PEACE OF MIND COUNSELING, LLC

Client Intake Form – Adult (18 & Older)

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—Adult

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

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

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 been bothered by the following problems?	**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. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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.

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

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional, or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability, or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting, and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped, or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation, and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, or **a court orders it.** [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.

- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Care and Treatment Services (DCTS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Care and Treatment Services or designee. Send your request to the DCTS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or DHS 94, Wisconsin Administrative Code is available upon request.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
www.dhs.wisconsin.gov
P-23112 (09/2016)

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

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.