Touchstone Counseling
Services
1625 Bethel Road, Suite 103
Columbus, Ohio 43220

Today's Date ____________________ Therapist______________________

This questionnaire is to obtain current and background information important to your therapy, and to obtain billing information.

Information about you

Name____ Date of Birth____________Age_____

Marital Status (circle one): Single Married Divorced Widowed

Social Security Number __________________________ Sex: ___Male ___Female

Telephone: Home__________________ Work ___________________ Cell_________________

May we leave a message? Y N May we leave a message? Y N May we leave a message? Y N

Street Address ____

City _____________________________________ State___________Zip Code____________

Occupation____________________________ Employer_______________________________

Years of Education Completed_________ Diploma/Degree ______________________________

Contact Person in case of emergency____

Contact Person's phone number______________________ Relationship to you_____________

Are you now seeing another therapist? ___ Yes ___No

If yes, please specify: ___Individual ___Couple ___Family ___Group

If yes, please give the name of the therapist_________________________________

Have you had counseling in the past? ___Yes ___No If yes, please specify:

Date	Type (Individual, couple, etc.)	Reason for Termination
_______	_______________________	_____________________
_______	_______________________	_____________________
_______	_______________________	_____________________

Are you presently on any medication? ___Yes ___No If yes, please list: _____________

____

Name of your physician/psychiatrist ____

Information about (check one): your [ ] spouse or [ ] partner

Name______________________________ Date of Birth______________ Age__________

Sex: ___Male ___Female Occupation______________________________

Employer____

Years of Education Completed__________ Diploma/Degree ______________________________

Number of years together ________ We are now living ___together ___apart

Information about the children

List each child, their age and sex, and indicate if the child is yours (Y), your partner's (P), or both of yours (B), and if the child is living with you.

Name	Age	Sex	Y	P	B	Living with You Yes	Living with You No

Information about others

List anyone else living in your home and their relationship to you.

Name	Relationship to You

Referral Information

Who referred you to Touchstone? ____

May we thank them? ____Yes ____No

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STATEMENT OF UNDERSTANDING

Touchstone Counseling Services (TCS) provides counseling, psychotherapy, assessment, consultation, training, and education services to adults, adolescents, children, and families. Our services are open to clients regardless of ethnic origin, creed, gender, age, or sexual orientation.

CONFIDENTIALITY AND YOUR BASIC RIGHTS AS A CLIENT: You have a basic right to treatment where your problems are dealt with in a confidential manner and with respect and dignity. No information about you or your therapy will be revealed to anyone outside TCS unless (l) you give consent in writing, (2) the law requires (such disclosure is generally limited to the event of suspected child abuse or serious threat to your own or another's life or safety), or (3) as otherwise specified in the TCS Notice of Privacy Practices. Parents/guardians provide the written the consent for minors (individual under the age of 18). The Notice of Privacy Practices is posted in the lobby; you may obtain a copy of this notice by requesting it from your therapist.

FEES AND PAYMENTS: Payment in full is expected at each session unless prior arrangements have been established before your visit by you and your therapist. All co-payments must be paid at the time of service. The standard fees are as follows: initial assessment session $135.00; counseling session (45-50 Min.) $100.00; abbreviated counseling session (20-25 Min.) $50.00; form completion and letter preparation $50.00 per hour. Record copying/forwarding requests are charged in accordance with the State of Ohio guidelines. Checks returned for non-payment are subject to a $25.00 charge. If finances become an issue, we ask that you discuss this with your therapist before your visit. Outstanding or delinquent accounts may be sent for review with a collection agency or attorney; this review may result in further action.

CANCELLATION POLICY AND CHARGE: 24 hours notice is required to cancel a scheduled appointment. If the office is closed, we ask that you leave a voice-mail message for your therapist. If you do not keep or you cancel your appointment as outlined above, you will be charged the full counseling session fee. Please understand that insurance companies will not cover this fee.

FOLLOW-UP AFTER A MISSED OR CANCELLED APPOINTMENT:
If you do not contact your therapist within fourteen days of a cancelled or non-kept appointment, we will assume that you do not wish to continue therapy at that time and your file will be closed. Contact with your therapist would be required to resume counseling services.

I have read and understand this document and I consent to treatment under its terms.

______________________ ______________________ ____________
NAME (PLEASE PRINT) SIGNATURE DATE

______________________ ____________
WITNESS SIGNATURE DATE

BILLING AND INSURANCE: Unless TCS is billing your insurance, full payment of the fee for services you receive is your responsibility and due at the time of service. If you wish TCS to file your insurance please complete the following releases:

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary to bill my insurance company or other third party payer for services rendered by TCS. This authorization will remain valid until termination of care and the closing of your account. At any time, I may terminate this release by forwarding a request in writing to TCS and no information will be released after that date.

SIGNATURE______________________________ DATE ____________

Release of Payment: I authorize payment of medical benefits to TCS or provider for services rendered. This authorization will remain valid until termination of care and the closing of your account unless written notice is received requesting discontinuation of payment to TCS.

SIGNATURE______________________________ DATE____________

Updated 03/24/2011

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Today's Date____________________

Client Name____________________________________ Date of Birth____________________

[ ] Private Pay [ ] Insurance [ ] Other (specify) __________________________

INSURANCE INFORMATION

Primary Insurance Subscriber (the person who holds the policy) Information

Name________________________________ Social Security Number ______________________

Date of Birth__________________ Employer____

Street Address (if different than Client) ____

City ______________________________________ State___________ Zip Code_____________

Telephone: Work__________________ Home ____________________ Cell_________________

Secondary Insurance Subscriber (the person who holds the policy) Information (complete this section ONLY when there is a second insurance policy involved):

Name________________________________ Social Security Number ______________________

Date of Birth__________________ Employer____

Street Address (if different than Client) ____

City ______________________________________ State___________ Zip Code_____________

Telephone: Work__________________ Home ____________________ Cell_________________

If you are using insurance, we will need a copy of the front and back of your insurance card(s).