Tri-County Christian Counseling Services Inc.

8050 Beckett Center Dr., Suite 210, West Chester, OH 45069
(In the CMC Office Building)
Mailing Address
8216 Princeton Glendale Road # 154 West Chester, OH 45069
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www.tcccs.com
info@tcccs.com

WELCOME TO *TRI-COUNTY CHRISTIAN COUNSELING SERVICES (TCCCS)*

This introduction has been prepared to give you general information about our practice at TCCCS. Please read this carefully, and sign the last page indicating your understanding of our policies. Carol will be pleased to answer any other questions during your initial session.

Carol Williams is licensed to practice in the State of Ohio as a Professional Clinical Counselor.

Carol works with adults, couples, and families who find themselves faced with a crisis or difficult situation. She applies Christian principles because she knows they provide the basis for coping with life's problems. Your physical, mental, emotional, and spiritual welfare are very important to her. Although she can make no guarantees, she will do her best to aid your growth in those areas. If at any point during the counseling relationship either you or she is not confident of her ability to help you, you will be referred to another appropriate professional.

Carol has studied and uses many different counseling theories and techniques and finds each one to have some valuable use. The ability to integrate and apply the most helpful aspects of a number of approaches will better help you with the issues presented.

Some of the problems you are experiencing may have been with you for years, so do not become discouraged if they are not resolved immediately. During the counseling process you may experience some personal discomfort. This is very normal and gives you the opportunity to bring about changes toward more healthy thought process and behavior. In some cases your situation may appear to become worse. Do not give up. Most changes take time to become a part of your thinking and behavior.

Regular assignments may be given for you to complete between your appointments. It is important that you do your best to accomplish these as it will hasten and enhance the changes you are working toward.

CONFIDENTIALITY

Ohio law requires that issues discussed during the course of therapy with a counselor be confidential, meaning that the information that you reveal will not be discussed with others without your consent. If you or your therapist believes it would be useful to discuss your situation with someone else, you will need to sign a **release of information** form before this can occur.

Limits to confidentiality: potential harm to oneself, threat of harm to others, suspected child abuse, or neglect, and in situations where the law requires the release of confidential materials.
I understand that **TCCCS, Inc**. is not directly responsible for what happens between me (the client) and my therapist.

PRIVACY PRACTICES

We use health information about you for treatment purposes, to obtain payment for treatment (including turning unpaid accounts to a collection attorney for legal action), for administrative purposes, and to evaluate the quality of care you receive. In most cases, you have the right to look at or get a copy of health information about you. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that any information in your record is incorrect, you have the right to request that we correct the existing information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information. We are required by law to protect the privacy of your information, provide this notice about our information practices, follow these information practices, and seek your acknowledgment of these notices. For more information about our privacy practices, contact the Privacy Officer-our Business and Marketing Director. You may also send a written complaint to the U.S. Department of Health and Human Services.

APPOINTMENTS/CANCELLATIONS/MISSED APPOINTMENTS

Your session is scheduled for 45 minutes. It is important that you be prompt as the session cannot be extended past the already scheduled time. (Sometimes Carol must respond to an emergency or crisis in which case your appointment must be cancelled. Every effort will be made to notify you of the cancellation and to reschedule your appointment.) **Our office requires a 24-hour notice for you to cancel an appointment. Failure to do so will result in your being charged the rate of *$95.00.***
This is intended to encourage your faithfulness in the growth process, and to give us the opportunity to schedule another client for that appointment time.

INSURANCE: **For those clients who have "out of network" benefits with your health care provider, you will have the necessary information on your *walk-out receipt* so that you can submit your claim to your health care provider. They are to mail their payment directly to you and NOT to TCCCS. TCCCS will not submit claims. TCCCS is not on any health care provider panels, so we do not accept "in-network" payments. By signing the form at the end of this *"INTRODUCTION",* you agree to the amount covered or not covered by your insurance.**

FEES:

Initial Office Fee:	**$ 95.00 is due at time of visit**
Ongoing Sessions:	**$ 95.00 is due at time of visit**
Consulting with other professionals:	**$150.00 per hour**
Cancellation Fee (less than 24 hour notice):	**$ 95.00**

If payment is not made at the time of your session, a $10.00 fee will be added to your account. Payment must then be received in our office within a week to avoid additional fees.

PHONE/E-MAIL CONSULTATION FEES:

Any communication via E-mail, SKYPE, and/or non-emergency phone sessions will be charged in 15-minute increments at $30.00 per increment. We must have your credit card information on file before these sessions are scheduled or conducted. A charge to your credit card account will be run at the time of reading and/or corresponding via the E-mail, SKYPE, or after the phone session has ended. Carol will tell you the amount that will be charged at that time.

FINANCIAL RESPONSIBILITIES:

- **I understand that payment is the responsibility of the client.**
- **I understand that my payment is to be made in full at each appointment.**
- **I understand that if it becomes necessary to mail statements because a payment was not made at the time of my visit, and/or if a payment is not sent after billing, then a $30.00 billing fee will be added to my account for each month in which a payment is not made.**
- **I understand that if I cancel my appointment less than 24 hours prior to my session, I will be responsible to pay $95.00 for that session. I understand that if my account becomes delinquent, it will be turned over to an attorney and/or Small Claims Court, and I will be responsible for all fees incurred as a result of this.**
- **I understand that if someone other than myself is paying for my sessions and for some reason they fail to pay the fees, I will be responsible for those fees.**

I understand that TCCCS will not submit : a diagnosis, Tax ID.#, or any other information that is not already on the receipt that I receive at the end of each session. TCCCS will not submit insurance claims on behalf of clients.

For your convenience, Visa, MasterCard, American Express, and Discover cards are accepted.

CHILDREN ARE TO BE SUPERVISED AT ALL TIMES. TCCCS TAKES NO RESPONSIBILITY FOR THE SAFETY AND ACTIVITIES OF UNATTENDED CHILDREN.

We try to return calls as soon as possible. If you have an emergency and are unable to reach us soon enough, please go to a hospital emergency room.

Please call or text Carol on her cell # at: 513-509-4021 if you are either in the lobby and/or running late.

"This information is required by the counselor, social worker, and marriage and family therapist board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state. If you have complaints about professional services from a counselor, social worker and/or marriage and family therapist contact the:"

State of Ohio Counselor and Social Worker, Marriage and Family Therapist Board
77 South High Street 16th Floor
Columbus, Ohio 43215-6108
(614) 466-0912
Website: www.cswmft.ohio.gov.

Carol Williams M.Ed. M.A., NCC, CEAP
Professional Clinical Counselor
M.Ed. - Guidance and Counseling-Miami University
M.A. - Counseling-Liberty University
Clinical Studies-Wright State University

Thank you for the opportunity to be of assistance to you.

PLEASE COMPLETE IN FULL ALL OF THE INFORMATION BELOW. THIS MUST BE COMPLETED BEFORE YOUR INITIAL SESSION. THANK YOU

RECEIVED AND READ:

_____ _____ _____
Signature Date (Date of Birth)

_____ _____ _____
Signature (Spouse/person responsible for payment) Date (Date of Birth)

Home Address:_____
Telephone Number: Home: _____Work: _____(Ext.)_____
Cell Phone: _____
At which number/s may we leave messages?_____
Driver's License #:_____State of Issue: ___SS#_____
E-Mail:_____
Place of Employment:_____
Address: _____

"In Case of Emergency" Contact Name:_____
Telephone Number/s: Cell: _____**Work:**_____
Home:_____ **Other:**_____

(This page will be kept in your file. You may take pages 1-3 with you.)

E-MAIL , CELL PHONE & SKYPE VULNERABILITIES

"Because e-mail connects through many routers and mail servers on its way to the recipient, it is inherently vulnerable to both physical and virtual eavesdropping. Current industry standards do not place emphasis on security; information is transferred in plain text; every e-mail leaves a digital paper trail in its wake that can be easily inspected months or years later."
It is important that you, the client, are also made aware of the eavesdropping vulnerability, both physical and virtual, that can be inherent in the conversations and information transmitted via SKYPE, E-mail, and Cell Phones.

Please sign below that you are aware and willing to take these inherent risks should you choose to conduct sessions via E-mail, Cell Phone, and/or SKYPE.

_____ _____
(Signature) (Date)

_____ _____
(Spouse) (Date)

State of Ohio Counselor and Social Worker Board
77 South High Street 16th Floor
Columbus, Ohio 43266-0340
614-466-0912
Website: www.cswmft.ohio.gov.

CREDIT CARD INFORMATION AND CLIENT SIGNATURE

Please provide/update your credit card information. This will be kept on file in the computer. Please indicate whether this is a FSA or HSA account.

Client Name: _____

Billing address of credit card: _____

_____

Credit Card #:_____

Visa Master Card Discover FSA HSA (please circle)

Expiration Date: _____ **CVV code #**_____

Authorized Signature: _____Date:_____

Print Name: _____

Authorized Signature: _____Date:_____

Print Name: _____

Cell Phone Number: _____

E-Mail address: _____

Please indicate whether you want your receipt sent to your cell phone as a text message or to your email account.

Cell Phone Email