Erica L. Daniels, PCC, LLC
1000 Jefferson Ave.
Cincinnati OH 45215-3236
513-268-5828

1. Welcome Letter

Hello,

Thank you for taking the time to complete the intake paperwork. Attending therapy is an important step in helping you or your child cope with adversity experienced. Counseling sessions will help with thoughts, feelings, and behaviors. As therapy progresses, there may be times there is reluctance to attend; however, the effectiveness of therapy depends on being able to tolerate short-term, painful emotions, and attendance at sessions is necessary to do that.

Therapy is a collaborative venture with both the client and therapist, as well as the client's caregivers if the client is a child. Caregivers are expected to participate in their child's treatment. Caregiver participation might include attending individual sessions with the therapist, participating in the child's individual sessions, attending family sessions, and/or completing homework assignments based on the child's sessions.

Please remain in the building or on the premises during your child's appointments. We ask that all people age 10 or older who are inside the building wear masks.

Appointments are reserved in advance. As such, if you need to cancel an appointment, please do so in a timely manner so the therapist can have the opportunity to see other clients during that time. Counseling works best if sessions are weekly at first. As progress is made, session frequency is reduced. Bi-weekly sessions may be arranged if financial and/or scheduling burdens arise. Appointments are offered during the day. While daytime appointments mean missed school time or work time, this is a short-term situation for long-term healing.

We do not provide court testimony, nor do we release client records to 3rd parties, unless the release is related to insurance claims. We will release information about a client's diagnosis, service plan, and progress in verbal or written form to 3rd parties with written consent.

We are not a custody evaluators. If you are seeking counseling services for your child because of a custody dispute, you will need to seek evaluation services from someone who does custody evaluations. Additionally, the CSWMFT Board, in accordance with the Ohio Revised Code, mandates counselors inform all parents with parental rights their child is receiving services, regardless of the parent's involvement with that child or that child's therapy unless a court has determined the parent should not have access to records related to the child.

Please note this practice is not capable of offering emergency services. Should an emergency arise with your child, your child should seek treatment at a local emergency center.

Welcome!

The Firefly Company

Erica L. Daniels, PCC, LLC
1000 Jefferson Ave.
Cincinnati OH 45215-3236
513-268-5828

2. Demographic and Contact Form

INTAKE FORM

Patient Name:

Date of Birth:

Gender:

Full Address:

Phone Number (s):

May We Leave a Message When Calling?:

How did you hear of The Firefly Company?:

Insurance Company:

Name of Policy Holder:

Policy Holder's Date of Birth:

Individual Policy Number:

Group Policy Number:

Responsible Party (RP):

RP's Date of Birth:

Relationship to Patient:

Address (if different):

Contact Phone Number:

Email Address:

Emergency Contact (Someone Not At Your Appointments):

Emergency Contact Phone Number:

Additional Parent Name & DOB:

Additional Parent Phone Number:

Additional Parent Email Address:

Names and Birthdates of Siblings/Step-Siblings::

Additional Household Members::

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3. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR PLEDGE REGARDING HEALTH INFORMATION:

We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. We are required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of our legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

II. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. We also may disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, we may disclose health information in response to a court or administrative order. We also may disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. We do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For our use in treating you.

b. For our use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For our use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate our compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, we will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, we will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although our preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on our premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although our preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with us. We also may use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

11. To another parent or guardian with medical rights to their child, regardless of that guardian's involvement in the child's treatment. **PLEASE NOTE: No one affiliated with The Firefly Company is a child custody evaluator or can make decisions regarding custody. The Ohio Counselor, Social Worker, Marriage and Family Therapist Board is the regulatory body for providers at this practice. The CSWMFT Board, in accordance with the Ohio Revised Code, mandates counselors inform

all parents with parental rights their child is receiving services, regardless of the parent's involvement with that child or that child's therapy unless a court has determined the parent should not have access to records related to the child.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if we believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How We Send PHI to You. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures We Have Made. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided us with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. I may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Signature & Date:

Erica L. Daniels, PCC, LLC
1000 Jefferson Ave.
Cincinnati OH 45215-3236
513-268-5828

4. Informed Consent for Mental Health Therapy

General Information

The office address is 1000 Jefferson Ave., Cincinnati, OH 45215. The office phone number is 513-268-5828. There are multiple providers with TFC with different credentials. You can find their credentials by going to https://www.thefireflycompany/about.html.

The Firefly Company and its providers are licensed in the state of Ohio and can provide services to people who are physically in Ohio. A client does not have to be a resident of Ohio to receive services, only located within Ohio's state lines during the time of sessions.

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can promise to support you and do our very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Your Rights as a Client

In Ohio, you have rights as a client. Those rights are listed on our Client's Rights Form and also can be found on the Ohio Administrative Code 5122-26-18.

Confidentiality

The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you

acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

Additionally, we will not engage in communication with or accept friend requests from clients or their families over social media (Facebook, Instagram, Twitter, Snapchat, etc.).

Telehealth

Confidentiality rules apply the same to telehealth appointments as to in-office appointments. TFC offers secure online platforms as well as a secure environment during telehealth appointments.

You are responsible for being a secure and confidential environment during your telehealth appointment. You must have access to a computer, laptop, tablet, or smartphone with a working camera and microphone and access to Internet browsers. Please use a secure Internet connection and not public or free WiFi.

Neither you nor your TFC provider are to record your telehealth appointments without consent.

Telehealth may not be appropriate for each individual. You do not have to engage in telehealth, even at the request of your provider. If you and your provider do not agree on the mode of delivery of therapy services, your provide will supply you with referral information.

Benefits and Risks of Telehealth

Telehealth allows people to receive services at times or in places where the service may no otherwise be available; allows for more convenience and flexibility in scheduling; and might allow for a more familiar and comfortable setting for the patient.

Telehealth can be less private; can have connectivity issues; and has a risk for a breach in confidentiality.

Emergencies During Telehealth

Your provider will ask for a number where you can be reached during your telehealth appointment in the event your session is disconnected. Your provider also will ask for an emergency number in the event an emergency arises during your appointment and you are in need of assistance.

Gifts & Bartering

The Firefly Company recognizes that some clients, especially from specific cultures, like to give gifts. TFC also has to

recognize ethics codes put forth by the American Counseling Association in regards to gift-giving. As such, TFC and its providers will not accept gifts valued at over $20. Additionally, TFC is not located in an area that universally recognizes bartering, and will not barter for services rendered.

Communication Between Appointments

The best way to contact your provider between sessions is to call 513-268-5828. Your provider will respond to your message within 48 business hours. Please note that all electronic messages sent to your provider by you become a part of your health record.

TFC is not an emergency center as is not equipped to handle mental health emergencies in office or via telehealth. You must call your local crisis line or go to your local emergency center if you are having a mental health emergency.

Signature

Your signature below signifies you are consenting to you or your child receiving mental health services.

Client or Guardian Signature:

Date:

Erica L. Daniels, PCC, LLC
1000 Jefferson Ave.
Cincinnati OH 45215-3236
513-268-5828

6. Non-Secure Communication Consent

The Firefly Company and its staff follow HIPAA guidelines to ensure secure communication regarding your personal health information by using the Client Portal offered by our electronic health record company, TheraNest. TFC also uses secure audio & video for telehealth appointments.

TFC, however, cannot require you to use the above secure communication methods in regards to your Personal Health Information. You have the right to receive information, including personal health information, by insecure methods such as personal e-mail, messaging apps, or audio and video platforms.

The risks involved in using insecure methods include, but are not limited to:
- Access breach to your e-mail, messaging, audio/video platforms
- Dissemination of your personal health information contained in your e-mail, messaging apps, or audio/video platform by someone other than you.

If you prefer to use less secure communication methods such as personal e-mail, messaging apps, or audio and video platforms, please sign below. Your signature acknowledges you are allowing insecure methods of communication between you and The Firefly Company, including its staff. You have the right to revoke this consent in writing at any time by contacting The Firefly Company or your provider.

If you do not consent to receive communication by insecure methods, please set up a Client Portal account so that TFC and your provider can communicate with you securely.

☐ Yes, I consent to use insecure methods of communication to communicate with The Firefly Company and my provider.

Client or Guardian Signature:

Date:

☐ No, I do not wish to use insecure methods of communication to communicate with The Firefly Company and my provider.

Signature & Date:

Erica L. Daniels, PCC, LLC
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7. FEE AGREEMENT

This fee agreement is between the client (Responsible Party) and the Service Provider. The Responsible Party will be referred to as RP and the Service Provider will be referred to as SP throughout the rest of this agreement. Fees are reassessed yearly.

SERVICE FEES

• Initial Assessment $180.00
• Therapy Session (Up to 30 minutes) $60.00
• Therapy Session (30-60 minutes) $120.00
• Therapy Session (75+ minutes) 30 minute or 60 minute combo rates (e.g., 90 minute session = $180; 120 minute session = $240)
• Group Therapy $40.00
• After-hours Session add-on $25
• Complex Session add-on $25
• Phone Conversation per 15 minutes $25
• Crisis Session add-on (1st 60 minutes) $50
• Crisis Session add-on (each additional 30 minutes) $25

Co-payments are due at the beginning of each session. Denied insurance claims are due 10 days after the date on the client bill.

Returned checks are $35.00 per occurrence.

RECORDS REQUESTS
Records requests must be made in writing. Contact Erica L. Daniels to receive the request form. A signed release of information must be on file before records are released if applicable. The Ohio Revised Code 3701.741 allows for the following fees to be collected in association with records requests: $3.11 per page for the first 10 pages; .65 cents for pages 11-50; .26 cents for pages 51 and higher; actual cost of postage. The fees set forth by the ORC will be followed by Erica L. Daniels, PCC, LLC.

ANCILLARY SERVICES
Ancillary services usually are not covered by an insurance company. The RP is expected to pay the cost of ancillary services. The SP will be reimbursed for the following expenses incurred in connection with providing services:
- Phone calls, excluding calls about appointment times, are $20.00 per 15 minutes.
- E-mail or other electronic communication, excluding communication about appointment times, is $5 per occurrence.
- Treatment summary or letter: $50 per occurrence.

COURT ACTION / LEGAL FEES
Court Action/Legal Fees: Clients are discouraged from having their SP subpoenaed. Even though you are responsible for the testimony fee, it does not mean SP's testimony will be in your favor. SP can testify only to the facts of the case and to

SP's professional opinion.
• Preparation time (including submission of records): $150/hr
• Phone calls: $120/hr
• Depositions: $120/hour
• Time required in giving testimony: $120/hour
• Mileage: Will be charged at the current federal reimbursement rate
• Time away from office due to depositions or testimony: $120/hour
• All attorney fees and costs incurred by the therapist because of the legal action.
• Filing a document with the court: $85
• A retainer of $500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $150 "express" charge. Also, if the case is reset with less than 72 business hours notice, the client will be charged $300 (in addition to the retainer of $500).
• All fees are doubled if SP must cancel vacation plans to be present in court.

LATE PENALTY FEES
RP will be referred to collections for unpaid charges over 90 days old.

NO SHOW / LATE CANCELLATION FEE
The appointment time is reserved for the client only; therefore, a charge will be imposed if the client fails to show for a scheduled appointment or does not cancel 24 hours in advance. Late cancellations for emergencies can be discussed with SP. The no show/late cancellation charge is $40.00.

3RD PARTY PAYERS
The SP may disclose the minimum necessary confidential information for reimbursement: To a 3rd party insurance provider where the Client or RP presents an insurance card/company as a reimbursement source. In the event Client or RP accounts have gone unpaid for 90 days, the SP may release a copy of this agreement, Client or RP contact information, and a copy of any billing sent to the client to a 3rd party collection service. No other confidential information will be released. RP is responsible for all collection of fees, including attorney fees and court costs.

MODIFICATIONS
Any amendment or modification of this agreement or additional obligation assumed by either party in connection with this agreement will be binding only if evidenced in writing and signed by each party or an authorized representative of each party.

Your signature represents your agreement to the terms above. Your signature represents your agreement for you or your 3rd party payer to pay for the services rendered. Your signature represents your acknowledgement that, even if using a 3rd party payer for reimbursement, you, solely, are responsible for any fees not paid by the 3rd party where applicable.

Signature & Date

Name & Date:

Erica L. Daniels, PCC, LLC
1000 Jefferson Ave.
Cincinnati OH 45215-3236
513-268-5828

8. Medical History

Doctors / Medical Professionals Involved in Patient's Care:

Physical Conditions / Ailments & Age of Diagnosis:

Mental Health Diagnoses:

Mental Health Providers Involved in Patient's Care:

Current Medication Taken & Dosage:

Surgeries & age at time of surgery:

Major Illnesses & Age at time of Illness:

Accidents & Age at time of Accident:

Developmental Delays:

Significant Family History of Medical or Mental Health Conditions (relationship to patient and the name of their condition):

Alcohol or Drug Use or Dependence (age at time of use and substance used):

Family History of Alcohol or Drug Use or Dependence (relationship to patient and substance used):

History of Abuse or Assaults (sexual, physical, emotional, neglect):

History of Adversity (homelessness, gang violence, multiple schools/moves, deaths of loved ones/pets, etc.):

Check Current Mental Health Symptoms

- [ ] Anger or Aggression
- [ ] Anxiety / Worry
- [ ] Panic
- [ ] Sadness / crying / isolation / Hopelessness
- [ ] Lack of Energy / Loss of Interests or Motivation
- [ ] Fear / Phobias
- [ ] Hallucinations
- [ ] Flashbacks / Intrusive Memories / Nightmares
- [ ] Dissocation
- [ ] Self-harm
- [ ] Suicidal Thoughts / Suicide Attempt(s)
- [ ] Irritability
- [ ] Mood Swings
- [ ] Euphoria
- [ ] Sleep Disturbance
- [ ] Bed wetting or soiling
- [ ] Inattentive / Lack of Concentration or Focus
- [ ] Restlessness / Hyperactivity / Fidgety
- [ ] Impulsive / Interrupts
- [ ] Delusions / Paranoia
- [ ] Obsessive
- [ ] Compulsions
- [ ] Sensory Problems (sounds, sights, touch, etc.)
- [ ] Behavioral Problems

Other:

Goals for Counseling

What would you like to accomplish through counseling?:

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9. Ohio Client Rights & Grievance Policy

CLIENT RIGHTS

People in the state of Ohio who are seeking or undergoing mental health counseling have the following rights as set for by the Ohio Administrative Code 5122-26-18:

(1) The right to be treated with consideration and respect for personal dignity, autonomy and privacy

(2) The right to reasonable protection from physical, sexual or emotional abuse, neglect, and inhumane treatment

(3) The right to receive services in the least restrictive, feasible environment

(4) The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation

(5) The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency

(6) The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it

(7) The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others

(8) The right to be informed and the right to refuse any unusual or hazardous treatment procedures

(9) The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas

(10) The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations

(11) The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction

(12) The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary

(13) The right to be informed of the reason for denial of a service

(14) The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion,

gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws

(15) The right to know the cost of services

(16) The right to be verbally informed of all client rights, and to receive a written copy upon request

(17) The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations

(18) The right to file a grievance with CCP or with Ohio Counselor, Social Worker, Marriage & Family Therapist Board

(19) The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested

(20) The right to be informed of one's own condition; and

(21) The right to consult with an independent treatment specialist or legal counsel at one's own expense.

GRIEVANCE POLICY

If you are displeased with your provider or TFC or think your provider or TFC has acted unethically, we encourage you to follow these steps:

1. Communicate your displeasure to your provider. Some concerns could be caused by miscommunication, a lack of knowledge by either the provider or the client of the other's cultural norms, or plain error, and, oftentimes, these concerns can be alleviated with honest communication between you and your provider.

2. If you remain displeased after your communication with your provider, you may send a written complain toThe Firefly Company, 1000 Jefferson Ave., Cincinnati, OH 45215. Your written complaint should include the reason(s) for your complaint, the name of your provider at TFC, and steps you already have taken,, if any, to address your concerns. TFC's owner, Erica Daniels, will review and respond to your complaint within 2 (two) weeks of the date the complaint was received. Erica Daniels may seek consultation from other licensed mental health clinicians, the Ohio CSWMT Board, and/or an attorney in order to respond to your complaint accurately. Your personal information will remain private if such consultations occur, and only the nature of the complaint will be revealed.

3. If, after completing steps 1 & 2 you still think TFC and/or your provider have acted unethically, you may file a complaint with the Ohio Counselor, Social Worker, and Marriage & Family Therapist Board. You may send an online written complaint to Ohio CSWMFT Board by going to https://cswmft.ohio.gov/Information-for-the-Public/How-do-I-File-a-Complaint.

By signing below, you acknowledge having received and read TFC's Client Rights & Grievance Policy form. Please talk to your provider if you have questions regarding this form.

Signature:

Erica L. Daniels, PCC, LLC
1000 Jefferson Ave.
Cincinnati OH 45215-3236
513-268-5828

10. CRISIS PLAN

In The Event of a Mental Health Emergency...

You have several options when you think you or your child needs emergency services for your or their mental health, and all require seeking assistance outside of The Firefly Company, which is not an emergency center.

1. Call your local crisis line
If you are unsure if you should go to or take your child to a hospital, you can call your local mental health crisis center to discuss the situation and ask for a crisis worker to respond to your or your child's location to assess your or their mental health needs. The crisis worker will arrive at the location with a deputy who will escort you or your child, or help you escort yourself or your child, to the nearest hospital if the worker determines there's a need for further assistance.
a. HAMILTON County Crisis Line: 513-584-5098 or 513-584-8577
b. BUTLER County Crisis Line: 1-844-427-4747
c. CLERMONT County Crisis Line: 513-528-7283
d. WARREN County Crisis Line: 1-877-695-6333

2. Go to or take your child to the nearest emergency center
If you or your child has created calm down techniques in therapy, try to engage in those techniques; however, if you or your child already is at a point of needing emergency services, additional assistance likely will be required.
If you do need to go to the hospital, try to remember to sign a Release of Information at the hospital so the hospital will release your your hospital records for the crisis visit to your therapist at The Firefly Company. A therapist at TFC will see yo or your child for an after-hospital appointment as soon as possible upon discharge. Please note, you or your child may not see the normal assigned therapist at this appointment because this appointment is for continuation of care upon discharge and the assigned therapist might not be able to accommodate seeing you or your child directly after discharge.

We are invested in your health and want you or your child to receive services as quickly as possible when in an emergency. Please remember that The Firefly Company is not an emergency center and does not handle mental health emergencies outside of your scheduled appointment times. Again, if you or your child is having a mental health emergency, seek immediate assistance through the designated emergency centers listed above. You and your individual therapist can discuss situations that may and may not constitute an emergency.