TREEmendous Care

Client Registration Form

Name:____ **Date:**_______________
Address:____
City:_______________________________ State:__________ Zip:_______________
Primary Number to leave a message:____
Home Number:_____________Mobile Number:_____________Work Number:_____________
Birthdate:_________ Gender: _________ Social Security Number:_____________________
Are You: Single Married Divorced Separated Widowed
Email address:____

Employer Name:____
Employer Address:____

Primary Care Physician (PCP):_______________________________ Phone Number:_________
PCP Address:____
Pharmacy Name:____
Pharmacy Address:____

Primary Insurance Company Name:_____________Secondary Insurance Company Name:____________
ID #:____________________ ID #:______________________________

Policy Holder Information ☐ **Same as client**

Primary Policy Holder ___________________ Secondary Policy Holder ___________________
Name: ___________________ Name:___________________
Address:___________________ Address:___________________
City:___________________ City:___________________
Primary Contact Number: ___________________ Primary Contact Number:___________________
DOB:_________ SS:_____________ DOB:_________ SS:_____________
Responsible Party: Client Policy Holder Other (fill out information below)
Are we able to contact this person regarding payment and billing information? YES NO
Name:____
Address:____
City:____
Home Number:_____________Mobile Number:_____________Work Number:_____________
DOB:_________________ SS:______________________________

Emergency Contact:____
Name:____________________________ **Relationship:**____________________
Home Number:_____________Mobile Number:_____________Work Number:_____________
Email address:____

Health History Questionnaire

Name:____ **Date:**_____________________
Birthdate:_____________ Gender: ______________

Please answer all questions with as much detail as possible. Your treatment plan will be tailored to your own needs. Please remember ALL information you provide is protected with applicable confidentiality laws.

Any herbal remedies you are using: ____
Please list any complimentary or alternative treatment you are using. Please indicate dates if you have used a treatment listed in the past.
Chiropractic_________ Acupuncture_________ Homeopathic______________ Other: _____________________

Medical Health History

Primary Care Physician Name	**Address**	**Phone Number**
Last Physical Exam	**Last Tetanus Shot**	**Ever had surgery?**
		☐ No ☐ Yes
Last PAP test	**Last Period**	**Ever shared needle(s)?**
		☐ No ☐ Yes

Other Physicians Name	**Specialty**	**Address**	**Phone Number**

Mental Health Treatment ☐ **N/A**

Agency/Practice Name	**Check if current**	**Past (date)**	**Clinician Name**
	☐		
	☐		

PMH: Problems & Dev. History	**Yes**	**No**	**Description of Problems (describe all "yes" responses):**
Allergies: Drug	☐	☐	
Allergies: Other	☐	☐	
Anemia (low iron)	☐	☐	
Asthma	☐	☐	
Bedwetting	☐	☐	
Birth Complications	☐	☐	
Chronic Snoring / Apnea	☐	☐	
Developmental Delay	☐	☐	
Diabetes	☐	☐	
Elevated Lead	☐	☐	
Enuresis	☐	☐	
Encopresis/Constipation	☐	☐	
Fetal Drug / Alcohol Exposure	☐	☐	
Fetal Nicotine Exposure	☐	☐	
Frequent Fractures	☐	☐	
Frequent Lacerations	☐	☐	
Head Trauma/Concussions	☐	☐	
Hospitalizations	☐	☐	
Jaundice	☐	☐	
Meningitis	☐	☐	
Recurrent Otitis (ear infections)	☐	☐	
Seizures	☐	☐	

Sleep problems	☐	☐	
Speech problems	☐	☐	
Surgical Procedures	☐	☐	
Other Problems	☐	☐	
Number of Pregnancies:			Number of Living Children:

Psycho-social History:	**Yes**	**No**	**Additional Description (describe all "yes" responses):**
Intact Biological Family	☐	☐	
State Custody	☐	☐	
Adopted	☐	☐	
Physical Abuse	☐	☐	
Sexual Abuse	☐	☐	
Emotional Abuse	☐	☐	
Neglect	☐	☐	
Other Trauma Exposure	☐	☐	
Cultural Factors	☐	☐	
Religious Factors	☐	☐	
Legal Issues	☐	☐	
Employed	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Current Medications (Prescription and Over-the-Counter) ☐ N/A

Medication	**Reason**	**Dose/Frequency**	**Compliance**	**Past or Current**

Family History	Mother	Father	MGM	MGF	PGM	PGF	Sibling	MA	MU	PA	PU	Other
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hx of sudden death	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
School drop out	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Panic attacks/ anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tics/ Tourette's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Felony convictions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aspergers syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psyche Hospitalizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental health problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Additional Comments on Family History:												

Educational History

Current School:	
Current Grade Level:	
Education Services:	☐ Regular Classroom ☐ 504 Plan ☐ IEP (specify type):
Previous Schools:	
Grade Retentions:	☐ No ☐ Yes--specify grade(s):
Attendance:	☐ No concerns ☐ Miss 1x/week ☐ Miss 2x/week ☐ Miss 3+ times/week
Suspensions:	☐ None ☐ 1-2 per year ☐ 3-4 per year ☐ 5+ per year
Expulsions:	☐ None ☐ Yes--specify year(s):
Academic achievement:	☐ Above average ☐ Average ☐ Below Average ☐ Failing
Peer relationships	☐ Excellent ☐ Average ☐ Minimal ☐ Bully ☐ Target of bullies
Other School Concerns:	
Comments:	

Alcohol/Drug History (include abuse of prescription drugs) ☐ N/A

Substance Used	Age at First Use	Date of Last Use	Frequency of Use (# of days/past month	Amount	Method	Treatment Received
Comments (List past treatment providers, dates of treatment and whether or not treatment was successfully completed):						

Which substance is of most concern?	
How long was your last voluntary abstinence from above substance?	From: To:
How much money did you spend in past 30 days on drugs and alcohol?	
Which substances do your peers use?	
Have you ever been concerned about your peers' use of drugs or alcohol?	☐ No ☐ Yes
Has anyone ever expressed concern about your use of drugs or alcohol?	☐ No ☐ Yes
Have you ever experienced withdrawal symptoms?	☐ No ☐ Yes--
Have you ever overdosed on drugs?	☐ No ☐ Yes
How important do you feel it is for you to receive treatment for your substance use?	☐ It's not a problem ☐ Thinking about stopping/reducing use ☐ Actively trying to stop/reduce use ☐ Maintaining sobriety
Comments:	

Current Treatment	☐ OP ☐ IOP ☐ Residential ☐ Other:
Past Treatment	☐ OP ☐ IOP ☐ Residential ☐ Detox ☐ Hospital ☐ Other:

Name of Facility	Service Provided	Date of Treatment	Successful Completion
			☐ No ☐ Yes
			☐ No ☐ Yes

Have you ever been the victim of abuse?	☐ No ☐ Yes
If yes, have you received help?	☐ No ☐ Yes

TREEMENDOUS CARE FINANCIAL POLICY

Thank you for choosing TREEmendous Care LLC Therapeutic Services for your mental health provider. We believe that all clients deserve the very best mental health treatment we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. All clients must complete information and insurance forms before seeing the mental health provider.

Full payment is due at the time of service. We accept Cash, Check, All Major Credit Cards, and Debit Card.

Regarding Insurance
Any co-payments, deductibles and services not covered by your insurance plan, including no show fees, are to be paid at the time the service was provided. The balance is your responsibility whether your insurance company will pay it or not. Your insurance policy is a contract between you and your insurance company. TREEmendous Care LLC is not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account.

Usual and Customary Rates
TREEmendous Care LLC Therapeutic Services is committed to providing the best treatment for our clientele and we charge what is usual and customary for our area and specialization. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Our providers will diagnose and treat based on your individualized needs and best practices for mental health supports, not your insurance coverage.

Minor Patients
The adult accompanying a minor and/ or parent/ guardian are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit/ debit card, payment by cash or check at the time of service, or insurance automatic billing plan previously established has been verified.

Collections
Any Account that has not received payment in 60 days will be sent to a collections agency that will pursue the responsibly party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality mental health care in a holistic environment.

I have thoroughly read the financial policy. I understand and agree to this financial policy.

____________________________________ ____

Printed Name & Relationship to Client Signature & Date

PLEASE CONTACT TREEMENDOUS CARE AT 513.400.5425, IMMEDIATELY IF THERE IS A CHANGE IN CUSTODY OR FUNDER

PERSONAL INFORMATION

Responsible Party: ____ **Relationship to Client:** ________________________________

Address: ____ *City:* ____________________*State:* ________ *Zip:* ________

Home No.______________________ **Work No.**______________________ **Cell Phone No.**______________________

Responsible Party SS # _______-_____-_______ **DOB**________________

Other Responsible Party: ____ **Relationship to Client:** ____________________________

Address: ____ *City:* ________________________*State:* _______*Zip:* ________

Other Responsible Party SS # _______-_____-_______ **DOB**________________

Emergency Phone No. ___________________________ *Alternative Phone No.* _____________________________________

INCOME AND EMPLOYMENT INFORMATION Employed ____ Yes ____ No

Employer____ Work No.______________________ Gross Annual $________________

Spouse (Other) Employer____ Work No.______________________ Gross Annual $________________

Adults in Household #______ **Children in Household #**______ **Total in Household #**______

Other Income Source Annual Amounts (please reference definitions of "other" income)

Alimony	$______________	Child Support	$______________	Savings/Investments	$______________
SSA	$______________	TANF	$______________	Disability Insurance	$______________
SSDI	$______________	GA	$______________	Unemployment	$______________
SSI	$______________	Retirement	$______________	Other (____________)	$______________

Total Annual Income **$______________**

Exceptional Family Expenses in Excess of 10% of annual income, i.e., (**Med. Expenses, Child Support or Daycare**)

Expense	Amount	Expense	Amount	Expense	Amount

TOTAL EXCEPTIONAL EXPENSES $________________

Adjusted Annual Income (Income – Expenses) **$______________**

INSURANCE INFORMATION

Medicaid Case Name____ Medicaid Case #_____________________________________

Insurance Carrier ____ Tel No#____________________ Policy #____________________

Policy Holder Name ____ Policy Holder SS # _______-_____-_______

DOB________________

Insurance Carrier #2____ Tel No#____________________ Policy #____________________

Policy Holder Name ____ Policy Holder SS # _______-_____-_______

DOB________________

If you have private insurance, you will be responsible to pay our full rate for services provided. TREEmendous Care, may assist you in obtaining information regarding benefits from your insurance carrier as a courtesy. However, you are responsible for verifying benefits with your insurance company before commencing services. TREEmendous Care, will not be liable in any way for having performed this courtesy service.

SERVICES	AGENCY RATE
Mental Health Assessment/Individual Service Plan (non-physician)	$175 per hour
Mental Health Crisis Intervention	$175 per hour
Behavioral Health Counseling and Therapy, Individual & Family*	$150 per hour
Behavioral Health Counseling and Therapy, Group	$100 per hour
Alcohol and/or Other Drug Assessment/Individual Service Plan	$175 per hour
Alcohol and/or Other Drug Counseling, Individual & Family*	$150 per hour
Alcohol and/or Other Drug Counseling, Group	$100 per hour
Alcohol and/or Other Drug Crisis Intervention	$175 per hour
Court Testimony, Preparations, and/ or related activities	$3000 per day in-person; $1500 per day virtual; $750 per document

*Collateral services may be included during treatment, i.e., face-to-face or phone contacts with external entities intended to improve functioning of child. Phone contacts for Community Psychiatric Supportive Treatment services are billable when intended to improve functioning of child.

PAYMENT FOR SERVICES

I understand that and agree to the following:

√ I am liable for the full cost of the services not covered by third-party payers. If Medicaid lapses and is not restored, I understand that I am responsible for charges for all services provided during the period of the lapse.

√ I am responsible for paying TREEmendous Care, for all treatment at the time services are rendered unless other arrangements have been agreed upon in advance. If I am not prepared to render payment at the time of service, then the appointment will have to be rescheduled. TREEmendous Care,, can accept checks or credit/debit card payment (Visa, MasterCard, Discover, American Express) for your convenience. Cash is not accepted at the office for reasons of security. I understand that I am required to pay the full amount of services on the day of service. If I have authorized payment by credit/debit card, said charge will be billed on or within four (4) days of scheduled appointment.

√ I understand that a $50.00 fee will apply for all returned checks, in addition to the amount originally owed. In the event of a returned check, my privilege to pay by check during future visits may be terminated.

√ If TREEmendous Care, has to bill me for any service, I am responsible to pay billed amount upon receipt of a statement. Failure to pay any outstanding amount upon receipt of a third and final statement may subject my account to be forwarded to a collection agency and reported to the credit bureaus. In addition, all future service will be cancelled. Any additional fees charged by the collection agency will be added to the original amount owed. It is understood and agreed that in the event my overdue balance is referred to a collections agency or attorney for recovery of fees, I am fully responsible for any and all costs incurred, including, but not limited to, attorney fees.

√ I agree that if at any time while services are being received through TREEmendous Care,, the agency learns of possible third-party insurance then said agency may provide third-party payer with information necessary for determining benefits and eligibility.

√ Third-party payers (Medicaid, Medicare, private insurance, etc.) will be billed for any covered services, to the extent I am eligible. I give consent to TREEmendous Care,, to provide third-party payers information necessary for filing claims on my behalf and for payments to be made directly to said agency. If such is prohibited under my policy, I hereby instruct and direct stated insurance company to make out the check to me and forward the check as follows: c/o TREEmendous Care,. I understand this to be a *direct assignment of my rights and benefits under this policy*.

SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account.

In choosing to initiate mental health and/or AOD services for the above-identified client, I understand that:

√ TREEmendous Care, offers a variety of Mental Health and AOD services all of which are covered by this agreement, whether the service is initiated now or at a later date. I will not be required to execute another financial agreement if I add services later unless there has been a significant change in circumstances, i.e., residency, employment, income, custody, or insurance coverage.

√ TREEmendous Care, is to be **notified in writing within five (5) working days** regarding changes (financial or other, such as change of address or custody or insurance) that may impact the eligibility of service reimbursement or coverage.

Fees are subject to increase without notice.

I understand that TREEmendous Care, will make every effort to work with me in order to assist me in meeting my financial obligations as outlined above. If I fail to meet my financial obligations as outlined above, the result could be an interruption in service. If I am unwilling to work with the agency, further action may be taken which could lead to collection fees, court costs, and/or attorney fees and/or reports to local as well as national credit reporting agencies.

I hereby certify that all of the above information on this form is true and complete to the best of my knowledge, and if it is necessary, I agree to provide proof of information given on this form. I have received a fee schedule, I have read or have had read to me and understand this agreement, and I was given an opportunity to have any questions answered by the Agency Representative, this __________ day of _______________________, 201_____.

Responsible Party	Other Responsible Party	Agency Representative
______________________________	______________________________	______________________________
Signature	Signature	Signature

Date(s) of service covered by this agreement: ________ / ________ / ________ through ________ / ________ / ________.
(start date) (start date + 364)

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to TREEmendous Care LLC. When you schedule an appointment with TREEmendous Care LLC we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

Effective January 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged the **full fee**.

Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged **the full fee**.

If a **third** No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be **dismissed** from TREEmendous Care LLC services.

Any new patient who fails to show for their initial visit will not be rescheduled.

The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

As a courtesy, when time allows, we make reminder text/emails/calls for appointments. If you do not receive a reminder communication or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact your Therapist, who may be able to waive the No Show fee. You may contact TREEmendous Care 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message or email communication. **(513) 866-4645 or info@treemendouscare.com**

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

______________________________	______________________________
Signature (Parent/Legal Guardian)	Relationship to Patient
______________________________	______________________________
Printed Name	Date

TREEmendous Care LLC Therapeutic Services Consent to Treat

I hereby certify that TREEmendous Care LLC Therapeutic Services (TC) has informed me of their professional qualifications, certifications, and licensure. TC has provided both an explanation and copy of client rights, responsibilities, grievance policy, crisis protocol, financial schedule, and attendance policy. TC has also informed me of the assessment, diagnosis and treatment planning. By signing below, I agree to participate in the proposed treatment as recommended by the undersigned TREEmendous Care LLC clinician and that information concerning my treatment may be shared with another clinician from TREEmendous Care LLC should it be deemed useful for my treatment.

Furthermore, I understand that TREEmendous Care LLC currently utilizes electronic medical records for provider communication and storage of any and all medical information. The electronic health record will be utilized for client and clinician access to information concerning both present and past mental health treatment.

Client Signature Date   Client Signature Date

Parent/ Guardian Signature Date   Clinician Signature Date

Consent to release patient information to Primary Care Physician and Coordination of Care

☐ I do not wish my primary care provider to be contacted at this time.

☐ I authorize TREEmendous Care LLC Therapeutic Services to contact my primary care physician:

______________________________, M. D.

____
Phone

____
Address

____
City, State, Zip

To provide information regarding my treatment, diagnosis, behavioral, mental and emotional functioning, and behavioral health treatment status.

Client Signature Date   Client Signature Date

Parent/ Guardian Signature Date   Clinician Signature Date

TELEPHONE, TEXT & EMAIL COMMUNICATION CONSENT

I, ____, give TREEmendous Care LLC Therapeutic Services my permission to send communications by telephone (including voicemail), text or email.

Check all that apply to authorized communication types:

Home Phone at ____

Mobile Phone at ____

Text Message at ____

Voice messages at ____

I understand that text messages and email messages may be transmitted over a public network and as such may not be secure; however, I am aware that TC will not transmit any information which would enable me to be identified.

I understand that I may withdraw or opt out of this consent at any time in writing. This consent will expire at the termination of my treatment with TREEmendous Care LLC unless I withdraw my consent during treatment.

____ ____
Client Signature Date Client Signature Date

____ ____
Parent/ Guardian Signature Date Clinician Signature Date