to the extent that action based on this consent has already been taken.

Signature _____ Date _____
 Client or Guardian

Signature _____ Date _____
 Witness / Facilitator

I have received a copy of the Client Handbook → Client initials _____
I have declined a copy of the Client Handbook → Client initials _____

If questions, I may discuss with my clinician, or obtain the Handbook at anytime during my course of treatment.

➤ **CLIENT HANDBOOK** includes information about:

- Crisis Intervention
- Special Treatment Conditions Concerning:
 - Risk Of Harm to Myself or Others
 - Child and Older Adult Abuse
- My Individual Treatment Process
- Clinical Treatment Process
- My Rights, Responsibilities and Satisfaction
- Benefits and Risks of Treatment and Services
- Privacy Policies
- Safety Practices on Agency Premises
- Various Health Information
- Community Resources Available

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WITHDRAWAL OF CONSENT FOR TREATMENT

CLIENT NAME _____ DOB _____ ID# _____

I wish to withdraw my consent for treatment at Pickerington Area Counseling Services. My clinician has explained the consequences and implications of refusing or withdrawing from the proposed treatment to me. This information is also located in the Benefits and Risks of Treatment and Services packet provided during my Intake.

Signature _____ Date _____
 Client or Guardian

Signature _____ Date _____
 Witness / Facilitator

Signature _____ Date _____
 New Horizons employee

PICKERINGTON AREA COUNSELING SERVICE
HEALTH ASSESSMENT FORM

Client name: _____ Client ID # (office use): _____

Sex: Male Female Age: _____ Date of birth: _____

What types of problems are occurring in your life? What are the primary reason(s) for your attendance at Pickerington Area Counseling? _____

Allergies to medications? No Yes → names of medications /types of reaction _____

Other allergies (food, environmental, etc.)? No Yes → _____

Family doctor: _____

Date last seen by doctor: _____ Date of last physical: _____

Are you currently under treatment? No Yes → Type of condition(s): _____

MEDICATIONS: List all medications currently being taken, or that have been discontinued within the past 30 days. Include birth control and over-the-counter medications. No medications taken.

Name of medication	Dosage	How often taken	Doctor / clinic prescribing	How long taken	Rx or over-the-counter

Tobacco use? No Yes → Type, frequency, packs per day _____

Alcohol use? No Yes → How much, how often: _____

Drug use? No Yes → Type, how much, how often: _____

Caffeine use? No Yes → Type, amount: _____

MEDICAL HISTORY: Please check if you have or have had any of the following:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV pos. | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Nerve problems / anxiety | <input type="checkbox"/> Bleeding tendencies |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Gall bladder disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures / epilepsy | <input type="checkbox"/> Alcohol / drug abuse |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Severe arthritis | <input type="checkbox"/> Gonorrhoea, syphilis or herpes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Thyroid / goiter | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Urine infections | <input type="checkbox"/> Heart attack / heart problems |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Tuberculosis or
or positive tine | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Hernia | | <input type="checkbox"/> Polio | <input type="checkbox"/> Mumps |
| | | | <input type="checkbox"/> Malaria |

List past surgeries/injuries/hospitalizations and dates: _____

Other significant medical history / problems: _____

Family history:

Mother's age: _____	Father's age: _____		
Has any blood relation had:	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizures / epilepsy	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Drug / alcohol problems	

WOMEN ONLY:

Number of pregnancies: _____ Age of onset of menstruation: _____

Number of children: _____ Number of days between periods: _____

Living: _____ Duration of bleeding: _____

Deceased: _____ Date of last period: _____

Number of miscarriages: _____ Date of last pap smear: _____

Have you ever had:

Severe discharge? Y N

Painful menstruation? Y N

Bleeding between periods? Y N

Bleeding after intercourse? Y N

Painful intercourse? Y N

Pregnant? Yes No Breast feeding currently? Yes No Menstrual cycle: Regular Irregular

PICKERINGTON AREA COUNSELING SERVICE
437 HILL RD., PICKERINGTON, OHIO 43137
RELEASE - EMERGENCY CONTACT

CLIENT NAME _____

DATE OF BIRTH _____ CLIENT ID# _____

IN CASE OF AN EMERGENCY PACS STAFF MAY CONTACT YOUR:



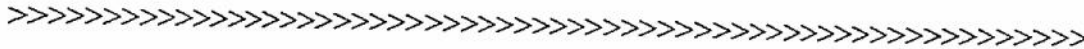
Relationship to Client _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE () _____



IF WE ARE UNABLE TO REACH YOU

MAY WE CALL YOUR EMERGENCY CONTACT PERSON? _____ yes _____ no
IS THERE ANYONE ELSE WE MAY CALL? _____ yes _____ no
(for example your employer, family member, neighbor, friend, pastor etc.)

NAME _____ PHONE: () _____

Relationship to client _____

ADDRESS, CITY _____

NAME _____ PHONE () _____

Relationship to client _____

ADDRESS, CITY _____

PACS staff would NOT release any CLINICAL INFORMATION to this contact person. Your authorization would allow us to leave a message to call us, to confirm or change an appointment, ask if your whereabouts are known, or obtain your new address and phone if you've moved. Your treatment is

STRICTLY CONFIDENTIAL

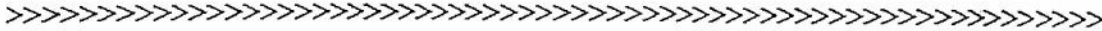


I understand that I may revoke my authorization at any time, except to the extent that action will have been taken prior to the revocation of my consent. Otherwise, this authorization is valid for the duration of my treatment at PACS.

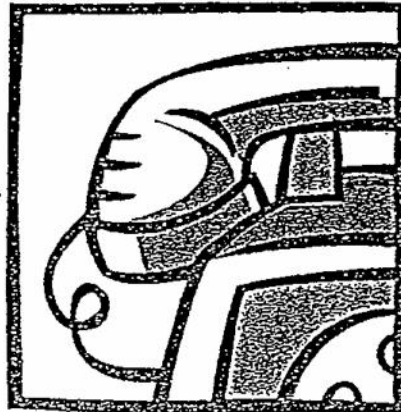
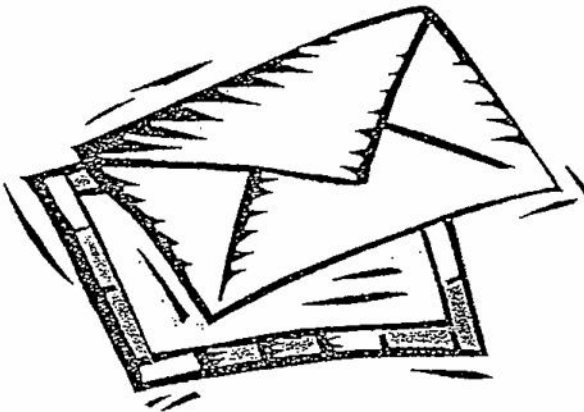
Signature of Client _____ Today's Date _____

Signature of Guardian _____ Today's Date _____

Witness Signature _____ Today's Date _____



I wish to revoke my consent _____ Today's Date _____
(Your Signature)



over please