PEACE OF MIND COUNSELING, LLC

Client Intake Form – Children (11 & Younger)

TODAY'S DATE_____

CLIENT NAME_____

BIRTHDATE_____

ADDRESS_____

CITY_____STATE_____

ZIP _____County of Residence _____

GENDER: (circle one) Male Female Self-Identify

RESPONSIBLE PERSON NAME_____

RELATIONSHIP TO CLIENT_____

ADDRESS_____

CITY_____STATE_____

ZIP_____ County of Residence_____

PRIMARY PHONE: _____ Home Cell Work Other Okay for us to leave a message? No Yes

OTHER PHONE: _____ Home Cell Work Other Okay for us to leave a message? No Yes

May we contact you by e-mail? No Yes If yes, Email Address: _____

May we contact you via text? No Yes At which number: _____

Texting and email are for scheduling and correspondence, not for therapy. All efforts will be made not to include any personal or identifying information in electronic correspondence. We do not add clients to social media.

CLIENT MARITAL STATUS: (Circle one) SINGLE MARRIED DIVORCED SEPARATED DOMESTIC PARTNER WIDOW/ER

EMPLOYED: (Circle one) FULL TIME PART TIME SHELTERED EMPLOYMENT RETIRED HOMEMAKER UNEMPLOYED STUDENT

EMPLOYER: _____

How did you hear about our services? Online Friend/Family Phone book Other _____ Referred by _____

EMERGENCY CONTACT:

Name _____ Relationship to client_____

Phone_____ Do we have permission to call this person if we feel client is experiencing an emergency situation? Y N

CLIENT'S CURRENT MEDICATIONS: _____

ALLERGIES or serious medical conditions? (List) _____

PHYSICIAN (Name and clinic) _____

Do we have permission to contact client's physician? Yes No

Staff only: ROI Signed Y N

... Continued on other side...

All counseling appointments are scheduled in advance. We reserve a specific time period (usually 50 minutes) to each client. It is important that you realize that a block of time has been set aside for you. If an appointment is not canceled ("No Show"), you may be charged for the time set aside for you.

Financial Agreement

___**Self Pay**: I do not have insurance or other third-party coverage. I will pay for the services I receive at Peace of Mind Counseling, LLC. I will make a payment of $_____ each time I come for services; if there is any balance it will be due each month.

Note: If you choose to use this Self Pay option, this clinic will not re-bill any insurance at a later date.

_____**Insurance payment:** I will give all insurance information required to Peace of Mind Counseling, LLC staff, including an outside billing agency, and request that they submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for all charges. This includes my deductible and/or copay. I authorize this clinic and its billing agency to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents.

Regardless of your payment method, any uncollected balances may be forwarded to a collection agency.

Please present your insurance card at time of initial appointment and fill out the following thoroughly:

Name of Insurance: _____

Address of Insurance Company: _____

Policy ID# _____ **Group #** _____

Name of Policy Holder: _____

Address of Policy Holder: _____

Date of Birth of Policy Holder: _____ **Employer:** _____

Assignment of Benefits

I hereby direct my insurance company to pay for my services by check made out and mailed to:

Peace of Mind Counseling, LLC; 115 5th Ave. So. #523; La Crosse, WI 54601

If my current policy prohibits direct payment to provider, I hereby also instruct and direct my insurance company to make the check out to me and mail it to the above aress for the professional expense benefits allowable, and otherwise payable to me under my current policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay any balance of said charges for professional services over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original.

I have read and understand my Rights and Responsibilities as written in the "Client Information Booklet."
I have read and understand the above financial policy of Peace of Mind Counseling, LLC.

Client signature (if age 14 or older): _____ Date: _____

Parent or guardian signature (if client is a Minor): _____ Date: _____

For Clinical Staff use only:

Witness/Therapist Signature: _____ Date: _____

Initial Dx: _____

Peace of Mind Counseling

Informed Consent Notice

Risks and benefits:
When receiving treatment for mental health problems there are both risks and benefits. Risks or side effects may include discomfort from sharing personal information, or discomfort from trying/applying treatment strategies to your daily living routine. There may also be times of strong unpleasant feelings. This is a normal part of the counseling process and can be discussed with your therapist at any time.

There are also clear possible benefits. Benefits may include: increase in ability to cope with stressors, a decrease in mental health symptoms, better relationships, increased self-understanding and acceptance, and an overall feeling of being understood and unconditionally accepted. In short, you may feel better and get along with people better.

As a client or guardian of a client, you have numerous rights (see next page). You have the right to refuse or decline any proposed treatment methods or services. However, your refusal may result in, among others, symptoms or problems intensifying or becoming chronic, or symptom relief may take longer to achieve.

Confidentiality:
During the course of serving you, Peace of Mind Counseling may find it necessary to share information with other health care or business associates. Reasons we might share information include:

Use of a billing service to receive payment *
Health insurance requests for information *
*Your permission is granted if you sign our intake form
Therapists who are receiving supervision will consult with Supervisor as required. Licensed therapists will engage in peer review or professional collaboration to ensure you are receiving high quality care

Confidentiality of your information will be disclosed without your consent in these instances:

In certain situations involving suicide or threatening another person's life
The possibility of abuse or neglect of a child or vulnerable adult
Court ordered release of records

Peace of Mind Counseling adheres to all Federal, State, and local laws and regulations regarding Privacy Practices. Any disclosures of information other than those listed above including sharing information with your other care providers) will only be released with your written authorization. You may revoke that authorization at any time in writing.

Treatment:
On the first day, you will be asked to fill out forms that provide us with your personal demographic information as well as why you are seeking treatment, symptoms, and other questions about your past and present that inform us in an effort to provide you with best care. You may also be asked questions regarding your family, current or past relationships, previous counseling, medications, and more. This information will be kept confidential as described above.

Generally you will receive a diagnosis at the first session, which allows the therapist to develop a treatment plan with you. Your therapist will discuss treatment approaches to address your symptoms or struggles. Treatment approaches used within this agency include, but are not limited to, Cognitive-Behavioral Therapy, Choice Theory, Relaxation/Anxiety Reduction, Play Therapy, and Family Therapy. It may take time and several strategies to find the best method for you as an individual. Discussing your goals and strategies/options is an important part of your active participation in the counseling process.

Summary of Client Rights: *All consumers of outpatient mental health services are guaranteed the following rights under Wisconsin State law:*

- Nondiscrimination on the basis of race, religion, age, sex, or sexual orientation, ethnic origin, physical or mental impairment, financial or social status.
- The right to the least restrictive treatment conditions necessary.
- The right to receive prompt and adequate treatment.
- The right to be free from any unnecessary or excessive medications at any time.
- The right to be informed of your treatment and care and to participate in the planning of your treatment and care.
- The right to a humane psychological and physical environment.
- The right to confidentiality of all treatment records, to review and copy certain records, and to challenge the accuracy, completeness, timeliness or relevance of information in your records in accordance with the provisions of DHS35.
- Be informed about the costs of treatment.
- The right to file a grievance about violation of these rights without fear of retribution.
- The right to go to court if you believe that your rights were violated.
- The right to be treated with respect and recognition of the patient's dignity and individuality by all employees of the treatment facility or community mental health program and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact.

Source: Ch. 51 Wisconsin Statutes

You have also received a client rights brochure which explains your rights more completely and lists persons to contact if you have a complaint or grievance.

Consent:

I have read and understood the policies and confidentiality exceptions described herein. I am requesting professional services from Peace of Mind Counseling. I understand that I can ask questions or discuss concerns at any time regarding my treatment with my counselor or their supervisor. I also understand I may terminate counseling or withdraw this consent at any time for any reason, but the withdrawal must be in writing and signed by me or my legal guardian.

and

I have been informed of my rights as a client and given the opportunity to ask questions.

Client Name (print) _____

Client Signature (if age 14 or over) _____ *Date* _____

Parent or Guardian signature (if relevant) _____ *Date* _____

Therapist Signature _____ *Date* _____

Child _____ Child age _____

Caregiver: _____ Date: _____

Pediatric Symptom Checklist-17 (PSC-17)

INSTRUCTIONS: Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

	Please mark under the heading that best fits your child			For Office Use		
Does your child:	Never	Sometimes	Often	I	A	E
1. Feel sad.	☐	☐	☐			
2. Feel hopeless.	☐	☐	☐			
3. Feel down on him/herself.	☐	☐	☐			
4. Worry a lot.	☐	☐	☐			
5. Seem to be having less fun.	☐	☐	☐			
6. Fidget, is unable to sit still.	☐	☐	☐			
7. Daydream too much.	☐	☐	☐			
8. Distract easily.	☐	☐	☐			
9. Have trouble concentrating.	☐	☐	☐			
10. Act as if driven by a motor.	☐	☐	☐			
11. Fight with other children.	☐	☐	☐			
12. Not listen to rules.	☐	☐	☐			
13. Not understand other people's feelings.	☐	☐	☐			
14. Tease others.	☐	☐	☐			
15. Blame others for his/her troubles.	☐	☐	☐			
16. Refuse to share.	☐	☐	☐			
17. Take things that do not belong to him her.	☐	☐	☐			
TOTAL						

PSC 17 Gardner W, Murphy M, Childs G et al. (1999)

Peace of Mind CHILD History Form

For Youth Ages 11 and Under

Child (Client's) Name _____ Today's Date _____

Gender F____ M____ Date of Birth _____ Current Age _____

Form completed by _____ Relationship_____

HOME ENVIRONMENT: With whom does child live?

Full Name	Age	Relationship to child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other significant family members that live elsewhere? _____

Is child now or has ever been in foster care? Y N _____

Was child adopted? Y N At what age? _____ Is child a member of a Native tribe? _____

Development:

Was the child born prematurely or with complications at birth? Y N Describe any significant events during infancy or childhood that affected overall development _____

Did child receive "Birth-Three" Services? Describe _____

As best you can, indicate "**E**" (Early) "**N**" (Normal) or "**L**" (Late) development compared to other children:

Crawled _____ Sat up by self _____ Weaned_____ (Breast or bottle?) Walked_____

Talked_____ Dressed self _____ Slept through the night _____ Toilet trained _____

Medical History: Any medical conditions _____

Any significant medical concerns in child's family _____

Positives: Before we ask about concerns, tell us about what the child does well? Strengths? _____

_____

Favorite activities or hobbies_____

What would you like to accomplish from counseling? _____

_____

CHECK any of the following that this child struggles with. CIRCLE any that are *highly concerning*.

Cries or seems sad a lot _____ Tantrums _____ Impulsive ____

Worries a lot _____ Phobias or extreme fears ____ Separation anxiety ____

Aggressive, hurts others _____ Aggressive, breaks things ____ Easily frustrated ____

Victim of bullying _____ Bullies others_____ Argues a lot ____

Often angry ____ Obsessive/compulsive features ____ High activity ____

Trouble falling asleep _____ Trouble staying asleep ____ Bedwetting _____

Nightmares ____ Daytime wetting or soiling ____ Is not truthful _____

Does not follow rules ____ Takes things that belong to others ____

Difficulty with any of the following:

Staying on task ____ Following directions _____ Staying organized ____

Making/keeping friends ____ Sharing with others _____

Gross motor skills struggles (Walking, skipping, climbing stairs, riding a bicycle, etc.) ____

Fine motor skills struggles (Using a pencil, cutting with a scissors, picking up small items, etc.) ____

Eating or appetite concerns? Describe_____

Any strong *preferences* or *aversion* to sounds, smells, tastes or textures? Describe _____

_____

Has child talked about or threatened self-harm or wanting to die? Describe _____

_____

Abuse History: Has child experienced any of the following types of abuse in the past or present?

Sexual abuse _____ Physical abuse _____ Verbal abuse _____ Emotional abuse _____

Describe abuse_____

Other traumatic or difficult experiences_____

EDUCATION: Did the child attend Head Start? Y N Preschool? Y N

Current school and grade _____

Learning or academic difficulties_____

Behavioral difficulties at school_____

Does the child have an IEP? Y N If so is it for EBD ____ LD ____ CD ____ OHI ____ Spch/Lang _____

Describe accommodations _____

Previous Counseling:

Has child had counseling prior to this? When _____ Approx.# sessions _____

Therapist and clinic _____

Any medications for *emotional* or *behavioral* health taken in the past that child is not still taking? Y N

Was counseling and/or medication helpful? Y N Explain _____

Has the child received any other special services (mentor, respite care, County Social Worker, etc.)_____

_____

Family:

Which family member(s) is child close to? _____

Which family member(s) is child in frequent conflict with? _____

Does a *parent* have trouble controlling anger? Y N History of domestic violence in child's family? Y N

Have any family members had problems with alcohol or other drug abuse? Y N Describe _____

_____

Sexual development: Does child express dissatisfaction with his/her gender? Y N

Religious/Spiritual/Cultural: Does child or child's family affiliate with or participate in any religious, spiritual, or cultural practices? _____

Anything else you want the therapist to know _____

_____

Thank you for helping us get to know this child!

Please fill out Sections A, C, and F.

Peace of Mind Counseling, LLC
115 5th Ave. So. #503; La Crosse, WI 54601

Release of Information: Authorization For Disclosure of Client Information

A

Client Name:_____ DOB:_____
Address:_____ Phone:_____

B

Hereby Authorizes: _____ Peace of Mind Counseling, LLC_____
Address: __115 5th Ave. So. #503_____ City, State, Zip: ___La Crosse, WI 54601_____
Phone:_____ Fax: __608-782-4426_____ Email: _____

C

To: ◊ Receive from ◊ Release to ◊ Exchange with ◊ Includes verbal exchange

Name of Primary Care Physician Receiving the Request_____
Street Address:_____ City, State, Zip:_____
Phone:_____ Fax:_____ Email:_____

D

Information Requested:
I understand that this will include:

◊ Complete health record(s)
◊ Discharge Summary
◊ Progress Notes/Case Notes
◊ Prescriptions
◊ Client History
◊ Consultation Reports
◊ Diagnostic Assessment
◊ Other (specify)_____

Relating to:

◊ Mental and Behavioral Health
◊ Developmental Disabilities
◊ Treatment for alcohol and/or drug abuse
◊ Education
◊ Other _____

Covering the Time Period(s): from_____ to_____

E

For the purpose of:

◊ Coordination of health care
◊ Insurance purposes
◊ Legal Investigation -
◊ Personal
◊ Other (specify)_____

Your Rights with Respect to this Authorization

--Right to Inspect or Copy the Health Information to be Used or Disclosed

--Right to Receive Copy of This Authorization

--Right to Refuse to Sign-I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits on my decision to sign this form Information may be subject to redisclosure and no longer protected by the regulation.

F

I understand this authorization may be revoked in writing at any time. This authorization will expire one year from the date of my signature or otherwise designated date of_____. If I elect to revoke this authorization prior to its annual renewal date, or the designated date I selected, I understand that Peace of Mind Counseling cannot be held responsible for any records already released prior to written notification, to the appropriate employee, that I am revoking my consent.

The facility, its employees and therapists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. By signing this authorization, I confirm that it accurately reflects my wishes.

Your signature to disclose this information allows Peace of Mind Counseling to release your information by means of USPS, fax, telephone, and email.

Signed (Client if 14 or older):_____ Date:_____

Signed (Parent or Guardian, if applicable):_____ Date:_____

Witness (Peace of Mind Counseling staff member): _____ Date: _____

Client is: __A Minor __Incompetent __Disabled __Deceased
Signer is: __Legal Authority __Custodial Parent __Legal Guardian __Power of Attorney __Legal Authorized Representative

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by Peace of Mind Counseling. Requests for amendment or correction should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom Peace of Mind Counseling may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period. The request cannot include any disclosures made before April 14, 2003. Requests for an accounting of disclosures should be made in writing to the PoM Privacy Officer.We will respond to your request within 60 days after you submit the request.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to Peace of Mind Counseling will be made only with your authorization. If you authorize PoM to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization please contact your therapist or the clinic where you receive services.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with Peace of Mind Counseling, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

Who to contact with a complaint or grievance:

Cindy Ericksen, Client Rights Officer 608-785-0011

Secretary of Department of Health and Human Services: (877) 696-6775

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This information is available in Spanish and Hmong. Please ask a staff member if you need a copy in either of these languages. Esta información esta disponible en español. Se usted necesita una copia en español, por favor pregunte a miembro del personl. Cov ntau ntawv no nws muaj cov pes lus hmoob. Yog tias koj xa tau ib daim ntawv uas pes lus hmoob no thov noog cov neeg ua hauj lwm.

When we refer to "you" or "your" in this Notice we refer to the person or persons receiving the services provided by Peace of Mind Counseling (PoM). When we refer to disclosures of information to "you", we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from Peace of Mind Counseling.

Who follows this Notice:
This Notice applies to all **protected health information (PHI)** maintained by Peace of Mind Counseling (PoM) for services provided at any office of PoM or services provided at non-office locations by any employee of PoM in the course of their employment. If you have any questions after reading this Notice, please contact the Peace of Mind Counseling Privacy Officer listed at the end of this document.

Each time you receive services from Peace of Mind Counseling, a record of the services provided is created. Typically this record could contain information about the type of service you have received, the dates of service and the results of the service provided. At times this will include the reason you have come to PoM for service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by Peace of Mind Counseling.

Our Pledge to Protect Your Health Information: We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices.

We reserve the right to revise or change this Notice. Each time you sign a consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.
Effective March, 2016

How We May Use and Share Your Health Information With Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a worker or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your worker or therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from Peace of Mind Counseling so PoM can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may disclose PHI about you for business operations of Peace of Mind Counseling. These uses and disclosures are necessary for PoM to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that requires them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

Future Communications: We may use your name, address and telephone number to contact you to provide newsletters, information about programs or other services we offer. Your information will never be given to anyone outside of our agency.

Appointments: We may use your PHI for the purpose of sending to you appointment reminders through the mail or by telephone. Messages left for you will not contain specific health information.

Required or Permitted by Law: Peace of Mind Counseling is required by law to disclose your PHI in certain circumstances:

- For public health oversight activities
- To facilitate the functions of federal or state governmental agencies
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Prison officials if you are in custody
- Worker's Compensation officials if your condition is work-related
- If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of Peace of Mind Counseling, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for Peace of Mind Counseling.

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by Peace of Mind Counseling for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. PoM is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the PoM Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.