

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 _____

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

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, joint 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 Disclosures 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 abused, 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.

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: _____

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		

^aIf **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	4 = 1x/wk.
1 = < 1 x/mo.	5 = 2 to 3x/wk.
2 = 1x/mo.	6 = 4 to 6x/wk.
3 = 2 to 3x/mo.	7 = daily;

Insurance & Financial Policy

Innervisions Family Counseling Center is very pleased that you have chosen our agency for your therapy needs. The utmost confidentiality is upheld at our clinic.

As a service to you, our staff will attempt to contact your insurance carrier to determine your insurance benefits regarding your treatment with us. All insurance policies are contracts between you and your insurance carrier. Your therapy fee is an agreement between you and your therapist.

All co-pays, co-insurance and deductibles are due at the time of each session. You will be responsible to keep track of your insurance benefits (i.e., co-pays, co-insurance, deductibles) per year and are responsible for any payments that exceed or are not covered by your insurance.

If your therapist has not received payment from your insurance carrier within 45 days from your session date, you will be billed for that session.

Fee Schedule

Group Psychotherapy	\$75.00 / per group
Individual Psychotherapy	\$215.00 / per session
Couples Therapy	\$215.00 / per session

The therapy hour is a 40-50 time-frame. Non-emergency cancellation calls must be received at least 24 hours before the scheduled session to avoid a \$75.00 out-of-pocket cancellation fee.

Patient's 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.

Print Name

Signature

Date

Witness

Authorization for Electronic Communication

As a convenience to me, I authorize _____, to communicate with me regarding my treatment via electronic communications (email/text message/video chat) and to transmit my protected health information electronically as described below.

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.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, _____ 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 _____ 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 _____ may transmit my protected health information electronically as described above, unless and until I revoke or amend this authorization by submitting notice to _____ 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

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