Compass Point

ADULT REGISTRATION & ASSESMENT

Welcome to Compass Point Counseling Services. This new client packet contains all of your paperwork for both the front office registration and a clinical assessment that will ultimately help your clinician better serve you. Please take the time to fill out everything completely and to the best of your ability. We request that the entirety of this packet be completed *before* arriving at your appointment time to ensure that filling it out does not cut into your first session.

Here at Compass Point we respect your privacy and confidentiality and are HIPAA compliant. To read more about HIPAA and how it helps us serve you, you can review the policy on our website under printable forms and titled "Notice of Privacy Practices."

If you would like us to speak with your Primary Care Physicians, Psychiatrist, Therapist, or anyone besides the client, we will need you to print a release of information for each person in addition to this packet. You can find our release of information on our website under "printable forms."

Compass Point

ADULT REGISTRATION & ASSESMENT

FULL NAME _____ BIRTH DATE _____ GENDER _____
FIRST MI LAST

SS# _____ ADDRESS _____
STREET/APT CITY STATE ZIP CODE

HOME PHONE_____ CELL PHONE_____ EMAIL _____

*is it okay to call or leave a message at home? ☐ Yes ☐ No *is it okay to send email? ☐ Yes ☐ No

*is it okay to call or leave a message on your cell? ☐ Yes ☐ No *is it okay to send text message? ☐ Yes ☐ No

EMPLOYER _____ WORK PHONE _____ *is it okay to call at work? ☐ Yes ☐ No

INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____ DOB _____
FIRST MI LAST

_____
STREET/APT CITY STATE ZIP CODE

SS#_____ NAME OF EMPLOYER_____ EFFECTIVE DATE _____

INSURANCE COMPANY _____ MEMBER ID# _____

GROUP #_____ PROVIDER SERVICE PHONE (Located on back side of card) _____

Does the client have any additional insurance? ☐ NO ☐ YES, please complete the following:

NAME OF INSURED_____ RELATIONSHIP TO CLIENT_____ DOB _____
FIRST MI LAST

_____
STREET/APT CITY STATE ZIP CODE

SS# _____ NAME OF EMPLOYER_____ EFFECTIVE DATE _____

INSURANCE COMPANY _____ MEMBER ID# _____

GROUP #_____ PROVIDER SERVICE PHONE (Located on back side of card) _____

If you have two insurance carriers you will need to notify both plans so they are able to coordinate benefits. Without this your claims may be held.

ADDITIONAL INFORMATION

How did you learn about us? (If online, did you use a search engine?) _____

Name and phone number of person to be contacted in case of emergency:

Name_____ Phone number _____ Relationship _____

Name of Primary Care Physician _____ Phone_____ Date of Last Visit _____

Name of Psychiatrist_____Phone_____ Date of Last Visit _____

CLIENT NAME _____ DATE _____

HEALTH HISTORY

Do you have any physical impairments or limitations which may require special accommodations, special arrangements or may affect your treatment? (i.e. reading difficulties, hearing loss, speech impairment, etc)

☐ No ☐ Yes , _____

Please list your current: _____ Height _____ Weight

List any medication that you are currently taken, the amount and why you're taking it:

Briefly describe your reason for seeking counseling services:

How long has this been a problem? What have you done to resolve it?

What do you hope to accomplish in therapy:

Are you currently seeing any other therapist? ☐ NO ☐ YES, If yes who? _____

Please check any and ALL of the following areas in which are experiencing problems:

☐ Nervousness	☐ Depression	☐ Fears
☐ Shyness	☐ Sexual Problems	☐ Suicidal Thoughts/Attempts
☐ Separation	☐ Divorce	☐ Homicidal Thoughts
☐ Drug Use	☐ Alcohol Use	☐ Friends
☐ Anger	☐ Sleep	☐ Self-Control
☐ Unhappiness	☐ Stress	☐ Work
☐ Relaxation	☐ Headaches	☐ Tiredness
☐ Legal Matters	☐ Memory	☐ Grief/Loss
☐ Energy	☐ Making Decisions	☐ Spiritual Concerns
☐ Loneliness	☐ Inferiority Feelings	☐ Concentration
☐ Behaviors	☐ Health Problems	☐ Nightmares
☐ Defiant Behavior	☐ Appetite	☐ Bowel Troubles
☐ Stomach Discomfort	☐ Family of Origin Issues	☐ Abuse/Neglect
☐ Bed wetting/Soiling	☐ Thoughts	☐ Distractibility
☐ Weight	☐ Fighting	

Have you ever required hospitalization? If you have, please specify.

Regarding past treatment, what did you find most helpful and what did you find not particularly helpful:

Have any family members had problems with substance abuse or with mental/emotional problems? ☐ No ☐ Yes, _____

_____

Is there any history of physical, sexual or emotional abuse? If there is, please specify.

How would you describe the nutritional value of your diet: ☐ Good ☐ Fair ☐ Poor

Have you experienced weight changes in the past six months: ☐ No ☐ Yes

If yes, amount _____ ☐ Lost ☐ Gained

Have you experienced any significant appetite change over the past six months: ☐ Yes ☐ No

Tobacco product use: ☐ Current ☐ Past ☐ Never Used

If used , rate : _____

How many hours of sleep do you get per 24 hour period: _____

Are you having problems with your sexual functioning? ☐ No ☐ Yes , _____

Have you had any surgeries/accidents/conditions requiring hospitalization or same day surgery: ☐ No ☐ Yes, _____

_____

_____

_____

DAILY LIFE

Significant Life Events:

☐ Loss ☐ Divorce / Separation ☐ Moved/Moving ☐ Family Changes

☐ Frightening Past Incidence ☐ Serious Illness/Injury to Family or Friend ☐ Other, _____

List the people who live in your home:

NAME	AGE	RELATIONSHIP	NAME	AGE	RELATIONSHIP

CLIENT NAME _____ DATE _____

Please list any concerns you may have about family members: _____

_____

Describe involvement in activities outside of the home: _____

_____

Are you having issues with the following activities of daily living:

☐ Grooming/Hygiene ☐ Shopping ☐ Communication ☐ Homemaking

☐ Transportation ☐ Stress Management ☐ Mobility ☐ Time Management

☐ Cooking ☐ Leisure Skills ☐ Budgeting/Banking ☐ Child Care

Any spiritual/religious concerns that need consideration: ☐ No ☐ Yes, _____

Any cultural/ethnic/racial issues that need consideration: ☐ No ☐ Yes, _____

SUBSTANCE USE

Do you have any concern about your use of alcohol, prescription medication or other drugs? ☐ No ☐ Yes, describe _____

_____

Have others expressed concerns about your alcohol, prescription medications or other drugs? ☐ No ☐ Yes

Have you made the decision to cut down on or quit using alcohol or other drugs ? ☐ No ☐ Yes

Have you experienced any of the following in connection with your use of alcohol, prescription medications or other drug use?

☐ Financial Problems ☐ Increased Tolerance ☐ Emotional Problems ☐ Relationship Problems

☐ Blackouts ☐ Work Problems ☐ Cravings ☐ Withdrawal Symptoms

LEGAL HISTORY

Have you had any involvement with the legal system? ☐ No ☐ Yes, _____

Are you on probation or parole? ☐ No ☐ Yes, _____

Do you have any current/pending legal charges? ☐ No ☐ Yes, _____

Have you been incarcerated? ☐ No ☐ Yes, _____

Is there anything else you think we need to know about you?

_____

_____

CLIENT NAME _____ DATE _____

CONSENT TO TREATMENT

The undersigned, client/client's legal guardian, voluntarily consent to outpatient treatment for mental health, co-occurring, and/or substance use and authorize Compass Point Counseling Services (CPCS) to provide such outpatient treatment that is determined to be medically necessary or otherwise appropriate. These services may include individual or group counseling/therapy, Diagnostic Assessment, and Psychological Testing.

MEDICARE PAYMENT

I, the undersigned, certify that any information given by me in applying for payment under Title XVII of the Social Security Act is complete, accurate, and current. As a Medicare Beneficiary, I have the right to receive Medicare covered services. I acknowledge that I have the right to be involved in any decisions about my treatment and services and who will pay for them.

WAIVER OF LIABILITY FOR NON-APPROVED SERVICES

Ohio law requires CPCS to inform the undersigned that if your insurance company did not give prior approval for therapy services and you choose to have services provided, you would be required to pay for the services. My signature acknowledges I have read and understand the above. If my insurance company denies payment, I agree to be personally and fully responsible for the payment of all services incurred. These services include both formal and informal letters, appearances in court, reports, and extended phone calls.

EXPLANATION OF SERVICES

- We see clients Monday through Saturday.
- We share this suite with our colleagues and we provide ongoing supervision for each other.
- We provide Individual, Family and Group Counseling and are happy to discuss these options with you.
- If a crisis occurs when we are not in the office you may call our main number (513) 939-0300 and you will be directed as to how we may be reached.
- We make the assumption that you can change and grow, and that some of this change can occur within a relatively short period of time. We strive to do brief and effective treatment.
- Our fee is $120 per hour for a regular 45-55 minute session and $160 for the initial session for an LPCC/LISW, $180 per hour for a regular 45-55 minute session and $120 for the initial session for an LSW/LPC and $75 per session for a regular 30 minute session and $300 for the initial session for an MD
- Payment is expected at the time of service. You are responsible for the charges. If you are paying through your insurance, you are responsible for your co-pay or deductible at time of service and for any amount left unpaid by your insurance.
- Additional fees will be charged for letters, appearances in court, reports, no sow or late cancel charges and extended phone calls. These things are not covered by insurance. Your therapist will discuss any additional fee with you before it is charged.
- We view the therapeutic relationship as a partnership that is principally dedicated to your growth and to finding solutions. Part of our job is to remind you of your own strengths and abilities while you go about the business of creating more of the type of life that you want.
- As with nearly any type of treatment, there is the chance that it may not be helpful. The "fit" between client and therapist is important to good treatment outcome. In the beginning of treatment, you may feel worse before you feel better. Therefore, we want to hear from you throughout our work together about how we are doing – so that we can make any needed adjustments to help you more effectively.
- Information discussed within the therapy setting is held confidential and will not be shared without written permission except under limited situations which under reasonable circumstances would be discussed with you before disclosure is made. These situations include revelations of *unreported* child or elder abuse, imminent suicide or harm to others, or reports of exploitation by a therapist.

LATE CANCELLATIONS, MISSED APPOINTMENTS

I understand that I am required to provide at least 24 hours notice if I (or the client named below) are unable to keep a scheduled appointment. In the event that I do not provide 24 hours advance notice, I acknowledge that CPCS has the right to charge me for the scheduled appointment. If I fail to cancel a scheduled appointment, and do not come to set appointment at my (or the client's) scheduled appointment time, I understand that CPCS will charge me $50.00 for the scheduled appointment. I agree to pay CPCS $50.00 for late cancellation or missed appointment charges incurred.

RETURNED CHECK FEE: CPCS charges a fee for any check returned by my financial institution, regardless of reason. In such event, I agree to pay CPCS the returned check fee of up to $50.00.

DELINQUENT ACCOUNT: I understand that CPCS may turn my account over to a collection agency if I do not pay on a timely basis. CPCS has a separate collection policy, which will be provided to me if I ask for it. I also understand that if my account is sent to a collection agency a 35-50% surcharge will be applied to the balance by the collection agency.

ANCILLARY SERVICES

These are any extra services not covered by your insurance.

- Letter or Report writing- $150 per hour prorated. Payment is required prior to writing letter.
- Telephonic Services- $40 per 15 minute increments. Coaching calls will not apply
- Court Related Charges-Your therapist will not go to court voluntarily. Please understand that when your therapist goes to court other clients have to have their appointments canceled for the week. The Magistrate or Judge hearing your case must subpoena the therapist.
  - The office must receive a retainer cost of $500.00 prior to therapist blocking out their schedule to appear in court.
  - $150 per hour from portal to portal
  - Any additional charges over that will be billed to you following the hearing.
  - In the event the therapist believes that testifying in court would be detrimental to the therapy process the therapist may hire their own attorney to have the subpoena overruled. Any legal fees resulting from this action will be charged to the client that has requested the therapist's appearance.
- Testing- Prices for testing vary and are available upon request.
- Medical Record request: Prices are based on Ohio regulations and are subject to change
  - $18.61 initial fee for record search
  - $1.22 per page for the first 10 pages, then $0.63 per page 11 – 50, $0.26 per page 51 & higher
  - Actual cost of postage to send records

CLIENT NAME _____ DATE _____

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of services received or to be received, the undersigned requests that payment of authorized insurance benefits, including Medicare, if the client is a Medicare beneficiary, be made on the client's behalf to CPCS for any services provided to the client. It is my responsibility to notify CPCS of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined by CPCS and/or my mental health care insurer if the submitted claims or any part of them are denied for payment. The undersigned acknowledges that by signing this form I am accepting financial responsibility as explained above for all payment for services received.Compass Point Counseling Services appreciates the trust you have in choosing us to provide mental health care services to you, or a client of the office for whom you have responsibility. Our client-and family-centered treatment philosophy requires that we openly communicate our policies and expectations about payment for our services before treatment is initiated. Please take a moment to familiarize yourself with these policies.I acknowledge that I am financially responsible for all charges associated with mental health services provided by CPCS to me (or the client named below). I understand that payment for services is due at the time services are rendered unless special arrangements are made in advance.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance and/or EAP benefits. I also hereby authorize payment of insurance and/or EAP benefits otherwise payable to me directly to the therapist/CPCS.

AUTOMATIC BILLING OR PAY AT TIME OF SERVICE

Accounts with Compass Point Counseling Services may enroll to automatically have account balances billed to your credit card. If you wish to take advantage of this service please complete the lines below. By providing your billing information you acknowledge consent for us to automatically process charges to the credit card you have provided below.

We will **only** charge services rendered to your card. Your card will **NOT** be charged in the event that you are assessed a charge for canceling within 24 hours of an appointment or for not keeping a scheduled appointment. However, we do ask that you pay these charges in a timely manner.

I understand that I have given Compass Point Counseling Services permission to charge my credit card. I also understand that if my insurance applies any amount to my deductible or denies payment, the full amount of the visit will be billed to my credit card.

EMAIL REMINDERS

We can send you an appointment reminder by email. The appointment reminder will include only the date and time of your appointment and your clinician name. These emails are not encrypted. Health care information sent by regular e-mail could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, we need you to confirm you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

By providing your email you acknowledge consent for us to send you appointment reminders to the email you have provided below.

Part of our mission here at CPCS is to provide excellent training to upcoming professionals. All of our professionals in training work under the close supervision of qualified supervisors. We sometimes use audio/video recording for training purposes. Those present are made aware and always have the option to refuse. These recordings are used strictly for training purposes. Without exception, the staff at CPCS is trained in and expected to adhere to privacy practices. (Please check the appropriate box)

☐ I agree and consent to participate in supervised training sessions **with audio/video recordings** upon my permission.

☐ I agree and consent to participate in supervised training sessions **without audio/video recordings**.

☐ **I do not consent** to participate in supervised training sessions.

OTHER INFORMATION

I, the undersigned, agree to abide by CPCS's policies and procedures and recognize that my compliance will minimize the danger of accidents or injury to myself, other Clients and employees of CPCS. I, the undersigned, acknowledge responsibility for myself and my actions and liability arising or resulting from my actions/omissions while I am being treated at CPCS. I, the undersigned, acknowledge that CPCS is not responsible to me or my property for the actions/omissions or any liability arising from the actions/omissions of any other clients at CPCS.

☐ I read and understood the Client Responsibility agreement.

- ☐ Please bill all of my appointments to the insurance or EAP that I have provided you.
- ☐ I prefer to be billed for all appointments at the agreed upon private pay rate, whether or not I have insurance coverage.

☐ I read and understand the supervised training consent

☐ I read and understand the email reminders. Email: _____

☐ I read and understand the Credit Card Automatic Billing ***OR*** ☐I will pay the expected amount at the time of service

Client Name:_____ Cardholder Name:_____

Credit Card Number:_____ Expiration Date:_____ Security code:_____

I, the undersigned, understand that at any time I may elect to participate in other services or refuse any services, treatment or therapy upon full explanation of the expected consequences of such refusal

I have received a copy of the NOTICE OF PRIVACY PRACTICES (HIPPA) which includes the client's rights and grievance policy.

NAME	RELATIONSHIP TO CLIENT	DATE	SIGNATURE

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	