

PROFESSIONAL PASTORAL-COUNSELING INSTITUTE, INC.

INITIAL INFORMATION FOR YOUNG ADULTS

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 _____ Employment _____
Sex _____ Birth Date _____ Age _____ Height _____ Weight _____ SSN# _____

HEALTH INFORMATION

Any medical illnesses? _____ Allergies _____
Sensitivity to Drugs _____ Physician _____
Are you currently taking medication? _____ If yes, please name _____
Do you smoke? _____ If yes, how much _____ Current or previous use of alcohol
or drugs? _____ If yes, when and how much? _____
Are you sexually active? _____ If yes, do you use protection? _____

RELATIONSHIPS

FAMILY:

Table with 4 columns: Name, Age, Live with me (YES/NO), How well get along with? (1-5). Rows 1-8.

(1 is the least to 5 being the most)

CLOSE FRIENDS:

Table with 3 columns: Name, Age, Can trust & talk openly with them? (Yes/No). Rows 1-3.

Do you consider yourself part of a group? _____ Make friends easily? _____

My strengths are:

- 1) _____
- 2) _____
- 3) _____

My weaknesses are:

- 1) _____
- 2) _____
- 3) _____

My Interests are:

Faith / Beliefs

Do you attend church? _____ If yes, where? _____

Has your faith in God helped you to be a more effective family member, student, friend? _____

If yes, how? _____

Feelings / Emotions

Put a (✓) check in front of each word that applies to you:

- | | | | |
|------------------------|----------------------|--------------------------|-----------------------|
| _____ Anxious, worried | _____ Depressed, sad | _____ Change in appetite | _____ Frequently sick |
| _____ Happy | _____ Frightened | _____ Trouble sleeping | _____ Lonely |
| _____ Stressed | _____ Motivated | _____ Angry a lot | _____ Pressured |

Reason for coming to PPI? _____

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