Ronald Fox, LPCC, Inc & Associates
5221 East Main Street
Columbus, Ohio 43213

Submit

Please be patient with our paperwork.
Our services are regulated by over a dozen credentialing organizations and four licensing boards in addition to state and federal regulators.

RONALD FOX, LPCC, INC & ASSOCIATES
5221 East Main Street
Columbus, OH 43213
(614) 577-0445

CLIENT NAME_____

INSURANCE COMPANY_____

I am planning to use the above-named insurance to cover all or a portion of my psychotherapy sessions:

☐ Yes ☐ No

If "Yes": I understand that in order for any of my claims to be filed, that I must provide the office with accurate and current information and will update that information with the office promptly when that information changes. In addition, I will take full responsibility for paying any fees that insurance denies or does not fully cover, including copays, co-insurances, missed session charges and/or any deductibles that have not been met. Further, I understand that the office is acting only as an agent on my behalf in filing insurance claims for me.

If "No": I understand that I am responsible for making full payment for each session, after each session, unless other payment arrangements have been made with the Office Manager.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE

RONALD FOX, LPCC, INC & ASSOCIATES

This packet of materials contains a Client Information Sheet, a Client/Responsible Party Contract and Assignment of Benefits, and a Consent to Enter Treatment/Rights/Responsibilities. Please fill out completely and return it to your clinician.

You may be given a symptom history or medical checklist also. This clinical information is important for the evaluating professional. Please complete and return it to your clinician. Thank you for your cooperation. Please read over the following information that we hope will provide you as framework for understanding the basic procedures for our practice. We feel it is important that prospective clients be aware of specific rights and responsibilities before entering into a counseling relationship. If you have any questions after reading these materials, please discuss them with your clinician.

OFFICE POLICIES

The cost of evaluation and treatment is based on the amount of time spent with a professional and time for reviewing tests, records and for documentation. Telephone consultations or discussions with physicians, pharmacists, teachers, etc., will be billed at the same rate or less.

BILLING & MISSED APPOINTMENTS AND CANCELLATIONS

We expect clients to pay for their appointments at the time of service. If payment is not received on the date of service, the charges will be payable upon receipt of your itemized monthly statement. You will be provided with a contract that will serve as an agreement between the clinician/FOX and you, regarding the financial arrangements. Individual financial situations may be discussed with our office staff. As a convenience to you, FOX will bill your primary insurance. If you ask us to bill your secondary insurance there may be an additional charge. There will be times when sensitive information will need to be discussed with representatives of your insurance company for purposes of utilization review and benefit determination.

You will be charged $50 for missed appointments with less than 24 hours notice.

COMMUNICATION

Calls are handled by our office staff and voice mail system. Messages left will be returned as soon as possible. Information will be given on how to reach your therapist or a staff member on call in the event of an emergency. Clinicians have a voice mail system.

SUPERVISION MANAGEMENT

If the treating professional is receiving supervision, the supervisor will be identified on your treatment plan and on billing forms. If you have any questions about our services, you may contact the appropriate supervising professional or schedule an appointment. This information is provided for your convenience and as required by The State of Ohio Counselor, Social Worker and Marriage and Family Therapist Board, which regulates all licensing and registration of counselors, and social workers. The Counselor, Social Worker and Marriage and Family Therapist Board: 65 W Broad St, Columbus, Ohio 43215.

RONALD FOX, LPCC, INC & ASSOCIATES
5221 East Main Street
Columbus, Ohio 43213

CLIENT INFORMATION
(Please complete the following information. All information will be held confidential.)

Client's Full Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: _____ Birth Date: _____ Social Security Number: _____

Status: _____ (S = single, M = married, W = widowed, D = divorced, P = separated, O = Other)

Employer: _____ School (if student): _____

Email: _____

Person to contact in case of an emergency: _____ Phone: _____

FILL OUT THIS SECTION IF CLIENT IS A MINOR

Mother or Legal Guardian's Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father or Legal Guardian's Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Party responsible for payment: _____

PRIMARY INSURANCE INFORMATION
(This section must be completed or we will expect full payment at time of service.)

Insurance Co. Name: _____ Phone: (_____) _____

Member (Subscriber) ID #: _____ Group #: _____

Claims Mailing Address: _____ City: _____ State: ___ Zip Code: _____

Subscriber's Name: _____ Birth Date: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Client's relationship to Responsible Party: _____ (1 = self, 2 = spouse, 3 = child, 4 = other)

Subscriber's Employer: _____

Have you obtained Pre-Certification for services from your health insurance company? _____ Y es _____ N o

If yes, what is the certification #: _____

RONALD FOX, LPCC, INC & ASSOCIATES

CONSENT TO ENTER TREATMENT/RIGHTS/RESPONSIBILITIES

This is your consent for us to provide professional services, and a list of your rights and responsibilities as a client of RONALD FOX, LPCC, INC & ASSOCIATES (FOX). This list represents our intent to comply with federal, state and statutes, as well as professional standards and ethics. Please review any questions with your treating professional.

RIGHTS:

1. First and foremost, you have the right to be treated with dignity and respect.
2. You have the right to treatment. This includes, but is not limited to:
    a. The right to a humane psychological and physical environment that is the least restrictive environment appropriate to your needs.
    b. The right to a current, written, individualized treatment plan, which you have participated in establishing, and to see and sign the plan.
    c. The right to be informed of alternative and additional treatment resources and the right to request and receive aid in referral to another agency.
    d. The right to be informed of any contraindications resulting from treatment.
    e. The right to be protected from abuse and neglect.
    f. The right to refuse medication and/or treatment of any type.
3. The right to have equitable access to treatment regardless of race, religion, sex, ethnicity, age, handicap, or source of payment for services.
4. The right to confidentiality in accordance with federal and state law.
5. The right to full disclosure of all costs and fees.
6. You have the right to know that under the following conditions your rights to confidentiality may be limited and FOX staff will, under the "duty to warn" directive:
    a. Report suspected physical or sexual abuse to the appropriate authorities.
    b. Report homicidal intentions to the identified victim(s) and your local police department.
    c. Report suicidal intentions to your family if you fail to follow treatment recommendations.
    d. Report confidential information for peer and utilization review and to insurance representatives for purposes of utilization review and benefit determination.
7. The right to express complaints and grievances through outlined channels and to have grievances heard and a response obtained.
8. The right to appeal any decisions made concerning treatment, or any complaints and grievances, and to obtain a response.
    a. Take your problem directly to any staff person who will in turn take it to the Practice Manager for review within the next working day.
    b. If you are not satisfied, you may submit a formal complaint in writing to the Practice Manager to review the complaint and respond within one week.

RESPONSIBILITIES:

1. I have voluntarily chosen to receive mental health services and I understand that I may terminate at any time.
2. I understand that material may be discussed which might be upsetting or distressful in nature.
3. I understand that there is no assurance that services will provide desired results and that evaluation and treatment is a cooperative effort between staff and myself and I will work in a cooperative manner to resolve my difficulties.
4. I accept the financial responsibility to pay for services received, including all time for preparation, and/or travel for attorney consultations, depositions or court appearances as an expert witness. I understand prepayment may be required for expert witness services.
5. Some psychological symptoms have biological causes. I understand it is my responsibility to obtain and maintain sufficient contact with a physician regarding my physical health and psychological symptoms.
6. I understand there will be times when sensitive information will need to be discussed with representatives of my insurance company for purposes of benefit determination, or with professional peers for review or consultation.
7. I agree (FOX) may request information about my progress and satisfaction with services during and after completion of services.

I HAVE READ OR HAD THIS FORM READ TO ME. I FULLY UNDERSTAND ITS CONTENTS AND I ACKNOWLEDGE THAT MY SIGNATURE BELOW INDICATES MY CONSENT TO RECEIVE SERVICES AS STIPULATED.

Signature:
Client/Responsible Party _____ Date: _____

Witness: _____

RONALD FOX, LPCC, INC & ASSOCIATES
5221 East Main Street
Columbus, Ohio 43213
Phone: (614) 577-0445 Fax: (614) 577-1342

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Ronald Fox, LPCC, Inc & Associates is hereby granted my permission to:

Release to _____ **Receive from** _____ **Exchange with**_____

Name: _____

Address:_____ City/State: _____Zip Code: _____

Phone: _____Fax: _____

Such information as may be necessary regarding the treatment and condition of:

_____ _____ _____
Name of Client Date of Birth Social Security Number

Purpose or Need for Disclosure:

❑ Evaluation ❑ Therapy/Continuity of Care ❑To communicate my acceptance for EAP referral

❑ Consultation ❑ The EAP's evaluation of me ❑The EAP's recommendations

❑ Substance Abuse Professional Evaluation ❑ Other _____

Specific Information Requested:

❑ Medical Records ❑ Psychological Records

❑ Educational Records ❑ Substance Abuse/Evaluation or Treatment Records

❑ Other _____

This Consent will expire:_____
(Not beyond 90 days)

This information is being disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2, Section 2.31 of PL 93-232) prohibit an individual from making any further disclosures without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. This information is also protected by HB244 of the Ohio Revised code (SL22.3). This client has the right to withdraw this consent at any time.

_____ _____
Signature of Client/Guardian Date

_____
Witness

RONALD FOX, LPCC, INC & ASSOCIATES

CLIENT/RESPONSIBLE PARTY CONTRACT & ASSIGNMENT OF BENEFITS

This is contract between myself, _____and Ronald Fox, LPCC, Inc & Associates (FOX).

I am seeking services from (FOX) and understand that assessment, treatment and/or consultation services will be provided by health care providers for my benefits, the benefits of my spouse, the benefit of those in my guardianship, or any combination of us, and that the fees for those services will be charged to me directly. I understand that payments for these services are my responsibility. The fees for services have been explained to me and I agree to the following.

Usual Psychotherapy Fees:	Other Fees:
$175 Initial assessment interview	Testing fees vary (Ask your clinician)
$155 Clinical Hour (40 - 50 min.)	$45 Returned check fee
$85 Clinical Half-Hour (20 - 39 min.)	$250/hour for Expert Services

In addition to actual meetings, I understand and agree to pay for time spent by health care providers in consultation with other professionals, on testing and interpretation, during telephone contact, and for report preparation (when requested) as part of assessment, treatment, and/or consultation services (but not for time to schedule appointments and to deal with administrative matters). "Expert Services" are services related to testimony or rendering professional opinion in or for legal proceedings. Expert Services include the preparation for, travel to, and time of, consultations with attorneys, depositions, and court appearances as witnesses (whether or not actually called to the stand to testify). I understand that prepayment is required for Expert Services.

I also understand that unless I provide FOX with 24 hour advance notice of cancellation, I will be charged $ 50 (fifty dollars) for each missed appointment. Initials: _____

If I am a member or party to, or beneficiary of an insurance policy or contract, an HMO, or other arrangement where a third party pays for, reimburses for, or provides health care or health care benefits, then the party obligated to pay for, reimburse for, or provide the health care or health care benefits is called the "third-party payor" in this agreement. As a convenience to me, FOX or its billing agent will bill my primary third-party payor. I hereby assign all medical-related benefits to which I am entitled from any third-party payor to FOX and I hereby authorize FOX to maintain my signature on file for use in filing any claims.

FOX maintains provider contracts with numerous insurance companies as a provider. I understand this does not alter my responsibilities as agreed herein.

I understand that it is my responsibility to determine that amount of, and pay any deductible amount and co-insurance. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by any third-party payor unless otherwise indicated above.

I understand that my payment for office visits, less any amount to be paid by any third-party payor, is to be paid at the time of each visit. If co-payment is not made at the time of service, there will be a $10 fee to offset billing costs. I agree that under no circumstances, is the balance on my account (including amounts expected to be paid by any third-party payor) to exceed $500. If that happens, I will pay the balance in full, or make specific arrangements to pay it in full, before incurring any other fees.

I also agree not to let any fees remain unpaid for more than sixty (60) days from the date fees are billed to me. If any fees (including any amounts expected to be paid by any third-party payor) do remain unpaid for more than sixty (60) days, then **I agree to pay an interest charge equal to one and one-half percent (1.5%) of the fees that have remained unpaid for more than sixty (60) days.** I understand and agree that this late charge will be assessed each month on the fees that have remained unpaid for more than sixty (60) days, but no interest charge will be assessed on other outstanding and unpaid late charges.

I authorize disclosure of portions of my records as deemed necessary by FOX in order to obtain payment from any third-party payor and to the extent necessary to determine liability for payment. I also authorize disclosure as necessary for consultation with other professionals and for quality assurance reviews when required by any third-party payor or by professional standards.

I understand that FOX maintains provider contracts with some third-party payors, one of which may be providing benefits for the services I receive from FOX. If this is true, then I agree that where there is a conflict between this agreement and any other agreement to which FOX is a party, then this agreement supersedes the other agreement or agreements with regard to my relationship with FOX.

Signed:

By: _____
Client/Responsible Party

Date Signed: _____

Ronald Fox, LPCC, Inc & Associates

By: _____
Agent/Clinician

Date Signed: _____

Ronald Fox, LPCC, Inc & Associates

NOTICE OF PRIVACY PRACTICES - BRIEF VERSION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ASSESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. **This is a shorter version of the full, legally required NOTICE OF PRIVACY PRACTICES (NPP). The full version is available to you for the asking.** There are also copies to review on tables in the waiting areas. If there are any questions or problems, please talk to your clinician.

We will use the information about your health, which we get from you or from others, mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read the NPP we will ask you to sign a consent form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization to allow this. Of course, we will keep your health information private but there are some times when the laws require us to use it or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers' Compensation and similar benefit programs. There are some other situations like these which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information:
1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree with your request, if we do agree, we will keep our arrangement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact your clinician to arrange how to see your records.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and give it to your clinician. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from your clinician.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with your clinician and with the Secretary of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

The effective date of this notice is May 5, 2019.

_____ _____

Signature of client or his/her legal representative Date

RFOX **PERSONAL INFORMATION** **ADULTS**

Name**:**_____ Briefly describe your reason for seeking help: _____

_____

_____

_____

How long ago did the problem begin? _____

Have you sought counseling before? _____ If so, briefly describe the problem, who you consulted, when, whether or not it was helpful and why you terminated:_____

_____

Have you had problems with anxiety or depression? _____ Are these problems current? _____

Have you felt out of control of your own thoughts? _____ If yes, explain: _____

Have you experienced or expressed violent thoughts or behavior? _____ If yes, explain:_____

_____

Have you experienced suicidal/self-destructive thinking recently or in the past? _____ If yes, did this involve a plan? _____

Explain:_____

Have you ever actually attempted suicide? _____ If yes, how recently, and by what method? _____

Have problems in the above questions occurred during or after alcohol or drug use? _____

Identify any excessive behavior (alcohol, eating, gambling, sex, etc.) _____

Have you ever been in trouble with the law? _____ If yes, what was the problem, and at what age did it occur? _____

_____

What are your hobbies? List three and how often you do these things: _____

Please check any significant events in the past 1-2 years: Marriage: _____ Divorce: _____ Job Change: _____ Deaths: _____

Moving: _____ Serious illness of self or family member _____ Other: _____

EDUCATION/EMPLOMENT HISTORY

Current employer, position and duration: _____

Previous employment & dates: _____

Current part-time or volunteer work: _____

Years of education: _____ Highest degree obtained: _____

MARITAL/RELATIONSHIP/FAMILY HISTORY

Name of spouse/significant other: _____

Address, if different _____ Phone: _____

Date of marriage: _____ Have you or your spouse been married before? _____

Spouse's years of education: _____ Highest degree obtained: _____ Occupation: _____

Spouse employer: _____ Business phone: _____

List dates of previous marriages/divorces: _____

List names/birth dates of children from present marriage: _____

List names/birth dates of children from previous marriages: _____

List names/birth dates of spouse's children from previous marriages: _____

Your father's name: _____ Your mother's name: _____

If either of your parents is deceased, please indicate your age at the time: _____

Did you experience any emotional, physical or sexual abuse as a child? _____

FAMILY ALCOHOL/DRUG HISTORY

Indicate each family member's typical chemical use. Chemicals can include: alcohol, marijuana, tranquilizers, barbiturates, amphetamines (diet pills), sleeping pills, crack, cocaine, etc.

	Chemical used	How often (i.e., daily)	Additional information
Yourself			
Spouse			
Former spouse			
Father			
Mother			
Child			
Other			

Have you or anyone else in your family been treated for alcoholism or substance abuse? _____

MEDICAL HISTORY

Physician:_____ Address: _____

Physician:_____ Address: _____

Weight: _____Height: _____Date of last physician contact: _____

Indicate any psychological or medical difficulties experienced by other family members: Parents:_____

_____

Siblings: _____ Spouse/Other relatives: _____

Indicate medications you have or are taking; prescription and non-prescription, purpose, frequency, and duration: _____

_____

_____

If you have ever been hospitalized for psychiatric or alcohol/drug problems, please indicate where, when, and for what: _____

_____

_____

MEDICAL CONDITIONS & SYMPTOMS Check the following medical conditions your physicians have diagnosed.

Past	Now	
❑	❑	Alcoholism
❑	❑	Allergies
❑	❑	anemia (type)_____
❑	❑	Arthritis
❑	❑	Asthma
❑	❑	Cancer (type)_____
❑	❑	Cirrhosis
❑	❑	Colitis
❑	❑	Appetite diminished
❑	❑	Anxiety
❑	❑	Binging food
❑	❑	blackouts
❑	❑	Chest pain (angina)
❑	❑	Craving sweets
❑	❑	Depression
❑	❑	Dieting
❑	❑	Difficulty working under pressure
❑	❑	Dizzy spells
❑	❑	Exhaustion
❑	❑	Fainting spells
❑	❑	Fast pulse
❑	❑	Fatigue easily
❑	❑	Grinding teeth
❑	❑	Hallucinations
❑	❑	Hand tremor

Past	Now	
❑	❑	Color blindness
❑	❑	Diabetes
❑	❑	Fibrositis
❑	❑	Genetic syndrome (type)_____
❑	❑	Heart condition (type)_____
❑	❑	Hepatitis
❑	❑	HIV positive
❑	❑	Hypertension (high blood pressure)
❑	❑	Heart palpitation
❑	❑	hyperventilation
❑	❑	Itchy skin
❑	❑	laxative use
❑	❑	Leg cramps
❑	❑	Loose bowels
❑	❑	Lose temper easily
❑	❑	Lower bowel gas
❑	❑	Menstrual difficulty
❑	❑	Moist palms
❑	❑	Moodiness
❑	❑	Muscle twitching
❑	❑	Nervousness
❑	❑	Overeating
❑	❑	Pain - acute
❑	❑	Pain - chronic
❑	❑	Pain - joint
❑	❑	Sweating excessively

Past	Now	
❑	❑	Lupus
❑	❑	Migraine headaches
❑	❑	Multiple sclerosis
❑	❑	Pancreatitis
❑	❑	Seizures (Epilepsy)
❑	❑	Sexually transmitted diseases (STDs)
❑	❑	Thyroid condition
❑	❑	Ulcer
❑	❑	Perfectionism
❑	❑	Poor memory
❑	❑	PMS (premenstrual syndrome)
❑	❑	Self-induced vomiting
❑	❑	Sexual dysfunction
❑	❑	Stomach upsets
		From: ___food ___ liquor ___ medicines
❑	❑	Frequent headaches
		_____ morning
		_____ evening
		_____ For how long _____
		_____ What part of head _____
❑	❑	Sleep disturbance
		_____ getting to sleep
		_____ staying asleep
		_____ early awakening
		_____ avg. hrs. sleep/night