CF30
Rev. 08/26/2025

Syntero
Care · Counsel · Support

Client Contact Information *To be completed by the client or a parent or guardian.*

Legal Name (First M Last)		How would you like to be addressed? (nickname)		Age
DOB	SSN	Gender (On record with health insurance)		
Physical Address		City	State	Zip
Mailing Address ☐ Same as Physical Address		City	State	Zip
Home Phone	Cell Phone	Receive Reminders at the Following number: ☐ Home Phone ☐ Cell Phone ☐ Other:		
Email Address				
Primary Language		Does client need interpreting services? ____ No ____ Yes Language:		
Does the client need assistive technology to access sessions? ____ No ____ Yes Details:		Does the client require written materials to be read to them? ____ No ____ Yes Details:		

Demographic Information: The information collected is 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	☐ Not of Hispanic/ Latino Origin	☐ Unknown
	☐ Hispanic - Not Specified	☐ Other Hispanic	
	☐ Mexican	☐ Puerto Rican	
Client's Living Arrangements:	☐ Community Residence	☐ Homeless	☐ Private Residence
	☐ Correctional Facility	☐ Nursing Facility	☐ Residential Care
	☐ DD/Operated Facility	☐ Other	☐ Temporary Housing
	☐ Foster Care	☐ Permanent Supported	☐ Unknown
Client's Marital Status:	☐ Divorced	☐ Separated	☐ Widowed
	☐ Married (or Living Together)	☐ Single (Never Married)	☐ Unknown
Military Status: ☐ None	☐ Active	☐ Disabled Veteran	☐ Discharged
Military Service: ☐ None	☐ Overseas	☐ Reserve	
Tobacco Use:	☐ User	☐ Non-user	
Smoking Status:	☐ Current Smoker	☐ Former Smoker	☐ Never Smoked
Current grade or highest level of education:	☐ 4th Grade	☐ 10th Grade	☐ 2 yr College Degree
	☐ 5th Grade	☐ 11th Grade	☐ 4 yr College Degree
☐ < 1st Grade	☐ 6th Grade	☐ 12th Grade	☐ Graduate Degree
☐ 1st Grade	☐ 7th Grade	☐ High School/GED	☐ Unknown
☐ 2nd Grade	☐ 8th Grade	☐ Tech School	
☐ 3rd Grade	☐ 9th Grade	☐ Some College	

Household Members: Please include anyone also living in the household. Use back of paper if you need additional space.

Name:	Relationship:	Age:

Medical History

Primary Care Physician. ☐ Do not have one

Name	Phone Number

Practice Name

Current Medications Use back of paper if you need extra space.

Medication	Dose	Frequency	Reason	Start Date	Prescriber

Medical Conditions Check "C ☐" for Current Issue and "P ☐" for Past Issue

Current	Past		Current	Past	
C ☐	P ☐	AIDS/HIV	C ☐	P ☐	Head Injury/Brain Tumor
C ☐	P ☐	Arthritis	C ☐	P ☐	Headaches/Migraines
C ☐	P ☐	Asthma/Lung Disease	C ☐	P ☐	Hearing Issues/Deafness
C ☐	P ☐	Blood Pressure Issues	C ☐	P ☐	Heart Disease
C ☐	P ☐	Bone/Joint Issues	C ☐	P ☐	Hepatitis/Jaundice
C ☐	P ☐	Cancer	C ☐	P ☐	Hyperactivity
C ☐	P ☐	Cirrhosis/Liver Disease	C ☐	P ☐	Kidney Disease
C ☐	P ☐	Diabetes	C ☐	P ☐	Sexually Transmited Illness
C ☐	P ☐	Eating Issues	C ☐	P ☐	Sleep Disorder
C ☐	P ☐	Epilepsy/Seizures	C ☐	P ☐	Stomach/Bowel Issues
C ☐	P ☐	Eye Disease/Blindness	C ☐	P ☐	Stroke
C ☐	P ☐	Fibromyalgia/Muscle Pain	C ☐	P ☐	Thyroid Issues

Emergency Contact

Name

Relationship	Phone

Additional Information (Optional) Please provide any additional information you would like your clinician to know.

Name of person completing form

Print: _____ Relationship to client: ☐ Self ☐ Parent ☐ Guardian

Sign: Date:

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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
  - Telebehavioral Health Addendum
- 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 provide services via telehealth
  _____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**

For a Minor Seeking Treatment without Parental Consent:

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)

2025 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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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 Parent Form

PURPOSE: The Y-OQ® 30.2 is designed to describe a wide range of situations, behaviors, and moods that are common to children and 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 your child 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.

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
1/05/2007

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. My child has headaches or feels dizzy.	○	○	○	○	○
2. My child doesn't participate in activities that used to be fun…….	○	○	○	○	○
3. My child argues or speaks rudely to others.	○	○	○	○	○
4. My child has a hard time finishing assignments or does…….. them carelessly.	○	○	○	○	○
5. My child's emotions are strong and change quickly.	○	○	○	○	○
6. My child has physical fights (hitting, kicking, biting, scratching) with family or others his/her age.	○	○	○	○	○
7. My child worries and can't get thoughts out of his/her mind.	○	○	○	○	○
8. My child steals or lies…….....	○	○	○	○	○
9. My child is has a hard time sitting still (or has too much energy).	○	○	○	○	○
10. My child uses alcohol or drugs…….	○	○	○	○	○
11. My child seems tense and easily startled (jumpy).	○	○	○	○	○
12. My child is sad or unhappy……...	○	○	○	○	○
13. My child has a hard time trusting friends, family members, or other adults.	○	○	○	○	○
14. My child thinks that others are trying to hurt him/her even …….. when they're not.	○	○	○	○	○
15. My child has threatened to, or has run away from home.	○	○	○	○	○
16. My child physically fights with adults……	○	○	○	○	○
17. My child's stomach hurts or feels sick more than others his/her age.	○	○	○	○	○
18. My child doesn't have friends or doesn't keep friends very long...	○	○	○	○	○
19. My child thinks about suicide or feels s/he would be better off dead.	○	○	○	○	○
20. My child has nightmares, trouble getting to sleep, oversleeping, or waking up too early.	○	○	○	○	○
21. My child complains or questions rules, expectations, or responsibilities.	○	○	○	○	○
22. My child breaks rules, laws, or doesn't meet others expectations on purpose	○	○	○	○	○
23. My child feels irritated	○	○	○	○	○
24. My child gets angry enough to threaten others…….....	○	○	○	○	○
25. My child gets into trouble when he/she is bored.	○	○	○	○	○
26. My child destroys property on purpose…….....	○	○	○	○	○
27. My child has a hard time concentrating, thinking clearly, or sticking to tasks.	○	○	○	○	○
28. My child withdraws from family and friends…….....	○	○	○	○	○
29. My child acts without thinking & doesn't worry about what will happen	○	○	○	○	○
30. My child feels like s/he doesn't have any friends and that no one likes them	○	○	○	○	○

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.

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YOQ30ENG Version 1.0
1/05/2007

	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….....	○	○	○	○	○