For use in Schools in which we offer Psychiatric Services ETCP

THE COUNSELING SOURCE, INC.

FAX REFERRAL SHEET/ PHONE INTAKE FORM

Phone: (513) 984-9838 (800) 618-0688 FAX: (513) 984-8075 (800) 738-9854

INCLUDE STUDENT FACESHEET **and if Applicable:** DASL Sheet, Insurance Cards, Guardianship Papers

PLEASE *COMPLETE* ***ALL FIELDS CLEARLY*** *AND WITH* ***DARK INK***

REFERRAL DATE: _____

_____ **ROUTINE: Appointment scheduled within 2 weeks** **TELEHEALTH: YES ____NO____**

_____ **PRIORITY: Appointment scheduled within 1 week: serious, non-urgent, symptomology displayed**

URGENT - DANGER TO SELF OR OTHERS. The Counseling Source (TCS) will respond immediately if a TCS staff member is on site at the time of the crisis. If there is no TCS staff person on-site then the host facility should dial 911.

SCHOOL _____ **GRADE**_____ **TEACHER**_____

NAME _____ **SEX AT BIRTH: FEMALE**_____ **MALE**_____

DATE OF BIRTH _____ **SOCIAL SECURITY #**_____ **PRONOUNS: SHE** ____ **HE** ____

ADDRESS _____ **CITY**_____**STATE OH ZIP**_____

GUARDIAN NAME(s) _____ **RELATIONSHIP**_____

ADDRESS ***(if different)*** _____**CITY**_____**STATE**____ **ZIP**_____

PHONE_____ **EMAIL**_____

HAS THE PARENT BEEN INFORMED OF THE REFERRAL? No_____ **Yes**_____

OHIO MEDICAID No___ **Yes**___ **Medicaid (MMIS) # (12 Digits)** _____

MCO Name (if applicable e.g. Caresource) _____ **MCO MEMBER ID**_____

PRIVATE INSURANCE (PI) PROVIDER _____ **PI POLICY #** _____

PI POLICY HOLDER NAME_____ **PI POLICY HOLDER DATE OF BIRTH**_____

PRESENTING PROBLEM(s) ***Circle all that apply***

1. Suicidal Statements/Attempts	6. Appetite Problems	11. Emotional Outbursts	16. Problem Behaviors
2. Acting Sexually Inappropriate	7. Being Depressed	12. Impulsivity	17. Psychotic Thinking
3. Adjustment Difficulties	8. Being Withdrawn	13. Inattention	18. Relationship Problems
4. Anger Problems	9. Changes in Sleep Patterns	14. Substance Use	19. Thought Distortion
5. Anxiety	10. Fears	15. Mood Swings	20. Worries

21. Other_____

_____

NAME/TITLE OF PERSON MAKING REFERRAL _____

PHONE NUMBER _____ **EMAIL**_____

CONSENT FOR EVALUATION/TREATMENT/CPST/PSYCHIATRY SERVICES
FEE AGREEMENT AND INSURANCE AUTHORIZATION

THE COUNSELING SOURCE, INC.
10921 Reed Hartman Highway, Suite 133
Cincinnati, Ohio 45242
Phone: (513) 984-9838 or 800-618-0688 Fax: (513) 984-8075 or 800-738-9854

Client Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone: (_____)_____ E-Mail:_____
Area Code

I, the above named individual (or legal representative of this individual) acknowledge and agree to the following:

General Consents/Acknowledgments:

1. I consent to receive mental health services as provided by The Counseling Source, Inc. These services will include evaluation, individual or group counseling, and Community Psychiatric Support Treatment (CPST), as recommended. Treatment and CPST will be provided consistent with an Individual Service Plan developed with my input. I consent to receive these services either face to face or via telehealth (video conferencing, phone, email or texting) as appropriate. I understand that some forms of electronic communication may not be HIPAA compliant and I consent to these modes of communication.
2. I acknowledge that I have been informed of the risks and benefits of treatment and my right to refuse or withdraw consent for treatment and of the availability of the Client Handbook and HIPAA information on The Counseling Source (TCS) website at www.thecounselingsource.com.
3. I authorize review of my records for quality assurance purposes.
4. Should I be transferred to an inpatient hospital, I authorize The Counseling Source to exchange verbal and written information with the hospital regarding clinical services provided to me in order to assure continuity of care.
5. I acknowledge that repeated cancellation of sessions without 24 hour prior notice may result in termination of services by The Counseling Source, Inc.
6. I understand that, consistent with HIPAA, The Counseling Source, Inc. can contact and exchange information about my care with my physician, and other involved health care professionals.
7. I acknowledge that I have been informed that the Client Rights and Grievances Policy and Procedures are available to me on the TCS website at www.thecounselingsource.com. This information is contained within the Client Handbook.
8. If I am typically served and physically present in either a nursing home or school setting, I acknowledge that in a mental health crisis my best course of action is to inform nursing home or school staff. If I am at home or in the broader community, I should call 911 and provide the dispatcher my location and the nature of my crisis. For less emergent needs, TCS has a clinician on call at 1-800-618-0688. Further, I acknowledge that I understand it is not appropriate to communicate urgent concerns to a TCS therapist through email, texting, or clinician specific voice mail as the clinician will not receive or review these messages in real time.

Client Name_____ Date_____

Fee Agreement/Insurance Authorization:

1. I authorize The Counseling Source, Inc. to act as my agent in obtaining payment from all third party payers and authorize third party payers to make payment directly to The Counseling Source, Inc. Based on the payer information we have at this time your costs for services will be as follows:

$_____/hour of evaluation. $_____/hour of treatment. $_____/hour of CPST. $_____ / hour of Psychiatry

Treatment and CPST times may be provided in individual or group sessions. Treatment formats and/or duration of sessions may vary and will ultimately determine fees billed.

2. I understand that in signing this document I authorize release of sufficient information to OMHAS, ODM and any related MCO's to determine my eligibility for publically funded services.
3. I understand that I am liable for the full cost of services not covered by third party payers.
4. Third party payers (Medicare, Medicaid, private insurance, etc.) will be billed for any covered services, to the extent that I am eligible. I understand that tele-health services may be treated differently by payers.
5. I authorize release of information from my clinical records as necessary to process claims for third party payers.
6. I agree that should I be paying for services on a sliding fee scale (SFS) I will provide the requested information to The Counseling Source to verify household size and income. Also I agree to provide a deposit prior to the intiation of services on a sliding fee scale basis.
7. I acknowledge that I am responsible for notifying The Counseling Source, Inc. of changes in my insurance coverage or financial status which may affect my billing rate for TCS services.
8. I acknowledge that with appropriate prior warning The Counseling Source, Inc. may terminate services due to non-payment of my bill.

_____ _____

Signature of Client or Legal Representative Date

If not signed by client, please provide the following information:

Name of Legal Representative:_____

Indicate Legal Representation Type: Guardian Durable Power of Attorney Other (specify):_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone Number: (_____)_____ Email_____

I acknowledge that I have reviewed the above information with the client and/or legal representative. I have presented orientation material to (client / guardian name) _____ _____, (Client SS#)_____ and if there were any questions, I answered them to the client's / guardian's satisfaction or helped obtain relevant answers.

_____ _____

Signature of Representative of The Counseling Source Date of First Billable Contact