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 Occupational Therapy

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 received occupational therapy or an OT 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: _____

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INFORMED CONSENT
CONFIDENTIALITY AND DENIAL OF RIGHTS

For Occupational Therapy

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 occupational therapy services at this clinic. This clinic is designed to provide integrative therapeutic services, including occupational therapy and mental health services. 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) Occupational therapists work with individuals who may have difficulties because of an accident, disability, disease, emotional, social or developmental problem, or change related to aging. OTs help people learn or re-learn to manage day-to-day activities. Occupational therapists help people to learn new ways of doing things; regain skills and develop new ones; use materials or equipment that makes life easier, or adapt their environment to work better for them. These solutions help people to do as much as they can – safely and effectively – at home, at school, at work or in other settings.

2) Occupational therapy may have some risks. You have the right to ask about these risks and have any questions answered about you/your child's condition, prior to treatment. Treatment may have unintended negative side effects such as sleep disturbance, frightening memories, or unfamiliar and uncomfortable body sensations which may include pain. These side effects are usually temporary as the physical body and nervous system adjust and re-organize during and following treatment. The therapist, of course, will not give any treatment or health care if he/she is aware that such care may be contradicted. The occupational therapist provides a specialized, non-duplicating health care service. Your therapist is licensed in a special practice and is available to work with other types of providers in your health care regime.

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

4) Personal commitment to counseling and treatment including other appropriate modalities is crucial for success. In order to maximize the effectiveness of occupational therapy services, you should make counseling and treatment including other appropriate modalities a high priority, and should not cancel sessions except in the case of an emergency.

5) If you forgo occupational therapy, 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

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INFORMED CONSENT
CONFIDENTIALITY AND DENIAL OF RIGHTS

For Occupational Therapy

CONTINUED

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 an occupational therapist 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.

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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INTEGRATIVEPSYCHE

FINANCIAL POLICY

For Occupational Therapy

Please understand that when you come for occupational therapy 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 THERAPISTS

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

MASTERS LEVEL THERAPISTS

Initial Diagnostic Interview: ..... $225 per 45 – 60 minute session
Therapy: ..... $125 per 45 – 50 minute session
..... $175 per 60 – 75 minute session
Evaluation: ..... $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 Occupational 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 Occupational 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

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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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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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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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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