thrive
COUNSELING & COACHING

We are so pleased to work with you toward your goal to thrive! Our hope and goal is to make the process of getting started as easy and clear as possible. Below is a checklist of documents. Please take the time to read and complete each document. If you have any questions, you may address those with your helping professional at the time of your appointment.

Please complete the following documents:

1. Adult Intake (Fill out only if the client is over 18 years of age)
2. Minor Intake (Fill out only if the client is 17 years old or younger)
3. Informed Consent
4. Notice of Privacy Practices
5. Release of Information (If you would like coordination of care with your doctor, psychiatrist, pastor, school official or therapist)

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Adult Intake Questionnaire

Name: _____ Date: _____

Address: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Home Phone: _____ Work Phone: _____

Employer: _____

In Case of Emergency, Contact: _____

Current Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Please list the number of times you have been: ___ Married ___ Separated ___ Divorced ___ Remarried

Spouse's Name: _____ Spouse's Date of Birth/Age: _____

Spouse's Employer: _____ Work Phone: _____

Highest Education Degree: You: _____ Spouse: _____

Please list all information regarding your children and dependents:

Name	Age	Gender	Living at home?
_____		☐ M ☐ F	☐ Yes ☐ No
_____		☐ M ☐ F	☐ Yes ☐ No
_____		☐ M ☐ F	☐ Yes ☐ No
_____		☐ M ☐ F	☐ Yes ☐ No

Do you attend church? ☐ Yes ☐ No If so, where? _____

How would you rate your sleep? ☐ Excellent ☐ Good ☐ Average ☐ Poor

How would you rate your appetite? ☐ Excellent ☐ Good ☐ Average ☐ Poor

Please check any areas that may be of concern to you:

☐ Family	☐ Spiritual/Religious	☐ Sexual Abuse	☐ Physical/Medical
☐ Work/Career	☐ Marital	☐ Women's Issues	☐ Men's Issues
☐ Social/Relationship	☐ Depression	☐ Physical Abuse	☐ Divorce
☐ Sexual	☐ Pre-Marital	☐ Crisis	☐ Addictive Behavior
☐ Alcohol/Drugs	☐ Anxiety	☐ Stress	☐ Financial
☐ Children	☐ Eating Disorders	☐ Grief	

☐ Other: _____

Please explain what makes these issues areas of concern for you: _____

_____

_____

_____

_____

Have you or are you currently seeing another professional for any of these or other issues? ☐ Yes ☐ No

If so, please give their name: _____

Who is your family physician? _____

Are you currently taking any medications? ☐ Yes ☐ No

If so, please list name of medication and reason for taking:

_____

_____

Is counseling court ordered? ☐ Yes ☐ No If yes, please give a brief reason below

_____

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Minor Intake Questionnaire

Date: _____

Child's Name: _____

Parent's Name: _____ Phone Number: _____

Address: _____

Child Information:

Child's Sex: ☐ Male ☐ Female Date of Birth: _____ Age: _____

School attending: _____ Teacher: _____

School Counselor: _____ Grade: _____

Has the child seen the School Counselor? ☐ Yes ☐ No Academic grades: _____

Does the child attend day care? ☐ Yes ☐ No If so, where? _____

Do you/your child attend church? ☐ Yes ☐ No If so, where? _____

Who has custody of the child? _____

In case of emergency, contact: _____

Parent Information:

Mother: _____ Home number: _____

Address (if different from child's): _____

Employer: _____ Work number: _____

Highest grade or degree earned: _____

Current marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Please list the number of times you have been: ___ Married ___ Separated ___ Divorced ___ Widowed

Father: _____ Home number: _____

Address (if different from child's): _____

Employer: _____ Work number: _____

Highest grade or degree earned: _____

Current marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Please list the number of times you have been: ___ Married ___ Separated ___ Divorced ___ Widowed

Stepmother: _____ Home number: _____

Address (if different from child's): _____

Employer: _____ Work number: _____

Highest grade or degree earned: _____

Current marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Please list the number of times you have been: ___ Married ___ Separated ___ Divorced ___ Widowed

Stepfather: _____ Home number: _____

Address (if different from child's): _____

Employer: _____ Work number: _____

Highest grade or degree earned: _____

Current marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Please list the number of times you have been: ___ Married ___ Separated ___ Divorced ___ Widowed

Please list all information regarding your children and dependents:

Name	Age	Gender	Living at home?
_____		☐ M ☐ F	☐ Yes ☐ No
_____		☐ M ☐ F	☐ Yes ☐ No
_____		☐ M ☐ F	☐ Yes ☐ No
_____		☐ M ☐ F	☐ Yes ☐ No

Describe your child's relationship with his/her siblings:

_____

_____

Please check any areas that may be of concern:

☐ Family	☐ Depression	☐ Problems at School	☐ Sadness
☐ Anxiety	☐ Sexual Issues	☐ Eating Disorder	☐ Excessive Fears
☐ Stress	☐ Sexual Abuse	☐ Weight Loss or Gain	☐ Mood Swings
☐ Nightmares	☐ Physical Abuse	☐ Dishonesty	☐ Poor Concentration
☐ Sleep Disturbance	☐ Obsessions	☐ Stealing	☐ Grief
☐ Social/Relationships	☐ Alcohol or Drugs	☐ Bursts of Anger	☐ Compulsions
☐ Physical or Medical issues			
☐ Other: _____			

What areas of concern do you have regarding your child?

_____

_____

_____

Please list any Medications your child is currently taking and the reason it was prescribed:

_____

_____

Please describe how Thrive can help you:

_____

_____

What hobbies and interests does your child have? _____

Has your child been to a counselor before? ☐ Yes ☐ No

If yes, what helped your child? _____

If yes, what did not help your child? _____

Informed Consent To Being Helped By A Thrive Helping Professional

Your Helping Professional will be professionally trained at the master's level or above in counseling. Some of the helping professionals are licensed with the state of Ohio. Some were or are licensed as professional counselors in states where they previously lived. Others may be pastoral counselors with degrees in not just theology, but also accredited counseling degree programs that have the ability to train people to be qualified to pursue professional state licensure.

Thrive Counseling and Coaching assists individuals in becoming whole in every facet of their lives. Toward this end, our Helping Professionals, while qualifying themselves professionally, remain involved in continuing education and supervision in an effort to become increasingly more effective in their areas of specialty. Our intent is to offer professional services that are both clinically sound and operate within our broad values of the Christian faith. As a result, we hope to develop a therapeutic relationship with you that will empower you to reach the goals that have brought you to us seeking growth. To facilitate this process in as efficient a manner as possible, we ask you to observe the following policies and procedures:

Payment of Fees: Payment is expected in full at the time of the counseling session. Any exceptions to this should be discussed prior to the first session. Checks should be made payable to **Thrive Counseling and Coaching.** If during the helping process, payment of fees becomes delinquent by two (2) sessions, no future appointments will be allowed until the bill is made current. If necessary, collection fees or legal fees associated with collection are different from our regular client fees and will be added to any bill.

Punctuality: Your prompt arrival at all appointments will insure that you receive the benefit of a full fifty (50) minute session.

Cancellations: Cancellations must be made a full twenty-four (24) hours prior to the scheduled appointment time. This gives us ample time to schedule someone else into that appointment slot. This is an important policy as it allows us to accommodate walk-in and emergency clients. **Failure to abide by this policy will result in the full fee being charged to you, payable at the time of your next scheduled appointment**.

Confidentiality: This is a strictly maintained policy in our helping services. Access to your file by those who are not directly related to your care is only permitted by your signed release of that information except for the following reasons:

1. If a client threatens bodily harm or death to another person, the Helping Professional may be required to inform the appropriate legal authorities.
2. If a client expresses what appears to be a serious intent to grievously harm themselves, it may be necessary for the Helping Professional to reveal this information to persons authorized to respond to such emergencies in order to protect the client from harm.
3. If a court of law issues a legitimate subpoena, a Helping Professional is required to provide the information that is requested in the subpoena
4. If a client is being evaluated or treated by order of a court of law, the results of the evaluation or treatment ordered must be revealed to the court.
5. If a Helping Professional has good reason to suspect that a child is a victim of physical or sexual abuse or neglect, they must inform the Department of Human Services.
6. If a Helping Professional has good reason to suspect physical or sexual abuse or neglect of an elderly person, they must inform the Department of Human Services.

Helping Professional/Client Ethics: The policy of Thrive Counseling and Coaching discourages the socialization between the Helping Professional and their clients for the duration of the counseling relationship. Clients are encouraged to meet their social support needs through a personal support network or other recommended groups.

Phone Calls: For the duration of the helping relationship, related out of session phone calls or emergency calls should be directed through the Thrive Counseling and Coaching center's main phone number. Please avoid calling the Helping Professional's private number for Thrive related discussions.

Use of Alcohol/Mind Altering Drugs: We ask that no alcohol or mind-altering drugs be used at least twenty-four (24) hours prior to a scheduled counseling appointment. If the Helping Professional has any reason to suspect that the client is under chemical influence, they may, at their discretion, terminate the appointment. **No refund of fees will be given in such cases.**

By my signature below, I attest that I have read and understood the above information and that I consent to and authorize Thrive Counseling and Coaching to provide me with helping services. By my signature I also agree to release, indemnify and hold harmless the Thrive Counseling and Coaching and its related legal entity of Quest Community Church, the Helping Professionals, and their supervisors from liability for damages, distress or any claims as a result of seeing a Helping Professional from Thrive Counseling and Coaching. I also agree to abide by the cancellation policy, understanding that I will be charged for all appointments I miss without prior 24-hour cancellation.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

Notice of Privacy Practices

THIS NOTICE DECRIBES HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE READ CAREFULLY!**

INTRODUCTION

This notice describes the privacy practices of THRIVE COUNSELING AND COACHING (hereinafter referred to as TCC). This notice applies to all of the health records that identify you and the care you receive from us. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

PRIVACY AND THE LAWS

We are required to give you this Notice of Privacy Policy because of federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPPA). We will follow the terms of the Notice while it is in effect and inform you of any changes. At TCC we believe that your mental health information is personal. We keep records of the care and services that you receive at our facility. We are committed to keeping your mental health information private, and we are also required by law to respect your confidentiality.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your clinical record, all employees, staff and other personnel at the practice who may need access to your information must abide by this Notice of Privacy Practices. All businesses associates such as our billing electronic claims submission service and credit card submission for this practice may share information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

PROTECTED HEALTH INFORMATION (PHI)

Any information we collect regarding your physical or mental health is called Protected Health Information (PHI). This may include the intake assessment, counseling session, psychological testing, records requested from other treating professionals and payment for your care. All of this information comprises your clinical record, which may be stored as paper charts and files, computer and electronic data. The Clinical record is the property of TCC but the PHI in the clinical record belongs to you.

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use. This is when your information is read by your counselor or other approved TCC personnel for routine purposes (i.e.: insurance billing)

Disclosure. This is when your information is shared with or sent to others outside of TCC.

Consent Form. By law, we may not treat you, unless you give us written authorization to use your PHI for the purposes of treatment, payment and healthcare operations. We may use and disclose this information without your specific consent.

Treatment. We may use and disclose your PHI to provide, coordinate or manage your mental health care and related services. For example, if we consult with other health care providers regarding your treatment with us, or if we refer you to another professional such as a physician or psychiatrist, for additional services.

Payment. We may use and disclose your PHI to bill you, your insurance provider or others, to be paid for the treatment we provide you. We may contact your insurance company to check exactly what your insurance covers. They may request information from us such as dates of services, your diagnosis, treatment received and planned and progress made. We may also disclose limited PHI to consumer reporting agencies relating to collections of payments owed to us.

Mental Health Care Operations. We may use and disclose your PHI for mental health care operations to ensure that you receive quality care. For example, to review our treatment and services and to evaluate the performance of our staff as it relates to your care.

APPOINTMENT REMINDERS, TEST RESULTS AND TREATMENT INFORMATION

TCC may contact you to provide appointment reminders, test results or to give you information about other treatments or health-related services that may be of interest to you. Ways we may contact you include, but are not limited to voice mail messages, postcards, letters and e-mail unless you direct us otherwise, in writing.

OTHER USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

The law lets us use and disclose some of your PHI without your consent or authorization. **When required by law**. There are some federal, state or local laws, which require us to disclose PHI. By law we are required to report:

- Suspected child and elder abuse or neglect
- Abuse and neglect of an incompetent adult (such as a severely mentally retarded adult)
- Incidents of domestic violence

If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request or other lawful process, we may have to release some of your PHI. We will only due so after attempting to inform you of the request, consulting your lawyer or trying to get a court order to protect the information requested. We have to release information to the government agencies with check on us to see that we are obeying the privacy laws. **For Law Enforcement Purposes.** We may release PHI if asked to do so by a law enforcement official to

investigate a crime or criminal. **For Public Health Activities.** We may disclose PHO to agencies which investigate for the purposes related to preventing or controlling disease, injury or disability. **Relating to descendants.** We may disclose PHI to coroners, medical examiners or funeral directors and to organizations relating to organ, eye, or tissue donations or transplants. **For specific government functions.** We may disclose PHI of military personnel and veterans to government benefit programs relating to eligibility and enrollment, to worker's compensation programs, to correctional facilities if you are an inmate, and for national security reasons. **To prevent a serious threat to health and safety.** If we believe that there is a serious threat to your health and safety, or that another person, or the public, we can disclose some of your PHI. We will only do this to persons who can prevent the danger.

USES AND DISCLOSURES TO WHICH YOU HAVE AN OPPORTUNITY TO OBJECT

We may share your PHI with your family or others involved in your care such as close friends or clergy. You may inform us as to whom you wish us to contact and the limits of what we may share. We will honor your wishes as long as your request is not against the law. In an emergency we may share information if we believe it is what you would have wanted and is in your best interest. We will tell you as soon as possible of the action we have taken. We will discontinue such action at your request as long as it is not against the law.

YOUR PERSONAL HEALTH INFORMATION RIGHTS

Right to Request Restrictions. You may submit a written request indicating the PHI you wish to restrict or limit being disclosed. We are not required to agree with your request.

Right to a Accounting of Disclosures. When we disclose your PHI we keep records of to whom it was sent, when and what was sent. You may submit a written request for a list of these disclosures. You must state the time period of disclosures you are requesting that is not longer than 6 years and may not include dates before April 14, 2003.

Right to Amend. You may request in writing and amendment to your PHI that is incorrect or incomplete indicating a reason that supports your request. If we deny your request you have the right to file a statement of disagreement with TCC. Such statements and our rebuttal with be kept on the file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to Inspect and Copy. You may make a written request to inspect and copy your PHI. We may deny your request in limited circumstances, including psychotherapy notes, information for use in civil, criminal and administrative action and PHI to which access is prohibited by law. If we deny access you may request the denial be reviewed by another licensed mental health professional TCC reserves the right to charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Confidential Communication. You may specify, in writing, how or where you wish to be contacted by TCC regarding the confidential communication of your PHI. You do not need to give us a reason for such a request. We will accommodate all reasonable request, but reserve the right to deny those that impose an unreasonable burden on the practice.

Right to a Paper Copy of this Notice. If you have agreed to receive this Notice of our Privacy Practices electronically, you may request a paper copy.

USES AND DISCLOSURES WHICH YOU AUTHORIZE

If you need more information or have questions about the privacy practices described in this brochure, please speak to the Privacy Officer whose name and telephone number appears on below. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a complaint with TCC and with the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care here or take any actions against you if you complain.

US Department of Health and Human Services
23 Michigan Avenue, Suite 240
Chicago, IL 60601
312.886.2359

Office for Civil Rights
Department of Health and Human Services
Mail Stop Room 506F
Hubert H Humphrey Building
200 Independence Avenue SW
Washington, DC 20201
202.205.8725

Thrive Counseling and Coaching
4901 Central College Road
Westerville, OH 43081

Effective September 1, 2006

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This is to acknowledge that I have read Thrive counseling and coaching's *Notice of Privacy Practices* (effective September 1,2006) on the date below and can request a coy to take with me if I would like to do so.

Signature of patient or personal representative

Date of patient's or personal representative's signature

Patient's name (Please Print)

Street address (Please Print)

City State Zip Code

Signature of patient or personal representative

Name of Personal Representative (if applicable)

Description of representative's authority to act for the patient (If applicable)

Release of Information

(PLEASE PRINT)
Client's Name:_____ D.O.B. ___/___/___
(First) (Middle) (Last)

Regarding the use or disclosure of protected health information about me, I hereby grant my permission for THRIVE COUNSELING AND COACHING/_____ to:
(Professional's Name/Credential)

☐ Release information to and/or ☐ Receive information from:

Name of Agency and/or Individual: _____

Contact Information of Agency/Individual: _____

INFORMATION TO BE DISCLOSED:
☐ Clinical Diagnosis ☐ Drug/Alcohol Information ☐ Educational Information ☐ Individual Treatment Plan
☐ Initial Evaluation ☐ Psychiatric Evaluation ☐ Psychological Testing ☐ Other _____
☐ Psychosocial Summary ☐ Clinical Diagnosis

FOR THE PURPOSE OF:
☐ Clinical Diagnosis ☐ Psychological Evaluation ☐ Continuity of Treatment ☐ Other_____

I UNDERSTAND:
1. That the information used or disclosed may be subject to redisclosure by the agency or individual receiving it and no longer protected by federal privacy regulations. However, this information will not be re-released by THRIVE COUNSELING AND COACHING without my written consent.
2. That I may withdraw or refuse this consent, in writing any time. However, if I revoke this authorization it will not have any effect on actions taken by THRIVE COUNSELING AND COACHING in reliance on it before revocation.
3. If drug and/or alcohol abuse information has been disclosed, I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
4. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

THIS AUTHORIZATION WILL EXPIRE:
☐ When received ☐ On ___/___/___ ☐ Other_____

Client/Parent/Guardian/Authorized Representative Signature: _____ Date:_____

Parent/Guardian/Authorized Representative Printed Name: _____ (if applicable)

Representative's authority to act on behalf of client: _____ (if applicable)

Witness Signature: _____ Date:_____