Rosalino Counseling Services

Suelem Rosalino, MSW, LICSW
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383 West Fountain Street *Providence, RI 02905 * OFFICE 401-400-1863 * FAX 401-270-5322
ROSALINOCOUNSELING @YAHOO.COM

Welcome to RCS Counseling. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us to better understand your situation as well as potential solutions in helping you get your life back on track. Please note, this information is confidential, for our use only, and will not be released to anyone without your written permission. Personal Information

DATE _____

REFERRAL SOURCE (AGENCY/PERSON) _____

ADDRESS _____ PHONE _____

Fax Number _____ EMAIL Address_____

CLIENT'S NAME _____ DOB _____

SOC. SEC. # _____ GENDER _____ AGE _____

ADDRESS _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____

LANGUAGES SPOKEN_____

Home Phone Is it okay to leave a message? Yes /No

Work Phone Is it okay to leave a message? Yes /No

Cell Phone Is it okay to leave a message? Yes/ No

Email Address: May we email you? Yes/No

In an emergency, who do we call?

□ **BIOLOGICAL PARENT** □ **LEGAL GUARDIAN (MUST PROVIDE LEGAL DOCUMENTS FOR VERIFICATION)**

PARENT/GUARDIAN _____ HOME PHONE:

Does the client have any other form of insurance? Yes/No

If no insurance

BILLING INFORMATION

primary insurance company_____

policy # _____

GROUP NUMBER_____ PHONE (_____) _____

name of insured _____ D.O.B_____

Contact Name:
Policy Owner's Address (only if different than above): Please be prepared to provide our office staff with your insurance card so that we may make a copy.

Social / Family Information

Never Married Married Separated Divorced Widowed Engaged Living Together Same-Sex Partners

If you are currently in a romantic relationship, for how long?

On a scale of 1 to 10 (with 10 being best),

How would you rate your satisfaction with your current relationship?

Do you have children?

If so, please provide names and ages:

If you have listed children, with whom do they live?

Do you have any pets in the home? If so, what type?

List any other individuals living in your home (other than you and any children listed above):

Medical and Mental Health History / Information

Are you currently being treated by a physician for any medical conditions?

If so, please describe: Are you currently taking prescription, over-the-counter or herbal medication? No Yes;

Medication name/dose: Have you ever seen a Psychiatrist or other mental health provider? No Yes; If yes, when?

What was the focus of treatment?
Was it helpful? Yes No

Counseling Concerns

What are the issues for which you are currently seeking assistance? Please be as specific as possible.

1_____ 2. _____
3._____ 4._____

What have you previously tried in order to resolve these issues (e.g. religious counseling, talking with family/ friends)?

Has anything been helpful?

What are some of your coping strategies?

What do you consider to be your strengths?

Counseling Goals Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1. _____
2. _____
3. _____
4. _____

Risk Assessment

Is there any family history of mental illness or substance abuse?

If so, please list relationship & diagnosis:

Please list family, friends, support groups and community groups which are helpful to you:

List any personal history of emotional, physical, and/or sexual abuse:

Has a family member or close friend ever committed suicide? No/ Yes
Have you been having any thoughts of harming yourself or others?

Are there any guns or weapons in your house (specify whose & what type)?

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)?

If so, please state who and under what circumstances:

Alcohol / Substance Use Survey

How often do you have a drink containing alcohol?

Daily Weekly Monthly

How many drinks containing alcohol do you consume on a typical day that you are drinking?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

Do you use marijuana or other "street drugs"? (Remember, this information is confidential)

No Yes

What type/quantity/frequency of use:

Credit Card Payment Authorization

Form Please complete the information below:

I _____ authorize Rosalino Counseling Services to charge my credit card for any balances on my account, to also include copays if not paid via cash, check or PayPal invoice. In the event that I do not cancel an appointment within 24 hours and my appointment cannot be rescheduled that same week, I authorize my credit card to charge a **$50 cancellation fee.**

_____ Please keep my debit/credit card information on file to charge each visit. initial Billing

Address_____
City, State, Zip_____
Phone#_____
Email_____

SIGNATURE:_____ DATE:_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Account Type: Visa MasterCard

Cardholder Name _____
Account Number _____
Expiration Date _____ CVV2 (3 digit number on back of Visa/MC, the charge will show on your credit card statement as " Rosalino Counseling

Client Services Agreement

Name of Client:_____
Name of Responsible Party (if different):_____

TREATMENT: I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision prior to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services from Hopeful Counseling Services & Education.

PAYMENT & INSURANCE REIMBURSEMENT: I understand that I (the client) am fully responsible for the payment of all fees for services provided regardless of any insurance coverage I may have. I understand that it is HC's policy that the fee for any session is payable at the beginning of the session. HC's accepts cash, checks or credit cards as forms of payment. All sessions are 45 minutes in length. The fee for an initial intake session is $ 150. Follow up session fees for individuals ($ 85), couples or families ($165-$200).

PHONE SESSIONS: Rosalino Counseling is able to conduct visits by phone or Telemental Health that is HIPPA compliant if there is an emergency, illness, and inclimate weather. RCS reserves the right to bill your insurance for all telephone sessions. Rosalino Counseling Services will also charge you your regular copay. Any phone consultation that is initiated by the client, the first 10-minutes are at no charge. However, $25.00 will be billed to your account for each subsequent 15- minute period. I understand that if I have insurance, HC will either file the claim on my behalf or will provide me with the necessary information so that I can file the claim. I understand that I am ultimately responsible for any therapy fee(s) not covered by my insurance carrier. Co-pays and non-covered services are payable at time of service unless other arrangements have been made. In the event that insurance is billed on my (the client) behalf, I authorize payment of mental health benefits to Rosalino Counseling Services or the name of the therapist as indicated above (please check name of attending therapist).

My signature below indicates that I have read, understand, and agree to the statements made above regarding Treatment, Payment & Insurance Reimbursement, and Cancellations and Missed Appointment Policy.

Client (or responsible party's) signature:_____ Date: _____

INFORMED CONSENT FORM THE COUNSELING PROCESS:

The counseling process is a partnership between you and a clinician to work on areas of dissatisfaction in your life or assist you with life goals. For counseling to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, listening to the clinician, being honest with the clinician, discussing the counseling process with the clinician, and completing outside assignments agreed upon with the clinician. Counseling can have both benefits and risks. While counseling can be of benefit to most people, the counseling process is not always helpful. The counseling process also can evoke strong feelings and sometimes produce unanticipated changes in one's behavior. It is important that you discuss with a clinician any questions or discomfort you have regarding the counseling process or any behavioral changes you may be experiencing. Your clinician may be able to help you understand the experience and/or use different methods or techniques that may be more satisfying.

COUNSELING: is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY: Rosalino Counseling Services (RCS) recognizes that confidentiality is essential to effective counseling. We believe that for counseling to work best, you must feel safe about sharing personal information about yourself with your clinician. When you share information about yourself with your clinician, he or she will respect the importance of that information. **Counseling records are destroyed 7 years after your last contact with us in a way that protects your privacy.** Under most circumstances, all information about you obtained in the counseling process (including your identity as a client) is confidential and will be related to other parties only with your expressed written consent. However, it is because of the strength of our belief in the importance of you feeling safe about sharing information about yourself with your clinician that we want to inform you about the circumstances in which we may share information about you without your consent.

- Information Released to other professionals involved in your treatment. Most commonly, this would be the other members of the counseling staff at RCS or your medical providers

- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.
- If you are reasonably suspected to be in imminent danger of harming yourself or someone else.
- If you disclose abuse or neglect of children, the elderly, or disabled persons.
- If you disclose sexual misconduct by a therapist.
- To qualified personnel for certain kinds of program audits or evaluations.
- In criminal proceedings.
- In legal or regulatory actions against a professional.
- Upon the issuance of a court order or lawfully issued subpoena
- Where otherwise legally required The above is considered to be only a summary. If you have questions about specific situations or any aspect of the confidentiality of RCS records, please ask a member of the counseling staff.

***All interactions with Rosalino Counseling Services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.**

CONSULTATION: When appropriate, therapists consult with a psychiatrist regarding any medication concerns discussed on behalf of the client or to gain psycho-education regarding medications.

COUNSELING RECORDS: Counseling records are stored in locked files and/or electronically on a secure server that is only accessible by our staff. Upon request, you may review your counseling records. In order to ensure the information contained is clearly understood, you will be asked to arrange an appointment with your therapist or another member of the counseling staff to go over the information. Appropriate fees will be charged for making copies of client records.

FORMS THAT NEEDS TO BE SIGNED BY THERAPIST: Please give the office 7 days to fill out and sign any forms. The fee for the services is $25.

COUNSELING DECISIONS: Frequency of sessions, number of sessions, goals, type of counseling and any alternative counseling methods will be discussed and negotiated between you and your therapist. You are encouraged to regularly discuss your progress and review your goals with your therapist. If you have questions about recommendations or the approaches used by

therapist, please discuss your questions or concerns with the therapist. If you feel these recommendations are not appropriate, you may refuse to accept them. If you feel you are not making satisfactory progress toward your goals, please discuss this with your therapist, if you are able to resolve questions or concerns you have about the progress of counseling, the process of referring to another provider will be implemented.

ACCESS TO SERVICES: Counseling services are generally available during normal business hours (Monday thru Friday until 8pm and Saturdays until 3:00pm) throughout the year (including breaks between semesters) except on designated holidays. An individual in crisis can the RCS therapists at any time during office hours and be worked into a schedule for a brief evaluation. If it is after office hours and you are in imminent crisis, please call 911 or visit your local emergency room.

ELECTRONIC COMMUNICATION: Rosalino Counseling Services seeks at all times to maintain and respect the confidentiality of each client, including not only the details of any services rendered, but also the fact that an individual may be in contact with HC. With this in mind, HC wishes to remind each person that electronic communication (e.g., email, texts, faxes) is not a secure form of communication. Because confidentiality cannot be assured, the use of electronic communication is discouraged in regard to communications with HC. When necessary, electronic communication may be used for scheduling appointments but should not be used for counseling purposes or major forms of communication. The suitability of any clinical consultations or recommendations can only be determined through counseling sessions. electronic communication is not appropriate for emer or time-critical situations. The fastest way to contact therapists is by phone. Please call your clinician or the office directly (401) 400-1863 or 401-203-4440. Please give the therapist 24 hours to answer your phone call. **If it is after office hours and you are in imminent crisis, please call 911 or visit one of your nearest emergency rooms.**

COUNSELING APPOINTMENTS: The therapist can be expected to respect you as an individual and to convey this respect by keeping appointments or contacting you if a change in times is necessary, by giving you his/ her complete attention during sessions, and by avoiding interruptions during sessions. On rare occasions however, sessions may be interrupted if the clinician is called to respond to a crisis. It is also expected that you will be prompt for appointments, and that you will call in advance if you will be more than a few minutes late or have to miss an appointment. **In the event of inclement weather our therapists will be doing therapy sessions with our clients through Theranest Telemental Health or by phone. Our therapists will contact clients in advance. This service will count as a therapy session.**

FEES: Fees are charged for services rendered on behalf of Rosalino Counseling Services. The fee schedule is as follows if you are opting to not bill your insurance company (e.g., pay out of pocket):

- Intake/Assessments/Evaluations (up to 60 mins): $150
- Individual sessions (45 mins): $85-$150
- Family sessions (60-90 mins): $150-$200
- Mediation (45 mins): $175
- Court appearances: $ 550
- Treatment team meetings: $100

NO-SHOW/LATE CANCELLATION CHARGE: We appreciate prompt arrival for appointments. Please notify Suelem Rosalino (401) 400-1863 or Sabrina Rosalino (401) 203-4440 for any late arrivals. IF a client does not provide notice within 24 hours of his/her scheduled appointment, the **$50** fee will be charged to the client's account and will be asked to pay this balance prior to scheduling his/her next appointment. Clients may leave a message on Rosalino Counseling Services's voicemail to cancel an appointment; however this message must be left at least 24 hours before the scheduled appointment.

Consent: I certify that I have read, understand and agree to abide by the information, terms and conditions contained in this Informed Consent for counseling services form. I have had the opportunity to discuss any questions about the information contained in this form, or any other aspect of Rosalino Counseling Services.

I hereby give my consent to Rosalino Counseling Services to evaluate, provide counseling services and/or refer me to others as needed.

Signature of Client Signature_____
Therapist Signature_____
Client's Guardian (if applicable):_____

Rosalino Counseling Services

Suelem C. Rosalino, MSW LICSW

Sabrina C. Rosalino, MSW

383 W. Fountain Street

Providence, RI 02906

Phone: (401) 419-4846

Fax: (401) 270-5322

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Rosalino Counseling Services reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the client. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our clients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Rosalino Counseling Services
383 West Fountain Street
Suite 106 and 108
Providence, RI 02903

Consent To Bill Insurance and Receipt of Privacy Policy Name of

Patient: _____ Date of Birth: _____

I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill. Payment in full is due at time of service unless other arrangements have been made.

Note: Bring your medical insurance cards to your appointment.

If no insurance card is available, please supply the name of the insurance company number in the space below. Ins. Company: _____
ID#_____ Policy Holder's Name: _____
Policy Holder's Date of Birth: _____

Consent to Bill Insurance, Authorization, and Release:

- **I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or other health practitioners.**
- **I authorize and request my insurance company to pay directly to the mental health practitioner insurance benefits otherwise payable to me.**
- **I understand that my insurance carrier may pay less than the actual bill for services.**
- **I agree to be responsible for payment of all services rendered on my behalf or my dependents.**
- **I agree that Telemental health therapy sessions will be billed to my insurance company.**
- **I agree that if I keep my therapist on the phone for longer than 15 minutes my medical insurance will be billed.**

Client Signature:_____ Date:_____

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CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal

guardian of _____, born

_____, do hereby consent to behavioral health services to

be administered by Rosalino Counseling Services.

Signature of Parent or Legal Guardian:

_____

Date: _____

383 W. Fountain Street Providence, RI 02906 Phone: (401) 419-4846 Fax: (401) 270-5322

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____, OR _____parent or legal guardian of _____, authorize Rosalino Counseling Services to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #:_____
Signature of Client /Guardian Date OR
Date of Birth:_____

_____
Signature of Witness Date