Gregory S. Rusk, LISW, DCSW

1117 Fehl Lane, Cincinnati, Ohio 45230 • 513-800-3588

CONFIDENTIAL CLIENT REGISTRATION and HISTORY

Today's Date: _____

Last Name	FIRST	Middle Initial	AGE	DOB	GENDER

Address	City	State	Zip

Social Security # | Home Phone | Work Phone

Single Married Divorced Separated Widow/er — Marital Status (Circle one)

YES NO — Military Veteran

Religion | Education (highest grade) | Other Training

Current Employer | Occupation | How long employed?

Previous Employer | Occupation | How long employed?

Name of Spouse or Partner | Spouse/Partner Address if different from above address

Names and ages of children and/or stepchildren

Names and ages of other persons living in household

IF THIS IS A REGISTRATION FOR A MINOR/CHILD: List residential and non-residential parents' names

IF THIS IS A REGISTRATION FOR A MINOR/CHILD: List residential and non-residential parents' addresses

REGISTRATION FOR STUDENT: Current School | Grade | Course of Study

EMERGENCY CONTACT FOR YOU: Name, Address, Phone

CONFIDENTIAL CLIENT REGISTRATION and HISTORY

Client Name: _____

Your Doctor's Name, Address, Phone
Current Health and/or Medical Problems
Current medications prescribed and over the counter
Allergies and drug sensitivities
Date of last physical examination and results of physical exam
Serious physical illness: Most recent hospitalization: Where? When?
Mental health/substance abuse treatment: When? Where? With whom?
Do you drink alcohol? How much per day? How many times per week?
What do you drink? Beer, wine, whiskey, etc.
Do you often drink more alcohol than you planned to drink? How many DUI/OVI in the past five years?
Do you have blackouts after drinking? How often?
Who has expressed concern about how much you drink? When?
Do you use non-prescribed drugs? Which drugs do you use? How often?
Do you take more prescription medication than the prescribed dose? How often?
Who has expressed concern about your drug use? When?
Have you been arrested for alcohol/drug offenses? When? Where?
What additional information do you want to share about your health? Use blank sides of papers if needed.

Behavioral Health and Medical Information * Patient Coordination of Care

Patient Information

Print last name, first, middle initial	Birth date mm/dd/yyyy	Insurance ID number
Street address City, State, ZIP		Daytime telephone

Medical Information ☐ I do not have a doctor

Print doctor's name	Doctor's phone number
Doctor's street address City State ZIP	Fax number

Patient Rights

- You can end this authorization (permission to use or disclose information) at any time by contacting Gregory S. Rusk, LISW.
- If you request to end this authorization, it will not include information that has already been used or disclosed based on your previous consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information disclosed on this form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire six months from the date of my signature, unless another date I specified. I have read and understand the above information and give my authorization.

PATIENT, CHECK ONE BOX BELOW.

☐ I DO authorize the release of any applicable medical information and/or mental health/substance abuse information between Gregory S. Rusk and my doctor.

☐ I DO NOT authorize the release any mental health/substance abuse information to my doctor.

Patient signature	Date

The section below may include important patient information. With permission, it may be sent to the doctor.

Behavioral health (BH) provider ***Gregory S. Rusk, LISW***	BH provider phone ***513-800-3588***	Best time to reach me ***Afternoons***
Street address, City, State, ZIP ***1117 Fehl Lane, Cincinnati, Ohio 45230***		Fax number ***513-832-2993***
Patient diagnosis		Comments
Patient medications/herbal remedies/dosages		
Risks/Concerns (homicidal/suicidal ideation, etc)\		

WARNING NOTICE TO RECIPIENT(S) OF PATIENT INFORMATION

Unauthorized interception of this telephonic communication could violate Federal and State law.

This electronic message transmission contains information belonging to Gregory S. Rusk, LISW that is solely for the recipient named above and may be confidential or privileged. Gregory S. Rusk, LISW EXPRESSLY PRESERVES AND ASSERTS ALL PRIVILEGES AND IMMUNITIES APPLICABLE TO THIS TRANSMISSION. If you are not the intended recipient, know that any disclosure, copying, distribution, or use of this communication is STRICTLY PROHIBITED. If you have received this electronic communication in error, notify sender by telephone at the number above to arrange for the return of the original documents. This information has been disclosed to you from records that may be protected by federal confidentiality rules (42 CFR, Part 2) and/Q1 state laws regarding confidentiality of patient records. These rules prohibit you making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. General authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. ***Thank you.***

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513.800.3588

New____ Change____

Patient Information

Name (Last, First. Mi); Sex M F Birthdate: Social Security number:

Address:

City: State: Zip:

Home telephone: Work telephone: Employer:

Responsible party:

Primary Insurance Information

Name *of* subscriber (Last. First, Mi): Sex: M F Birthdate: Social Security number:

Address: City:

Zip: Marital Status: Single Married Divorced Widowed

Relationship.to patient (spouse, child, etc.): Employer: Work telephone:

Insurance company name: Insurance Co. Phone:

Address *of* insurance company:

Member identification number. Group number: Effective date:

Secondary Insurance Information

Name of subscriber (Last. First, Mi): Sex: M F Birthdate: Social Security number:

Address: City: State:

Zip: Marital Status: Single Married Divorced Widowed

Relationship to parent (spouse, child, etc.): Employer: Work telephone:

Insurance company name: Insurance Co. Phone:

Address *of* insurance company:

Member identification number: Group number: Effective date:

Workers Compensation number: Employer:

Employer address: Data of injury:

Have you listed all your insurance coverage? ☐ YES

☐ No

I authorize payment of medical benefits to Gregory S. Rusk, LISW. I hereby guarantee payment of all charges incurred for this account and authorize release of any medical information necessary to process this claim.

Responsible Party Signature **Dependent Signature (over18)**

OFFICE USE ONLY. Forward form and copy of insurance cards lo Billing Dept.

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1117 Fehl Lane
Cincinnati, OH 45230
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FEE SCHEDULE[1]

1. Individual Therapy	$125 per session[2]
2. Family Therapy (WITH/WITHOUT THE PATIENT)	$125 per session
3. Conjoint Therapy	$125 per session
4. Substance Abuse Professional Service	$125 per session[3]
5. Letters & Reports	$100 per letter/report[4]
6. Court Appearance	$1200 retainer

- Clients are responsible for providing information necessary for billing purposes – including authorization numbers, copay or deductible amounts.
- Clients who do not want to use their insurance agree to pay the full fee for the provided service.
- Clients are responsible for payment at the time of service.
- Insurance copayments or deductibles are due at the time of service.
- All insurance, including EAP, payments will be assigned to the provider – Gregory S. Rusk, LISW.
- A payment agreement is necessary for continuation of services if there is an outstanding balance due.
- Missed appointments or cancellations less than 24 hours prior to the appointment are charged $125 payable prior to the next appointment.
- A $25 fee is charged for all returned checks.

I acknowledge that by signing below I have read and agree to the terms stated above.

Signature of patient/legal guardian Date

Signature of witness Date

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.

State of Ohio
Counselor and Social Worker, Marriage and Family Board
50 West Broad St., Suite 1075
Columbus, OH 43215-5919
614.466.0912

[1] Fees listed are fee-for-service and insurance billing rates. Different insurers contract insurance reimbursement for services at different rates.

[2] A "session" is 45 minutes of psychotherapy and 10-15 minutes of documentation.

[3] Includes reports.

[4] Minimum charges. Additional charges for extensive reports.

Rev. 2/20

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TELEHEALTH COUNSELING CONSENT

I, (_____) agree to receive Telehealth Counseling, also called Internet Counseling, for the issues and symptoms I have presented to Gregory S. Rusk, LISW via the Internet. In signing this form I will present myself via the Internet in a truthful representation as to the person I am with the issues and symptoms I am experiencing.
I consent to participate in the following Telehealth modalities as determined to be clinically appropriate by Gregory S. Rusk, LISW:

1. Individual Telehealth Counseling, including substance abuse counseling.
2. If a need for direct in-person services arises, such as a more intensive level of treatment in my community, it is my responsibility to contact practitioners in my area such as:

   _____ or

   to contact my primary care physician if do not have a local clinician or if my behavioral practitioner is unavailable.
3. If a need for medication evaluation/management in my community arises it is my responsibility to contact:

   _____ or

   to contact my primary care physician if do not have a physician that can prescribe medication for me.
4. If the need arises, I will seek a referral to community support/self-help groups in my area.
5. The following are names and telephone numbers of my local emergency contacts, including local physician, crisis hotline, trusted family or friend(s):

   Name:_____ Phone #_____
   Name:_____ Phone #_____
   Name:_____ Phone #_____
   Name:_____ Phone #_____

6. If I think I may be facing a crisis situation that could result in harm to me or another person I will not seek a Telehealth consultation and will call my local emergency services at 911 or go to the nearest hospital emergency department.
7. If Telehealth services should be interrupted for a technical reason, then I can be contacted at the following phone # _____ or by TEXT messaging that number. Another way to reach me is _____
8. I also understand that it is my responsibility to insure the privacy on my end of communications with Gregory S. Rusk, LISW. This means insuring privacy during our telecommunications and any records that I keep. I will be utilizing my own private computer/tablet or smart phone that is secure and protected by whatever means I feel is necessary.

I will be fully informed of recommendations and realize that following them is my own choice. I further agree to fully participate in a mutually agreed upon counseling plan that is designed to improve the issue(s) and/or symptom(s) for which I am seeking counseling. I accept the responsibility to negotiate a counseling plan to the best of my ability. I also understand that I, or Gregory S. Rusk, LISW, can terminate this agreement for Telebehavioral Health Counseling at any time without jeopardizing my access to future care or services.

I further agree to fully pay all fees for Telehealth Counseling services or provide billing information if this is a covered service. Gregory S. Rusk, LISW will comply with the State of Ohio's standards of Social Work practice and professional conduct, including those for electronic service delivery. I understand that no video or audio recordings of my session will be made without my written consent. I further understand that notes of each session will be made in a chart that will be maintained in a confidential manner by Gregory S. Rusk, LISW and will not be kept in an electronic format.

Signature:_____Date:_____

Witness:_____Date:_____

Please sign, witness and date, then return by mail to the above address,

Or scan and email to gsr1014@aol.com,

Or fax to (513) 832-2993