Form CF01
Rev. 03/25/2024

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF SYNTERO POLICIES AND CONSENT FOR TREAMENT

- I hereby certify that Syntero has provided me with copies of:
  - Orientation to Rules, Expectations, and Risks/Benefits of Treatment
  - Financial Policies
  - Client & Family Rights
  - Grievance Procedure
  - Privacy Notice including a summary of 42 CFR Part 2 Laws and Regulations
  - Information regarding exposure and transmission of infectious diseases
  - Agency maps
  - ADAMH Board of Franklin Notice of Privacy Practice
  - Delaware Morrow Mental Health & Recovery Services Board Privacy Notice

- If I self pay for appointments or are uninsured, I certify that I have received a Good Faith Estimate for the total expected cost of services. I understand that it may be updated as needed or at a minimum, on an annual basis.

- Syntero makes an effort to communicate with clients through different mediums to gather input on our services, provide updates regarding our services, send appointment reminders, obtain outcome information, and send personalized links to telehealth sessions. Please initial if you provide consent:
  ____I consent to receive phone calls/voicemails
  ____I consent to receive text messages
  ____I consent to receive emails

- For parent/guardian of minor child:
  ____I hereby give Syntero my permission to send my child service related emails
  ____I hereby give Syntero my permission to send my child service related text messages

- Further, I certify I have read and understand the aforementioned documents

- Consent for Treatment
  I hereby give Syntero my permission to provide services including, but not limited to, counseling, psychotherapy, alcohol and other drug treatment and case management to:

Please Print Client's Name	**Signature of Client**	**Date**
Parent/Legal Guardian Name	**Signature of Parent/ Legal Guardian**	**Date**

<u>For a Minor Seeking Treatment without Parental Consent:</u>

As a minor 14 years of age or older, I understand I am entitled to receive counseling services for no more than six sessions or thirty days, whichever comes first, without the consent of my parent/guardian and without that parent/guardian being informed. If services extend beyond that point, I will work with my therapist to involve my parent/guardian in treatment.

Minor without Parent/Guardian Signature	**Date**
Signature of Witness	**Date**

INFORMED CONSENT FOR MINORS

_____ _____

Client Name Client Date of Birth

Parent/Guardian communication regarding services:

We believe parents play an important role in their children's treatment. Our practice is to include all parents/involved adults in treatment to support children with having healthy relationships and a strong support network. It is Syntero's policy to provide you with general information about your child's treatment, but not to share specific information that your child has disclosed without your child's agreement. Therapy is most effective when a trusting relationship exists between the behavioral health provider and the client. Confidentiality is especially important in earning and keeping that trust, which is why it is important for minors to have a "zone of privacy," where they are able to discuss personal issues without fear that their thoughts and feelings will be immediately communicated to their parents/guardians or other third parties. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. If, at any time, we have concerns about your child's safety, we will immediately inform you.

Consent for services with minors:

I understand that behavioral health services may include, but are not limited to, discussions on family history, educational achievements and aspirations, social connections, meaningful and/or challenging experiences, legal history, health and trauma history. I understand that my child's provider will review my child's symptoms and behaviors in order to diagnose (or rule out diagnoses). Examples of diagnoses that I consent to, as long as they are applicable to my child, with resulting treatment, include, but are not limited to: depressive disorders, anxiety disorders, attention-deficit hyperactivity disorders, obsessive-compulsive disorders, gender dysphoria, gender-related conditions, trauma and stressor-related disorders, autism spectrum disorder, eating disorders, disruptive and impulse control disorders, bipolar disorders, substance use disorders, and/or personality disorders.

I hereby give Syntero my permission to provide services including, but not limited to, counseling, psychotherapy, alcohol and other drug treatment, psychiatry services and case management to:

_____ _____ _____

Print Parent/Guardian Name Signature of Parent/Guardian Date

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SERVICE AGREEMENT

Client Name:_____ **SSN:** _____ **DOB:** _____
(Please Print)

Responsible Party Name: _____ **Date of Birth:** _____
(Please Print)

2024 Standard Rates
**Subject to change-updates are posted in our agency lobbies*

Service Type:	Rates:
Diagnostic assessment	$200 per clinical hour
Individual psychotherapy	$160 per clinical hour
Psychiatric assessment	$267 per clinical hour
Group psychotherapy	$55 per clinical hour
Intensive outpatient for substance use (IOP)	$218 per group

Please be aware that your services at Syntero begin with an assessment, completing your assessment may take multiple appointments and if your provider is not in network with your insurance, you will be responsible for the full charge

- I understand that failure to provide insurance or supplemental coverage information in a timely manner will result in my being responsible for full payment for my services.
- I understand that I am responsible for providing up-to-date and accurate insurance information and that a change in my insurance plan could result in a full fee charge/change in payment or change in provider.
- I understand that Syntero will bill my insurance carrier as a courtesy, but that I am responsible for understanding my own benefits and ensuring Syntero receives payment.
- I understand that, if my insurance is considered Out of Network with Syntero and if the cost of services is higher than what my insurance will cover, my explanation of benefits (EOB) can state a zero-dollar amount Client Responsibility. However, I will still be responsible for paying the remaining balance that my insurance does not cover.
- I understand that at each visit I am expected to make a payment as a deposit toward my patient financial responsibility but that it may not be the total amount that I will be responsible for, as the total amount due is based on my insurance plan.
- I understand that if I have a high balance, services may be discontinued until a payment plan is arranged.
- I assign to Syntero any third-party benefits due from any and all insurance benefits in an amount not to exceed Syntero's regular and customary charges for services.
- I assume responsibility for determining in advance whether the services provided and the provider are covered by my insurance or other third-party payer.
- I authorize Syntero to disclose medical information as required by any third-party payers to process a claim for service.
- I understand that I am expected to keep my appointments and, if I must cancel or reschedule an appointment, I will provide as much notice as possible**. I understand that, should I have to cancel my appointment, and I am not able to give a full business day notice, I may be charged a $25 cancellation fee.**

SIGN

_____ _____
Client/Parent/Guarantor/Responsible Party Signature **Date**

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INFORMED CONSENT ADDENDUM FOR TELEBEHAVIORAL HEALTH SERVICES

Syntero continues to monitor the latest preventative measures recommended by the Centers for Disease Control and the State of Ohio to curb the spread of the COVID-19 virus. Effective immediately, we are providing telebehavioral health services rather than face to face services at our offices.

What is Telebehavioral Health?
Telebehavioral health includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing or phone calls. Services may include counseling, case management and psychiatry including the prescribing of medications.

1. Benefits include greater flexibility by geographical location, reduction of travel to a physical office and participation from your own home environment.
2. Risks include the potential breakdown in the technology including poor connection, loss of sound or loss of connection. A second factor that may impact the communication is that nonverbal cues are less readily available to both the clinician and the client.
3. All existing laws regarding privacy, confidentiality, access to mental health information, and client rights and grievance procedures apply the same as face-to-face sessions.
4. Nobody will record the session without the permission from the other person(s).
5. It is important to be in a quiet, private space that is free of distractions (including computers, additional phones, or other devices) during the session.
6. Only agreed upon participants will be present in the room of the clinician and the client during the telebehavioral health session.
7. The clinician will verify the physical address of the client's location at the start of each session. This is to ensure we are "meeting" at a place that will protect your confidentiality (e.g. No coffee shops or public places). Sessions will not occur while any of the participants are driving.
8. It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the clinician in advance by phone.
9. We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
10. We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
11. If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telebehavioral health sessions.
12. Your clinician may determine that due to certain circumstances, telebehavioral health is no longer appropriate and that we should consider alternative resources for your treatment.

Client Name	Client Signature	Date
If minor: Parent/Guardian Printed Name	Client or Guardian Signature	Date

* Pursuant to Ohio Revised Code 5122.04, a minor 14 years of age or older is entitled to receive counseling services for no more than six sessions or thirty days, whichever comes first, without the consent of a parent/guardian and without that parent/guardian being informed. Pursuant to Ohio. Revised Code 3719.012, individuals of any age can request and consent to substance use prevention/treatment services with no specified time limit for such services, without the consent of a parent/guardian and without that parent/guardian being informed.

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CLIENT CONTACT INFORMATION: This form is to be completed by the client (or parent/guardian/foster if client is under 18)

Legal Name (First, M, Last)		Preferred Name:		Age:
DOB:	SSN:	Preferred Pronouns:		Gender:
Physical Address		City	State	Zip
Mailing Address		City	State	Zip
Home Phone	Cell Phone	Receive reminders at the following number		
Email				
Primary Language	Does client need interpreting services? ○ Yes, please specify: _____ ○ No			
Syntero provides training to future counselors and social workers. Is client comfortable with an intern sitting in on your sessions? ○ Yes ○ No				

DEMOGRAPHIC INFORMATION: The information collected used for internal reports and state reporting.

Race:
☐ Alaskan Native ☐ Black/African-American ☐ Two or More Races
☐ American Indian ☐ Pacific Islander ☐ Unknown
☐ Asian ☐ Other Single Race ☐ White

Ethnicity:
☐ Cuban ☐ Mexican ☐ Other Hispanic ☐ Unknown
☐ Hispanic Not Specified ☐ Not of Hispanic/Latino Origin ☐ Puerto Rican

Client's Living Arrangements:
☐ Community Residence ☐ Foster Care ☐ Other ☐ Residential Care
☐ Correctional Facility ☐ Homeless ☐ Permanent Supported Housing ☐ Temporary Housing
☐ DD/Operated Facility ☐ Nursing Facility ☐ Private Residence ☐ Unknown

Client's marital status:
☐ Divorced ☐ Separated ☐ Widowed
☐ Married (Or living Together) ☐ Single (Never Married) ☐ Unknown

Military Status: ☐ Active ☐ Disabled Veteran ☐ Discharged ☐ None
Military Service: ☐ Overseas ☐ Reserve

Tobacco Use? ☐ User ☐ Non-User
Smoking Status: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Current or highest level of education
☐ <1st Grade ☐ 4th Grade ☐ 8th Grade ☐ High School/GED ☐ 4yr College Degree
☐ 1st Grade ☐ 5th Grade ☐ 9th Grade ☐ Tech School ☐ Graduate Degree
☐ 2nd Grade ☐ 6th Grade ☐ 10th Grade ☐ Some College ☐ Unknown
☐ 3rd Grade ☐ 7th Grade ☐ 11th Grade ☐ 2yr College Degree

HOUSEHOLD MEMBERS: Please include anyone also living in the house. Additional space provided in the ADDITIONAL INFORMATION.

Name	Relationship	Birthdate	Age

EMERGENCY CONTACT INFORMATION: In case of emergency, Syntero has my permission to notify

Name:	Relationship:
Address:	Phone Number:

HEALTH HISTORY QUESTIONNAIRE: This form is to be completed by client and/or parent/guardian/foster parent (if client is under 18) and reviewed by medical or clinical staff.

Has the client had any of the following health problems? (If never, leave blank)	Now	Past	If you received treatment add the type and date(s)
1. AIDS/HIV	☐	☐	
2. Anemia	☐	☐	
3. Anxiety	☐	☐	
4. Arthritis	☐	☐	
5. Asthma	☐	☐	
6. Bipolar Disorder	☐	☐	
7. Bleeding Disorder	☐	☐	
8. Blood Pressure (high or low)	☐	☐	
9. Bone/Joint Problems	☐	☐	
10. Cancer	☐	☐	
11. Cirrhosis/Liver Disease	☐	☐	
12. Depression	☐	☐	
13. Diabetes	☐	☐	
14. Eating Disorder	☐	☐	
15. Epilepsy/Seizures	☐	☐	
16. Eye Disease/Blindness	☐	☐	
17. Fibromyalgia/Muscle Pain	☐	☐	
18. Glaucoma	☐	☐	
19. Head Injury/Brain Tumor	☐	☐	
20. Headaches	☐	☐	
21. Hearing Issues/Deafness	☐	☐	
22. Heart Disease	☐	☐	
23. Hepatitis/Jaundice	☐	☐	
24. Hyperactivity/ADD	☐	☐	
25. Kidney Disease	☐	☐	
26. Learning Problems	☐	☐	
27. Lung Disease	☐	☐	
28. Menstrual Pain	☐	☐	
29. Oral Health/Dental	☐	☐	
30. Schizophrenia	☐	☐	
31. Sexual Problems	☐	☐	
32. STD	☐	☐	
33. Sleep Disorder	☐	☐	
34. Speech Problems	☐	☐	
35. Stomach/Bowel Problems	☐	☐	
36. Stroke	☐	☐	
37. Suicide Attempts Thoughts	☐	☐	
38. Thyroid	☐	☐	
39. Tuberculosis	☐	☐	
40. Other	☐	☐	

Please note family history of any of the above conditions and client's relationship to that family member.

Do you have a healthcare advanced directive? ◯Yes ◯No
If Yes, please provide a copy.

NUTRITIONAL SCREENING: Please check box if there have been any recent changes

Height: _____ft _____in Weight: _____lbs.	Height changed within past year? ○Yes ○No Weight changed within past year? ○Yes ○No	Yes, how much? Yes, how much?

Has your thirst:	☐ Decreased	☐ Increased	☐ No change
Has your appetite:	☐ Decreased	☐ Increased	☐ No change
Do any apply?	☐ Nausea	☐ Special diet? Please Specify: _____	☐ Vomiting
	☐ Picky Eater	☐ Trouble chewing or swallowing	

PAIN SCREENING

Does pain currently interfere with your activities? ○Yes ○No If yes, what is the source of the pain and the treatment regimen?
If yes, how much does it interfere with your activities? ○Extremely ○Mildly ○Moderately ○Severely ○Not at all

PREGNANCY AND MENSTRUAL HISTORY (☐ does not apply)

Currently pregnant? ○Yes ○No	If yes, expected delivery date:
Currently breastfeeding? ○Yes ○No	Any significant pregnancy history?
Age at first menstrual period?	
Last menstrual period:	

ALLERGIES OR DRUG SENSITIVITIES If you have any of the following please check and specify as best you can: (☐ None)

☐ Food:
☐ Medication:
☐ Other:

IMMUNIZATIONS: Only required for children or individuals with developmental delays.

☐ 1. Chicken Pox	☐ 3. German Measles	☐ 5. Measles	☐ 7. Polio	☐ 9. Tetanus
☐ 2. Diphtheria	☐ 4. Hepatitis B	☐ 6. Mumps	☐ 8. Small Pox	☐ 10. Other:

LAST PHYSICAL EXAMINATION: (Client does not have a Primary Care Physician ☐)

Primary Care Doctor	Phone number
Address/Location	Date of last visit

Has the client had any of the following symptoms in the past 60 days?

☐ 1. Ankle Swelling	☐ 14. Hair Change	☐ 27. Shakiness
☐ 2. Bed-wetting	☐ 15. Hearing Loss	☐ 28. Sleep Problems
☐ 3. Blood in stool	☐ 16. Lightheadedness	☐ 29. Night Sweats
☐ 4. Breathing Difficulty	☐ 17. Memory Problems	☐ 30. Swelling
☐ 5. Chest Pain	☐ 18. Mole/Wart Changes	☐ 31. Tingling in limbs
☐ 6. Confusion	☐ 19. Muscle Weakness	☐ 32. Tremor
☐ 7. Loss of Consciousness	☐ 20. Nervousness	☐ 33. Urination Difficulty
☐ 8. Constipation	☐ 21. Nosebleeds	☐ 34. Vaginal Discharge
☐ 9. Coughing	☐ 22. Numbness	☐ 35. Vision Changes
☐ 10. Cramps	☐ 23. Panic Attacks	☐ 36. Vomiting
☐ 11. Diarrhea	☐ 24. Penile Discharge	☐ 37. Other:
☐ 12. Falling	☐ 25. Pulse Irregularity	☐ 38. Other
☐ 13. Gait Unsteadiness	☐ 26. Seizures	

HOSPITALIZATIONS: Has the client had medical hospitalizations/surgical procedures in the last 3 years? Additional space provided in the ADDITIONAL INFORMATION page

Hospital	City	Date	Reason

LIST OF CURRENT MEDICATIONS: List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (i.e. Viagra, Albuterol, Nitroglycerin, etc.)

Medication	Dose	Frequency	Reason	Start date	Prescriber

ADDITIONAL INFORMATION: Include here additional information you wish your clinician to know.

If the document was completed by a Parent/Guardian/Custodian:

Name	Address
Signature	Phone number

FOR STAFF USE ONLY:	
Clinical Reviewer Comment (if any):	
Clinical Signature and Credentials	Date

CLIENT QUESTIONNAIRE: Please complete the following questions. Your responses will be very helpful in understanding why you have chosen to be involved in treatment at this time and what you would like to achieve in the process.

1. Please describe the issue(s) that brings you and/or your child here. Be as specific as you can. Try to include such details as the duration of the problem, how often it occurs, and under what circumstances
2. How does this interfere with your or your child's life? Who else is being affected?
3. If treatment is successful, how will life be different for you and/or your child? (What are your goals for treatment?)
4. Please tell us about your family's culture, beliefs, practices, and traditions.
5. Are there any special needs or preferences you have?
6. How did you hear about Syntero?

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PATIENT HEALTH QUESTIONNAIRE 9 Only for clients over the age of 11				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult

Name:_____ DOB:_____ Today's date:_____

Youth Outcome Questionnaire Name: _____ ID: _____ Date: ____/____/_____

Y-OQ®-30.2 English Youth Omni-Form

PURPOSE: The Y-OQ® 30.2 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but mark the "Never or almost never" category. When you begin to complete the Y-OQ® 30.2 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

DIRECTIONS:

- Read each statement carefully.
- Decide how true this statement is during the **past 7 days.**
- Completely fill the circle that most accurately describes the past week.
- Fill in only one answer for each statement and erase unwanted marks clearly.

DIRECTIONS FOR PARENTS OR GUARDIANS:

If your child is under 12, the parent or other responsible adult is asked to complete this questionnaire. In this case, respond to the statements as if each began with "My child…" or "My child's…" rather than "I…" or My…." It is important that you answer as accurately as possible based on your personal observation and knowledge.

Please mark your answers like this:

Not like this:

Developed by:
GARY M. BURLINGAME, PH.D., M. GAWAIN WELLS, PH.D., MICHAEL J. LAMBERT, PH.D., AND CURTIS W. REISINGER, PH.D.

For More Information Contact:

OQ Measures, LLC
P.O. Box 521047
Salt Lake City, UT 84152

Toll-Free USA: 1-888-MH-SCORE (1-888-647-2673)

Phone: (801) 649-4392
Fax: (801) 747-6900
Email: INFO@OQMEASURES.COM
Website: HTTP://WWW.OQMEASURES.COM

YOQ30ENG Version 1.0
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	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I have headaches or feel dizzy.	○	○	○	○	○
2. I don't participate in activities that used to be fun……	○	○	○	○	○
3. I argue or speak rudely to others.	○	○	○	○	○
4. I have a hard time finishing my assignments or I do them …….. carelessly.	○	○	○	○	○
5. My emotions are strong and change quickly.	○	○	○	○	○
6. I have physical fights (hitting, kicking, biting, or scratching) ..…... with my family or others my age.	○	○	○	○	○
7. I worry and can't get thoughts out of my mind.	○	○	○	○	○
8. I steal or lie……...	○	○	○	○	○
9. I have a hard time sitting still (or I have too much energy).	○	○	○	○	○
10. I use alcohol or drugs……...	○	○	○	○	○
11. I am tense and easily startled (jumpy).	○	○	○	○	○
12. I am sad or unhappy…….	○	○	○	○	○
13. I have a hard time trusting friends, family members, or other adults.	○	○	○	○	○
14. I think that others are trying to hurt me even when they are not…..	○	○	○	○	○
15. I have threatened to, or have run away from home.	○	○	○	○	○
16. I physically fight with adults……	○	○	○	○	○
17. My stomach hurts or I feel sick more than others my same age.	○	○	○	○	○
18. I don't have friends or I don't keep friends very long…….	○	○	○	○	○
19. I think about suicide or feel I would be better off dead.	○	○	○	○	○
20. I have nightmares, trouble getting to sleep, oversleeping, or …….. waking up too early.	○	○	○	○	○
21. I complain about or question rules, expectations, or responsibilities.	○	○	○	○	○
22. I break rules, laws, or don't meet others' expectations on purpose.	○	○	○	○	○
23. I feel irritated.	○	○	○	○	○
24. I get angry enough to threaten others……...	○	○	○	○	○
25. I get into trouble when I'm bored.	○	○	○	○	○
26. I destroy property on purpose……...	○	○	○	○	○
27. I have a hard time concentrating, thinking clearly, or sticking to tasks.	○	○	○	○	○
28. I withdraw from my family and friends……...	○	○	○	○	○
29. I act without thinking and don't worry about what will happen.	○	○	○	○	○
30. I feel like I don't have any friends or that no one likes me….....	○	○	○	○	○