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 number: _____
Primary Care Physician name and date of last visit:
_____
Psychiatrist (if applicable) name and phone number:
_____

Insurance Information

It is the Client's responsibility to confirm mental health benefits directly with their insurance carrier. Sophia Center may assist with understanding the information provided; however, insurance quotes are not guaranteed and may 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 understand and agree that:

- I am responsible for verifying my mental health coverage, including deductibles, copays, and prior authorizations.
- I am financially responsible for all fees not covered by insurance, including denied claims.
- I must notify Sophia Center immediately of any insurance changes.
- I am responsible for charges incurred during any lapse in coverage.
- When insurance is billed on my behalf, I authorize payment directly to Sophia Center and permit release of necessary information for billing.

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

_____ _____
Signature of Client or Responsible Party Date

Financial Policies -Please Initial

Testing Fees

_____ Academic testing is **$540**. A **$200 deposit** is due upfront; the remaining **$340** is due at the conference. Testing fees are **not covered by insurance** unless otherwise specified. Any exceptions will be discussed in advance.

Cancellation and No-Show Policy

_____ Appointments must be canceled **24 hours in advance**.

- Late cancellation: **$35 fee**
- No-show: **$50 fee**
  These fees are **not covered by insurance** and are automatically charged to the card on file.

_____ Consistent late cancellations or two consecutive no-shows may result in discontinuation of services and referral to another provider. Contact Sophia Center as soon as possible if you wish to request the fee be waived.

Default on Payments

_____ Balances unpaid **60 days** from service date will be automatically charged to the card on file. Services may be paused until the account is current.

Collection of Account Balances

_____ Client balances and outstanding insurance charges are visible in the TherapyNotes patient portal. If insurance has not responded within **90 days**, the billed amount becomes the Client's responsibility. Non-payment may result in termination of scheduling and referral to another agency.

Returned Checks

_____ Clients are responsible for all bank fees associated with returned checks, in addition to the original amount owed.

Secure Payments

Payments can be made online once you login to your therapy portal.

Self-Pay Rates

_____ Self-pay Clients must pay at the time of service unless arrangements are made.

- Assessments: **$175**
- 1-hour appointments: **$125**

Charity Care / Sliding Fee Scale

_____ Reduced fees may be available based on Federal income guidelines and documentation.

Letters and Records Requests

_____ Letter writing or record requests require a **$35 fee** prior to completion.

Phone Consultation

_____ Client-initiated or collateral consultations (teachers, probation officers, etc.) are billed at **$1.00 per minute after the first 10 minutes**, unless insurance allows billing. Emergency phone sessions are charged at the session rate.

Court Appearance Policy

_____ Clinicians do **not** serve as witnesses or participate in depositions. Sophia Center clinicians may provide written summaries for court when appropriate; fees may apply.

Payment Authorization

Sophia Center submits claims directly to insurance. Copays, deductibles, non-covered charges, and administrative fees (letters, records, phone consults, etc.) are the Client's responsibility and will be charged to the card on file at time of service.

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 been processed (deductible, copays etc.), will be charged to my card on file automatically at time of service.

Cardholder's signature:

_____ Date: _____

Limits of Confidentiality -Please Initial

_____ Therapy records are confidential and cannot be released without written authorization, except in the following legally mandated situations:

- Suspected abuse or neglect of a child, adult, or vulnerable adult
- Serious threats of harm to self or others
- Minors: reported self-harm, suicidal ideation, substance use, and potential gender related concerns.
- Legal reporting requirements for insurance billing

Clinicians consult with other professionals for quality of care; identities are not disclosed.

Emergency Coverage

Messages are returned within **48 business hours**. Weekend messages are returned the next business day. For emergencies:

- **National Crisis Line:** 419-904-2273
- **988 Suicide & Crisis Lifeline**
- **Text:** 741741
- **Nearest Emergency Room**

Email and Text Messaging Informed Consent

_____ Sophia Center offers email (and in some cases, text) communication. Security cannot be guaranteed. Email and texts should **not** be used for emergencies and become part of the clinical record.

Text Communication: Yes ☐ No ☐
Authorized phone number(s): _____

Email Communication: Yes ☐ No ☐
Authorized email address(es): _____

Teletherapy Informed Consent

_____ Teletherapy is voluntary and can only occur when the Client is physically located in **Ohio**. Privacy cannot be fully guaranteed; Clients and providers must ensure secure, private locations.

_____ Teletherapy Clients authorize charges to the card on file 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

Clients may end therapy at any time; however, discussing termination with the provider is recommended. Providers may initiate termination if treatment goals are met, medical necessity is no longer present, or if the Client has been inactive for **60 days**.

Consent for Treatment

I understand:

- Consistent attendance is important for effective therapy.
- No guarantees are made regarding treatment outcomes.
- I have the right to respectful, collaborative care.
- I may file concerns or grievances without retaliation to the executive director, Dr. Rachel Nijakowski.
- I may not attend sessions under the influence or with weapons in my possession.
- Emergencies require immediate help via 911 or the nearest ER.

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: _____

Signature of Staff: _____Date: _____