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 child's therapy.

Personal Data of Child

Child's Name_____ Date of Birth_____

Child's Street Address _____

City_____ State_____ Zip _____ Home Phone _____

School_____ Grade_____ School Phone_____

If parents are divorced, who has legal custody? _____

Personal Data of Parent 1

Parent's Name_____ Date of Birth _____

Street Address (if different than child's) _____

City_____ State_____ Zip _____ Home Phone_____

Employer_____ Work Phone _____

Social Security Number _____ Marital Status_____ Years of Education _____

Please list names and ages of other children living in this home _____

_____

Personal Data of Parent 2

Parent's Name_____ Date of Birth_____

Street Address (if different than child's) _____

City_____ State_____ Zip _____ Home Phone_____

Employer_____ Work Phone _____

Social Security Number _____ Marital Status_____ Years of Education _____

Emergency Contact Information

Name of Person to contact in case of emergency _____

Phone Number _____ Relationship to Client _____

Therapy History

Currently is anyone in your home seeing a therapist (including your child)? ____Yes ____No

If yes, who is in therapy? _____ For what reason_____

Please give name of the therapist _____

In the past has anyone in your home had counseling (including your child)? ____Yes ____No

If yes, who was in therapy? _____ For what reason_____

Please give name of the therapist _____

Medical History

Is your child presently on any medication? ____Yes ____No

If yes, please list medications_____

Does your child currently have any medical conditions? ____Yes ____No

If yes, what is the treatment? _____

Has your child been treated for significant health problems in the past? ____Yes ____No

If yes, please list health problems and treatments _____

_____

Your child's physician _____Telephone _____

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 (I) 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_____

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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).