PEACE OF MIND COUNSELING, LLC

Client Intake Form – Adolescent (12 - 17 Years Old)

TODAY'S DATE_____

CLIENT NAME_____

BIRTHDATE_____

ADDRESS_____

CITY_____STATE_____

ZIP _____County of Residence _____

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.

Current gender identity: _____

Relationship Status *Circle One*

Single	Domestic Partner	Widowed
Married	Separated	
Partnered	Divorced	

Employment *Circle One*

Full Time	Unemployed	Employer: _____
Part Time	Homemaker	
Student	Retired	

How did you hear about our services?

Online
Friend/Family
Referred by: _____
Other: _____

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? Y N

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 areas 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 <u>without your consent</u> 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* _____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	❑ Yes			❑ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	❑ Yes			❑ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	❑ Yes			❑ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	❑ Yes			❑ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	❑ Yes			❑ No		
	25.	Have you EVER tried to kill yourself?	❑ Yes			❑ No		

Peace of Mind Counseling, LLC
Personal History Form

In the following form, "you" refers to the client:

Client Legal Name _____ **Today's Date** _____

Client Preferred Name _____ **Client Date of Birth** _____ **Current Age** __

Client Pronouns _____

Client's current gender identity: _____

Client sex assigned at birth: _____

Client sexual orientation is: _____

Form completed by (if other than client) _____ Relationship _____

HOME ENVIRONMENT: With whom do you live?

Full Name	Age	Relationship to You

If not included above, how many siblings do you have? _____ Are your parents living? _____

Were you adopted? Y N At what age?_____

WORK/SCHOOL: School attended, highest grade or degree achieved_____

Describe any learning difficulties in elementary or high school_____

Place of employment / type of job _____Schedule _____

Do you experience difficulties at school and/or work? If so, explain_____

_____

REASON FOR COUNSELING: Briefly explain your issues of concern_____

_____

Length of time you have had these concerns _____

How would you rate the intensity of the concern? (1=Mild, 5=Moderate, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

Describe ways you have attempted to cope _____

What would you like to see accomplished through counseling (your goals)?_____

_____

Medical History: Any medical concerns you have _____

Any significant medical concerns in your family _____

List any known allergies you have, including allergies to medication _____

Your primary physician and clinic/hospital location _____

Previous Counseling: Have you ever participated in counseling services prior to this occasion? Y N

When _____ Approx. # of sessions _____

Therapist and clinic_____

Was it helpful? Y N Why or why not?_____

Have you taken any medications for *mental health* symptoms? Y N

Medication _____ For what symptom _____ How long _____

_____ For what symptom _____ How long _____

_____ For what symptom _____ How long _____

Are/were you satisfied with the outcome of medication treatment? Y N

List current medications you take for *physical* symptoms _____

Legal History: List any past legal involvement, crimes you have committed _____

_____

Military History: Y N If yes, Branch, year(s) served, other details _____

MOOD ASSESSMENT: Check if you have or are experiencing problems with any of the following:

Impaired: Concentration _____ Thinking _____ Reasoning _____ Perception _____ Memory _____

Depressive Symptoms:

Distressing thoughts ____

Lack of energy _____

Restlessness or Mania _____

Appetite increase ____

Appetite decrease _____

Change in Weight: Up __lbs or Down __lbs

Increased sleep_____

Decreased sleep _____

Avg. # hrs. sleep/night _____

Suicidal Symptoms:

Preoccupation with death _____ Talked about suicide or had suicidal thoughts_____

Number of previous attempts _____ Specific action _____

Do you habitually cut, burn or otherwise harm yourself without intent to die? Y N Describe _____

_____ How frequently? _____

Anxiety Symptoms:

List signs of anxiety, describe_____

Name the source of the anxiety, if known_____

Do you have a history of panic attack(s)? Y N

Describe what was happening at the time _____

Obsessive or Compulsive Symptoms: Y N Explain _____

_____

Anger: Short temper or trouble controlling anger? Describe _____

_____

Did either parent have trouble controlling anger? Y N History of domestic violence in your family? Y N

Have you had any significant consequences or legal charges due to anger/domestic violence Y N

Describe_____

Alcohol or Substance Use/Abuse History:

Are you currently using alcohol? _____

How much/how often? _____

Are you currently using other substances? _____

What substances/how much/how often? _____

Have any family members had problems with alcohol abuse? Y N Who?

_____

Have any family members had problems with substance abuse? Y N Who? _____

Have you ever experimented with drugs/other substances? _____

Which one(s)? _____

Consequences (self, family, health, legal) _____

Is anyone close to you concerned about your use of alcohol or other substances? Y N Who? _____

Abuse History: Have you experienced any of the following types of abuse in the past or present?

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

Describe _____

Family and Social Functioning:

Do you have close friends? _____How often spend time together? _____

Which family member(s) are you close to? _____

Which family member(s) are you in frequent conflict with? _____

Your favorite activities or hobbies _____

Sexuality: Do you have any sexual concerns? _____

Religious Affiliation: Do you have a religious affiliation? Y N Describe _____

What are your personal strengths? _____

_____

What are your personal struggles or weaknesses?_____

_____

Thank you for filling out this form! It will help us understand you and serve you better.

Peace of Mind Counseling, LLC

Personal History Form

For clients under 18 years of age

Was the child born prematurely or with any complications at birth? Y N Describe _____

Any significant events during infancy or childhood that affected child's overall development? _____

_____

At approximately what age was the child able to do the following? If you do not remember the age, indicate "E" (Early) "N"(Normal) or "L"(Late) compared to other children.

Crawl_____ Sit up by self _____ Weaned_____ (Breast or bottle?) _____
Walk_____ Talk_____ Dressed self_____
Slept through the night _____ Toilet trained _____
Spoke 4-5 word sentences _____

Other developmental milestones the child achieved earlier or later than most _____

_____

Emotional/Behavioral History Check any that this child has experienced or displayed to a concerning level

Thumb sucking _____ Nail biting _____ Separation anxiety ____ Clingy _____
Whining_____ Irritability_ Quick to anger _____ Tantrums_____
Biting others _____ Worrying ____ Afraid of dark_____ Nightmares____
Tics _____ Bedwetting _____ Soiling other than in toilet _____
Sleepwalking _____ Hyperactivity_____ Other (describe) _____

Difficulty with: Getting to sleep____ Staying asleep _____ Staying on task _____
Making or keeping friends _____ Bullies others____ Victim of bullying_____
Sharing _____ Following directions _____
Fear of social situations_____ Unusual fears/phobias (List) _____

Education:

Did the child attend Head Start? Y N Preschool? Y N # of years _____
Does the child have an IEP? If yes, for EBD ___ LD ____ CD ____ OHI _____ Spch/Language _____

Describe IEP accommodations _____

Is child attending regular school or special location? If so, where? _____

Other:

Has the child had any legal or delinquency problems? Describe _____

_____

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

_____

Any other emotional or behavioral concerns?_____

_____

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

III. AODA TREATMENT (continued)

C. If you are 12 or older, you can be provided some limited treatment without your parent or guardian's consent or knowledge.

IV. TREATMENT RIGHTS

A. You must be provided prompt and adequate treatment.

B. If you are 14 years old or older, you can refuse treatment until a court orders it.

C. You must be told about your treatment and care.

D. You have the right to and are encouraged to participate in the planning of your treatment and care.

E. Your relatives must be informed of any costs they may have to pay for your treatment.

V. PERSONAL RIGHTS

A. You must be informed of your rights.

B. Reasonable decisions must be made about your treatment and care.

C. You cannot be treated unfairly because of your race, national origin, sex, religion, disability or sexual orientation.

VI. RECORD ACCESS AND PRIVACY

A. Staff must keep your treatment information private (confidential). However, it is possible that your parents may see your records.

B. If you want to see your records, ask a staff member.

1. You may always see your records on any medications you take.

2. Staff may limit how much you may see of your other records. They must give you reasons for any limits.

C. If you are at least 14, you can consent to releasing your own records to others.

VII. PATIENT RIGHTS HELP

If you want to know more about your rights or feel your rights have been violated, you may do any of the following:

A. Contact the patient rights staff if you have any questions. Their contact information should be provided to you by the service provider.

B. File a complaint. Patient rights staff will look into your complaints. They will keep your complaints private (confidential); however, they may need to ask staff about the situation.

C. Call Disability Rights Wisconsin (DRW). They are advocates and lawyers who can help you with patient rights issues. Their telephone number is (608) 267-0214 or 1 (800) 928-8778.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Mental Health and
Substance Abuse Services
P-20470B (12/2008)
www.dhs.wisconsin.gov

State of Wisconsin

RIGHTS OF CHILDREN AND ADOLESCENTS In Outpatient Mental Health Treatment

What every young patient needs to know to be aware of his/her legal rights.

I. OUTPATIENT TREATMENT CONSENT

A. **If you are less than 14 years old:**

A parent or your guardian must agree, in writing, to your receiving outpatient mental health treatment.

B. **If you are 14 years or older:**

1. You and your parent or guardian must agree to your receiving outpatient mental health treatment.

2. If you want treatment but your parent or guardian is unable to agree to it or won't agree to it, you (or someone on your behalf) can petition the county Mental Health Review Officer (MHRO) for a review.

3. If you do not want treatment but your parent/guardian does, the treatment director for the clinic where you are receiving your treatment must petition the MHRO for a review.

II. REVIEW BY MHRO AND/OR COURT

A. Each Juvenile Court appoints a MHRO for that county. A list of MHRO's by county is at: http://dhs.wisconsin.gov/clientrights/minors/MHRO.htm

B. The Juvenile Court must ensure that you are provided any necessary assistance in the petition for review.

C. The MHRO must inform your county of the petition for review.

D. If you request it and the MHRO thinks it is in your best interests, review by the MHRO can be skipped and the review will be done by the court.

E. If the MHRO does the review:

1. A hearing must be held within 21 days of the filing of the petition for review.

2. Everyone must get at least 96 hours (4 days) notice of the hearing.

3. To approve your treatment (against your will or despite the refusal of your parent/guardian) the MHRO must find that all these are true:

   a. The refusal of consent is unreasonable.
   b. You are in need of treatment.
   c. The treatment is appropriate and least restrictive for you.
   d. The treatment is in your best interests.

4. You and your parent/guardian will be informed of the right to a judicial review.

F. Judicial Review

1. Within 21 days of the MHRO's ruling (or if that review is skipped), you (or someone acting on your behalf) can petition the Juvenile Court for a judicial review.

2. If you do not want the treatment, the court must appoint you an attorney at least 7 days prior to the hearing.

3. If it is your parent/guardian who does not want the treatment and you do not already have a lawyer, the court must appoint you one.

4. A court hearing must be held within 21 days of the petition.

5. Everyone must get at least 96 hours notice of the hearing.

6. To approve your treatment (against your will or despite the refusal of your parent/guardian) the Judge must find that all these are true:

   a. The refusal of consent is unreasonable.
   b. You are in need of treatment.
   c. The treatment is appropriate and least restrictive for you.
   d. The treatment is in your best interests.

7. A court ruling does not mean that you have a mental illness.

8. The court's ruling can be appealed to the Wisconsin Court of Appeals.

III. AODA TREATMENT

A. **At any age, if your parent or guardian agrees to it,** you can be required to participate in treatment for alcohol or other drug abuse.

B. **If you are less than 12,** you may get limited treatment (like detox) without your parent or guardian's consent only if they cannot be found or you do not have one.

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.