PROFESSIONAL PASTORAL-COUNSELING INSTITUTE, INC.

INITIAL INFORMATION

Instructions: This confidential information form is for the use of your counselor. Complete it as carefully as you can. Be sure to complete ***both*** sides. **PLEASE PRINT**

DATE _____ **How did you learn about PPI?** _____

IDENTIFICATION DATA *please indicate whether we may communicate with you through the following:* ☐ Yes ☐ No

Your name _____ Preferred Phone #_____ Gender _____

Address _____ Alternate Phone # _____ Age _____

City _____ Email _____

State_____ Zip Code _____ Occupation _____

Birth Date _____ CompanyName_____

INSURANCE INFORMATION

Do we have your permission to file claims, treatment plans and have contact with your insurance? ☐ Yes ☐ No

If yes, please provide a copy of your current insurance card, and **sign here** ➔ _____

EDUCATION TRAINING ***(highest level)***

_____

EMERGENCY CONTACT

Name of Contact _____

Phone Number of Contact _____

Relationship _____

Permission to contact in an emergency ☐ Yes ☐ No

HEALTH INFORMATION

Physician _____ Physician Phone # _____

Date of Last Medical Exam _____

How is your physical health at present? Poor Fair Satisfactory Good Excellent (circle one)

How is your sleep? Too much Too little Poor quality Bad dreams Fine (circle one)

Please list any persistent physical symptoms or health concerns (e.g chronic pain, headaches, diabetes, etc.)

_____

_____

Please list any prescribed medications you are presently taking. Who is the prescribing physician?

_____

_____

Do you use tobacco products? Yes No

Do you regularly use alcohol? Yes No

Do you engage in recreational drug use? Yes No

Have you had previous counseling or psychotherapy? Yes No Name of Counselor _____

Reason for previous counseling _____

RELIGIOUS / SPIRITUAL BACKGROUND

Religious or Spiritual Preference _____

RELATIONSHIP INFORMATION

Relationship Status *(circle)* Single Married Committed relationship Divorced Widowed Remarried
Date of *Current Marriage* _____
Name of Spouse/Partner_____ Address _____
Current Age _____ Preferred Phone #_____
Education _____ Occupation _____
Company Name _____

Previous marriages:

Date of Marriage	Date Ended	How Ended

INFORMATION ABOUT CHILDREN

NAME	AGE	LIVING?	MARITAL STATUS
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D

FAMILY OF ORIGIN

Were you raised by your birth parents? Yes ☐ No ☐
Were your parents divorced? Yes ☐ No ☐ If yes, how old were you? _____
Your age when Mother remarried _____ Your age when Father remarried _____
Rate your parents marriage: (Unhappy) 1 2 3 4 5 6 7 8 9 10 (Happy)

Parents or Parental Figures

NAME	AGE	LIVING?	MARITAL STATUS
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D

Brothers and Sisters in Birth Order

NAME	AGE	LIVING?	MARITAL STATUS
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D
		Y N	S M W D

PROFESSIONAL PASTORAL-COUNSELING INSTITUTE, INC.
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513-791-5990

I. PROFESSIONAL CLINICAL SERVICE

P.P.I. offers individual, couple, family and group counseling and psychotherapy under the professional supervision of Richard Donnenwirth, Professional Clinical Counselor; Florence DeWitt, Professional Clinical Counselor; Nancy Fox, Psychologist; Sandra Morgenthal, Professional Clinical Counselor or Julie Tiemeier, Professional Clinical Counselor. Supervisors have ultimate responsibility for the professional service, therefore either your therapist or one of these names will appear on all correspondence, financial statements and insurance forms. Other members of our staff who may participate in group supervision include Psychologists William Cahalan and Marshal Compton, M. Harvey Sticklin, Professional Clinical Counselor, and Professional Counselors J. Clark Echols, Jr., Judy Kroger, William Jones, Rosalie Laurenti, Mary LeGouellec and Chloe Davis.

All therapists are expected to maintain appropriate professional boundaries at all times. Any client having a question concerning this is encouraged to discuss the matter with the therapist. If not satisfactorily resolved, one of the supervisors should be contacted.

II. SCHEDULE OF FEES

A. Usual and customary rate is $110.00 per session. An annual administrative paperwork fee of $20.00 will also be charged, except for Medicaid clients.
B. Sliding fee scale is available for clients with no insurance and financial hardship.
C. **Cancellations without 24 hour notice and "no shows" will be charged the regular fee, which is not insurance reimbursable.**
D. If your health insurance provides benefits for outpatient psychotherapy by a Licensed Professional Clinical Counselor, Psychologist or Licensed Professional Counselor PPI will be happy to assist you in filing for reimbursement within 60 days of the date of service; however, we will **not backdate filings**.
Remember your insurance is a contract between you, your employer and the insurance company.
All inquiries about pre-authorization, benefits, coverage, etc. are the client's responsibility.
E. **Payment is expected at the time of service and clients have ultimate responsibility for their account including making sure insurance payment is received if filing.**
F. Any long term unpaid balances will result in termination of counseling. If account was not paid and had to be written off for bad debts, client will not be allowed to resume counseling.
G. Any refunds due client at the end of counseling that are unable to be paid due to incorrect mailing address, moved with no forwarding address, etc. will be considered donations to PPI.

III. COMMUNICATION PROCEDURE

A. Office Staff is available Monday through Thursday, 8:00 a.m.-5:00 p.m. Therapists' hours include evenings, Fridays and Saturdays.
B. **Phone messages are more quickly responded to if left in the therapist voice mailbox system.**
An answering service is available 24 hours per day, seven days a week for emergencies.
C. In an emergency, if the primary therapist is not immediately available, another PPI therapist is always on call.

IV. CONFIDENTIALITY

Professional services at PPI carry the same guarantees of confidentiality as a physician-patient relationship. Privileged communications will be respected within the boundaries of the law of the State of Ohio and the Federal HIPAA regulations, which would include reporting child and elder abuse, as well as mandatory response to a court order.

Client agrees to contact between their PPI therapist and their Primary Care Physician (PCP.) (*please circle)* **NO YES**
_____ (name of Physician)

I have read and understand all aspects of the procedures, fee schedule, cancellation policy and privacy practice notice as stated and give my permission for treatment.

_____ _____
Client Signature and Date **Therapist Signature and Date**