Counseling Center
5508 W. Vliet St., Milwaukee, WI 53208
414-476-1073

New Client Paperwork Policy

All clients must complete our intake paperwork before they are able to be seen. These forms may be completed and submitted manually either by email, in person, or via regular USPS mail. Paperwork must be submitted no later than 48 hours before your appointment or your appointment will be automatically cancelled unless other arrangements with you have been made with your therapist or clinic staff.

Please note:

- Couples will each need to complete an individual copy of the paperwork.
- For clients age 14+, both client & parent must sign where each signature is required.
- For clients age of 14+, it is strongly recommended you fill out an Authorization to Release Information Form for third parties (e.g., a parent, spouse, or healthcare provider) you want to include in your care, including making appointments and discussing billing.

Insurance Benefit Sheet

Date:_____

Name of Client: _____

Date of Birth:_____

Address: _____ City: _____ State:

Zip Code: _____ Phone #: ( ) _____
May we call you and/or leave message? Yes or No

Email:_____

Insurance Company: _____

Insurance Company phone:_____
Member ID #: _____ Group #:_____
Subscriber:_____ Date of birth: _____

Signature._____ Date:_____
Patient or Authorized person's signature: I authorize the release of any medical or other information necessary to process this claim.
Insured's or Authorized person's signature: I authorize payment of medical benefits to the undersigned physician or supplier for services described above.

Office Use Only
Benefit Inquiry

Spoke with:_____ Date of Call: _____

Deductible: $ _____
Individual Family

How much of deductible has been met: $ _____

Is the policy: (circle one) calendar year _____ Policy year_____
Benefit: _____
Co-pay $_____
Co-insurance $_____
# of sessions allowed per year_____

Pre-certification required: (circle one) Yes No
CPT Code 90834 _____ 90837_____

Address to send claims:_____
Payer ID # To send claims electronically: _____

Patient Goals for Treatment

Name: _____

Date: _____

As you begin treatment, it is important that you think carefully about what you want to accomplish. In addition, the medical care you may need, you may want to change some of your behaviors or address some of your personal problems. To help get your treatment goals in mind and to help us work with you in achieving these goals, please complete this form.

Please read each statement. If it is an important issue for you, place an **X** in the space provided. If it is not important, leave the space blank. When complete, go back and put **XX** on those issues you feel are most important to address.

1. Finding or holding a job. _____
2. Getting into school or job training. _____
3. Getting along with people. _____
4. Improving relationships with my family. _____
5. Avoiding the use of alcohol. _____
6. Learning how to control the use of alcohol _____
7. Avoiding the use of drugs _____
8. Learning how to control the use of drugs _____
9. Learning how to manage my money _____
10. Applying for financial assistance or welfare _____
11. Maintaining a better personal appearance _____
12. Using my leisure time better _____
13. Learning how to make and keep friends _____
14. Learning how to have fun without alcohol or drugs _____
15. Learning how to express my anger _____
16. Controlling my temper _____
17. Learning how to express my ideas to others _____
18. Avoiding the feeling that everything must be perfect _____
19. Learning how to trust others _____
20. Getting rid of feelings of guilt _____
21. Overcoming shyness _____
22. Avoiding depression _____

Health History - Confidential Record

Information contained here will not be released except
when we are authorized to do so.

Patient Name: _____

DOB: _____ Age: _____ Sex:_____

Marital Status: _____ Religion/Spirituality: _____

Occupation: _____

Person to notify in case of emergency: _____

Address: _____

Phone #: _____ Relationship: _____

Date of last physical Exam: _____
Physician: _____
Address: _____
Phone #: _____

Name & address of person who referred you (We want to send a thank you note):
_____
_____

Types of Surgeries & Year Performed:
_____
_____

Hospitalizations / Date:
_____
_____

Serious Illness / Date:
_____
_____

List any allergies to drugs/food/chemicals:
_____
_____

Do you regularly smoke? Yes_____ No_____

How long have you smoked? _____

Do you drink coffee/caffeine? Yes_____ No_____ How Much? _____

Do you use other chemicals/drugs? Yes_____ No_____ What_____ How Often_____

Do you have difficulty with sleep? Yes_____ No_____

If answered "Yes" to difficulty with sleep, then which apply (mark below with an "x"):

Falling asleep? _____ Staying asleep? _____ Sleeping too much? _____ Sleeping too little? _____

Family History

	If Living	Health Status	If Deceased, Age at Death	Cause of Death
Father's Age				
Mother's Age				
Brother's Age(s)				
Sister's Age(s)				
Spouse's Age				
Son/Daughter's Age(s)				

Do you know of any blood relative with the following diagnosis? Check and give the relationship:

Stroke_____ Heart Attack_____
High Blood Pressure_____Kidney Disease_____
Cancer_____Stomach Ulcers_____
Tuberculosis_____Goiter_____
Diabetes_____ Arthritis_____
Leukemia_____ Colitis_____
Epilepsy_____ Nervous Breakdown_____
Suicide_____ Rheumatic Heart_____
Migraine_____ Insanity_____
Asthma_____ Congenital Heart_____
Hay Fever_____ Drinking Problem_____
Bleeding Tendency_____Substance Abuse_____

Education History
Name of High School: _____
Name of College: _____
Graduate Studies: _____

ALL OF THE ABOVE INFORMATION IS GIVEN TO THE BEST OF MY KNOWLEDGE

Print Name: _____

Signature: _____ Date:_____

Witness: _____ Date:_____

Medication Log

Name: _____

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Date Prescribed

ATTENDANCE POLICY

Valuable time has been set aside for your treatment sessions. You can maximize the gains from your sessions by starting your treatment on time and by attending all scheduled appointments. In an attempt to provide all of our clients with very good care, we ask that you follow these guidelines:

-If you arrive late for your appointment, your therapist will start your sessions, but will end the session with the amount of time left on the 45-minute therapy hour allowed.
-For virtual and phone sessions, please be available in a private, quiet area for focus and confidentiality.

Discharged from therapy policy:

You will be discharged from therapy when any of the following occur:

-Five cancelled appointments within a two-month time period.
-Three appointments cancelled with less than 24 hour's notice.
-There are two consecutive no call/no shows.
-All future appointments will be cancelled with discharged.

Clinic policy for weekend sessions:

-Saturday, Sunday, & Monday appointments must be cancelled by 4:30PM on the Thursday prior.
-Weekend appointments are prime times.

Thank you for your cooperation.

Patient or Authorized Person's Signature

I authorize the release of any medical or other information necessary to process my insurance claim. I have read the financial, billing and insurance information and policies. I understand the policy and agree to comply with the terms. Thank you.

_____

Signature

IMPORTANT:

When you book an appointment with your therapist, you are securing that hour of the therapist's schedule to address your needs.

Non-emergency late cancellations must be received at least 24 hours before the scheduled session to avoid $100 out of pocket fee.

A non-emergency no-call no-show will be charged $100 out of pocket fee as well.

This policy will allow our therapists to serve other clients within this time slot, as appointments are in high demand. Please be advised that insurance plans will not reimburse you for late cancellations or for not showing up for appointments, and it is your responsibility for payment at or before your next appointment.

Signature:_____.

Date: _____

DRUG HISTORY QUESTIONNAIRE

DRUG CATEGORY	Ever Used Circle Yes or No[a]	Total Years Used[b]	Intravenous Drug Use NA=Not Applicable	Year Last Used (e. g., 1998)	Frequency of Use Past 6 Months[c]
ALCOHOL	No Yes		NA		
CANNABIS: Marijuana, hash oil, pot, weed, blow	No Yes		NA		
STIMULANTS: Cocaine, crack, blow	No Yes		No Yes		
STIMULANTS: Methamphetamine — meth, ice, crank	No Yes		No Yes		
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine, speed, bennies, uppers	No Yes		NA		
BENZODIAZEPINES/ TRANQUILIZERS: Valium, Librium, Xanax, Diazepam, roofies, downers	No Yes		NA		
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital	No Yes		NA		
HEROIN: smack, scat, brown sugar, dope	No Yes		No Yes		
STREET OR ILLICIT METHADONE	No Yes		NA		
OTHER OPIOIDS: Tylenol #2 & #3, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid	No Yes		NA		
HALLUCINOGENS: LSD, PCP, mescaline, peyote, mushrooms, ketamine, ecstasy (MDMA)	No Yes		NA		
INHALANTS: glue, gasoline, aerosols, paint thinner, poppers, rush, whippets	No Yes		NA		
STEROIDS: Deca-Durabolin, Durabolin, Equipoise, Winstrol, Anadrol, Oxandrin, roids, juice	No Yes		No Yes		
ILLEGAL USE OF PRESCRIPTION DRUGS (describe) _____	No Yes		NA		

[a] **If EVER USED is NO** for any given line, the **remainder of the line should be left blank**.

[b] **Infrequent Use** (≤ 2 x/year) **or Brief Experimental Use** (< 3 months lifetime use) = **write 87**

[c] **Frequency Codes**:
0 = no use
1 = < 1x/mo.
2 = 1x/mo.
3 = 2 to 3x/mo.
4 = 1x/wk.
5 = 2 to 3x/wk.
6 = 4 to 6x/wk.
7 = daily;

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Clinic Policy for Client's Under 18 Years of Age:

I, _____, give Inner Visions Family Counseling Center permission to see my child for therapy sessions with _____.
(therapist name)

_____
Parent Signature

_____
Therapist Signature

_____
Date

Counseling Center
Helen F. Jurgensen, LCSW
5508 W. Vliet St., Milwaukee, WI 53208
414-476-1073

Guidelines for Children Under 16 at Our Clinic

Children under the age of 16 are not to be left alone in the waiting room or in cards in the parking lot of our property. They must be with an adult at all times.

This guideline is set to keep your children safe while on our property and in our building.

Thank you for cooperation.

Date:_____

Signature:_____

WISCONSIN HIPPA NOTICE ACKNOWLEDGEMENT

By signing this form, I acknowledge that_____, provided me a copy of the ***Wisconsin Notice****. This Notice describes how psychological and medical information about me may be used and disclosed and how I can get access to this information.*

I acknowledge that _____ may use or disclose my protected health information (PHI) for treatment, payment and health care operations.

Patient Signature (or Parent/Guardian if patient is a minor) *Date*

Witness *Date*

Authorization for Electronic Communication

As a convenience to me, I authorize Inner Visions Family Counseling Center to communicate with meregarding my treatment via electronic communications (email/text message/video chat) and to transmit my protected health information electronically as described below. All electronic forms of communication at Inner Visions Family Counseling Center are encryptedand password protected.

I understand there are risks inherent in the electronic transmission of information by email or text message:

- Such communication does not provide a completely secure means of communication.

As such, Inner Visions Family Counseling Center shall not have any responsibility or liability with respect to any error, omission, claim, or loss arising from or in connection with the electronic communication of information by Inner Visions Family Counseling Center to me.

Text Communication: __Yes __No
Authorized phone number(s):_____

Email Communication: __Yes __No
Authorized email address(es):_____

Video Chat: __Yes __No
Authorized service(s):_____

Your treatment does not depend on consent. You have the right to terminate or amend this agreement at any time.

I understand that Inner Visions Family Counseling Center may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Inner Visions Family Counseling Center in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

_____
Patient Name

_____ _____
Signature of Patient Date

Wisconsin Notice Form

Notice of Psychotherapists' Policies and Practices to Protect the Privacy of your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations:

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination
- "*Use*" applies only to activities with my [office, clinic, practice group, etc.], such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, join or family counseling session, which I have kept separate from the rest of your medical records. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy

III. Uses and Disclosers with Neither Consent nor Authorization:

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child abuse**: If I have reasonable cause to suspect that a child seen in the course of my professional duties has been abused or neglected, or have reason to believe that a child seen in the course of my professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, I must report this to the relevant county department, child welfare agency, police or sheriff's department.
- **Adult and Domestic Abuse**: If I believe that an elder person has been abuses, or neglected, I may report such information to the relevant county department or state official of the long-term care ombudsman.
- **Health Oversight**: if the Wisconsin Department of Regulation and Licensing requests that I release records to them in order for the Psychology Examining Board to investigate a complaint, I must comply with such a request.
- **Judicial or administrative proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release the information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance, if this is the case.
- **Serious Threat to Health or Safety**: If I have reason to believe, exercising my professional care and skill, that you may cause harm to yourself or another, I must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings
- **Worker's Compensation**: if you file a worker's compensation claim, I may be required to release records relevant to that claim to your employer or its insurer and may be required to testify.

IV. Patient's Rights and Psychologists Duties

a. ***Patient's Rights:***

i. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

ii. Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example; you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address

iii. Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.

iv. Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

v. Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

vi. Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

b. Psychotherapist's Duties:

i. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI

ii. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect

iii. If I revise my policies and procedures, I will notify you. [Notice must also describe how the psychologist will provide individuals with a revised notice; by mail, email, etc.]

V. Questions and Complaints

a. If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact the counseling center directly at (414) 476-1073
b. If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to:
c. 5508 W. Vliet Street, Milwaukee, WI 53208
d. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.
e. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on September 1, 2020

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by written letter.

InnerVisions Family Counseling Center
Directives Regarding In-Person Services

I knowingly and willingly have agreed to provide in-person services with the full understanding and disclosure of the risks associated with the Coronavirus (COVID-19)

I understand that the novel Coronavirus has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and can still be contagious.

For all on-site and in-office services (Client):

- I understand that I must cancel any in-person appointment if:
    1. I am experiencing any of the following symptoms of COVID-19: fever, shortness of breath, dry cough, runny nose, sore throat, and/or loss of taste or smell.
    2. I have been in close contact (defined as 6 feet/1.8 meters or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above-stated symptoms in the last 14 days.
    3. I have traveled outside of my country of residence in the past 14 days.
    4. I have traveled domestically by commercial airline, bus, or train within the last 14 days
    5. I will practice social distancing by maintaining at least 6 feet/1.8 meters from others whenever possible and will wear a face mask at all times.
    6. I will wash hands often with soap and water for at least 20 seconds or use hand sanitizer with at least 60% alcohol if soap and water are not available. Key times to clean hands include:
        - Before and after in-person services
        - After blowing nose, coughing, or sneezing
        - After using the restroom
        - After putting on, touching, or removing face coverings

For all in-office services (Provider):

- I will comply with all national and local health regulations and guidelines in the jurisdiction where my business operates or where I am based.
- I understand that by permitting access to my workplace, I am assuming the risk of exposure to COVID-19 (or other public health risks).
- I will communicate my entrance procedures and requirements to the client prior to their arrival.

- I will practice routine cleaning and disinfection of frequently touched objects and surfaces such as workstations, keyboards, telephones, handrails, and doorknobs. Dirty surfaces can be cleaned with soap and water prior to disinfection. To disinfect, use products that meet EPA's criteria for use against SARS-CoV-2, the cause of COVID-19, and that are appropriate for the surface.
- I will avoid using other employees' phones, desk, offices, or other work tools and equipment, when possible. Clean and disinfect them before and after use.
- I will take appropriate steps between appointments to minimize my exposure to COVID-19.
- You have our support to deny services to anyone not following our procedures, including wearing a mask.

With full awareness and appreciation of the risks involved, and to the fullest extent permitted by applicable law, I hereby acknowledge and assume all risks arising from in-person services and hereby forever release, waive and discharge workplace options, its employees, officers, affiliates, providers, independent contractors, successors and assigns from any and all liability, claims, demands, actions and causes of action whatsoever, directly or indirectly arising out of or relate to any loss, damage, or injury, including death, that may be sustained by me related to COVID-19 whether caused by workplace options or any third-party

I am informed and agree that if a dispute arises it shall be governed by and pursuant to the laws of the jurisdiction of the defending party; and any dispute resolution proceeding shall be conducted by arbitration pursuant to the rules of arbitration as established by the International Chamber of Commerce ("ICC"), conducted by one arbitrator as appointed by the parties on mutual consent, or in the absence of agreement, accordance with the rules of the ICC. The proceedings shall be as mutually agreed by the parties. I further agree that any ICC award with regard to the dispute shall be final and binding and no appeal will be applicable.

I have read, or have had read to me, the above directives pertaining to the covid-19 crisis for in-person services. I appreciate that it is not possible to consider ever possible complication to care. I have also had an opportunity to ask questions about its consent, and by signing below, I agree with the terms contained in this document.

Client Signature Date

Client Information Sheet on Therapists' Duty to Report Child Abuse or Neglect

As therapists we are legally obligated to break confidentiality and report and child or elder abuse (including physical, emotional, or sexual) or neglect.

Physical Abuse includes any action that causes:

- Impairment of a bodily function (limb, organ)
- Impairment of a physical condition or health
- Pressure sores
- Failure to thrive
- Dehydration
- Any physical condition that imperils a child's health or welfare
- Any physical injury that creates a reasonable risk of death
- Disfigurement
- Skin bruising
- Bleeding
- Malnutrition
- Burns
- Head injury
- Injury to an internal organ
- Soft tissue swelling
- Fracture of any bone

Emotional Abuse includes any action or neglect of a parent/caregiver that causes a child to experience:

- Severe anxiety, depression, withdrawal, or aggressive behavior

Sexual Abuse is engaging in sexual conduct with a minor. This includes direct or indirect touching, fondling, or manipulating any part of the genitals, anus or female breast by any part of the body or by any objector causing a person to engage in such conduct. It also includes:

- Sexual exploitation of a child
- Child prostitution
- Furnishing harmful items to minors over the internet
- Photographing or filming a minor:
    - In a restroom, bathroom, locker room, bedroom, or other location where the person has a reasonable expectation of privacy
    - While the person is urinating, defecating, dressing, undressing, nude or involved in sexual intercourse or sexual conduct.

Neglect is when a parent/caregiver fails to provide a child with adequate:

- Supervision
- Food
- Clothing
- Shelter
- Medical Care

In the event that any child abuse or neglect is disclosed, your therapist will inform you that report must be made. We are also obligated to release your records if we are ordered by a court to do so. Lastly, we must take action if we believe that you may harm yourself or another person.

I have read and understand the above information regarding the duty for PCS to report any child abuse or neglect

Client's Signature Print Name Date

Client's Signature Print Name Date