



# SOPHIA CENTER

**SOPHIA CENTER, INC.**

## REGISTRATION AND POLICIES – FOR LOURDES STUDENTS

5335 Silica Drive, Sylvania, OH 43560

Phone: 419.882.4529

Fax: 419.885.7612

sophiacenterinfo@sophia.center

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### CLIENT INFORMATION

Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

First Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Birth Sex: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Responsible Party (if client is a minor): \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Best phone #: \_\_\_\_\_

E-mail: \_\_\_\_\_

Employer/School: \_\_\_\_\_

Emergency Contact Person Phone: \_\_\_\_\_

Primary Care Physician name and date of last visit:

\_\_\_\_\_  
Psychiatrist (if applicable) name and number:

# INSURANCE INFORMATION

It is very important that the Client find out exactly what mental health services his/her insurance policy covers. Sophia Center can try to help the Client understand the information received, but please note that anything the insurance company quotes could be inaccurate and subject to change at any time. **If insurance is billed, Lourdes University will cover costs of deductibles and copays.** The Sophia Center will personally submit claims to Lourdes University. Should you receive a bill, please speak with your counselor.

- Lourdes Student with insurance
- Lourdes Student without insurance
- Lourdes Student requests no billing of insurance

## Policy Holder's information:

Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to Client: \_\_\_\_\_

Address (if different from client):  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance** Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

**Secondary Insurance** Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

# FINANCIAL POLICIES

\_\_\_\_\_ Cancellation and No-Show Policy: Cancellations must be made 24 hours in advance.

\_\_\_\_\_ If appointments are cancelled on a consistent basis or there is a failure to attend scheduled appointments twice in a row, the Sophia Center reserves the right to deny further services to the Client and a referral to another agency will be offered.

\_\_\_\_\_ Testing fees: Academic testing can be discussed with your counselor.

\_\_\_\_\_ Court Appearance: Upon request we will agree to write a summary or statement for the purpose of court. However, there may be a fee involved in the request. The Sophia Center clinicians will not, at any time, agree to serve as a witness in a court case or agree to be deposed for any court-related matter.

## LIMITS OF CONFIDENTIALITY

\_\_\_\_\_The content of therapy sessions is confidential. Both verbal and written records cannot be shared without the Client's (or Responsible Party's) written authorization. However, as licensed mental health providers in the State of Ohio, the Sophia Center clinicians/staff are mandated reporters, and thus, are required to report the following regardless of Client authorization: any or all concerns of reportable abuse, including, but not limited to the physical, emotional, or sexual abuse of children, adults and vulnerable adults, or a Client's threats of violence to themselves or others. In addition, the Sophia Center is permitted by law to share the Client's mental health information with insurance companies to obtain payment for services. The Client's mental health information will not be shared for any other purpose without written authorization. However, we consult regularly with other professionals regarding our Clients in order to provide you with the best possible service. Names or other identifying information are never mentioned; Client identity remains completely anonymous, and your confidentiality will be fully maintained.

\_\_\_\_\_Emergency Coverage: Voice messages are checked regularly and we endeavor to respond to messages received during the week within 48 hours unless otherwise noted in an extended leave message. Messages received over the weekend are returned during the next business day. For emergencies, call Mental Health Crisis line at 419-904-2273 or 988 or text 741741 or go to your local emergency room.

## EMAIL AND TEXT MESSAGING INFORMED CONSENT

\_\_\_\_\_The Sophia Center provides the Client with the opportunity to communicate by email, and some of the Sophia Center clinicians provide the opportunity to communicate by text. The Sophia Center will use reasonable means to protect the security and confidentiality of the messages, but cannot guarantee the communications will be private. The Sophia Center is not liable for improper disclosure of confidential information, unless caused by gross negligence or wanton misconduct on the Clinician's part. Likewise, the Client should not use email or text in a medical or other emergency as it is not guaranteed that any particular message will be read and responded to within any particular period of time. Emails and texts will be a part of the client's record.

Text Communication:  Yes  No

Authorized phone number(s): \_\_\_\_\_

Email Communication:  Yes  No

Authorized email address(es): \_\_\_\_\_

## TELETHERAPY INFORMED CONSENT

\_\_\_\_\_Teletherapy services are optional and voluntary, and, at the current time, cannot be conducted across state lines. Therefore, since the Sophia Center is physically located in the state of Ohio, teletherapy can only be conducted if the Client, likewise, is physically located in the state of Ohio at the time of the session. Some therapists may be able to use telehealth if the Client is in Michigan. Secure and private communication cannot be fully assured with this type of service, so it is important that both the Client and their counselor take reasonable measures to be located in private places during their sessions, and that the security of their technology be up to date with appropriate security protection. The Sophia Center will not record our sessions without the Client's consent. The Client agrees not to record sessions without the consent of the provider.

## EMERGENCY PROTOCOL

In the event of an emergency, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. These are the names and telephone numbers of whom to contact in case of an emergency (i.e. local physician, crisis hotline, trusted family, friend, or adviser).

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

## CONSENT FOR TREATMENT

I understand that I must be committed to attending sessions on a consistent basis in order to receive the greatest benefit from therapy. I may stop therapy at any time. If my therapist believes that I can receive more effective treatment elsewhere, referrals will be provided. I acknowledge that no guarantees have been made to me as to the results of my treatment. I understand that I have the right to be respected and included in my or my child's treatment. If I ever feel that my or my child's rights are violated, I can: Discuss my concerns with my/my child's clinician and/or clinician's supervisor. I can file a written grievance with the executive director, Dr. R. Nijakowski. Grievances will continue up the hierarchy, as needed, and we will not retaliate against you for filing a complaint. In addition, I understand that I may not attend sessions if I am under the influence of alcohol or illegal drugs, or if I am in the possession of a dangerous weapon. If I experience an emergency at any time over the course of treatment, I agree to seek immediate help through the nearest emergency room or by contacting 911.

## TERMINATION OF SERVICES

You have the right to terminate services at any time. However, if you decide to end therapy, it is best to notify the provider and discuss the process. Providers are required to measure progress of treatment and evaluate the outcome of therapy. If the therapist deems the Client does not meet medical necessity for further treatment, a discussion will be initiated to discuss preparation for completion of services. Also, after 60 days without communication between the provider and the Client, including no show or cancellation of sessions, the provider will close the case and the Client will be responsible to contact the provider to re-open the case for services.

My signature below indicates my desire and consent to receive mental health services from the Sophia Center.

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Witness signature: \_\_\_\_\_ Date: \_\_\_\_\_