NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.
REGISTRATION FORM

CLIENT INFORMATION **DATE: _____**

Client Name _____ Soc Sec. # _____

Address: Street _____Phone # _____

City _____State _____ Zip _____ County _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____

Occupation (even if currently unemployed) _____
Employer _____Phone _____
Address _____
Major source of income (employment, unemployment, welfare, etc.) _____

Race: Asian Black/African Amer. Native Amer./Amer.Indian White Unknown
Ethnicity: Puerto Rican Mexican Cuban Other Hispanic Not Hispanic or Latino

GUARANTOR INFORMATION (Party responsible for charges not covered by insurance)
_____Same as Above
Name _____ Soc. Sec. # _____
Address _____ Phone # _____
_____ D.O.B. _____

INSURANCE INFORMATION
Primary:
Name of Insurance Company _____
Policy Number _____Group Number _____
Name of Policy Holder _____ Birthdate _____
Relationship to Client _____ Effective Date _____
Address: Street _____ Phone # _____
City _____State _____ Zip _____

Secondary:
Name of Insurance Company _____
Name of Policy Holder _____
Policy Number _____Group Number _____
Relationship to Client _____ Effective Date _____

Other:
Medical Assistance Program _____ 12 Digit Medical Assistance Number _____

Is this a Workman's Compensation Case? Yes _____ No _____
If Yes: Name of Attorney: _____
Billing Address: _____
_____

Does insurance require precertification for treatment? _____

(over)

AUTHORIZATION FOR RELEASE OF INFORMATION:

I Hereby authorize Northeast Ohio Behavioral Health, LTD to release such information in connection to my treatment to the above named insurance company(ies) for the purpose of processing the insurance claim.

GUARANTEE OF ACCOUNT:

I understand I am financially responsible for charges not covered by this authorization.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment of the benefits otherwise payable to me by the designated insurance companies directly to Northeast Ohio Behavioral Health, LTD. The amount not to exceed regular charges.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signed _____ Date _____
Client (parent, if minor – guardian – legal representative)

Signed _____ Date _____

Witness _____ Date _____

REMINDER CALLS:

In order to provide our clients with appointment reminder calls, NEOBH requires written permission from the client/parent or guardian.

I would like an appointment reminder call _____
(Signature)

Phone numbers: (1) _____ (2) _____

It is permissible / not permissible for NEOBH to leave a message.

Leave message _____
Signature

DO NOT leave message _____
Signature

NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.
FEE AGREEMENT FORM

- Diagnostic Assessment/Initial Intake Interview - $140 per 45-60 minutes session.
- Individual Counseling - $99.99 per 45-60 minute session, $60.00 per 20-30 minute session.
- Group Counseling - $45 per person per hour.
- Specialized Services/Evaluations/Assessments – fees vary and are explained under a separate document which will be presented if applicable.
- Fees for reports, testing, letters, summaries, telephone consultations and other services will not be billed to Insurance, Medicaid or most third party payers and are therefore your financial responsibility.
- There will be a $25 charge for checks returned for non-sufficient funds.
- **We reserve the right to charge for your visit if there is not a 24 hour notice of cancellation.** This will not be billed to Insurance, Medicaid or third party payers and is therefore your financial responsibility. Additionally, we reserve the **right to refuse to provide future services** should you demonstrate a history of no shows and/or late cancellations.
- **Deductible and co-pay amounts, in addition to those services not covered by another payer, are due at the time of each visit**.
- Although we may bill your insurance company and/or third party payer, **you are ultimately responsible for payment of services rendered, and for contacting your insurance company and/or third party payer if payment is not received in a timely manner.**
- If your bill for services rendered is not paid promptly, we may find it necessary to turn your account over to a collection agency. We will make every effort to avoid this by working with you to ensure timely payments on your account. However, if it does become necessary to turn your account over to a collection agency, we reserve the right to charge an additional collection fee.
- For your convenience, we accept Visa, MasterCard, Cash, Personal Checks and Money Orders.

I have read and fully understand the above provisions. I give permission to and request that Northeast Ohio Behavioral Health, Ltd. bill my Insurance, Medicaid or any third party payer for services rendered to me or to a member of my family. I clearly understand that it is still my responsibility to make sure that the bill is paid in a timely manner. If, for any reason, any portion or the entire bill is not paid by Insurance, Medicaid or any third party payer, I agree to make arrangements for prompt payment to Northeast Ohio Behavioral Health, Ltd.

***REQUIRED INFORMATION FOR ALL CLIENTS**: Family Income: $ _____ per month Family Size: ____ persons

_____ _____
Signature of Client or Parent/Guardian Date Signed

_____ _____
Signature of NEOBH Representative Date Signed

MACSIS RESIDENCY VERIFICATION

The purpose of this form is to clarify which county is responsible for adjudicating claims for behavioral health services provided to the client being enrolled. It should be completed and provided to the enrolling board when:

- The county of the treating facility does not match the legal county of residence of the client as noted on the enrollment form (child or adult, out-of-county).
- The physical address of the client as noted on the enrollment form does not match the legal county of residence of the client (example: domestic violence shelter case, client temporarily living with relatives, child or adult, out-of-county).
- The child's physical address as noted on the enrollment form does not match the legal custodian's address (child only, in or out-of-county).

A client's or legal custodian's signature on this form shall be sufficient for documenting residency with the exception of adults who reside in specialized residential facilities or who are committed pursuant to special forensic categories referenced in the residency guidelines.*

Adult

Client is an adult? ☐ Yes ☐ No **If yes, complete the following information.**	
Client Name (please print)	
Street Address for Residency Determination Purposes	
City, State, and Zip for Residency Determination Purposes	
Signature of Client	Date

Minor

Client is a Minor? ☐ Yes ☐ No	**If yes, indicate if child is in legal custody of the following (this is not the foster parent).** ☐ Parent ☐ CSB ☐ DYS ☐ Court ☐ Other (specify): _____
Client Name (please print)	
Name of Legal Custodian Marked Above	Phone No. of Legal Custodian
County of Legal Custodian	
If Parent, Address of Parent (if different from client's physical address on enrollment form)	
Signature of Legal Custodian	Date

*For the special exceptions noted, this form should not be used. Refer to the residency guidelines for more information on how to determine residency in these cases and/or what documentation is needed to provide proof of residency.

NEOBH

NORTHEAST OHIO BEHAVIORAL HEALTH, LTD.

Authorization for Disclosure of Confidential Information and/or Enrollment into the Multi-Agency Community Services Information System (MACSIS)

To be eligible to receive public funds to help pay for the cost of your services, we must provide information to the Mental Health and Recovery Services Board of Stark County and/or to the Agency/Board in your county of residency.

The information must be provided in order to:

- Enroll you in your residing counties plan
- Determine what public funds can be used to pay for your services
- Pay NEOBH through a system connected with the Ohio Department of Mental Health, Ohio Department of Alcohol & Drug Addiction Services, and the Ohio Department of Job and Family Services

ALL INFORMATION COLLECTED WILL BE KEPT CONFIDENTIAL, consistent with State and Federal law. All uses for the information collected are described in NEOBH's HIPAA Privacy Practices Policy.

_____ _____

Signature of Client or Parent/Legal Guardian Date

Northeast Ohio Behavioral Health, Ltd.

PERMISSION FOR TREATMENT

I hereby authorize Northeast Ohio Behavioral Health, Ltd. to provide _____
Client's Name

with the following services:

_____ Individual Psychotherapy
_____ Psychological Testing/Evaluation/Assessment
_____ Family Counseling
_____ Custody Evaluation
_____ Parent Consultation
_____ CPST – Community Psychiatric Supportive Treatment
_____ Other _____

I understand that mental health services sometimes carry a risk of undesirable side effects and am aware that I am entitled to an explanation of such possible side effects. I further understand that only those services listed above will be provided unless I give signed authorization for additional services.

_____
Signature of Client or Parent/Legal Guardian

_____
Relationship to Client (if under 18)

_____
Signature of Witness

_____
Date

Client Rights, Civil Rights and Grievance Procedures:

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Client Rights, Civil Rights and Grievance Procedures. I understand that I can ask any questions that I may have about these policies, at any time.

_____ _____ _____
Signature of Staff Member Signature of Client/Parent/Guardian Date

Privacy Practices Policy:

I have received a copy of Northeast Ohio Behavioral Health, Ltd.'s Notice of Privacy Practices. I understand that I can ask any questions that I may have about these policies, at any time.

_____ _____ _____
Signature of Staff Member Signature of Client/Parent/Guardian Date

Northeast Ohio Behavioral Health, Ltd.

PRIMARY CARE PHYSICIAN COMMUNICATION FORM

Client: Please fill out the data in the box only and sign at the "X". Thank You!

Client's Name: _____ D.O.B._____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

☐ Check here if client does not have a Primary Care Physician.

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in regards to it. This release will automatically expire twelve (12) months from the date signed.

I, _____, hereby authorize _____
(Print Client's Name) (Print Treating Clinician's Name)

☐ To release any applicable information TO my Primary Care Physician (as listed above).

☐ NOT to release information to my Primary Care Physician (as listed above).

☐ To receive the following information FROM my Primary Care Physician (as listed above):

_____

X_____ _____/_____/_____
Signature of Client or Guardian Date

********** Office Use Only **********

Dear Dr. _____:

Your patient, _____, was recently seen in our office for outpatient counseling. We hope that the following information will help in coordinating this patient's care. Please call if further information would be helpful.

Date of initial consultation: _____ Date of next appointment: _____

Diagnosis and brief description of presenting problem(s): _____

_____

_____

Treatment Recommendations: _____

Treating Clinician's Name: _____

Address/Phone: Sincerely,

☐ 2795 Front Street, Suite A; Cuyahoga Falls, OH 44221; 330-945-7100.

☐ 4510 Dressler Rd. NW; Canton, OH 44718; 330-494-5155. _____

☐ 213 Market Avenue N., Suite 200; Canton, OH 44702; 330-494-5155 Clinician's Signature

Northeast Ohio Behavioral Health, Ltd.

SUPERVISION DISCLOSURE STATEMENT

Dear Client:

Your therapist, _____, is a (circle appropriate title):

- Psychology Assistant
- Pre / Post-Doctoral Psychology Trainee
- Professional Counselor
- _____

who is being supervised by (circle appropriate Supervising Psychologist/Supervisor):

- Robin Tener, Ph.D.
- Aimee Thomas, Ph.D., P.C.C.-S
- Gail Mager, P.C.C.-S.
- Leah Schilling, L.P.C.C.-S
- Name of Supervisor:_____ Credentials_____

Treatment services provided to you may include Intake Evaluation/Diagnostic Assessment, Individual, Group, Family or Conjoint Counseling, and Psychological Testing. Through methods such as the taping of treatment sessions, review of psychological testing data, review of notes of treatment sessions and discussion of the content of treatment sessions, your therapist will receive supervision that will enable him/her to develop important skills. Supervision of your therapist will enable Northeast Ohio Behavioral Health, Ltd. to ensure that you are receiving the best possible treatment services.

Confidentiality is important at NEOBH. Both your therapist and his/her supervisor are bound by specific State and Federal laws, as well as by professional ethics that govern confidentiality. Any information that may be recorded within a counseling session is strictly confidential, is used only for training, and is erased when training is completed. Detailed information about confidentiality can be found in the Client Rights and HIPAA Privacy Rules materials that are provided to each client/guardian during the initial appointment. Please note that all therapists at NEOBH follow relevant laws regarding the duty to report suspected child abuse, or imminent harm to another person.

You have already received information regarding the financial policies of NEOBH. If we are billing insurance, bills will be submitted under the name of our agency and/or under the name of the Supervising Psychologist/Supervisor. In either case, it will be clear who provided the billed service.

The Supervisor is ultimately responsible for the services that are provided by your therapist. You may request a meeting with your therapist's supervisor before, during or following your treatment. If you have concerns about your treatment, please contact the supervisor at the following numbers:

- Dr. Robin Tener: (330) 945-7100 or (330) 494-5155
- Dr. Aimee Thomas: (330) 494-5155
- Gail Mager, P.C.C.-S.: (330) 945-7100 or (330) 494-5155
- Leah Schilling, L.P.C.C. (330) 945-7100

- Supervisor:_____Phone:_____

Any additional concerns regarding your treatment at Northeast Ohio Behavioral Health, Ltd. may be reported to Dr. Robin Tener, Executive Director, at (330) 945-7100 or (330) 494-5155.

I have read the above and understand the nature of the supervisory procedures. I recognize that I can ask any questions regarding supervisory issues, and may speak to my therapist's supervisor. I consent to having my counseling sessions taped for the purposes of supervision.

Client's Name: _____ Client's/Guardian's Signature: _____

Date: _____ NEOBH Representative's Signature: __ _____

Date: _____ NEOBH Supervisor's Signature: _____

NORTHEAST OHIO BEHAVIORAL HEALTH
ADULT BACKGROUND INFORMATION

Name (First, MI, Last)		
Date	Date of Birth	Age

LIVING SITUATION

My Home	**Residential Care/Treatment Facility (if applicable)
☐ Rent ☐ Own	☐ Hospital ☐ Temporary Housing ☐ Residential Care ☐ Nursing Home

**Other (if applicable)
☐ Relative's/Guardian's Home ☐ Friend's Home ☐ Adult Foster Care Home
☐ Homeless in Shelter/No Residence ☐ Respite Care ☐ Other:

**Identify Person's Name or Facility in which you live:

Household Member Names	Relationship to Client	Age	How do you get along with this person?

Significant Family Members/ Others Not Listed Above	Relationship to Client	Age	How do you get along with this person?

SOCIAL INFORMATION

Which family members or friends provide you with the greatest support?

What kinds of activities do you enjoy?

Are you involved in any support or self-help groups?

Are you involved in a church or do you practice a religion?

EDUCATION, EMPLOYMENT, AND MILITARY INFORMATION

Education History (check all that apply) ☐ GED ☐ HS Graduate	Highest Grade Completed	Years of Vocational Training Completed

☐ College

Number of Years, Quarters or Semesters Degree/Major ☐ Other Degrees:

History of Learning Difficulties

☐ None ☐ Learning Disability Type(s):_____

☐ Developmental Disability

Employment (check all that apply)

☐ Full Time (35 hrs. or more per week) ☐ Part Time (less than 35 hrs. per week)

☐ Unemployed/Date Last Worked:_____

Not in Labor Force

☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐ Living in Institution

☐ Other:_____

If employed, name of employer:

Job Performance History

# of Jobs in Last 5 Years	What kinds of jobs have you had?

Job Attendance

☐ Above Average ☐ Normal ☐ Tardiness ☐ Absenteeism

Job Performance

☐ Exemplary ☐ Good ☐ Average ☐ Below Average

Employment Interests/Skills

Do you like your job? ☐ No ☐ Yes (If not currently employed)

Do you make enough money? ☐ No ☐ Yes Do you want to work? ☐ No ☐ Yes

Have you had any special job skills training? If "yes" what kind?

Military History

☐ No ☐ Yes If yes, describe branch of service, duties, and any trauma experienced during service.

Type of Discharge	Date of Discharge

MENTAL HEALTH TREATMENT HISTORY

Outpatient Mental Health Treatment ☐ None

Agency	Check if Current	Past (Date)	Clinician Name

Previous or Current Diagnoses (if known):

MENTAL HEALTH TREATMENT HISTORY (continued)		
Psychiatric Hospitalizations/Residential Treatment Facilities ☐ None		
Facility	Date of Service	Reason (suicidal, depressed, etc.)

CURRENT MEDICATION INFORMATION (Prescription/Over-the-Counter/Herbal) ☐ None					
Medication	Reason for Taking Medication	How Much/How Often?	Is It Helping?		
			Yes	No	Unsure
Primary Care Physician/Family Doctor:			Last physical exam:		
Other Prescribing Physician(s):					

Past Medications for Mental Health Problems ☐ None	
Medication	Reason for Discontinuation

ALCOHOL/DRUG HISTORY				
Illegal drug use/abuse past 12 months? ☐ No ☐ Yes Non-prescription drug abuse? ☐ No ☐ Yes Prescription drug abuse past 12 months? ☐ No ☐ Yes Alcohol abuse past 12 months? ☐ No ☐ Yes				
Drug/Substance/Alcohol	Age of First Use	Date of Last Use	Frequency of Use	Amount

ALCOHOL/DRUG TREATMENT HISTORY		
Have you had any alcohol or drug treatment? ☐ No ☐ Yes Current: ☐ Outpatient ☐ Intensive Outpatient ☐ Residential ☐ Other: Past: ☐ Outpatient ☐ Intensive Outpatient ☐ Residential ☐ Detox ☐ Other:		
Name of Provider Agency	Type of Service	Date of Service

LEGAL HISTORY

Do you have a Legal Guardian/Custodian? ☐ No ☐ Yes
Name of Legal Guardian/Custodian:
Address:
Phone # :

Current Legal Status

☐ None ☐ On Probation ☐ Detention
☐ On Parole ☐ Awaiting Charge ☐ Alcohol/Drug Related Legal Problems
☐ Conditional Release ☐ Outpatient Commitment ☐ Court Ordered to Treatment
☐ Other:

History of Legal Charges

☐ None Juvenile: ☐ No ☐ Yes If yes: ☐ Status Offense (e.g., Unruly) ☐ Delinquency
Adult: ☐ No ☐ Yes If yes: ☐ Misdemeanor ☐ Felony

List and Date Most Recent Legal Charges

Convictions
☐ None

Incarcerations ☐ None	Name and Phone # of Probation/Parole Officer
Civil Proceedings ☐ None	Domestic Relations Court Problems (custody, protective services, restraining order)

Juvenile Court Involvement (related to child abuse, neglect, or dependency)

Current: ☐ No ☐ Yes Comment:_____

Past: ☐ No ☐ Yes Comment:_____

Child Support Enforcement Orders
☐ None

Children's Protective Services Involvement with Family
☐ None

Name of Children's Protective Services Caseworker(s) Assigned to Family
☐ None

ABUSE HISTORY

Please check any types of abuse you have experienced:

☐ None ☐ Physical Abuse ☐ Domestic Violence ☐ Community Violence
☐ Physical Neglect ☐ Emotional Abuse ☐ Elder Abuse ☐ Sexual Abuse/Molestation
☐ Other:

Comment on abuse history:

PROBLEM CHECKLIST	
What problems are you having?	
Check	Check All Current Problem Areas, Please Explain:
	Nutritional/Eating Pattern Changes
	Pain Management
	Depressed Mood/Sad
	Grief/Loss Issues
	Anxiety
	Distressing/Disturbing Life Events – Recent or Historic
	Anger/Aggression
	Oppositional Behaviors
	Problems Paying Attention/Concentrating
	Impulsivity
	Sees or Hears Things That Other People Do Not
	Mood Swings/Hyperactivity
	Substance Use/Addiction
	Other Addictive Behaviors (i.e. Food, Internet)
	Sleep Problems
	Difficult Circumstances at Home or at School
	Health Issues/Medical History (include any allergies and food/drug reactions)
	Other:

CURRENT SOURCES OF STRESS

PLEASE LIST YOUR MOST SIGNIFICANT SOURCES OF STRESS OR WORRY:

1._____

2._____

WHAT IS THE MAIN GOAL YOU WISH TO ATTAIN IN SEEKING SERVICES?

_____

_____

_____

HOW WOULD YOUR LIFE BE DIFFERENT IF YOU COULD MANAGE SOME OF THESE PROBLEMS BETTER?

_____

_____

_____

ADDITIONAL INFORMATION
PLEASE ADD ANY INFORMATION YOU FEEL MIGHT BE HELPFUL IN ASSISTING IN YOUR TREATMENT:

_____

_____

_____

_____

Your signature below indicates you understand the questions, could ask for assistance if needed, and that this information is true to the best of your knowledge.	
Client's Signature:	Date:
Therapist's Signature:	Date: