5335 Silica Dr. Sylvania, OH 43560
Phone: 419-882-4529 Fax: 419-885-7612
sophiacenterinfo@sophia.center

REGISTRATION AND POLICIES

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: _____
Both parents contact information (if client is a minor):
_____
Who has custody (if minor parents are separated):
_____

Address: _____
City: _____ State: _____ Zip: _____
Best phone #: _____
Email: _____
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.

- I authorize the Sophia Center to bill my insurance provider
- I do not have insurance/I do not want to use my insurance
- Self-pay

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 #: _____

I, the Client, understand that I am responsible for obtaining my mental health benefit information from my insurance company, including deductible, copay and coinsurance amounts, and authorization for treatment. I understand that I am ultimately responsible for any therapy fee(s) not covered by my insurance carrier, including denial of claims for any reason. If my insurance carrier changes at any time during my course of therapy, it is my responsibility to notify Sophia Center/my clinician. I am responsible for any charges incurred during a lapse of coverage. When insurance is billed on my behalf, I authorize payment of mental health benefits for services rendered, to Sophia Center, and the use of this signature on all my insurance submissions. I authorize the release of any and all information required for insurance and payment purposes.

_____ _____
Signature of Client or Responsible Party Date

_____ _____
Printed name of Client or Responsible Party Relationship to Client Date

Financial Policies

_____ **Testing fees**: Academic testing is $540. I understand that $200 is due up front with the remaining balance of $340 due at the conference which will not be covered by insurance and will be charged to my card on file. Some testing circumstances may be different and will be discussed prior to testing.

_____Cancellation and No-Show Policy: Cancellations must be made 24 hours in advance.
A cancellation that does not occur 24 hours in advance of the scheduled appointment will incur a $**35.00** fee. The failure to attend a scheduled appointment without a cancellation (a "no show") will incur a $**50.00** fee. Insurance does not cover these charges. Payment will automatically be charged to the Client's credit card.

_____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. Please contact the Sophia Center/your clinician as soon as possible for consideration of waiving this fee.

_____Default on Payments: If the Client has not made payment on his/her account within 60 days from the date of service, and/or any sessions thereafter, those payments will automatically be charged to the Client's credit card. If these actions are necessary, we will not schedule any further appointments with the Client, and a referral to another agency for continuation of services will be offered.

_____Collection of Account Balances: You will be given access to the Therapy Notes client portal to be able to review the client balance owed and the amount outstanding to your insurance carrier. If there has been no response from your insurance carrier within 90 days, the amount billed to that carrier will become your responsibility. Remember that the agreement for treatment is made between you and the Sophia Center, Inc., not your insurance carrier. You are responsible for all billed charges. Client account balances on which payment has not been received within 90 days will be notified by letter. If this action is necessary, no further appointments will be scheduled at the center and the Sophia Center staff will offer a referral to another agency for continuation of services.

_____Returned Check Policy: In the event of insufficient funds or returned checks, the Client will be responsible for the bank fees that incur due to a returned check, as well as the amount of the original check. Fees will automatically be charged to the credit card on file.

_____Secure Payments can be made through Therapynotes
https://www.therapyportal.com/p/sophiacenter2/ For billing questions please email billing@sophia.center

_____Self-Pay: Self-pay Clients are expected to pay for services at the time they are rendered unless prior arrangements have been made with the Office Manager. Assessments are $175 and 1-hour appointments are $125.

_____Charity Care Policy/Sliding Fee Scale: The Sophia Center, Inc. offers charitable care for clients provided necessary criteria is met. This is based upon the income level found on your tax forms. The Sophia Center, Inc. offers a sliding fee scale based on Federal guidelines regarding income status. Please contact the Office Manager, to discuss this option at 419-824-3662.

_____Letter Writing/Records Request: All letter writing and record requests are subject to a $35.00 fee prior to the letter or record being written and sent.

_____Phone Consultation: If consultation is initiated by the Client, or if the Client's clinician needs to consult with anyone on the Client's behalf (i.e. teacher, guidance counselor, probation officer, guardian ad litem, or other), the fee will be $1.00 per minute paid by the Client after the initial 10 minutes. Some insurances can be billed for this service. Emergency phone sessions will be billed at the session rate.

_____ 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.

Payment

The Sophia Center will personally submit claims to the Client's insurance company. Additional fees for all services not reimbursed by insurance will be the responsibility of the Client and made payable at the time of service. These include copays, coinsurances, unmet deductibles, private pay fees, late cancel/no show fees, and fees for letter-writing and records requests, as well as phone consultations, as detailed below. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the Client responsibility balance owed, it is your responsibility to contact your insurance carrier immediately. When we receive the EOB, we will enter all pertinent payment information into our system. At that time, any remaining balance owed by you will be charged to your credit card. The Client may pay for treatment by cash or check, or most major credit cards (Visa, Master card, AMX, and Discover). Currently, payments may also be made automatically through the secure portal https://www.therapyportal.com/p/sophiacenter2/ .

Credit card information is required, regardless of payment preferences, prior to the first session.

Name on card: _____

Signature of Client (or Responsible Party) if different from cardholder:

_____

Credit Card Type: ☐ Visa ☐ MasterCard ☐ HSA/FSA ☐ Amex/Discover

Card #: _____

Exp. Date: _____ Security code: _____

_____ I authorize and understand that any balance owed for testing/counseling after insurance has paid (deductible, copays etc.), will be charged to my card on file automatically at time of service.

Cardholder's signature:

_____ Date: _____

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.

_____Teletherapy Clients will have their card on file charged for services after insurance is billed.

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 #: _____

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.

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.

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: _____

Staff signature: _____Date: _____