INTAKE INFORMATION

Client's Name: _____ Today's Date: _____

Client's Date of Birth: _____/_____/_____ Client's Age: _____ Male_____ Female_____

Client's Race/Ethnicity: _____ Dominant Hand (circle one): Right Left Ambidextrous

Client's Address: _____

City: _____State: _____ Zip Code: _____

Client's Social Security Number: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email Address:_____

We may contact you by (check all that apply): Phone ____ Voicemail ____ Text ____ Email ____

Who referred you or how did you find us?: _____

Client's Education:_____ _____

Client's Occupation/School: _____ Employer: _____

Marital Status: _____ Spouse/Partner's Name: _____

Children's Names and Ages: _____

Parent's Names (if client is a minor): Mother _____ Father _____

Are the parents of the client divorced?: Yes _____ No _____

If Yes, and both parents hold legal authority, does each parent/guardian consent to psychological services: Yes _____ No _____

Person responsible for payments: _____; Relation to Client: _____

Emergency Contact Person: _____; Phone Number: _____

INSURANCE INFORMATION:

Primary Policy Holder (if different than client): _____

Date of Birth: _____/_____/_____ Social Security Number: _____

INTEGRATIVEPSYCHE

HEALTH ASSESSMENT

For Therapy and Testing

Client's Name: _____ Date of Birth: ____/____/_____

Please briefly explain client's reason for seeking services with our clinic:

_____

_____

Has client seen a psychologist or counselor in the past?: YES_____ NO_____

If Yes, with Who?: _____ When?: _____

Reason: _____

Has client had a (neuro)psychological evaluation in the past?: YES_____ NO_____

If Yes, with Who?: _____ When?: _____

Findings: _____

Is client currently under the care of a psychiatrist? YES _____ NO_____

If Yes, with Who?: _____ Where?: _____

Please list currently prescribed medications and dosages:

_____

_____

Please list any major health problems:

_____

_____

Client's primary care physician or pediatrician: _____

Date of last exam: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

INFORMED CONSENT
CONFIDENTIALITY AND DENIAL OF RIGHTS
For Therapy and Groups

Thank you for choosing to receive services from Integrative Psyche, LLC. In keeping with the State Statute section 51.61 and HSS 94, we are required to inform you of your rights when seeking psychological services at this clinic. This clinic is designed to provide individual, couples, family, and group therapy for children and adults. These services are beneficial only to the extent that the client(s) are actively participating with the staff in delivery of services. It is our belief that the providers and client(s) together design and implement the treatment program for the therapeutic services rendered.

1) The benefits from psychotherapy may include, but are not limited to, being better able to meet your needs, improve communication skills, more satisfying intimate relationships, and better understanding of your personal goals and values. Psychotherapy is conducted in individual, couples, family, and group contexts with a therapist/facilitator for purposes of identifying and resolving problems or concerns.

2) Psychotherapy may include the risk of remembering unpleasant events and can arouse intense emotions such as sadness, fear, and anger. Feelings of anxiety, depression, frustration, loneliness, and helplessness may also be aroused.

4) The therapist may suggest alternative treatment modes and will make referrals when appropriate or necessary.

5) If you forgo psychotherapy, it is possible that your problems may not resolve, or become worse than they are at the present time.

6) This informed consent will be in effect until such time that you are discharged from treatment either by mutual agreement with your therapist, your own decision, or your therapist's clinical decision that services with another provider or agency are more appropriate for your treatment needs.

7) You have the right to withdraw this informed consent at any time. Your request must be in writing.

Information discussed with a clinician is confidential and will not be discussed without your release of that information. However, Wisconsin Law requires that therapists break this confidentiality under the following conditions: 1) when there is a court order to do so; 2) there is a serious threat of harm to oneself or another person; or 3) if a child or older adult (over the age of 60) is being endangered through abuse or neglect.

As your clinician, there may be times in which it may be necessary to consult with other professional colleagues about your treatment. Should it be useful or necessary for the rendering provider to do so, your personal information will be kept confidential so that no identifying information will be shared without your consent.

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INFORMED CONSENT
CONFIDENTIALITY AND DENIAL OF RIGHTS

For Therapy and Groups

CONTINUED

Insurers sometimes require the release of certain information before they will authorize payment. In such instances, only the minimal information required for reimbursement will be released.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMED CONSENT/CONFIDENTIALITY AND DENIAL OF RIGHTS FORM AND AGREE TO ITS TERMS.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

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CONSENT TO PSYCHOLOGICAL CARE

For Therapy and Group

I, having legal responsibility and authority and knowing that I am/my child is in need of outpatient diagnostic or therapeutic psychological treatment, do authorize Integrative Psyche, LLC, including assistants, students and other staff to perform and prescribe treatment and other related care under the supervision of licensed psychologists and/or licensed clinicians. I understand that administrative support staff, students, assistants, and other staff members may not be employed by this agency. It is also understood and agreed upon that, at times, students may deliver, observe, and contribute to services in other ways under the supervision of authorized agency personnel such as licensed psychologists and other licensed professionals. I understand that some providers are not licensed and are accruing hours toward licensure or as a part of their educational requirements. These providers are under the care and supervision of licensed psychologists and/or other licensed clinicians.

I understand that Integrative Psyche, LLC has a training component which serves important educational functions. I also understand that without using my name or other identifying information, students may use material from my file for educational purposes. I approve the use of information from my file for educational purposes so long as my identity and privacy is protected.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE CONSENT TO PSYCHOLOGICAL CARE FORM AND AGREE TO ITS TERMS.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

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INTEGRATIVEPSYCHE

FINANCIAL POLICY

For Therapy

Please understand that when you come for psychological services, you and your therapist automatically contract with one another. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits. Any charges not covered by your insurance company are your responsibility. This includes deductibles, co-pays, co-insurance, lapses in coverage, or any private pay arrangements agreed upon between you and your therapist. Payments are due 30 days from the date of the statement. After three consecutive months, failure to make payment in full, or to make payment arrangements with office staff, result in your account being turned over for collections. If this occurs, a 25% collection charge will be added to your bill.

Cost of Treatment:

DOCTORAL LEVEL CLINICIANS

Initial Diagnostic Interview: ..... $250 per 45 – 60 minute session
Individual Psychotherapy: ..... $150 per 45 – 50 minute session
..... $200 per 60 – 75 minute session
Family Therapy:..... $200 per 45 – 50 minute session
..... $250 per 60 – 75 minute session

MASTERS LEVEL CLINICIANS

Initial Diagnostic Interview: ..... $225 per 45 – 60 minute session
Individual Psychotherapy: ..... $125 per 45 – 50 minute session
..... $175 per 60 – 75 minute session
Family Therapy:..... $175 per 45 – 50 minute session
..... $225 per 60 – 75 minute session

We reserved the right to charge a $25 fee for failure to cancel any appointments 24 hours in advance.

- I have read and understand this Financial Policy as indicated above. _____ Initial
- I authorize the use of my and/or my child's personal identifying information and release of information for insurance submissions. _____ Initial
- I understand that payments for services rendered are non-refundable, except and only under specific circumstances determined by insurance companies and/or Integrative Psyche/my treating clinician(s). _____ Initial

BY SIGNING THIS FORM, I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR PAYING, IN FULL, FOR MY AND/OR MY CHILD'S PSYCHOLGICAL SERVICES. THIS INCLUDES PAYMENT OF PRIVATE PAY FEES AND/OR ANY PORTIONS OF THE BILL THAT ARE NOT COVERED BY MY AND/OR MY CHILD'S INSURANCE COMPANY.

Printed Name of Client: _____
Signature of Client: _____ Date: _____
Printed Name of Parent/Guardian/Legal Representative (if applicable): _____
Signature of Parent/Guardian/Legal Representative (if applicable): _____
Relationship to Client: _____ Date: _____

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INTEGRATIVEPSYCHE

RELEASE OF INFORMATION

For Therapy

Client: _____ DOB: _____ Today's Date: _____

I hereby authorize Integrative Psyche, LLC to disclose information to and/or obtain information from the following individual(s) regarding my/my child's care:

❒ By checking this box, I decline consent for the release of information with the Primary Care Physician.

❒ By checking this box, I accept consent for the release of information with the Primary Care Physician.

Name and Relationship to Client: Primary Care Physician (PCP)_____
Address: _____
Phone/Fax Number: _____
Email Address: _____

For the following information:

- ❒ Release of evaluation notes/results
- ❒ Progress Notes
- ❒ Collaboration
- ❒ Other, please specify _____

For the purposes of:

- ❒ Continuity of care
- ❒ Employment
- ❒ Other, please specify _____

Upon fulfillment of the above stated purposes, this consent will automatically expire one year following the date of signature without my express revocation unless otherwise specified here:

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND AND AGREE THAT CONFIDENTIAL INFORMATION AND/OR PROTECTED HEALTH INFORMATION REGARDING THE IDENTIFIED CLIENT MAY BE DISCOLOSED TO THE IDENTIFIED INDIVIDUALS IDENTIFIED ABOVE.

Printed Name of Client: _____
Signature of Client: _____ Date: _____
Printed Name of Parent/Guardian/Legal Representative (if applicable): _____
Signature of Parent/Guardian/Legal Representative (if applicable): _____
Relationship to Client: _____ Date: _____
Witness Signature_____ Date: _____

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INTEGRATIVEPSYCHE

RELEASE OF INFORMATION

For Therapy

Client: _____ DOB: _____ Today's Date: _____

I hereby authorize Integrative Psyche, LLC to disclose information to and/or obtain information from the following individual(s) regarding my/my child's care:

❒ By checking this box, I decline consent for the release of information with others.

❒ By checking this box, I accept consent for the release of information with others.

Name and Relationship to Client: _____
Address: _____
Phone/Fax Number: _____
Email Address: _____

For the following information:

- ❒ Release of evaluation notes/results
- ❒ Progress Notes
- ❒ Collaboration
- ❒ Other, please specify _____

For the purposes of:

- ❒ Continuity of care
- ❒ Employment
- ❒ Other, please specify _____

Upon fulfillment of the above stated purposes, this consent will automatically expire one year following the date of signature without my express revocation unless otherwise specified here:

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND AND AGREE THAT CONFIDENTIAL INFORMATION AND/OR PROTECTED HEALTH INFORMATION REGARDING THE IDENTIFIED CLIENT MAY BE DISCOLOSED TO THE IDENTIFIED INDIVIDUALS IDENTIFIED ABOVE.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

Witness Signature_____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health Information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health related to health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed to others outside of my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, I would disclose your protected health information, as necessary to another health agency or health care provider that provides care to you to ensure that they had necessary information to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. Healthcare Operations: I may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Child abuse, physical neglect and/or sexual abuse; Adult and Domestic abuse of an incapacitated or vulnerable adult.

Health Oversight: Wisconsin Board of Psychological Examiners conducting an investigation.

Judicial and Administrative Proceedings: if you are involved in a court proceeding and a request is made for information about professional services I have provided.

Serious Threat to Health or Safety: if I believe there is an imminent risk of harm to yourself or others.

Worker's Compensation: it may be necessary to comply with laws relating to worker's compensation or other similar programs.

Other Permitted and Required Uses and Disclosures will be make only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that I have taken an action in reliance on the use or disclosure indicted in the authorization.

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HIPAA NOTICE OF PRIVACY PRACTICES

CONTINUED

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask me not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction that you may request. If I believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to choose another Healthcare Professional.

You may have the right to request an amendment of your protected health information. If I deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. I reserve the right to change the terms of this notice and will inform you in person of any change. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to Nicole Klepp, Psy.D., HIPAA Officer, if you believe your privacy rights have been violated. I will not retaliate against you for filing a complaint.

This notice is effective April 14, 2003. I am required by law to maintain the privacy of, and provide individuals with, this notice.

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HIPAA NOTICE OF PRIVACY PRACTICES

CONTINUED

I have read the information contained within this consent form and HIPAA notice of privacy practices. My signature below indicates my consent/assent to psychological services as well as my understanding and agreement to the terms contained within this consent form and HIPAA notice. I have been provided with a copy of the HIPAA form. I have also been provided with an opportunity to discuss any concerns that I may have.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

Witness Signature_____ Date: _____

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AGREEMENT FOR PARENTS OF SEPARATION/DIVORCE

For Therapy and Group

Psychotherapy can be a very important resource for children of separation and divorce. Establishing a therapeutic alliance outside of the home can:

- Facilitate open and appropriate expression of the strong feelings which routinely accompany family transitions, including guilt, grief, sadness and anger
- Provide an emotionally neutral setting in which children can explore these feelings
- Help children understand and accept the new family composition and the plans for contact with each member of the family
- Offer feedback and recommendations to a child's caregivers based on knowledge of the child's specific emotional needs and developmental capacities

However, the usefulness of such therapy is extremely limited when the therapy itself becomes simply another matter of dispute between parents. With this in mind, and in order to best help your child, we strongly recommend that each of the child's caregivers (e.g., parents, step-parents, daycare workers, *guardian ad litem* {GAL}) mutually accept the following as requisites to participation in therapy.

1. It is the primary responsibility of the treating psychotherapist to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gathering information relevant to understanding your child's welfare and circumstances as perceived by important others (e.g., pediatrician, teachers). In some cases, this may include a recommendation that you consult with a physician should matters of your child's physical health be relevant to this therapy.
2. It is vital that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being. Open communication about his or her emotional state and behavior is critical. In this regard, there remains an open invitation for frequent and open exchange and communication with your child's therapist.
3. It is important to recognize and, as necessary, reaffirm your child, that the treating therapist is the child's helper and not allied with any disputing party.
4. Please be advised regarding the limits of confidentiality as it applies to psychotherapy with a child in these circumstances:
    a. We keep records of all contacts relevant to your child's well-being. These records are subject to court subpoena and may, under some circumstances, be solicited by parties to your divorce, including your attorneys.
    b. Any matter brought to the attention of the treating therapist by either parent regarding your child's well-being may be revealed to the other parent. Matters which are brought to the therapist's attention that are irrelevant to the child's welfare may be kept in confidence.

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AGREEMENT FOR PARENTS OF SEPARATION/DIVORCE

For Therapy and group

CONTINUED

c. **We are legally obligated to bring any concerns regarding health and safety to the attention of relevant authorities. This includes, but is not limited to, threat of harm to oneself and/or others. When this occurs, confidentiality may be broken in attempts to protect the client and/or identified others. When possible, should this necessity arise, we will advise all parties regarding the concerns.**

5. This psychotherapy will not yield recommendations about custody. In general, it is recommended that parties who are disputing custody strongly consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation.
6. Payment for therapeutic services is due, in full, at the time of service and/or in a manner agreed upon by all parties involved. Any outstanding balance accrued (for example, in conference with attorneys, the GAL, or teachers), must be paid promptly and in full.

Your understanding of these six points and agreement in advance of starting this therapy may resolve difficulties that would otherwise arise and will help make this therapy successful. Your signature, below, signifies that you have read and accept these points.

Child's Name	Date of Birth	Age

Caregiver Signature (ex. Mother)	Date

Printed Name of Caregiver

Caregiver Signature (ex. Father)	Date

Printed Name of Caregiver

Witness	Date

_____ Copy accepted by mother (initials) _____Copy accepted by father (initials)

This is a strictly confidential patient medical record.
Re-disclosure or transfer is expressly prohibited by law.

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AUTHORIZATION FOR ELECTRONIC COMMUNICATION

As a convenience to me, I hereby request that Integrative Psyche, LLC and/or my treating providers communicate with me regarding my treatment by Integrative Psyche staff via electronic communications (e-mail, phone calls, voicemail, and text message). I understand that this means Integrative Psyche staff may transmit my protected health information such as information about my appointments, diagnosis, medications, progress, psychological evaluation report, and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, phone calls, or voicemail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted or password protected. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Integrative Psyche, LLC and/or my treating providers 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 between Integrative Psyche staff and me.

Please note that your provider may route your email, text, or voicemail messages to other staff members for informational purposes or for expediting a response. As such, designated staff may receive your electronic messages. During emergencies you should contact 911.

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.

I understand that in the event I no longer wish to receive electronic communications from Integrative Psyche, LLC, I may revoke this authorization by providing written notice to Integrative Psyche, LLC at 10150 W. National Avenue, Suite 390, Milwaukee, WI 53227, or via fax at 414-545-4454.

I HAVE BEEN PROVIDED NOTICE OF THE RISKS INHERENT IN THE USE OF ELECTRONIC COMMUNICATIONS. I HEREBY AUTHORIZE INTEGRATIVE PSYCHE STAFF TO COMMUNICATE ELECTRONICALLY WITH ME.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

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One-Time & Repeat Payment

Credit Card Authorization Form

CARDHOLDER INFORMATION

Name: _____

Billing Street Address: _____

City: _____ State: _____ Zip Code: _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

PATIENT INFORMATION

Patient Name: _____

❒ I authorize a one-time charge against my credit card for the following amount $ _____

❒ I authorize a recurring charge against my credit card for the following amounts:

$_____once every ❒ ____ day(s) ❒ ____ week(s) ❒ ____ month(s) ❒ ____year(s)

Beginning Date: _____ and ending after _____ payments.

CARDHOLDER INFORMATION

Credit Card Type: ❒ MasterCard ❒ Visa ❒ American Express ❒ Discover Card

Number: _____

Expiration Month: _____ Expiration Year: _____

Cardholder Signature: _____ Date: _____

Security Code: _____

❒ Check if this is an HSA Credit Card Account

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