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

ADULT INTAKE

Date________________________ Therapist________________________ Referred by________________________

Client’s Name________________________ Date of Birth________________________
Maiden Name________________________ Level of Education________________________
Age________________________ Sex________________________ Race________________________
Address________________________ Cell Phone Number________________________

What number can we leave a message on? Cell________________________ Home________________________ Work________________________

Work Status/Occupation________________________ Place of Employment________________________

( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated ( ) Significant Other

Spouse/Significant Other:
Name________________________ Date of Birth________________________
Age________________________ Sex________________________ Race________________________
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________________________

FAMILY OF ORIGIN

Family Member Name Age Education Occupation Marital Status If Deceased Date Cause of Death
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?
**SELF and 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.

<table>
<thead>
<tr>
<th>MEDICAL PROBLEMS</th>
<th>SELF/FAMILY MEMBER</th>
<th>MEDICAL PROBLEMS</th>
<th>SELF/FAMILY MEMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) Alcoholism</td>
<td></td>
<td>( ) High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>( ) Anxiety</td>
<td></td>
<td>( ) Hypoglycemia</td>
<td></td>
</tr>
<tr>
<td>( ) Asthma</td>
<td></td>
<td>( ) Hysterectomy</td>
<td></td>
</tr>
<tr>
<td>( ) Attention Deficit Disorder</td>
<td></td>
<td>( ) Kidney Disease</td>
<td></td>
</tr>
<tr>
<td>( ) Attention Deficit /Hyperactivity</td>
<td></td>
<td>( ) Liver Disease</td>
<td></td>
</tr>
<tr>
<td>( ) Autism Syndrome</td>
<td></td>
<td>( ) Lung Problems</td>
<td></td>
</tr>
<tr>
<td>( ) Back Problems</td>
<td></td>
<td>( ) Menopause</td>
<td></td>
</tr>
<tr>
<td>( ) Bipolar Disorder</td>
<td></td>
<td>( ) Miscarriage</td>
<td></td>
</tr>
<tr>
<td>( ) Blindness</td>
<td></td>
<td>( ) Obesity</td>
<td></td>
</tr>
<tr>
<td>( ) Cancer</td>
<td></td>
<td>( ) Obsessive</td>
<td></td>
</tr>
<tr>
<td>( ) Colitis</td>
<td></td>
<td>( ) Compulsive Disorder</td>
<td></td>
</tr>
<tr>
<td>( ) Crohn’s Disease</td>
<td></td>
<td>( ) P.M.S.</td>
<td></td>
</tr>
<tr>
<td>( ) Deafness</td>
<td></td>
<td>( ) Panic Attacks</td>
<td></td>
</tr>
<tr>
<td>( ) Depression</td>
<td></td>
<td>( ) Posttraumatic Stress</td>
<td></td>
</tr>
<tr>
<td>( ) Diabetes</td>
<td></td>
<td>( ) Disorder</td>
<td></td>
</tr>
<tr>
<td>( ) Drug Abuse</td>
<td></td>
<td>( ) Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>( ) Ear Infections</td>
<td></td>
<td>( ) Seizures</td>
<td></td>
</tr>
<tr>
<td>( ) Eating Disorders</td>
<td></td>
<td>( ) Sinus Infections</td>
<td></td>
</tr>
<tr>
<td>( ) Emphysema</td>
<td></td>
<td>( ) Sleep Disorders</td>
<td></td>
</tr>
<tr>
<td>( ) Head Injury</td>
<td></td>
<td>( ) Stroke</td>
<td></td>
</tr>
<tr>
<td>( ) Headaches/Migraines</td>
<td></td>
<td>( ) Stutter</td>
<td></td>
</tr>
<tr>
<td>( ) Heart Disease</td>
<td></td>
<td>( ) Thyroid Syndrome</td>
<td></td>
</tr>
<tr>
<td>( ) Heart Pain (Angina)</td>
<td></td>
<td>( ) Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>( ) Heart Attack</td>
<td></td>
<td>( ) Ulcers</td>
<td></td>
</tr>
<tr>
<td>( ) Hepatitis</td>
<td></td>
<td>( ) Other</td>
<td></td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>Doctor(s)</th>
<th>Clinic</th>
<th>Last Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor(s)</td>
<td>Clinic</td>
<td>Last Physical</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor(s)</td>
<td>Clinic</td>
<td>Last Physical</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Illnesses

<table>
<thead>
<tr>
<th>Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Allergies</td>
</tr>
</tbody>
</table>

Medications
Current Living Situation

<table>
<thead>
<tr>
<th>Alone</th>
<th>With Spouse</th>
<th>Significant Other</th>
<th>With Friend</th>
<th>With Relatives</th>
<th>With Parents</th>
</tr>
</thead>
</table>

Quality of Family Relationship

<table>
<thead>
<tr>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
</table>

Have you served in the military?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Which branch?

<table>
<thead>
<tr>
<th>Discharge Status</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, who?

Other significant losses during the past two years?

<table>
<thead>
<tr>
<th>Marriage</th>
<th>Relationship</th>
<th>Pet</th>
<th>Job</th>
<th>Home</th>
<th>Other</th>
</tr>
</thead>
</table>

Is your work satisfying?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If not, explain why:

Major Source of Annual Income

<table>
<thead>
<tr>
<th>Job</th>
<th>Spouse</th>
<th>Parents</th>
<th>Children</th>
<th>Relatives</th>
<th>Social Security</th>
<th>Pension/Savings</th>
<th>Disability</th>
<th>Does Not Apply</th>
<th>Other</th>
</tr>
</thead>
</table>

Organizations, Hobbies, Skills, Interests:

Current use of alcohol

<table>
<thead>
<tr>
<th>None</th>
<th>Occasional</th>
<th>Daily</th>
<th>Heavy</th>
<th>Binge drinking</th>
<th>Marked by occasional attempts at abstinence</th>
</tr>
</thead>
</table>

Current use of drugs

<table>
<thead>
<tr>
<th>None</th>
<th>Occasional</th>
<th>Regular</th>
<th>Heavy</th>
<th>Illegal</th>
<th>Prescription</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, please explain:

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If so, when:

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, please explain:

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Quit</th>
<th>&gt;1 pack per day</th>
<th>1 pack per day</th>
<th>&lt; 1 pack per day</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Bedwetting</th>
<th>Fears</th>
<th>Friends</th>
<th>Learning to talk</th>
<th>Learning to walk</th>
<th>Nail biting</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nightmares</td>
<td>recurrent dreams</td>
<td>Unusual illnesses</td>
<td>Toilet training</td>
<td>Sleep disturbance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Stuttering</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been sexually abused?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, please explain:

Have you ever been physically abused?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, please explain:

Have you ever been emotionally abused?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If yes, please explain:

Sexual Preference

<table>
<thead>
<tr>
<th>Heterosexual</th>
<th>Bisexual</th>
<th>Homosexual</th>
<th>Unknown</th>
</tr>
</thead>
</table>

Gender Identity

Current Legal Problems

<table>
<thead>
<tr>
<th>Child Custody</th>
<th>Divorce</th>
<th>Criminal Charges</th>
<th>None</th>
<th>Parole/Probation</th>
<th>Civil Suit</th>
</tr>
</thead>
</table>

History of Legal Problems

<table>
<thead>
<tr>
<th>Arrest</th>
<th>Driver’s License Revoked</th>
<th>Juvenile Record</th>
<th>Prison Record</th>
<th>Other</th>
<th>None</th>
</tr>
</thead>
</table>

History of Violent Acts

<table>
<thead>
<tr>
<th>Assault</th>
<th>Child Abuse</th>
<th>Spouse Abuse</th>
<th>Suicide Attempt</th>
<th>Murder</th>
<th>None</th>
</tr>
</thead>
</table>

Current Violent Thoughts

<table>
<thead>
<tr>
<th>Injury to Others</th>
<th>Self-Injury</th>
<th>Other</th>
<th>None</th>
</tr>
</thead>
</table>
What are the problems and symptoms for which you are seeking help?

- Abuse (Physical/Sexual/Verbal/Emotional)
- Divorce
- Alcohol Use
- Drug Use
- Anger
- Eating Disorder
- Anxiety/Worry
- Impulse Control
- Attention/Concentration
- Eating Disorder
- Autism Spectrum
- Family
- Change in Appetite
- Friends
- Change in Sex Drive
- Grieving
- Change in Sleep
- Learning
- Communication
- Mania/Hypomania
- Criminal Charges/Behaviors
- Marriage/Relationship
- Decision Making
- Memory
- Depression
- Mood Swings
- Disturbing Thoughts

When did these problems begin? ____________________________________________________________________________

Do these problems affect your:

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

Your Strengths:

- Assertiveness
- Impulse Control
- Problem Solving
- Support Network
- Attention/Concentration
- Insight
- Self-Care
- Other
- Boundaries
- Interests, Hobbies, Organizations
- Self-Esteem
- Other
- Empathy
- Judgment
- Sense of Humor
- Other
- Flexibility
- Mood Regulation
- Spirituality
- Other
- Functioning at Home/Work/School
- Motivation
- Spirituality
- Other

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

Revised 02-13-19
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 __________________________________________

4700 Dresser Drive, Suite 100, Janesville, WI 53546   608-752-7255
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:**

<table>
<thead>
<tr>
<th>Nurse Practitioner</th>
<th>Licensed Psychologists</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Evaluation - $260</td>
<td>Initial Assessment - $220</td>
<td>Initial Assessment - $205</td>
</tr>
<tr>
<td>Medication Evaluation - $120</td>
<td>Therapy Sessions - $150/$225</td>
<td>Therapy Sessions - $130/$195</td>
</tr>
<tr>
<td></td>
<td>Family Therapy - $160</td>
<td>Family Therapy - $140</td>
</tr>
</tbody>
</table>

**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 on our after-hours voicemail. 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. If you cancel your appointment less than 24-hours in advance or fail to arrive for your appointment, you are subject to the late cancellation fees noted above. **In addition, two late cancellations and/or no shows will result in all future appointments being cancelled.**

**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 calendar year; 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
ASSOCIATES IN PSYCHOTHERAPY, LLC
4700 Dresser Drive, Suite 100
Janesville, WI 53546

Business Policy and Patient Agreement
For Private Pay

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FEE INFORMATION – PAYMENT AT TIME OF SERVICE

<table>
<thead>
<tr>
<th>Nurse Practitioner</th>
<th>Licensed Psychologists</th>
<th>Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Evaluation - $200</td>
<td>Initial Assessment - $198</td>
<td>Initial Assessment - $184.50</td>
</tr>
<tr>
<td>Medication Evaluation - $75</td>
<td>Therapy Sessions - $135</td>
<td>Therapy Sessions - $117</td>
</tr>
<tr>
<td></td>
<td>Family Therapy - $144</td>
<td>Family Therapy - $126</td>
</tr>
</tbody>
</table>

OTHER FEES

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

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________________ (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.

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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 ___________________________
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 ___________________________ Date ______________
(If patient is unable to sign.)

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. 5130, 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 40 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 53707-7581.

You may talk with staff or contact your Client Rights Specialist, whose names are 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 Specialists for Formal Grievances are:

Carol Ann Ward, MS, LPC, NCC, Clinic Director  Tracy Douglas, MS, LPC, NCC

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 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.

To 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. The disclosure will be made 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, criminal, 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 receipt of health care or public benefits.

For 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 circumstances, you are a victim of a crime or in order to report a crime.

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 law enforcement custody.

For Worker's Compensation. 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.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

You are also permitted to sign an authorization permitting Provider to use or disclose your health information in circumstances other than those specified above. It is not necessary to sign an authorization to obtain treatment, payment, or health care operations. For example, you may authorize Provider to use or disclose your health information to individuals other than your family members who may be helping you.

Right to Request Restrictions. If you believe your health information is accurate and complete, you may request that Provider restrict the use and disclosure of your health information for treatment, payment, or health care operations. When requested, Provider will agree to restrict the use and disclosure of your health information for treatment, payment, or health care operations to another entity. You must specify the restrictions you want to apply to your health information and the entity to which you want the restrictions to apply. For example, you may request restrictions on the use and disclosure of your health information for treatment related to your work, or you may request that certain health information not be shared with your health insurance provider.

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 is inaccurate or incomplete. If you request an amendment of records must be made in writing to Debbie Steffensen, Office Manager, at 608-752-7255. Provider will notify you of their decision to deny your request in writing. If the request is denied, you will be informed of your right to file a complaint with the Department 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.

This Notice is effective January 1, 2003.
Electronic Communication Policy

The following policy is designed to maintain clarity regarding the use of electronic modes of communication during treatment at Associates in Psychotherapy, LLC. While various types of electronic communications are common and preferred, these modes of communication can put your privacy at risk and can be inconsistent with the law and standards of the mental health profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with our office staff or your therapist.

Email and Client Portal Communications

Email communication and/or text messaging are used only with your permission and only for administrative purposes unless other agreements have been made. That means that email exchanges and text messages with the office should be limited to things like setting and changing appointments, billing matters, and other related issues. Please do not email about clinical matters because email may not be the most secure method of communication. If you need to discuss a clinical matter, please feel free to call your therapist to discuss it on the phone or wait to discuss it during your next therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very insecure and impersonal mode of communication, in general, therapists do not text. Please do not text message your therapist unless other arrangements have been made.

Social Media

We do not communicate with, or contact, any clients through social media platforms like Twitter and Facebook. In addition, any online relationships that may have been accidentally established will be cancelled as these types of casual social contacts can create significant security risks for you.

Some providers participate on various social networks, but not in professional capacities. If you have an online presence, there is the possibility that you may encounter your therapist by accident. If that occurs, please discuss it during your session. Any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact your therapist in this way. There will be no response and any online contact will be terminated no matter how accidental.