R.E.A.C.H. For Tomorrow Inc
Business Phone | 1-877-99REACH | Fax | 937-288-8040
Office and Mailing Address: 910 South Street, Greenfield, OH 45123

* INDICATES REQUIRED FIELD

R.E.A.C.H. Client Intake Registration Form

Client Demographics

Clients Age
- 0-4
- 5-10
- 11-13
- 14-18

Gender
- Male
- Female
- Other _____

*Clients Name (first, last)

*Date of Birth (mm/dd/yyyy)

*Address

*City, State

Zip Code

Residing County

*Email

*Contact numbers (please check best # for contact):
- Home _____
- Cell _____
- Work _____

Is it okay to discuss scheduling via email?
- Yes
- No

Is it okay to leave voicemail?
- Yes
- No

Emergency Contact

*Name (first, last)

*Relationship

*Phone number

Insurance & Billing Information

- Self Pay (skip to Responsible Party Section)

*Primary Insurance Company

*Secondary Insurance Company

*Member ID#

*Member ID#

Copay

Copay

*Deductible

*Deductible

Co-Insurance

Co-Insurance

***Please send a copy of your child's insurance card (front and back) to kristaj.reach4t@gmail.com**

Do you have an EAP?
- Yes
- No
- Unsure

Do you have an HRA account associated with your Insurance?
- Yes
- No
- Unsure

Would you like assistance exploring insurance options?
- Yes
- No
- Unsure

Responsible Party

Billing Persons Name (first, last) Relationship to Client

Billing Address City, State Zip Code

Billing Phone Leave Message? Yes/ No

Email OK to send receipts or statements via email? Yes/ No

**REACH Restoration Counseling has chosen to waiver co-pays, however we are not allowed per our contracts with insurers to waiver deductibles. Deductibles will need to be paid by the client. There are options regarding payment. Please contact our office if you have any questions.*

Do you have a HSA Credit Card?

- Yes (please fill out HSA credit card information below)
- No
- Unsure

**Insurance policies with a deductible or out of network insurance coverage require an additional non-HSA credit card on file as back-up to any HSA card.*

HSA Credit Card or Primary Credit Card to keep on file

*Card Holders Name *Card Number

*Card (Mastercard, Visa, Discover, American Express, etc.) *Expiration Date (MM/YYYY) *CVV Code

Secondary Card to keep on file, or credit card in addition to HSA credit card

Card Holders Name Card Number

Card (Mastercard, Visa, Discover, American Express, etc.) Expiration Date (MM/YYYY) CVV Code

**I hereby give consent to charge my credit card(s) listed above for any outstanding balances such as deductibles, co-payments, fees, or other amounts my carrier determines as payable by me in regards to my services with R.E.A.C.H. For Tomorrow.*

*Card Holders Signature Date

Primary Care Physician

- I do have a primary care physician (please complete the following information below on this page)
- I do not have a primary care physician (skip to page 5)

Primary Care Provider/Clinic Phone Number

Address City/State/Zip Code

Consent and Release

The exchange for information regarding your clinical care is sometimes needed to coordinate treatment with your primary care physician. Understand that your records are protected under the Federal and State laws and guidelines regarding confidentiality and cannot be disclosed without your written consent, unless otherwise provided for in the regulations. You have the right to deny consent or revoke your consent at any time if you feel deemed necessary. If you choose to give consent, it will expire automatically as noted below. Information to be released includes diagnosis, treatment procedures, and details of your condition which may help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

- **I refuse/deny consent for my child's records to be exchanged with their primary care physician** (continue to page 6)

I hereby consent that my child;

Child Name (first, last) Date of Birth (MM/DD/YYYY)

Records are to be released to the above listed provider in regards to facilitating communication and/or coordination of services in regards to my child's care. Clinical information to be released include and is limited to the following:

(can check multiple boxes)

The following programs are authorized to:
- Disclose
- Receive
- Exchange

Purpose of Disclosure:
- To coordinate treatment
- To gather assessment information for treatment planning
- To gather information for ongoing treatment
- Other purposes

Amount of Information to be Disclosed:
- Information covering the previous three months
- Information covering the most recent admission
- Other amounts of information

Authorization to disclose expires 1 year after completion unless otherwise noted: _____

- **I hereby consent and authorize to the listed disclosure**

Signature of Parent/Guardian Date

If you completed a Release of Information during the Referral Form Previously sent you can skip to page 6. If you would like to include additional release of information for other helping professionals involved with your child please proceed below.

R.E.A.C.H. Release of Information

AUTHORIZATION TO DISCLOSE CLIENT INFORMATION

*Client Name (first, last) *Date of Birth

*Program/Individual Authorized To Make Disclosure (e.g. School, Probation, etc.)

*Program/Individual Authorized To Receive Information (e.g. Reach for Tomorrow)

(can check multiple boxes)

*The following programs are authorized to:
- Disclose
- Receive
- Exchange

*Purpose of Disclosure:
- To coordinate treatment
- To gather assessment information for treatment planning
- To gather information for ongoing treatment
- Other purposes

*Amount of Information to be Disclosed:
- Information covering the previous three months
- Information covering the most recent admission
- Other amounts of information

Authorization to disclose expires 1 year after completion unless otherwise noted: _____

- **I hereby consent and authorize to the listed disclosure**

***Signature of Client or Other Person Authorized to Permit Disclosure** **Date**

***Signature of Staff or Witness** **Date**

This authorization is subject to written revocation at any time except to the extent the program or person who is authorized to make the disclosure has already acted in reliance on it.
If you chose to revoke this consent at anytime in the future you will be asked to sign the following revoke consent:

Client Signature **Date**

Staff/Witness Signature **Date**

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

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

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**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.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Child and Adolescent Trauma Screen
Caregiver (CATS-C) - 7-17 Years

Name_____ Date_____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge.
Mark No if it didn't happen to the child.

1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	Yes	No
2. Serious accident or injury like a car/bike crash, dog bite, sports injury.	Yes	No
3. Robbed by threat, force or weapon	Yes	No
4. Slapped, punched, or beat up in your family	Yes	No
5. Slapped, punched, or beat up by someone not in the family	Yes	No
6. Seeing someone in the family get slapped, punched or beat up.	Yes	No
7. Seeing someone in the community get slapped, punched	Yes	No
8. Someone older touching his/her private parts when they shouldn't.	Yes	No
9. Someone forcing or pressuring sex, or when s/he couldn't say no.	Yes	No
10. Someone close to the child dying suddenly or violently	Yes	No

11. Attacked, stabbed, shot at or hurt badly	Yes	No
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed	Yes	No
13. Stressful or scary medical procedure.	Yes	No
14. Being around war	Yes	No
15. Has your child been through any other stressful or scary event? If yes, please describe below:	Yes	No

16. Out of all the questions you answered yes to, which event(s) do you feel is bothering your child the most now? (list question #'s, e.g. #1, #2, etc.)

(in reference to these questions please continue to question 17)

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks. Answer the best you can:

0 Never / 1 Once in a while / 2 Half the time / 3 Almost always:

1.	Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0	1	2	3
2.	Having bad dreams related to a stressful event.	0	1	2	3
3.	Acting, playing or feeling as if a stressful event is happening right now.	0	1	2	3
4.	Feeling very emotionally upset when reminded of a stressful event.	0	1	2	3
5.	Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6.	Trying not to remember, think about or have feelings about a stressful event.	0	1	2	3
7.	Avoiding anything that is a reminder of a stressful event (activities, people, places, things, talks).	0	1	2	3
8.	Not being able to remember an important part of a stressful event.	0	1	2	3
9.	Negative changes in how s/he thinks about self, others or the world after a stressful event.	0	1	2	3
10.	Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11.	Having very negative emotional states (afraid, angry, guilty, ashamed).	0	1	2	3
12.	Losing interest in activities s/he enjoyed before a stressful event.	0	1	2	3
13.	Feeling distant or cut off from people around her/him.	0	1	2	3
14.	Not showing positive feelings (being happy, having loving feelings).	0	1	2	3
15.	Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	0	1	2	3
16.	Risky behavior or behavior that could harmful.	0	1	2	3
17.	Being overly alert or on guard.	0	1	2	3
18.	Being jumpy or easily startled.	0	1	2	3
19.	Problems with concentration.	0	1	2	3

20. Trouble falling or staying asleep.	0	1	2	3

Please mark YES or NO if the problems you marked interfered with:

1. Getting along with others	Yes	No	4. Family relationships	Yes	No
2. Hobbies/Fun	Yes	No	5. General happiness	Yes	No
3. School	Yes	No			

*Important Signatures to Complete the Intake Forms

**If the client is a minor, please print the name of the parent/guardian(s) signing on behalf of the client*

*Name (first, last) *Relationship

*Signature *Date

*Consent for Counseling Services

I hereby consent that my child is allowed to receive counseling services from Reach For Tomorrow via the school, office, and/or home based on what best fits mine and my child's needs. I have read through all of the policies and procedures outlined in this Intake Registration packet, I understand and have agreed to each section and signed appropriately as requested. If I do not understand, I have asked for interpretation of the content listed and had a personnel help me to understand each section.

*Parent/Caregiver Signature Date

*By signing below I am acknowledging that I have reviewed *pages 14-19* of Reaches Intake and Registration Forms and understand that by signing below that I have agreed and understand all rules and conditions as outlined. I understand that *pages 14-19* is my copy to keep if I have any questions I can reach out to my assigned clinician/QBHS and or the office at ***877-977-3224.***

**My signature below indicates that I have been provided a copy of, and that I fully understand & agree to all the terms and conditions of the Counseling Policies. If I have questions, the information has been explained and/or Summarized for me.*

*Signature of Client or Guardian Date

Counseling Policies

We are a professional mental health counseling agency where your Counselor/QBHS maintains his or her private practice as independent contractors and are supervised by qualified supervisors within the agency to promote quality care for our patients. Within this model, your Counselor/QBHS is your primary point of contact for scheduling & account management (payment, statement/receipt requests, & billing questions). Our business office provides administrative support to your Counselor/QBHS. To update your insurance information or to schedule with another Counselor/QBHS within our group, please contact ***877-977-3224.***

Confidentiality Policy

The staff and Counselor/QBHSs at REACH Restoration Counseling, have an obligation to respect your right to confidentiality for the information you share within this clinical setting. Confidentiality applies to clients that are both adults and minors, in respect to each person's self determination in what information is willing to be shared with other parties. Confidentiality of client information is governed by federal law (Health Information Portability and Accountability Act) and by state law. The State of Ohio laws impose some limitations to your rights to confidentiality. The following is a list of situations in which confidentiality may be broken as required by law:

-Reports of plans to harm yourself or others.
-Reports of abuse or neglect to a child, elderly or disabled individual.
-If your counselor is court ordered
-Under medical emergencies.
-Information that may be necessary to share with a licensing board on behalf of a disciplinary proceeding involving a provider.

If you are a minor, you have a limited right to privacy in that your parents may have access to your records. Minor clients have rights to complete confidentiality in obtaining counseling for pregnancy & associated conditions, sexually transmitted diseases, & information about drug and alcohol abuse. However, if the Counselor/QBHS believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law unless safety concerns are of risk.
Group Therapy: The right to confidentiality is addressed in the group setting. However, RRC and group Counselor/QBHSs are not responsible for any breaches of confidentiality by group members.

Master's prepared therapy interns are an integral part of our counseling team and are obligated to abide by the relevant code of ethics and HIPAA privacy guidelines regarding confidentiality when participating in individual supervision with a primary clinical supervisor (licensed mental health professional), bi-monthly peer supervision staffed by our licensed clinical team, impromptu individual supervision and consultation by other licensed staff clinicians, as well as appropriate supervision within their academic community.
There are instances in which administrative individuals associated with REACH Restoration Counseling, have duties that require access to the information you may share for claim processing, scheduling, reports, consultations, etc.
In keeping with standards of practice, your Counselor/QBHS may consult with other mental health professionals within this group private practice regarding care and management of cases. The purpose of this consultation is to ensure quality of care. Your Counselor/QBHS will maintain confidentiality and protect your identity by not using real names or any identifying information. Counselor/QBHSs seeing members of your family or your significant others will obtain a signed Release of Information (ROI) prior to discussing specific details of your situation.

In the Case of an Emergency

Your Counselor/QBHS is NOT available for after-hours crisis or emergency situations. In a crisis or an emergency situation, please call 911 or go to the nearest emergency room.

Telephone & Email Communication

Voicemail is available between sessions. Messages will be returned as soon as possible during business days. Please do not rely on your Counselor/QBHS's voicemail in times of crisis or for an emergency.
Email or text messages should ONLY be used for scheduling purposes and may not be checked on a daily basis. Email, text messages & cellular correspondence is not considered to be a confidential medium of communication and your Counselor/QBHS is not responsible for any information transmitted via email, text message or cellular phone. When communicating with counselor/QBHSs via text messages, email, or other

forms of written communication available, it is important to advise clients that prudent information meant to be kept confidential should be considered when communicating through these network forms. Text messages, emails, or other forms of written communication are not always protected under HIPAA privacy guidelines and a potential risk for breach in confidentiality is open to others if private information is shared in these lines of communication.

A prorated charge is applicable to time spent with you on the telephone by your Counselor/QBHS beyond appointment scheduling or similar matters (lasting more than 5 min). Telephone sessions between sessions may be scheduled in advance, based on availability of both parties.

Missed Appointments

I am financially responsible for my child's attendance to all scheduled appointments, unless canceled with at least 24-hour notice. Minimum charges of $50 may be applied to my account for a late cancel and $85 for a no-show. This charge is not covered by insurance.

Insurance Billing

I authorize REACH Restoration Counseling, to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim. I authorize my insurance company to assign benefits to REACH Restoration Counseling, I understand that I am responsible for payment of services ren deferred by REACH Restoration Counseling, regardless of reimbursement for these services by the insurance company and that any inaccuracy in information on this form my result in nonpayment by my insurance company. I agree to notify REACH Restoration Counseling immediately whenever I have changes in my health plan coverage.

Account Responsibility

I am responsible for payment to REACH Restoration Counseling, for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, REACH Restoration Counseling, reserves the right to forward my information to collections, adn an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names REACH Restoration Counseling, as a creditor in any bankruptcy filing.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nore anyone else acting on your behalf will call on your QBHS to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Clinical Staff Release

I understand that as part of my professional clinical consultation, my situation may be reviewed using general clinical information during case review for professional development and enhanced delivery of services in your course of treatment with REACH Restoration Counseling.

Informed Consent & Notice of Privacy Practices

I am consenting to the treatment and have received and understand the contents of the Counseling Policies, including the Notice of Privacy Practice (HIPAA).

Telehealth Counseling Services

(as appropriate based on child's developmental age and needs)

About Telehealth

Telehealth is an online communication tool allowing face-to-face video, voice, or text-based chat/dialogue for clients who are unable to attend sessions face to face based on temporary circumstances and/or residing in distant areas. Any Internet-based communication is not 100% guaranteed to be secure/confidential. Your counselor will make every reasonable effort to implement technical security measures to reduce risks of a confidentiality breach. Telehealth sessions are not to take the place of the more optimal in-office counseling sessions, but are utilized when in-office sessions are not convenient or possible, and only at the client's request when deemed appropriate.

Responsibilities as the Caregiver

- I am responsible for ensuring confidentiality by closing other programs on mine or my child's computer while in a video session, planning ahead to minimize distractions, and not answering calls or text messages while on the telehealth call.
- I also agree to be no later than five minutes prior to the scheduled telehealth session appointment. It is recommended that telehealth sessions be carried out in a quiet room, alone and with the door closed to ensure confidentiality is protected (Headphones may be used to increase privacy of sessions).
- I agree that I and my child will not use telehealth in an emergency situation that needs immediate attention, whereby my child is considering self harm or harm to someone else. If a life threatening crisis should occur, I agree to contact 911 or the 24 hour suicide hotline at 1-800-SUICIDE, or go to the nearest Emergency Room.
- I agree to read the general informed consent form in addition to this form prior to engaging in telehealth counseling sessions.

Behaviors Health Assessor/Specialist Responsibilities (BHAS):

- The BHAS will establish the telehealth session with the client at the scheduled appointment time.
- The BHAS will ensure all other distractions such as phone calls are eliminated during the telehealth counseling session and that the office is free of distractions and/or other noise.
- If technical problems may occur and the call is disrupted, the BHAS will call you back unless technical difficulties persist. In this case, another appointment time either in-person or telehealth will be scheduled depending on the client's preferences.

Insurance Billing

Please call us at 877-997-3224 to update insurance or registration information.
We are in-network providers for most major insurance companies. As a courtesy to you, we work directly with your insurance company.
You must notify us in advance of your first appointment if you intend to use an Employee Assistance Program (EAP). Once services have been provided under insurance, we will not bill your EAP.
Once your appointment has been scheduled, we will verify your coverage and obtain any necessary authorizations. Verification of coverage is not a guarantee of claim payment. Coverage is subject to the terms and conditions (e.g. authorizations, network requirements) outlined in your member contract with your insurance company.
It remains your responsibility to understand your plan's limitations, deductibles and exclusions. For benefit coverage questions, please call the customer/member service number on the back of your insurance card. We have no authority to make specific representations to you regarding coverage of services. REACH Restoration will waive co-pays, although are not able to waive deductible payments.
It is your responsibility to provide us with updated information when your insurance policy changes or your coverage terminates. If the insurance information you provide to us is later determined to be inaccurate, resulting in denial of your claim, then you will be responsible for paying the amount of the denied claim.
If you attend any appointment without verification of your current insurance coverage, you are responsible to pay the private pay fee for services at the time of your visit.
There may be instances in which you will need to communicate directly with your insurance company to ensure a smooth billing process. If your insurance requests information regarding Coordination of Benefits (CoB) or Pre-existing Conditions, please promptly return any forms or call your insurance company directly to follow up. Once they request this information from you, all claims deny, and become your full financial responsibility until you provide it. Please call us at 877-997-3224 to let us know you have resolved any CoB or Pre-existing Condition requests so that we can have your insurance reprocess the denied claims immediately.

Account Responsibility

Because we are a "fee for service" provider, billing statements from REACH Restoration Counseling, will NOT automatically be sent - should you need a statement or itemized receipt, please inform your Counselor/QBHS, and we will provide this for you upon request.
Per your agreement with your insurance company, it remains your responsibility to immediately pay any copayments, deductibles, coinsurances or other amounts your insurance carrier determines as payable by you. This payment is to be collected by your Counselor/QBHS.

We do not have the ability to waive deductibles, or coinsurance amounts due, as this is a violation of the contract we have with your insurance company.
Cost estimation tools provided by your insurance company allow the collection of coinsurance and deductible amounts up front at the time of service, rather than waiting until after the claim is processed. This collected payment is based on an estimate of your out-of- pocket costs for services provided. Actual coverage and member liability amounts are determined once the claim is processed and you receive an explanation of benefits (EOB). Any overpayments will be applied to ongoing balances or refunded within 30 days of claim processing. Any underpayments must be paid by mail, online at our website, or at your next scheduled appointment (if scheduled appointment occurs within 1 week of receiving your EOB).
To ensure proper credit, please make checks payable to REACH Restoration Counseling. There will be a $40 fee for returned checks. Thereafter, payment will only be accepted in the form of cash, credit card or money order.
You are responsible for charges not eligible and/or covered by your medical insurance plan. If you discontinue care for any reason, all balances will become immediately due and payable in full by you, regardless of any claim submitted.
Should you default on any payment obligations, we reserve the right to forward your information to collections, and an additional 30% may be assessed to cover the costs of this action.
We are not obligated to provide continuing services in the event that REACH Restoration Counseling, is named as a creditor in any bankruptcy filing.

Missed Appointments

All services are provided by appointment only. We realize that on occasion you will not be able to make a scheduled appointment. However, please remember that your Counselor/QBHS has reserved this time for you alone, so our policy is to charge a minimum of $65 for missed appointments or a minimum of $50 for cancellations without a AT LEAST 24-hour advance notice. It is up to your Counselor/QBHS's discretion to require more than a 24-hour notice or to charge a higher rate for missed appointments.
This charge is NOT covered by insurance and will be billed as your responsibility. Please help us serve you better by keeping scheduled appointments. Clients with more than one missed appointment may be subject to same day scheduling and/or termination of care.

Making Payments

Please understand that payment of your bill is considered a part of your treatment. If mailing, please remit payment to:

REACH Restoration Counseling,
910 South St,
Greenfield, OH 45123

Online payments: Visit our website at www.REACHforTomorrowOhio.org to pay using our Secure Online Form or to pay with Paypal.

REACH Restoration Counseling Self Pay Fees		
Description	**Time Unit**	**Rate**
Intake/Assessment	N/A	$65
Individual Therapy	16-37 min	$30
Individual Therapy	38-52 min	$40
Individual Therapy	53 - 114 min	$50
Individual Therapy Add On	115 min	$100
Individual Therapy Add On	145 min	$150

Group Therapy Session	N/A	$15
Crisis Session	30 min	$30
Crisis Session	60 min	$50

Preparation of Forms and Reports

These require chart review and often, discussion with the client. A prorated charge is applicable to time spent and is not billable to your insurance.

Release of Records

Most of the information a clinician collects about you will be classified as confidential. However, when insurance is involved, REACH Restoration Counseling, does not have control over and cannot assure its clients of confidentiality. That means employees of the insurer and employees of contracted organizations of the insurer have access to your chart. This is provided for in the insurance policy between you and your insurance company. The client record is legally the property of REACH Restoration Counseling. However, clients may have access to information contained in the file, except in those cases where the release of such information may be deemed harmful to the client's well-being. Information can be released to others only upon written informed consent of the client. In a few cases, information is unavailable to a client. Certain confidential data may be available only to the clinician and particular government agencies. Classified material falling into this category might deal with adoption, civil or criminal investigations, some medical data and the names of persons who report suspected abuse of children or vulnerable adults. In the event of request for transfer of records, the records will be forwarded upon completion of a Release of Information form.

**Court & Legal Proceedings

RRC does NOT provide disability determination, custody studies, or handle court issues.

RRC providers do not perform court evaluations nor do they appear in court on behalf of individuals, children or adults. RRC services are designed to assist in alleviating problems through individual or relational psychotherapy. RRC providers are not trained for, nor do they maintain records with the intended purpose of court involvement.

In addition, the legal process is such that we may be compelled to reveal information about you that could affect you negatively or undermine your relationship with your Counselor/QBHS. Because the client-Counselor/QBHS relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the Counselor/QBHS to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition.

Should we be called to court by a court order, or our records court ordered or subpoenaed, we will charge the full amount applicable under law for our services.

In the event that it is necessary, by court order or by subpoena, for the Counselor/QBHS to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the Counselor/QBHS for his or her services, (including but not limited to: travel, necessary expenditures (copies, parking, meals, and the like), time spent speaking with attorneys, reviewing records and preparation of reports) @ the rate of $250.00 per hour, rounded to the nearest half hour.

The client further agrees to pay a retainer fee of $2,000.00 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your Counselor/QBHS at RRC to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. My informed consent signature shows that this litigation limitation is clearly understood and agreed to.

Client Bill of Rights

RRC does not discriminate on the basis of religion, race, gender, marital status, age, sexual orientation, national origin, previous incarceration, disability or public assistance status.

Every client:
"Shall be informed prior to, or at the time of, the intake appointment of services available at RRC and of any financial charges that are the client's responsibility to pay beyond the coverage of health insurance.
can expect complete and current information concerning his or her diagnosis and individual treatment plan in terms he or she can understand.
shall have the right to know by name, and the competencies of, the licensed mental health professional responsible for coordination of his or her treatment.
shall have the freedom to place grievances and recommend changes in policies and services to RRC staff free from restraint, interference, coercion, discrimination, or reprisal.
In addition to the rights listed above, services offered by practitioners licensed by the State of Ohio have the right to: (a) expect that a practitioner has met the minimal qualifications of training and has the experience required by state law; (b) examine public records which contain the credentials of the practitioner; (c) obtain a copy of the rules of conduct."

Every client:
"Has the right to be informed of and to refuse to participate in any experimental research.
may expect courteous treatment and to be free from verbal, physical, or sexual abuse by RRC staff.
has the right to a coordinated transfer of care when there will be a change of providers.
may assert the client's right(s) without retaliation.
has the right to choose freely among available mental health professionals and practitioners in the community and to change providers after mental health services have begun within contractual limits of the client's health insurance (if any)."

Comments, Question, Concerns

We value your opinion and strive to provide the best service possible. If you would like to share your comments, questions, or concerns, please contact our Chief Executive Officer, Danielle Ratcliff, at 877-997-3224, ext 801 or email Danielle.REACH4t@gmail.com. Responses to comments, questions, or concerns can be expected in 1-2 business days. You may also complete a confidential satisfaction survey online at our website: www.REACHforTomorrowOhio.org.

Notice of Privacy Practices (HIPAA)

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At the REACH Restoration Counseling, , we are very careful to keep your health information secure and confidential. This law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the

right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information. You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W, Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Chief Executive Officer, Danielle Ratcliff at Danielle.REACH4t@gmail.com , or 877-997-3224 or to file a complaint in writing, addressed to: REACH Restoration Counseling, 910 South St, Greenfield, OH 45123. If you choose to file a complaint, we will not retaliate in any way.