

Thank you for calling Associates in Psychotherapy, LLC for an appointment. Please read and complete the information in this envelope and bring it with you, along with your insurance card, to your first appointment. If you have questions about anything, our office staff or your therapist will help you find the answers and explain our procedures. Please arrive 10 minutes early the first time to provide our office staff with your insurance information.

A parent must sign all forms for children 18 and younger. If the child is 14 or older, they must sign also. A parent **must** attend the initial counseling session if the child is under 18.

We look forward to meeting with you.

# ASSOCIATES IN PSYCHOTHERAPY, LLC

4700 Dresser Drive, Ste. 100, Janesville, WI 53546 • 608-752-7255 • Fax 608-752-6942

[www.AssociatesInPsychotherapy.com](http://www.AssociatesInPsychotherapy.com)

## ADULT INTAKE

Date \_\_\_\_\_ Therapist \_\_\_\_\_ Referred by \_\_\_\_\_

Client's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Maiden Name \_\_\_\_\_ Level of Education \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Cell Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone Number \_\_\_\_\_

What number can we leave a message on? Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_  
Work Status/Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Employed Above for How Long? \_\_\_\_\_  
( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Significant Other

### If married:

Spouse's Name \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_  
Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Level of Education \_\_\_\_\_  
Work Status/Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
Date of Marriage \_\_\_\_\_ How Long? \_\_\_\_\_ Employed Above for How Long? \_\_\_\_\_

### Previous Marriage(s)

Ex-spouse's Name \_\_\_\_\_ Date of Marriage \_\_\_\_\_ How long? \_\_\_\_\_  
Ex-spouse's Name \_\_\_\_\_ Date of Marriage \_\_\_\_\_ How long? \_\_\_\_\_

### Children/Step-Children (First and Last Name)

Name _____	Age _____	School/Occupation _____
Name _____	Age _____	School/Occupation _____
Name _____	Age _____	School/Occupation _____
Name _____	Age _____	School/Occupation _____
Name _____	Age _____	School/Occupation _____

### FAMILY OF ORIGIN

Family Member	Name	Age	Education	Occupation	Marital Status	If Deceased Date	Cause of Death
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Mother \_\_\_\_\_

Father \_\_\_\_\_

Step-Mother \_\_\_\_\_

Step-Father \_\_\_\_\_

### Brothers/Sisters

Name	Age	Education	Occupation	Marital Status	If Deceased Date	Cause of Death
------	-----	-----------	------------	----------------	------------------	----------------

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where were you born and raised? \_\_\_\_\_

Are your parents divorced? ( ) Yes ( ) No If yes, how old were you? \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Please check all areas which apply to you and your family's medical history and indicate the relationship of that person who it pertains to.

<b>MEDICAL PROBLEMS</b>	<b>FAMILY MEMBER</b>	<b>MEDICAL PROBLEMS</b>	<b>FAMILY MEMBER</b>
<input type="checkbox"/> Alcoholism _____		<input type="checkbox"/> Hepatitis _____	
<input type="checkbox"/> Aneurysm _____		<input type="checkbox"/> High Blood Pressure _____	
<input type="checkbox"/> Anxiety _____		<input type="checkbox"/> Hypoglycemia _____	
<input type="checkbox"/> Attention Deficit Disorder _____		<input type="checkbox"/> Hysterectomy _____	
<input type="checkbox"/> Attention Deficit /Hyperactivity _____		<input type="checkbox"/> Kidney Disease _____	
<input type="checkbox"/> Autism Syndrome _____		<input type="checkbox"/> Lung Problems _____	
<input type="checkbox"/> Back Problems _____		<input type="checkbox"/> Menopause _____	
<input type="checkbox"/> Bipolar Disorder _____		<input type="checkbox"/> Miscarriage _____	
<input type="checkbox"/> Blindness _____		<input type="checkbox"/> Obesity _____	
<input type="checkbox"/> Cancer _____		<input type="checkbox"/> Obsessive	
<input type="checkbox"/> Colitis _____		<input type="checkbox"/> Compulsive Disorder _____	
<input type="checkbox"/> Crohn's Disease _____		<input type="checkbox"/> P.M.S. _____	
<input type="checkbox"/> Deafness _____		<input type="checkbox"/> Panic Attacks _____	
<input type="checkbox"/> Depression _____		<input type="checkbox"/> Posttraumatic Stress	
<input type="checkbox"/> Diabetes _____		<input type="checkbox"/> Disorder _____	
<input type="checkbox"/> Drug Abuse _____		<input type="checkbox"/> Schizophrenia _____	
<input type="checkbox"/> Ear Infections _____		<input type="checkbox"/> Seizures _____	
<input type="checkbox"/> Eating Disorders _____		<input type="checkbox"/> Sinus Infections _____	
<input type="checkbox"/> Emphysema _____		<input type="checkbox"/> Sleep Disorders _____	
<input type="checkbox"/> Head Injury _____		<input type="checkbox"/> Stroke _____	
<input type="checkbox"/> Headaches/Migraines _____		<input type="checkbox"/> Thyroid Problems _____	
<input type="checkbox"/> Heart Disease _____		<input type="checkbox"/> Tourette Syndrome _____	
<input type="checkbox"/> Heart Pain (Angina) _____		<input type="checkbox"/> Tuberculosis _____	
<input type="checkbox"/> Heart Attack _____		<input type="checkbox"/> Ulcers _____	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

**Past Psychiatric/Psychotherapy Treatment:**

Have you been in therapy before?  Yes  No Reason for previous treatment: \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_ Therapist (if known): \_\_\_\_\_

Medications taken: \_\_\_\_\_

Response to treatment: \_\_\_\_\_

Any hospitalizations for psychiatric purposes? \_\_\_\_\_ If so, where? \_\_\_\_\_

What family members have been treated for psychiatric purposes? \_\_\_\_\_

History of suicide in your family? \_\_\_\_\_ If so, who? \_\_\_\_\_

**MEDICAL INFORMATION and HISTORY**

Doctor(s) _____	Clinic _____	Last Physical _____
Doctor(s) _____	Clinic _____	Last Physical _____
Doctor(s) _____	Clinic _____	Last Physical _____

Illnesses \_\_\_\_\_

\_\_\_\_\_

Surgeries \_\_\_\_\_

\_\_\_\_\_

Medication Allergies \_\_\_\_\_

\_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Living Situation**

Alone \_\_\_\_\_ With Spouse \_\_\_\_\_ Significant Other \_\_\_\_\_ With Friend \_\_\_\_\_ With Relatives \_\_\_\_\_ With Parents \_\_\_\_\_

**Quality of Family Relationship**

Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

**Have you service in the military?**

Yes \_\_\_\_\_ No \_\_\_\_\_ Which branch? \_\_\_\_\_

**Has a close friend or member of your family died in the past two years?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, who? \_\_\_\_\_

**Other significant losses during the past two years?**

Marriage \_\_\_\_\_ Relationship \_\_\_\_\_ Pet \_\_\_\_\_ Job \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_

**Is your work satisfying?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If not, explain why: \_\_\_\_\_

**Major Source of Annual Income**

Job \_\_\_\_\_ Spouse \_\_\_\_\_ Parents \_\_\_\_\_ Children \_\_\_\_\_ Relatives \_\_\_\_\_ Social Security \_\_\_\_\_ Pension/Savings \_\_\_\_\_

Disability \_\_\_\_\_ Does Not Apply \_\_\_\_\_ Other \_\_\_\_\_

**Organizations, Hobbies, Skills, Interests:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current use of alcohol**

None \_\_\_\_\_ Occasional \_\_\_\_\_ Daily \_\_\_\_\_ Heavy \_\_\_\_\_ Binge drinking \_\_\_\_\_ Marked by occasional attempts at abstinence \_\_\_\_\_

**Current use of drugs**

None \_\_\_\_\_ Occasional \_\_\_\_\_ Regular \_\_\_\_\_ Heavy \_\_\_\_\_ Illegal \_\_\_\_\_ Prescription \_\_\_\_\_

**Have you or anyone else ever had concerns about your alcohol, medication or drug use?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

**Have you ever been treated for alcohol or other drug abuse?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If so, when? \_\_\_\_\_

**Have you or anyone else ever had concerns about your weight and eating habits?**

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

**Current Tobacco Use (i.e. Smoking, Chewing)**

Never \_\_\_\_\_ Quit \_\_\_\_\_ >1 pack per day \_\_\_\_\_ 1 pack per day \_\_\_\_\_ < 1 pack per day \_\_\_\_\_

**While you were growing up, did you have any problems with:**

Bedwetting \_\_\_\_\_ Fears \_\_\_\_\_ Friends \_\_\_\_\_ Learning to talk \_\_\_\_\_ Learning to walk \_\_\_\_\_ Nail biting \_\_\_\_\_ School \_\_\_\_\_

Nightmares, recurrent dreams \_\_\_\_\_ Unusual illnesses \_\_\_\_\_ Toilet training \_\_\_\_\_ Sleep disturbance \_\_\_\_\_ None \_\_\_\_\_

Other \_\_\_\_\_

**Have you ever been sexually abused?** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

**Have you ever been physically abused?** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

**Have you ever been emotionally abused?** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

**Sexual Preference** Heterosexual \_\_\_\_\_ Bisexual \_\_\_\_\_ Homosexual \_\_\_\_\_ Unknown \_\_\_\_\_

**Current Legal Problems**

Child Custody \_\_\_\_\_ Divorce \_\_\_\_\_ Criminal Charges \_\_\_\_\_ None \_\_\_\_\_ Parole/Probation \_\_\_\_\_ Civil Suit \_\_\_\_\_

**History of Legal Problems**

Arrest \_\_\_\_\_ Driver's License Revoked \_\_\_\_\_ Juvenile Record \_\_\_\_\_ Prison Record \_\_\_\_\_ Other: \_\_\_\_\_ None \_\_\_\_\_

**History of Violent Acts**

Assault \_\_\_\_\_ Child Abuse \_\_\_\_\_ Spouse Abuse \_\_\_\_\_ Suicide Attempt \_\_\_\_\_ Murder \_\_\_\_\_ None \_\_\_\_\_

**Current Violent Thoughts**

Injury to Others \_\_\_\_\_ Self-injury \_\_\_\_\_ Other: \_\_\_\_\_ None \_\_\_\_\_

**What are the problems and symptoms for which you are seeking help?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Marriage or Relationship                   | <input type="checkbox"/> Family Problems                              | <input type="checkbox"/> Depression   |
| <input type="checkbox"/> Anxiety or Worry                           | <input type="checkbox"/> Panic Attacks                                | <input type="checkbox"/> Mood Swings  |
| <input type="checkbox"/> Self-confidence                            | <input type="checkbox"/> Social Isolation                             | <input type="checkbox"/> Social Anxiety   |
| <input type="checkbox"/> Parent/Child Conflict                      | <input type="checkbox"/> Problems with Friends                        | <input type="checkbox"/> Work Related   |
| <input type="checkbox"/> Grieving                                   | <input type="checkbox"/> Abuse (physical/sexual/<br>emotional/verbal) | <input type="checkbox"/> Trauma other than abuse<br>(disaster, accident, crime, etc.) |
| <input type="checkbox"/> Sexual Functioning                         | <input type="checkbox"/> Impulse Control                              | <input type="checkbox"/> Alcohol Use  |
| <input type="checkbox"/> Anger                                      | <input type="checkbox"/> Physical/Health Problems                     | <input type="checkbox"/> Eating Disorder  |
| <input type="checkbox"/> Drug Use                                   | <input type="checkbox"/> Communication Problems                       | <input type="checkbox"/> Divorce Recovery   |
| <input type="checkbox"/> Obsessive/Compulsive Problems              | <input type="checkbox"/> Sexual Orientation Questions                 | <input type="checkbox"/> Thinking of Harming Self                                     |
| <input type="checkbox"/> Thinking of Harming Others                 | <input type="checkbox"/> Learning/Memory Problems                     | <input type="checkbox"/> Disturbing Thoughts  |
| <input type="checkbox"/> Change in Sleep                            | <input type="checkbox"/> Change in Appetite                           | <input type="checkbox"/> Change in Sex Drive  |
| <input type="checkbox"/> Criminal Charges                           |   | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Partner/Family Member wants me to get help |   |   |

When did these problems begin? \_\_\_\_\_

**Do these problems affect your:**

( ) Health ( ) Personal Relationships ( ) Work Performance ( ) No Significant Effect

**Your Strengths:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Assertiveness                     | <input type="checkbox"/> Self-Esteem       | <input type="checkbox"/> Support Network                          |
| <input type="checkbox"/> Problem Solving Skills            | <input type="checkbox"/> Self-Care         | <input type="checkbox"/> Functioning at Home, Work<br>&/or School |
| <input type="checkbox"/> Empathy                           | <input type="checkbox"/> Stress Management | <input type="checkbox"/> Judgment                                 |
| <input type="checkbox"/> Spirituality                      | <input type="checkbox"/> Insight           | <input type="checkbox"/> Mood Regulation                          |
| <input type="checkbox"/> Boundaries                        | <input type="checkbox"/> Motivation        | <input type="checkbox"/> Attention & Concentration                |
| <input type="checkbox"/> Behavior                          | <input type="checkbox"/> Self-Comforting   |   |
| <input type="checkbox"/> Interest, Hobbies & Organizations |  |   |

**What are the major stressors in your life at this time?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**On a scale of 1 to 10, my current functioning is at** \_\_\_\_\_

**What impact are your problems having on your daily functioning?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What is going well in your life?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What strategies or coping skills have you used in the past?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**My goals for therapy are?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How will you know when things are getting better?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

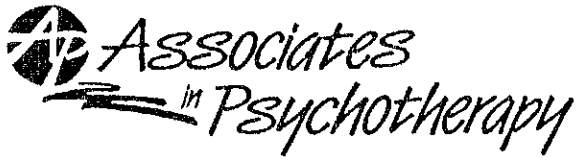
**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Therapist**



**INFORMED CONSENT FORM**

Client: \_\_\_\_\_

I have been provided information regarding psychotherapy treatment and understand I have the right to additional information concerning the following:

- a. the benefits of proposed treatment;
- b. the way the treatment is to be administered;
- c. alternative treatment modes;
- d. the probable consequences of not receiving proper treatment;
- e. the time period for which the Informed Consent is effective;
- f. the right to withdraw the Informed Consent at any time in writing.
- g. I understand that if I receive medications from this clinic, I have the right to know the reasons for the prescription of that medication as well as its potential side effects. I also understand that it is my responsibility to ask questions if I do not understand the directions, purpose or side effects of that medication, and to report problems to my physician at this clinic.
- h. Before the clinic involuntarily discharges a consumer because of the consumer's inability to pay for services or for behavior that is reasonably a result of mental health symptoms, the clinic notifies the consumer in writing of the reasons for the discharge, the effective date of the discharge, sources for further treatment, and of the consumer's right to have the discharge reviewed, prior to the effective date of the discharge, by the Behavioral Health Certification Section, Division of Quality Assurance, whose address is P.O. Box 2969, Madison, WI 53701-2969, fax (608) 261-0655. In general we do not involuntarily discharge clients for the above reasons. See Consumers Rights and Grievance Procedures section.
- i. The clinic has a twenty-four hour answering service. Emergency calls are given to your therapist. If your therapist cannot be contacted in a reasonable period of time, the on-call therapist will handle the call. If it is a definite emergency, 911 will be called.

In addition, I have been informed orally of and been given access to a written copy of the Client's Treatment Rights and Grievance Procedure.

Can we leave a message on your home answering machine and/or cell phone?

Yes \_\_\_\_\_

No \_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person Authorized by Client

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Witness

## ASSOCIATES IN PSYCHOTHERAPY, LLC

4700 Dresser Drive, Suite 100  
Janesville, WI 53546

### Business Policy and Patient Agreement

Welcome to Associates in Psychotherapy, LLC. We have designed this packet to help you understand our policies and procedures along with your rights as our client. We ask that you read this informational packet. Your signature is needed at the end of this packet to indicate your understanding and willingness to participate and abide by these policies. We want you to know that we are dedicated to giving you quality care. Please feel free to ask questions.

**OFFICE HOURS:** Because of the diversity of our clinical staff, our hours range from 8:00 a.m. to 7:00 p.m. Monday through Friday. The office staff is available from 8:30 a.m. to 7:00 p.m. Monday through Thursday and 8:30 a.m. to 4:30 p.m. on Friday with the exception of holidays. After normal business hours, you may leave a message on our voicemail. For an urgent matter after normal business hours, you may contact our answering service; they know how to contact your therapist.

#### **FEE INFORMATION:**

##### **Nurse Practitioner**

Psychiatric Evaluation - \$260  
Medication Evaluation - \$120

##### **Licensed Psychologists**

Initial Assessment - \$220  
Therapy Sessions - \$150/\$225  
Family Therapy - \$160

##### **Therapists**

Initial Assessment - \$205  
Therapy Sessions - \$130/\$195  
Family Therapy - \$140

#### **FEES NOT REIMBURSED BY INSURANCE COMPANIES**

Late Cancellation/No Show Fees:	Nurse Practitioner	\$ 50.00
	Psychologist	\$ 70.00
	Therapist	\$ 60.00
Record Requests:		
Administrative Costs		\$ 26.00
Copying Fee per Page		\$ 0.50
Actual Cost of Postage		

Consultation or Other Services:  
Per hour \$205.00

Court Preparation and/or Testimony:  
Per hour \$205.00

**24-HOUR CANCELLATION POLICY:** When it is necessary to cancel an appointment, you are expected to do so 24-hours in advance, even if it means leaving a message with our answering service. As a courtesy, Associates in Psychotherapy, LLC, attempts to make reminder calls regarding current appointments, however, there are times when this may not occur. Ultimately it is the client's responsibility to keep their appointments.

**DISCHARGE POLICY:** Reason(s) for discharge: Client completed services; Client referred out for services; Client discontinued treatment. Reason(s) for involuntary discharge: THREE No-Shows and/or Late Cancellations in a one-year period; Non-compliance with treatment recommendations.

**I HAVE READ AND I UNDERSTAND THE ABOVE NONREFUNDABLE FEES, CANCELLATION, and DISCHARGE POLICY:**

\_\_\_\_\_ (Initial)

**NOTE TO PARENT(S) OF MINOR CHILDREN:** It is the clinic's policy to accept parent's signature on these forms as an agreement to be responsible for payment of minor children's services with this clinic. In separated or divorced families, the person who initiates services with us is held financially responsible. We do not bill another person or an estranged spouse unless that individual informs us in writing of his or her willingness to pay for services rendered. Should another party be willing to assume financial responsibility for our services, they may sign the Business Policy & Patient Agreement form.

Parent(s) must attend the initial session with the child. Children are not to be left in the waiting room unsupervised. If only temporary guardianship has been issued, the minor's biological parent must sign all the admitting paperwork and releases. No minor with a guardian will be treated until guardianship has been verified.

**PRESCRIPTION REQUESTS:** Follow instructions from prescriber.

**INSURANCE AND BILLING INFORMATION:** While our services may be covered by private insurance, the ultimate responsibility for payment of your account is yours. Not all insurance policies are the same, therefore, it is advisable that you contact your insurance carrier to determine your individual benefit package.

**PATIENTS COVERED BY INSURANCE:** Please pay your deductible or co-payment at the time of service.

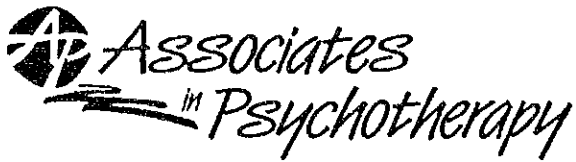
**PATIENTS NOT COVERED BY INSURANCE:** Payment is to be made at the time of service.

I have read the above and I hereby agree to be directly responsible to Associates in Psychotherapy, LLC, for charges incurred and I acknowledge that I fully understand the above and will comply with these guidelines. Furthermore, I agree that I have received a copy of this packet to take home with me.

\_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_  
Date





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### INSURANCE CONSENT FORM

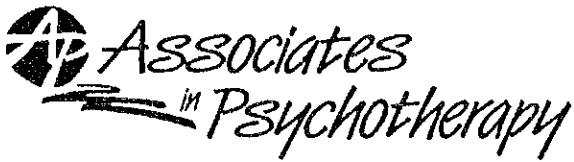
- I authorize the use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill.
- I authorize my doctor/therapist to act as my agent in helping me obtain payment from my insurance companies.
- I assign insurance benefits and authorize my insurance company to make payments directly to my doctor/therapist.

---

Signature

---

Date



**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
Federal Regulations**

Patient Name: \_\_\_\_\_

Date of Intake: \_\_\_\_\_

My signature on this form acknowledges that I have received a copy of Associates in Psychotherapy's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Associates in Psychotherapy and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's Representative  
(If patient is unable to sign.)

\_\_\_\_\_  
Date

**TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED**

1. Was the patient provided with a copy of the Notice of Privacy Practices?

Yes       No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was unable or unwilling to sign this form: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# CLIENT RIGHTS and the GRIEVANCE PROCEDURE for COMMUNITY SERVICES

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

## 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 HFS 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 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 of 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 electroconvulsive 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 HFS 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 records 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 HFS 92, Wisconsin Administrative Code, is available upon request.

## GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the services 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 Grievance Process**

- You are encouraged to talk with your therapist or the office staff about any concerns you have.
- If the matter is not resolved, you are encouraged to talk to the Clinic Director, Carol Ann Ward, MS, LPC, NCC.
- 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 limit.
- The program's Client Right 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, DSL, P.O. Box 7851, Madison, WI 53707-7581.

### **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 Supportive Living or designee. Send your request to the DSL 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 Right Specialist for Formal Grievances is:**

**Jennifer Campbell, Psy.D.**  
c/o Associates in Psychotherapy, LLC  
4700 Dresser Drive, Ste. 100  
Janesville, WI 53546

Ask Debbie Steffensen, Office Manager, for the grievance forms.

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

# FEDERAL REGULATIONS

## Privacy Practices

### HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 HIPAA PRIVACY COMPLIANCE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

#### USE AND DISCLOSURE OF HEALTH INFORMATION

Provider (Associates In Psychotherapy) may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care, and conducting health care operations. Provider has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed:

**To Provide Treatment.** Provider may use your health information to provide care to you and disclose your health information to others who provide care to you. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. Provider also may disclose your health care information to individuals outside of Provider involved in your care, such as your Primary Care Physician or the on-call psychiatrist.

**To Obtain Payment.** Provider may include your health information in invoices to collect payment from third parties for the care you may receive from Provider. For example, Provider may be required by your health insurer to provide or obtain prior approval from your insurer and may need to explain to the insurer your need for health care and the services that will be provided to you.

**To Conduct Health Care Operations.** Provider may use and disclose health information for its own operations in order to facilitate the function of Provider and as necessary to provide quality care to all of Provider's patients. Health care operations include activities such as quality assessment and improvement activities include: protocol development, case management and care coordination; contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment; professional review and performance evaluation; training programs including those in which students, trainees, or practitioners in health care learn under supervision; training of non-health care professionals; accreditation, certification, licensing, or credentialing activities; and review and auditing, including compliance reviews, medical reviews, legal services, and compliance programs.

**For Appointment Reminders.** Provider may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or medical care with Provider.

**When Legally Required.** Provider will disclose your health information when it is required to do so by any Federal, State, or local law.

**To Report Abuse, Neglect, or Domestic Violence.** Provider is allowed to notify government authorities if Provider believes a patient is the victim of abuse, neglect, or domestic violence. Provider will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

**To Conduct Health Oversight Activities.** Provider may disclose your health information to a health oversight agency for activities including: audits, civil, administrative, or criminal investigations; inspections; licensure or disciplinary action. Provider, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to you receipt of health care or public benefits.

**In Connection with Judicial and Administrative Proceedings.** As permitted or required by State law, Provider may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other protecting your health information.

**For Law Enforcement Purposes.** As permitted or required by State law, Provider may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

**In the Event of a Serious Threat to Health or Safety.** Provider may, consistent with applicable law and ethical standards of conduct, disclose your health information if Provider, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions.** In certain circumstances, the Federal regulations authorize Provider to use or disclose your health information to facilitate specified government functions relating to the military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

**For Worker's Compensation.** Provider may release your health information for worker's compensation or similar programs.

#### AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Associates In Psychotherapy will not disclose your health information other than with your written authorization. If you or your representative authorizes Provider to use or disclose your health information, you may revoke that authorization in writing at any time.

#### YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Provider maintains:

**Right to Request Restrictions.** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Provider's disclosure of your health information to someone who is involved in your care or the payment of your care. However, Provider is not required to agree to your request. If you wish to make a request for restrictions, please contact: Debbie Steffensen, Office Manager, at 608-752-7255.

**Right to Receive Confidential Communications.** You have the right to request that Provider communicate with you in a certain way. For example, you may ask that Provider only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact: Debbie Steffensen, Office Manager, at 608-752-7255. Provider will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy your Health Information.** You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to Debbie Steffensen, Office Manager, at 608-752-7255. If you request a copy of your health information, Provider may charge a reasonable fee for copying and assembling costs associated with your request.

**Right to Amend your Health Information.** You or your representative have the right to request that Provider amend your records, if you believe your health information records are incorrect or incomplete. That request may be made as long as the information is maintained by Provider. A request for an amendment of records must be made in writing to Debbie Steffensen, Office Manager, c/o Associates in Psychotherapy, 4700 Dresser Dr., Ste. 100, Janesville, WI 53546. Provider may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by Provider, if the records you are requesting are not part of Provider's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of Provider, the records containing your health information are accurate and complete.

**Right to an Accounting.** You or your representative have the right to request an accounting of disclosures of your health information made by Provider for certain purposes, which may include disclosures authorized by law. The request for an accounting must be made in writing to Debbie Steffensen, Office Manager, c/o Associates in Psychotherapy, 4700 Dresser Dr., Ste. 100, Janesville, WI 53546. The request should specify the time period for the accounting starting on April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. Provider will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

**Right to a Paper Copy of this Notice.** You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact Debbie Steffensen, Office Manager, at 608-752-7255.

#### DUTIES OF ASSOCIATES IN PSYCHOTHERAPY

Provider is required by law to maintain the privacy of your health information and to provide you and your representative this Notice of its duties and privacy practices. Provider is required to abide by the terms of this Notice as may be amended from time to time. Provider reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If Provider makes a material change to this Notice, Provider will provide a copy of the revised Notice to you or your appointed representative. You or your representative have the right to express complaints to Provider and to the Secretary of Health and Human Services, if you or your representative believe that your privacy rights have been violated. Provider encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

#### CONTACT PERSON

Provider has designated Debbie Steffensen, Office Manager, as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. If you have any questions regarding this Notice, you may contact this person at Associates in Psychotherapy, 4700 Dresser Dr., Ste. 100, Janesville, WI 53546, at 608-752-7255.

#### EFFECTIVE DATE

This Notice is effective January 1, 2003.