Momentum Counseling & Consultation
Moving YOU Toward Wellness
Offices in Celina, Sidney, Troy, Van Wert & Wapakoneta • Call 419.584.5123 to Schedule

Celina Locations: 401 & 441 E. Market Street * Sidney Location: 500 E. Court Street * Van Wert Location: 111 E. Main Street
Wapakoneta Location: 610 N. Dixie Highway * Troy Location: 1385 Stony Creek Road, Suite A/B

We hope you find your experience with us rewarding and life changing. We are excited for you and your decision to work toward your goals, and we hope to help you along the way. It is our honor and privilege to walk with you on your path to wellness.

www.MomentumCounselingAndConsultation.com

Consent for Treatment & Confidentiality

I understand that the clinical forms and records are confidential information. NO information will be released without my written permission (signed release of information form). All clinicians of Momentum Counseling and Consultation, LCC are mandated reporters in Ohio. As Counselors and Social Workers we are legally obligated to break confidentiality in the following situations:

- A client presents a clear and imminent risk of harm to him/herself or others
- There is a court ordered valid subpoena
- The client discloses there is suspicion of neglect, physical abuse, and/or sexual abuse of minor, a person with disability, or an elderly individual

We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate with your clinician via text or email for the purpose of scheduling, we will honor that wish. While we may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use electronic communication to discuss therapeutic issues and/or request assistance for emergencies.

I also understand that no individual or family will be refused services due to religion, race, color, national origin, age, lifestyle, physical or mental handicap, or developmental disability.

I understand that I have the right to be advised of the risks and benefits of treatment, or treatment alternatives, and no treatment. I further understand that I have the right to refuse or withdraw consent for treatment at any time and that my refusal or withdrawal can be done in writing. If I am an involuntary client (court ordered), I understand he possible consequences of my decision to refuse or withdraw consent.

I understand that Momentum Counseling and Consultation, LLC is an entity of independently licensed practicing Counselors and Social Workers. Each clinician is solely responsible for his/her clinical judgment, ethical behavior and standard of care. Momentum Counseling and Consultation, LLC and/or other clinicians not assigned to your case in the practice cannot be held liable or responsible in the event of a malpractice claim.

I understand that Momentum Counseling and Consultation, LLC and its clinicians do not provide emergency services. Clients may leave a message, but there may be an extended period of time before a clinician receives messages and responds. Clients requiring immediate assistance must call 911 or go to the nearest emergency room. If you need additional support, please make that request of your therapist. You can be referred to an outside agency that can provide emergency staff.

Insurance & Billing Policies

Client Responsibility: It is the client's responsibility to pay for all services provided, even if services are denied by insurance. These non-reimbursed costs may include, but are not limited to deductibles, copayments, missed session fee, unauthorized sessions, and non-covered procedures.

Fee: The fee for services is the contracted rate of your insurance company or $120 per therapy session. We reserve the right to periodically adjust the fee for self-pay clients. You will be notified of any fee adjustment in advance. Fees must be paid at the time that services are rendered. There is a 3% fee for paying with credit/debit cards.

Copayments: Clients are expected to provide copayment at the time of service. If writing a check, clients are asked to write it in advance to make best use of time.

Authorization & Limited Sessions: The client is responsible for obtaining necessary initial authorizations. Subsequent authorizations may require involvement from both client and therapist. Clients are strongly urged to know this detail of their policy and plan accordingly.

Appointment Scheduling and Cancellation Policies: Session scheduling will be discussed with you at each appointment. The typical recommendation for therapy is weekly or every two weeks. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. If an appointment is missed, or canceled with less than a 24-hour notice, you (not your insurance) will be charged a **$50 fee.** There are typically no exceptions to this rule, but it is at the therapist's discretion.

Phone/Email/Report Policy: There is no charge for returned phone calls or emails, provided that the contact does not exceed 10 minutes. Additional time, including collateral contacts and writing reports will be charged on a pro-rata basis and will be discussed with you prior to completing a requested project.

Claim rejections: If the insurance carrier for any reason denies the claim, including, but not limited to deductibles, non authorizations, pre-existing conditions, or non-response, the credit card on file will be charged and you will be notified via the email address that you provide on the intake form.

Collections: In the unlikely event that a client fails to remit payment and the credit card is declined, we will be forced to send the account to collections and/or seek legal action. Clients are held responsible to all associated fees, including lawyer fees, collections fees, administrative fees, and any additional expenses

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Please remember to have your PAYMENT OR CO-PAY ready for your appointment.
Payment is due at the time of service.

Thank you!

A charge of $50 will be assessed for failure to show for or late cancellation of your scheduled visit at Momentum Counseling & Consultation, LLC.

If you know that you will be unable to keep your scheduled visit, we ask
for a 24-hour notice. This will allow us to offer that appointment time to another client.

Please be aware that 3 No Shows or Late Cancels in a 3-month period could result in discharge from services

Our goal is to provide excellent care in a timely manner for all our clients.

Thank you for your consideration.

A copy of this consent & policy notification is available upon request for your records.

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Client Registration Form

Client Name: _____ Age: _____ DOB: _____
First, M.I., Last

Parent/Guardian(s) Name: _____
(Parent Information on page 4 must be completed)

Address:_____
Street, City, State, Zip Code

Phone Number: _____

Client Soc Sec #_____

Marital Status _____

Administrative Sex (Circle One): Male Female Unknown/prefer not to say

Email Address : _____

Appointment reminders will be sent via text and email. We also send an occasional newsletter.
If you would like to opt out of receiving our newsletter, please check the box. ☐

Emergency Contact _____

Relationship _____ Phone _____
(Emergency phone number will not be called unless a medical emergency)

How did you hear about us?

Why did you choose us rather than another provider?

In a few words, what brings you to us today?

Appointment Time:

Date: _____

Time: _____

Clinician: _____

Client or Authorized Person's Signature

I authorize payment of medical benefits to Momentum Counseling and Consultation, LLC (also referred to as MCC, LLC). I agree to the insurance and payment guidelines, and understand I am responsible for all costs of all services not covered by my insurance plan.

- I authorize MCC, LLC to submit claims on my behalf.
- I authorize the release of any medical or other information necessary to process this claim or any further claims.
- I acknowledge the receipt of MCC, LLC's Policy & Procedure Pamphlet. I have the opportunity to ask questions.
- I agree to abide by MCC, LLC's policies and procedure, and give my consent to be treated.
- If I am consenting for a minor, I attest that I have the legal status to do so.

I hereby consent to the provision of services by Momentum Counseling & Consultation, LLC and/or contractors. I agree to abide by the terms and conditions of this agreement and to hold MCC, LLC and/or contractors free and harmless from any claims, demands, and/or suits for damages from any injury or complications whatsoever, save negligence, and that may result from such treatment.

Printed Name: _____

Relationship to Client if not self: _____

Signature of Client or Guardian: _____

Date: _____

For Co-Pays, Deductibles & Self-Pay

Credit Card Authorization Form

Please complete the fields. You may cancel this authorization anytime by contacting us.

This authorization will remain in effect until canceled.

Credit Card Information	
Card Type: ☐ MasterCard ☐VISA ☐ Discover ☐ AMEX ☐Other	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (mm/yy):	Security Code (xxx):
Cardholder ZIP Code (from credit card billing address):	

I authorize ***Momentum Counseling & Consultation, LLC*** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Signature: _____ Date:_____

Insurance Coverage

Insurance ____ Self-Pay ____ Other, specify_____
(If self-pay, fill out Good Faith Estimate)

Primary Insurance:

Employer _____

Insurance Name _____

Policy ID # _____

Group # _____

Who carries this insurance? (policy holder)

_____

Relationship to client

_____

Policy holder's address (if different than client)

_____

Policy holder's date of birth _____

Secondary Insurance:

Employer _____

Insurance Name _____

Policy ID # _____

Group # _____

Who carries this insurance? (policy holder)

_____

Relationship to client

_____

Policy holder's address (if different than client)

_____

Policy holder's date of birth _____

Interactive Telehealth Consent

Name of Client: _____
Date of Birth_____

Mental health services through Interactive tele or video conferencing provide real-time interaction between a client and mental health provider. This form of mental health service can be helpful for clients who are hindered by transportation, long distances from a mental health clinic, or other factors that limit the ability for client access to mental health services.

I acknowledge that I have had a discussion with Momentum Counseling staff regarding the risks and benefits of using interactive tele and video conferencing for the provision of mental health services, including assessment and psychotherapy.

I understand that the risks of using such services include, but are not limited to the following:
● Risk of misunderstanding one another when communication lacks visual or auditory cues due to video/audio quality. It may be difficult to get a full read on body language, gestures, or other nonverbal communication that might otherwise be easily observed in the office.
● Momentum Counseling staff are limited in their ability to respond to imminent crisis situations and; therefore, other plans must be put in place for such circumstances.
● There could be disruption in services due to poor internet speed or connection and therefore, other plans must be put in place for such circumstances.
● Because interactive communication through tele and video conferencing is an electronic transmittal of information, there could be risk of security breaches. To reduce this risk, Momentum Counseling will only use methods of interactive tele and video conferencing that are secured and HIPAA-compliant to assure client privacy.

I understand that the use of interactive tele and video conferencing is a service that has been determined to be clinically appropriate by my treating clinical staff at Momentum Counseling; however, if at any time it is determined to not be in my best interest Momentum Counseling reserves the right to request in-office sessions or to discontinue the use of interactive tele and videoconferencing.
It might also be deemed appropriate for mental health treatment through interactive tele and video conferencing to include intermittent in-office services at a frequency agreed upon by me and Momentum Counseling staff.

Contingency Plans: In the event that services are disrupted due to connectivity issues or loss of electronic communication, clinical staff will provide alternative methods to provide or complete services for the scheduled day / time. This could include offering in-office appointments or reconnecting via phone to develop alternative plans.

In the event of an emergency, my treating clinical staff may request that I contact my local emergency crisis or suicide hotline or the police. The phone numbers for a close relative that I can contact in an emergency, the local crisis number, and local police are listed below:
● Close friend or relative
● Local Crisis or Suicide Hotline
● Local Police Department

I understand that, based on clinical judgment, Momentum Counseling staff may determine that I am at imminent risk and contact the police on my behalf. Privacy Momentum Counseling will take necessary means to assure that information pertaining to me is kept private and confidential pursuant to the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules and 42 C.F.R. Part 2.

To help assure this privacy, Momentum Counseling will use a secured, HIPAA-compliant service that requires name and password verification for each service provided. I understand that Momentum Counseling can only be held accountable for privacy at the originating site (office) and that I must take appropriate precautions at the client site (place where I am located at the time of service) to assure my own privacy. This includes making sure that I am located in a place away from others where they are unable to hear or have access to the communication that occurs through this service. I understand that the use of my own equipment is recommended, as information transmitted through other's equipment could be compromised.

I also understand that communication through the use of a work computer for such services is legally the property of my employer and is not guaranteed to be private.

Consent: I release and discharge Momentum Counseling of Ohio, its affiliate, agents, and employees; and any other organization involved in the interactive tele and videoconferencing from any liability in connection with my participation with mental health services through interactive tele and videoconferencing.

I acknowledge to have my name and email used in coordination of services through a secured, HIPAA-compliant tele and video conferencing service provider and that I will assure that only I (or guardian / designee) will have access to my log-in information, which will be used as verification when logging in at the time of scheduled sessions. The email address that I would like to be used for this service is as follows:
Email:_____ I have read this document carefully and fully understand the risks and benefits of mental health services through interactive videoconferencing. I have had the opportunity to ask questions and I have received satisfactory answers. I voluntarily consent to participate in the mental health services through interactive videoconferencing, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

_____
Client Signature

_____
Guardian Signature

_____
Momentum Counseling Representative Signature
Effective Date: 08/19/ 2024

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Complete for all minors: Parent/Guardian Information

Client Name: _____ DOB: _____

Parent/Guardian Name: _____

Phone Number: _____
Address if different than client:

_____

_____

Step-Parent Name: _____Phone Number: _____
(if applicable)

Parent/Guardian Name: _____

Phone Number: _____
Address if different than client:

_____

_____

Step-Parent Name: _____Phone Number: _____

Is there a custody agreement? Circle one: Yes No

If yes, please provide a copy noting the medical information section.

Name of Residential/Custodial Parent (if applicable): _____

Additional Information: _____

_____

_____