COLLABORATIVE WELLNESS

Client Information Form

*Provider Name: ______________________________

Client Information

Last Name	First Name and Middle Initial	DOB	Sex

Mailing Address	Apt#	City	State	Zip

Marital Status married single divorced widow	Legal Guardian (if minor)	Legal Guardian (if minor)

Home Phone	Work Phone	Mobile Phone	Email

Emergency Contact Name	Emergency Contact Address

Emergency Contact Phone	Release my records to my primary doctor: ☐ Yes ☐ No (If yes, complete a release of information)

Insurance Information

Primary Insurance Company	Policy#	Group#

Primary Insured Persons Name	DOB	Employer

Insured's Address	Phone

Secondary Insurance Company	Policy#	Group#

Secondary Insured Persons Name	DOB	Employer

Insured's Address	Phone

Thank you! How did you hear about us?

____

Assignment of Benefits

I understand that I am responsible in full of all charges. I authorize payment of benefits from my insurance to be paid directly to the provider. I also authorize the provider to release to my billing service and insurance company any and all information necessary for the processing of insurance claims.

____
Patient/Legal Guardian Signature Date

____
Patient/Legal Guardian Print Name Date

COLLABORATIVE WELLNESS

Mental Health & Substance Abuse
Welcome Letter

Collaborative Wellness affiliates include:
Blue Lotus, LLC; Growing Oak, LLC; Martin Counseling LLC; Olive Branch Counseling, LLC;
Shaffer Counseling & Consulting, LLC; SuaSponte Center, LLC;
and Willow Wellness Center, LLC; and supervised student interns

WELCOME TO COLLABORATIVE WELLNESS!

We understand the amount of paperwork presented for review and signatures during your initial session can be overwhelming. We urge you to let us know if you need a break or if you have any questions as we complete the required paperwork. We thank you for your patience and understanding.

Forms: Enclosed you will find several forms for your review and signature. You may request a copy of any of these documents for your records. Forms include:

- New Client Information sheet, collecting demographic and insurance information
- Psychotherapy Informed Consent
- Use of Technology Informed Consent
- HIPAA Notice of Privacy Practices
- Summary of your client rights
- Information about filing a grievance

Contact Numbers: You may call the clinic at 920-896-0189 to make an appointment or to speak to someone. Our fax number is 920-239-6021. Clients may also call this number to speak with some in case of a mental health crisis. **Always, in the case of emergency, dial 911.**

Fees & Payment: We accept many forms of insurance, including Medicaid (Badgercare/ForwardHealth). **Please contact your insurance company to verify your benefits and authorized provider.** We will submit claims forms to your insurance company but cannot guarantee their payment. You are responsible for payments not received, including co-pays and deductibles.
We are committed to providing services to our clients. In the case of insurance, our fees billed are as follows:

Intake session - $180.00
60-minute session - $180.00
45-minute session - $120.00
Group session - $120.00

In the case of cash pay, please request our *Out-of-Pocket Price Sheet* for details. If you are not able to pay the full charge for services, please speak individually with your counselor.

Clinic Hours are by appointment. We look forward to working with you!

_________________________ _________________________
Signature *Parent/Guardian (if applicable)*

COLLABORATIVE WELLNESS

INFORMED CONSENT

OUTPATIENT SERVICES CONTRACT

This document contains important information about professional services and business policies for Collaborative Wellness and all affiliates as listed in our Welcome Letter. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

CONFIDENTIALITY [for adult patients]

In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if they determine that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused or has been abused, I must [may be required to] make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm themself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PATIENT SIGNATURE ________________________________

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I may also ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that I believe it is important that all parents have the right to know that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will evaluate the circumstances and keep in mind what may be in the best interest of the child. If therapy ends, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship. Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused- physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that they have tried alcohol at a few parties, I would keep this information confidential. If you child tells me that they are drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.
>
> ***Example***: If your child tells me that they are having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that they were doing ________, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of [this State] may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask
me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.
Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator,

guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s).

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* ____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

________ ________

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

________ ________

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

________ ________

Parent/Guardian Signature ____

Parent/Guardian Signature ____

* For very young children, the child's signature is not necessary

Informed Consent for Use of Technology

Digital technology has transformed how people communicate, learn, and work; information is increasingly acquired and communicated online or through mobile devices. We take your privacy seriously and would like to inform you of the below complications with technology and HIPAA.

- Some issues related to maintaining the confidentiality of electronically transmitted communications include personal health information and demographic information being compromised via parties outside of our control.
- Colleagues who may have authorized access to your information include third-party billing specialist(s), outside providers such as county organizations, medical clinics/doctors, schools, and other community officials. Please be aware that we will communicate with you to sign a separate release of information if this type of transaction needs to occur.
- Please be aware of all authorized or unauthorized users including your family members and fellow employees who may have access to any of your own technology that you choose to use in the counseling process.
- We will use encrypted e-mail communications to help ensure confidentiality when possible and appropriate.
- When the use of encryption is not possible or appropriate, counselors will limit electronic transmissions to general communications that are not client specific, nor will they include demographic information.
- Email communication between student interns and clinic supervisors may occur and would include case notes. In this instance, we will use encrypted email or keep all demographic information out.
- In the case of cellular phone use, counselors will engage in appropriate communication, which may include text messaging. *Text message use is at your discrepancy as the client, understanding that this not an encrypted method of communication.*
- Social media engagement and website engagement is also at your discrepancy as the client, as this is not an

  encrypted platform.

By signing this document, you are confirming that you have read the above information and that you have spoken with your counselor about any concerns regarding such. You are authorizing the use of technology such as email, social media, and cellular phone use while you are an active client of this clinic. Entities included under the umbrella of Collaborative Wellness affiliated LLC's (per the Welcome Letter on page 2) and Collaborative Wellness student interns.

______________________________	______________________________
Client Signature	*Parent/Guardian Signature (if applicable)*

Privacy Practices
HIPAA

THESE NOTICES DESCRIBE HOW MENTAL HEALTH & SUBSTANCE ABUSE INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THESE NOTICES CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and/or your child that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). These notices of privacy practices describe how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *ACA Code of Ethics*. They also describe your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of these Notices of Privacy Practices. We reserve the right to change the terms of these notices at any time. We will provide you with a copy of the revised Notices of Privacy Practices by posting them on our website, or providing one at our next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those involved in your care for the purpose of providing, coordinating, or managing health care treatment and related services. This includes coordination with supervisors, interns, or other team members. We may disclose PHI to any other consultant only with your authorization. *Please also see the attached Informed Consent for Use of Technology, and Informed Consent Outpatient Services.*

For Payment. We may use and disclose PHI so that we can submit claims and receive payment for services provided to you. This will only be done with your authorization and sign consent in our Welcome Letter. Examples of payment-related activities are: determining your coverage eligibility, processing claims with your insurance company, providing insurance companies with your diagnosis as required by them, reviewing services provided to you to determine medical necessity.

For Healthcare Operations. We may use or disclose your PHI in order to support our business activities, including but not limited to, quality assessment activities, employee or intern review activities, and licensing.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Please see our Informed Consent Outpatient Services for a description of uses and disclosures permitted by HIPAA without an authorization.

GRIEVANCE PROCEDURE

We are fully committed to conducting services in strict conformance with the State of Wisconsin Department of Professional and Safety Services, American Psychological Association's Ethical Principles, National Association of Social Workers Code of Ethics, as well as the National Board of Certified Counselors. We strive to comply with all legal and ethical responsibilities.

Any person who believes they have been subjected to a counselor's failure to comply with these standards may file a grievance under this procedure. It is against the law for our clinic to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to Linda Richards, MSE LPC NCC immediately upon when the person filing the grievance becomes aware of the alleged action.

- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged, and the remedy or relief sought.

- Linda Richards, MSE LPC NCC shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. Linda Richards, MSE LPC NCC will maintain the files and records of our clinic relating to such grievances.

- Linda Richards, MSE LPC NCC will report to the appropriate board/authorities of the alleged issue.

- The availability and use of this grievance procedure do not prevent a person from filing a complaint with the U. S. Department of Health and Human Services, Office for Civil Rights.

We will make appropriate arrangements to ensure that clients are provided other accommodations, if needed, to participate in this grievance process. We will also address continuity of care for the client.

______________________________ ______________________________

Client Signature *Parent/Guardian Signature (if applicable)*

Fond du Lac School District
FONDY C.A.R.E.S. Program
72 West Ninth Street, Fond du Lac, WI 54935
920-929-2900

INFORMED CONSENT TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

1. Regarding Student:

____
Last Name First MI

____
Date of Birth Telephone Maiden/Previous Name

____
Street Address City State Zip

2. Release From:

Collaborative Wellness 920-896-0189
Name(business, physician, etc.) Telephone

303 Watson Street, Suite D Ripon WI 54971-1516
Street Address City State Zip

Attention:_______________________________

3. Release To:

Theisen Middle School 920-906-6732
Name (business, physician, etc.) Telephone

525 East Pioneer Road FDL WI 54935
Street Address City State Zip

Attention:_______________________________

4. Specific type of information to be disclosed (circle all that apply)::
   In the form of: • Photocopies • Verbal Communication • Other:

5. Purpose or need for disclosure/exchange (circle all that apply): • FONDY C.A.R.E.S. • Education Programming • Psychological
   • Speech & Language • Occupational/Physical Therapy • School Health Program/Vision/Audiologist

5. Disclosure includes future records regarding my services until the date or condition of expiration
   (one year maximum from the date of this signed consent)

Student/Parent Rights (please read before signing): You may request multiple releases of information identified on this authorization form. You may receive a copy of this authorization. Fond du Lac School District does not condition treatment, or eligibility for benefits based on the signing of this authorization. You have the right to inspect and receive a copy of the material to be disclosed in accordance with District policies. The District may charge for photocopies based on School Board policies. You may revoke this authorization at any time (except to the extent that the District has already acted in reliance upon it), by written notice to Fond du Lac School District.
Attention: Privacy Officer. If the person or organization requesting this information is not subject to the federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards. A photocopy of this authorization shall be as valid as the original.
I hereby release the Fond du Lac School District from all legal responsibilities or liability that may arise from this act of disclosure.

Student Signature:_________________________ **Date:**________________
(If 18 yrs. or older)

Authorized Person:_________________________ **Relationship**:________________
(Parent or Guardian)