SOPHIA CENTER, INC.

REGISTRATION AND POLICIES – FOR LOURDES STUDENTS

5335 Silica Road, Sylvania, OH 43560 Phone: 419.882.4529 Fax: 419.885.7612
sophiacenterinfo@sophia.center

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: _____