Sara Ridley Counseling Practice, LLC
15800 Detroit Rd. Lakewood, OH 44107
P: (440) 941-3285 || F: (440) 815-2189
sararidleylisw@gmail.com

Client Intake Form

Client Name: First _____ Mdl:_____ Last: _____

Address: _____ City: _____ State:_____ Zip: ___

Date of Birth: _____ Employer: _____

Phone- Home/Cell: _____ Work: _____

(circle preferred number to use) Consent to receive text messages- YES___ NO ___

Email: _____ Consent to receive emails- YES___ NO ___

Martial Status: _____ (Single, Married, Partnered, Widowed, Divorced, Separated) Gender: _____

Emergency Contact: _____ Phone: _____

Consent to contact in an emergency: YES___ NO ___ Initial____

Responsible Party Information: (Insurance Holder or Parent/Guardian of Minor Child):

SAME AS ABOVE- YES___ NO ___

Name: First _____ Mdl:_____ Last: _____

Address: _____ City: _____ State:_____ Zip: ___

Date of Birth: _____ Relationship to Client:_____

Phone- Home/Cell: _____ Work: _____

(circle preferred number for office to use) Consent to receive text messages- YES___ NO ___

Email: _____ Consent to receive emails- YES___ NO ___

Primary Care Physician- Name: _____ Phone: _____

Referral Information- Name: _____ Phone: _____

I am aware this is a HIPAA compliant office and have (circled one) received/declined a copy of the Practice Privacy statement (initial) _____

My signature indicates that I am in agreement with providing the above information.

_____ _____

Client/Guardian Signature Date

I allow Sara Ridley Counseling Practice, LLC to use my email address for billing statements and scheduling reminders from sararidleylisw@gmail.com I understand I am not to depend on these reminders that thare are being sent as a courtesy, and if a reminder is not received or sent it is not an excuse for not keeping an appointment. YES___ NO ___ Initial____

Office Policies

Thank you choosing Sara Ridley Counseling Practice, LLC. We are dedicated to working toward your goals and promoting positive mental health. The following Office Policies are to be read by the responsible party:

1. Sessions are made by appointment only. To make an appointment contact Sara Ridley, LISW. Phone calls are generally returned within 24 hours, Monday- Friday. You may choose to call, leave a voicemail, send a text message or an email regarding general scheduling concerns or to ask for a return call. Due to HIPAA concerns, please do not communicate any personal or sensitive information through these means of contact.
   Phone: (440) 941-3285 Email: sararidleylisw@gmail.com

If you are experiencing a mental health emergency, please call 911 or go to your local emergency room. DO NOT CALL the above number for an emergency, as calls are not always answered immediately.

2. Please provide 24 hours notice to cancel or reschedule an appointment using one of the above methods. If an appointment is cancelled without 24hrs notice there is a $25 late cancellation charge. If you do not show for a scheduled appointment there will be a $50 charge for the missed appointment. These penalty charges may be waived per discussion between client and clinician. Repeated late cancellations or missed appointments may also lead to termination of your case at Sara Ridley Counseling Practice, LLC.
3. The session fees are as follows: Initial Assessment: $150, 60 minute sessions and family counseling session: $120, and 45 minute session: $105. Self-pay fees are also accepted and are discussed and agreed to between client and clinician as needed. Fees are subject to change and you will be given at least 30 days of notice of any changes.
4. Payment is required at the time of service. Cash, check, and most major credit cards are accepted (including most HSA cards). (Checks should be made out to: Sara Ridley Counseling Practice, LLC)
5. We accept several insurance plans and can discuss the details of your particular plan. The client is responsible for any fees not covered by their insurance. Please note that any insurance quotes provided are an estimate based on information provided to us by the insurance company. We strongly encourage you to speak with your insurance company to fully understand your benefits as they apply to mental health services.
6. There are fees required for some letters to be sent out by this office. Those fees will be discussed between the client and clinician.
7. Please inform us of any changes to your basic information, including address, phone, email, and insurance.

Statement of Confidentiality

Any and all information and/or records that we have about you are kept in the strictest of confidence. Your confidentiality is protected by law and by standards of good practice. Under normal circumstances, we can release information about you only if you have completed, signed and dated "Release of Information" forms. Generally, we will tell no one what you tell us without your written consent, unless you are under the age 18, in which case, we will discuss the legal rights your parent(s)/ guardian(s) have to your records. **There are two primary circumstances in which we cannot guarantee confidentiality, legally or ethically:** (1) when we believe you intend to harm yourself or another person; and (2) when we believe a child or elder person has been or will be abused or neglected. In rare circumstances, a counselor

Office Policies

can be ordered by a judge to release information. Disclosure may be required by your health insurance carrier. Please see the HIPAA policy for more information.

Possible Risk of Treatment
As a consumer of psychotherapy you may experience some level of mood change or discomfort during the treatment process. This is a normal experience occurring within the process of mental health counseling. Please discuss any negative symptoms or concerns with your clinician.

Complaint Procedures
If you are not satisfied with any aspect of our work, please inform your therapist so that we can work with you to resolve the concern. If you think that you have been treated unfairly or unethically and cannot resolve this problem with the practice, you can contact:
Counselor, Social Worker & Marriage and Family Therapist Board
77 S High St., 24th Flr, Rm 2468 Columbus, Ohio 43215-6171
Telephone: (614) 466-0912 - Fax: (614) 728-7790

Treatment of Adults unable to exercise Rational Judgement or give Informed Consent
If an individual is seen for services who is unable to exercise rational judgement or give informed consent for services, the clinician will attempt to contact the individual's emergency contact person. If the emergency contact person is unavailable, contact to emergency services will occur, should the situation or circumstances arise.

Treatment of Minors
Written consent is required for any minor child receiving services. This consent is required and received by the office during the initial session with the minor child. If a minor child has a custody agreement between two parties: 1) The parent/guardian who signs and completes initial paperwork is determined as the responsible party; 2) The parent/guardian must provide a copy of the custody agreement to this office; 3) The parent/guardian must inform the other party of the services received by the minor child, as set forth by the custody agreement, if applicable.
****If you are a parent/guardian of a minor please provide your initials to indicate you have read and agree to this section (initial) _____**

Authorization to File Insurance/Financial Responsibility Statement
I authorize the release of information to secure insurance payments for the services provided. I assign all medical benefits, including any major medical benefits to which I am entitled including private insurance and other health plans to: Sara Ridley Counseling Practice, LLC. This authorization will remain in effect, unless revoked by the responsible party in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I have read, understand and am in agreement with the above information and office guidelines.

_____ _____
Client Signature Date
(or Guardian Signature if client is a minor)

_____
Print Name

Office Policies

As set forth by the state of Ohio Counselor, Social Work, Marriage and Family Therapist Board-

A Consumer's Bill of Rights

All consumers of services offered by licensed professionals of the State of Ohio Counselor, Social Worker & Marriage and Family Therapist Board (CSWMFT Board) have the legal right To:

- Receive competent professional services.
- Verify the credentials of licensed professionals and to know the names and titles of licensed professionals who provide service.
- Services that are respectful and sensitive to your cultural background.
- Clear explanations of the services being offered or provided and how much they cost.
- Refuse any services offered.
- Know what client records will be maintained and how to obtain copies; personally identifiable information normally cannot be revealed without the consumer's consent.
- File a complaint with the CSWMFT Board about a licensed professional or an unlicensed practitioner.
- Request and be provided reasonable accommodations to access professional services if you are a person with a disability.

You are encouraged to choose professionals who uphold the rights listed above and who also:

• Treat you with courtesy and respect.
• Explain your service options, including their consequences and any follow-up services which may be required or recommended.

For answers to questions about these rights and for more information about what services licensed professionals may provide, contact:
Email: cswmft.info@cswb.state.oh.us
Professional Misconduct Complaints: Call 614-466-0912 and ask for the Investigation Department.
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77 S High St., 24th Flr, Rm 2468
Columbus, Ohio 43215-6171
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Read & Received _____ (Initial)