PROFESSIONAL PASTORAL-COUNSELING INSTITUTE, INC.

INITIAL INFORMATION FOR CHILDREN

Date _____

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

WHO AM I

Your name _____ Address _____ City _____ State _____ Zip Code _____ Telephone _____

School _____ Grade _____ Sex ___

Birth Date _____ Age ____ Height _____ Weight _____

RELATIONSHIPS

My Family:	Name	Age	Live with me	
1)			YES	NO
2)			YES	NO
3)			YES	NO
4)			YES	NO
5)			YES	NO
6)			YES	NO
7)			YES	NO
8)			YES	NO

Best Friends:	Name	Age
1)		
2)		
3)		

Pets:	Name	What Kind?
1)		
2)		

Put a (√) check mark before the three that you feel closest to.

CHECKING IN Check the words that apply to you.

_____ Exercise regularly	_____ Like to read	_____ Feel worried
_____ Play sports	_____ Sleep late	_____ Feel afraid
_____ Make friends easily	_____ Wet the bed	_____ Headaches
_____ Like to spend time alone	_____ Feel angry	_____ Stomachaches
_____ Don't miss much school	_____ Feel sad	_____ Allergies
_____ Trouble going to sleep	_____ Frequent waking up	_____ Argue alot
_____ Been sick alot	_____ Feel great most of the time	

FAITH/BELIEFS

Do you go to church? Yes No
If so, where?_____ What do you like about it? _____ Do you have friends at church? Yes No

FAMILY

Put a (/)check in front of the words that best describe your family and your home.

_____	Happy	_____	Close	_____	Distant
_____	Confused	_____	Busy	_____	Angry
_____	Help each other	_____	Hurt each other	_____	Funny
_____	Playful	_____	Disagree		

PEOPLE WHO I TRUST AND TALK TO:

	Name	How Long Have You Known Them
1)	_____	
2)	_____	
3)	_____	

Why did I come here? _____
_____
_____
_____

The following information is to be completed by parent or guardian .

Permission to treat:

Permission is hereby given to _____ to evaluate by psychological testing and/or treatment services to _____ whose relationship to me is _____.

_____
(Signature or Responsible party)

Date _____ **Witness**_____

Insurance Information:

Responsible Party Name _____ Address _____
City_____ State _____ Zip Code _____ Telephone _____

Insurance Co. _____ I.D. # _____Group # _____
Policy Holder Name _____
Please sign for permission to file insurance claim. _____

PROFESSIONAL PASTORAL-COUNSELING INSTITUTE, INC.
8035 Hosbrook Road, Suite 300, Cincinnati, Ohio 45236
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, Professional Clinical Counselors M. Harvey Sticklin and Stephanie Tunison; Professional Counselors, J. Clark Echols, Jr., Judy Kroger, Rosalie Laurenti, Mary LeGouellec, Chloe Davis, Elizabeth (Jill) Croswell and Gianluca Bruno, Licensed Independent Social Worker, Richard Kasper; Rosa Reyes-Santana, Licensed Independent Social Worker; Darcy Jack, Professional Counselor and Brian Davis, Professional Clinical Counselor.

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. FEES and PAYMENT

A. Our fee per session is $110.00. An annual administrative fee of $20 will also be charged, except for government insurance clients.

B. If your health insurance provides benefits for outpatient psychotherapy by a Psychologist, Licensed Professional Clinical Counselor, Licensed Professional Counselor or Licensed Social Worker, PPI will file your insurance claim for you. However, because insurance benefits involve a contract between you and your employer and your insurance company, all inquiries about pre-authorization, benefits, coverage, etc., are ultimately your responsibility. We will file claims within 60 days of date of service and are not able to backdate claims beyond that time.

C. Payment of the session fee or co-pay is due on the day of treatment. Cash check or credit card payments are accepted at the office window upon arrival.

D. **Cancellations without 24-hour notice and missed appointments will be charged the session fee of $110 and are not reimbursable by insurance.**

E. Balances of $300 or more require payment before further sessions may be scheduled. Any long-term outstanding balances must be paid before counseling can resume.

F. A sliding fee scale is available for clients with no insurance and financial hardship.

G. Refunds due clients at the end of counseling that are unable to be returned due to incorrect mailing address, no forwarding address, etc. will be considered donations to PPI.

III. COMMUNICATION PROCEDURE

A. Office Staff is available Monday through Friday, 8:00 a.m.-4:00 p.m. Therapists' hours include evenings, 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**