Integrity Counseling, LLC

(920) 385-1420
office@integritycounselingllc.net
www.integritycounselingllc.net

Welcome to Integrity Counseling,

In this packet of information for Children and Adolescent Patients, you will find instructions to our online system and several additional forms that need to be completed and sent in via email to your therapist or printed and brought along with you to your first appointment.

To complete your new patient registration online please following the below instructions

Go to our website at: www.integritycounselingllc.net

1. Go to the tab "About Our Staff"
2. Find your counselor's name and Click on " Schedule An Appointment With" (the name of your counselor)
    a. Your user name will be set up within 24 hours after you talk with our office staff and schedule your first appointment. Your user name will be the following:
        i. the First Letter of the patient's first name (lower case) and the full last name of the patient.
        ii. Then the password would be the same as the user name, along with the last two numbers of the year of birth of the patient.
    a. So for example: If your (or the patient's) name is Joe Smith and the birth date is 7/22/1972, your user name would be: jsmith -- and your password would be: jsmith72.
    b. Once you log in you can change your log in information as you wish

This is what you will see when you log in:

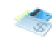
Please choose from the following:

Set, view or reschedule appointments

Update contact or insurance information

Complete a biographical information form

Send a secure message to Ms Dake

 View or pay online statement

Log out and quit

c. Click on Update contact or insurance information and complete that
d. **You DO NOT NEED TO COMPLETE** the Biographical information form for children and adolescent patients as the form you are completing above is sufficient.
e. In the future you may go to the link of "View or pay online statement" and you can see your account balance and makes payments right online.

Additionally, please complete the listed forms below that are included in this packet.

1) Patient Information and Consent for Treatment Form
2) Credit Card Authorization Form
3) Patient Demographic and Insurance Information Form
4) Intake Form- Child
5) Electronic Communication Consent Form

If you should have any questions regarding this information, please feel free to call our main office and we will assist you. Thank you very much! We look forward to working with you.

Integrity Counseling, LLC

Demographic

Client's Personal Information: **Intake Date:** ________________

Full Name (w/ M.I.) ________________ Prefer to be called: ________________

Address: ________________ City: ________________ State: ______Zip: ________

Date of Birth: ____________ Age: _____ ☐M ☐F Social Security No.: ________________

Name of school: ________________ City/State: ________________

Client Information Continued [or Parent/Guardian Information if Client is a Minor]

Home Phone: (____)______________Work Phone: (_____)____________ Cell: (____)________________

Best time to contact me: __________ ☐a.m. ☐p.m. on my ☐Home phone ☐Work phone ☐Cell phone

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

(Adults) Employer: ________________ City/Phone:________________ ☐Pt ☐Ft ☐Ret

Spouse or Parent's Name: ________________ Employer: ____________ Work Phone: ____________

Referred by: ________________Email: ________________

Responsible Party (will receive the statements) ☐ Check here if same as above

Name: ________________ DOB: ____________ SS#: ________________

Phone: (_____)____________ Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____________

Address: ________________ City: ________________ State: ______ Zip: ____________

Employer: ________________ Phone: (____)________________ State: ____________

Primary Insurance Information (Who is the Policy Holder?) ☐ Check here if same as above

Name of Insured: ________________ DOB: ____________ SS#: ________________

Address: ________________ City: ________________ State: ______ Zip: ____________

Phone: (_____)____________ Relationship to Client: ☐Self ☐Spouse ☐Child ☐Other: ________________

Employer: ________________ Address: ________________ Phone: ________________

Insurance Co. ________________ Subscriber # ________________ Group # ____________

Secondary Insurance Information (Who is the Policy Holder?)

Name of Insured: ________________ DOB: ____________ SS#: ________________

Address: ________________ City: ________________ State: ______ Zip: ____________

Phone: (_____)____________ Relationship to Client: ☐Self ☐Spouse ☐Child ☐Other: ________________

Employer: ________________ Address: ________________ Phone: ________________

Insurance Co. ________________ Subscriber # ________________ Group # ____________

Consent For Treatment

INFORMATION FOR CLIENTS and CONSENT FOR TREATMENT

The mission of Integrity Counseling, LLC is built on the foundation of empathetic and compassionate professionals who believe in the inherent strengths and well-being of those with whom we have the privilege to work. We view ourselves as partners with you and respect your values and experience and will work diligently to assist you as you confidently move forward in your life journey. Vision: Our vision is to help you see the value in the person you already are.

This sheet contains important information about our policies and procedures. Please read it carefully. Ask your therapist to answer any questions you may have.

Eligibility:

Eligibility for Integrity Counseling programs is based on the existence of a presenting problem. You may be referred to another community resource if you (1) do not meet the eligibility criteria; (2) there is not enough staff time available to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insurance company has another counseling resource for you.

After you begin working with Integrity Counseling services may continue: (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals.

The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Appointments:

Appointments are scheduled with individual therapists. A counseling or psychotherapy hour consists of a one 45-60 minute interview with your therapist. If you need to cancel an appointment, please do so at least 24 hours in advance. **You**, not your insurance, will be billed for missed appointments.

Hours:

The agency is open Monday through Friday 9:00a.m. to 8:00 p.m. Evening/Weekend hours are available by appointment.

Consultants:

Your therapist collaborates with other licensed therapists in his/her clinical work. Your therapist also has a supervisor who may be contacted if you have questions or concerns. The supervisor will meet with you when necessary or at your request.

Confidentiality:

All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Integrity Counseling, without your written consent. The primary exception to this rule is those situations in which reporting is mandatory under Wisconsin law (e.g., child abuse, child neglect, sexual abuse, etc.) In addition, please note that your signature on the fee agreement gives the agency permission to release information necessary for the processing of claims for payment.

Electronic Communication

Please note that our therapists will only respond to text messages during normal business hours. Texting as form of communication is up to the therapist and you may discuss this option with them during your sessions. Texting is not a form of communication that can be used to report a crisis. If you are in crisis please use the crisis hotline. Numbers for the crisis lines are located within this document. See the following section below.

Emergencies:

In an emergency, you may call the office 24 hours, 7 days a week at (920) 385-1420 and leave a message. Your message will be passed along to your therapist within one business day. Your therapist will provide you with their direct phone contact information. You may also contact your therapist directly at the number they provide to you. They will return your call within 24 hours during normal business hours Monday- Friday. The following are a list of additional numbers to call in the event of an emergency and you need to reach someone outside of our normal business hours:

Winnebago County Crisis: (920) 233 – 7707 or (920) 722 – 7707

Outagamie County Crisis: (920) 832 – 4646 or (800) 719 – 4418

Informed Consent:

It is the policy of Integrity Counseling that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive through the agency. You will be asked to read and sign the Informed Consent Policy form prior to beginning work with your therapist. Those patients receiving medication from an agency consultant will be asked to sign an Informed Consent specific to the medication being used.

Grievance Procedure:

Integrity Counseling shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Grievance and Requests for Administrative Review Policies and Procedures. Program staff shall be familiar with client rights and with these agency procedures. The program staff and their supervisor will forward the complaint to the local Client Rights Specialist.

No sanctions will be threatened or imposed against any client who files a grievance or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filling a grievance or participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.

If you have a concern about the services you are receiving, you are encouraged to discuss it with your therapist. If this does not resolve the issue, you may present a written complaint to one of the two co-owners of Integrity Counseling, LLC (Janet Hagen or Ann Dake). If you are still not satisfied, please request a written copy of the Grievance Procedure.

Client Access To Records:

Under Wisconsin law, you have a right to review your treatment record. Ask your therapist for the procedures used in sharing your file with you. If you feel that it contains incorrect information, ask your therapist for the procedure used to request a change in record information.

Fee Policy:

A fee is charged for professional services provided by the therapists at Integrity Counseling. If you have private insurance or medical assistance, we will bill for services at the established rate. If you do not have insurance, or if your insurance does not pay in full, you will be responsible for paying the rate established on your Fee Agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If you are receiving services under managed care, health insurance, medical assistance, or an EAP, the agency will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes Integrity Counseling to release any information necessary to process insurance claims.

My signature below indicates that I have been given a copy of this information sheet, the "Client Rights and the Grievance Procedure for Community Services" brochure and the Integrity Counseling Joint Notice of Privacy Practices". For clients age 12-17, I have been given a copy of the "Rights of Children and Adolescents in Outpatient Mental Health Treatment"

Consent to Evaluate/Treat:

I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Integrity Counseling, LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

Benefits to Evaluation/Treatment:

Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

Charges:

Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

Confidentiality, Harm, and Inquiry:

Information from my evaluation and/or treatment is contained in a confidential record at [Integrity Counseling, LLC], and I consent to disclosure for use by Integrity Counseling, LLC staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

Discharge Policy:

There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic. (explained above)

Right to Withdraw Consent:

I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

Expiration of Consent:

This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Signature (adult or minor age 12 or older): ______________________________ **Date:**______________

Signature of Guardian if signer is under the age of 18:______________________________ **Date:**______________

Therapist Signature: ______________________________ **Date:**______________

Integrity Counseling, LLC

Credit Card Auth

If you are using your insurance benefits, Integrity Counseling, LLC requires the patient portion of the first session be paid by credit/debit card – Visa or Master Card. This is due to the high incidence of unreported deductibles and the fact that insurance may not cover certain services such as Marriage Counseling, Family Counseling, Hypnotherapy, and sessions lasting longer than 45 minutes.
By paying via credit card, you acknowledge that this credit card information will be automatically kept on file via PCI-compliant encrypted code with the following credit card processor: CAYAN/
You further agree and understand that if insurance does not pay the contracted rate for services that any remaining balance due that is the patient responsibility will be charged to this credit/debit card. This amount typically includes co-pays, co-insurance, and deductibles that have not yet been met or were quoted to you or our organization incorrectly by the insurance company.

Integrity Counseling, LLC will provide you an accounting statement as well as a credit card receipt via email or regular mail reflecting the charges applied to your credit card.

By signing this form, I authorize Integrity Counseling, LLC to keep my credit card on file and to charge my credit card an amount not to exceed $______________per charge for all balances due including No Show Fees.

Patient Name:____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Name on Card:____ **Expiration Date:**____________ **CVV Code:** __ __ __

Signature____ ***Date***_____________________________

Billing Address for above account holder:

Street: ____

City: _______________________State:_____________________ Zip Code:__________________

Please fill out the below to indicate your preferences

Email Address where statement could be sent electronically to:

____

_______________ I do not wish to authorize credit card payment at this time, therefore I will be making payments at the time of service or visiting the patient portal to pay my bill.

_______________ Please send my patient statement via secure email to the email address provided above

_______________ Please mail my statement to me monthly.

INTAKE QUESTIONNAIRE – CHILD

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: ______________________ Date: ______________

Child is (circle one): my biological child my adopted child my foster child Other: ______________

IDENTIFYING INFORMATION (for individual receiving services)

Child's Name: ______________________ Date of Birth: ______________

Address: ______________________ Sex: ______________

______________________ Work Phone (indicate whose #): ______________

Home Phone: ( ) ______________ ( ) ______________

Social Security Number: ______________ Household Income: $ ______________

Who referred you to [name]? ______________________

Child's Race:
- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races

Child's Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Child's Language of Choice:
- ☐ English
- ☐ Hmong
- ☐ Russian
- ☐ Laotian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other: ______________

Family's Religious Affiliation:
- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Amish
- ☐ Mennonite
- ☐ Protestant (including Lutheran, Methodist, etc.)
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: ______________

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify: ______________
If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No
If no, please explain: ______________________

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

____

____

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)

a. Behavior at home	g. Overactivity	m. Grieving
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Relationship
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior at school	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. School performance	r. Other (explain):

____

____

2. How long has the child had this/these problem(s)? ________________________________

3. Has the child received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

   If yes when, where and with whom? ________________________________

FAMILY HISTORY

1. With whom does the child currently live (names and relationship)? ________________________________

   Has the child lived with anyone else in the past? ☐ Yes ☐ No With whom? ________________

2. Please provide the following information about the child (as applicable):

Father's Name: ________________________	Phone #: ________________	
Address: ________________________________		
D.O.B.: ____________	Occupation: ____________	Education: ____________
Mother's Name: ________________________	Phone #: ________________	
Address: ________________________________		
D.O.B.: ____________	Occupation: ____________	Education: ____________
Stepfather's Name: ________________________	Phone #: ________________	
Address: ________________________________		
D.O.B.: ____________	Occupation: ____________	Education: ____________

Stepmother's Name: ______________________ Phone #: ____________________

Address: ____

D.O.B.: ____________ Occupation: ____________ Education: ________________

Foster Father's Name: ______________________ Phone #: ____________________

Address: ____

D.O.B.: ____________ Occupation: ____________ Education: ________________

Foster Mother's Name: ______________________ Phone #: ____________________

Address: ____

D.O.B.: ____________ Occupation: ____________ Education: ________________

Guardian/Other's Name: ______________________ Phone #: ____________________

Address: ____

D.O.B.: ____________ Occupation: ____________ Education: ________________

3. Please provide the following information about the child's brothers and sisters and other children living in the home:

Name (First and Last)	D.O.B.	Relationship (full, half, step, foster)	Lives with Child?	If no, lives where?
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	

4. Does the child or any other family member have a history of alcohol or drug problems? ☐ Yes ☐ No

   If yes, please explain: ____

   ____

5. Has the child or any other family member experienced any type of abuse (physical, sexual, domestic or emotional)? ☐ Yes ☐ No If yes, please describe the circumstances: ____________________

   ____

LEGAL HISTORY

Please describe any involvement the child with themselves or others in their household has had with the legal system (arrests, convictions, probation, parole):

____

____

DEVELOPMENTAL HISTORY

1. Pregnancy and delivery were normal? ☐ Yes ☐ No ☐ I don't know

   If no, please explain: ____

2. Did mother use alcohol or other drugs during pregnancy? ☐ Yes ☐ No ☐ I don't know

   If yes, please explain: ____

3. Please list any medications taken during pregnancy: ______________________________________

4. Did the child reach developmental milestones at a normal age:

Developmental Milestones	Yes	No	Don't Know	If no, please explain
Slept through the night				
Sat alone				
Stood alone				
Walked without help				
Said first words				
Spoke in simple phrases				
Toilet trained – day				
Toilet trained - night				

MEDICAL HISTORY

1. Primary Care physician/pediatrician: ____

2. Please check the appropriate box if the child has experienced any of these problems:

☐ Eye disease, injury, poor vision
☐ Ear disease, injury, poor hearing
☐ Nose, sinus, mouth, throat problems
☐ Head injury
☐ Convulsions or seizures
☐ Memory problems
☐ Extreme tiredness or weakness
☐ Thyroid disease or goiter
☐ Skin disease
☐ Heart disease
☐ Cancer
☐ Bowel problems
☐ Hemorrhoids, rectal bleeding
☐ Loss of consciousness
☐ Frequent or severe headaches
☐ Sleep disturbances
☐ Neck stiffness, pain, swelling
☐ Marked weight changes
☐ Circulatory problems
☐ Allergies or asthma

- ☐ Back, arm, leg or joint problems
- ☐ Blood disease
- ☐ Stomach problems
- ☐ Premenstrual Syndrome (PMS)
- ☐ Eating disorder
- ☐ Liver, gallbladder disease
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Pregnancy
- ☐ High blood pressure
- ☐ Other

Please explain anything checked above: ____

____

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): ____________

____

SCHOOL INFORMATION

1. What school does the child currently attend? ______________________________
2. What is the child's teacher's name? ______________________________
3. What grade is the child in? ______________________________
4. How many schools has the child attended? ______________________________
   In which cities/towns were they located? ______________________________
5. Does the child have a written IEP? ☐ Yes ☐ No
   Is the child in special education classes? ☐ Yes ☐ No Type: ____________________
6. Is the child experiencing any problems in school?
   Academics (grades): ☐ Yes ☐ No
   Behavior: ☐ Yes ☐ No
   Social (peers or adults): ☐ Yes ☐ No

   Please explain any "yes" responses: ______________________________

   ____

SOCIAL RELATIONSHIPS / FRIENDS

1. How does the child get along with peers? ____________________

2. How does the child get along with adults? ____________________

3. Does the child spend more time with (check the closest answer):
   - ☐ Same age children
   - ☐ Adults
   - ☐ Older children
   - ☐ Mostly alone
   - ☐ Younger children

4. What are the child's hobbies and interests? ____________________

HOME LIFE

1. Is there a behavior problem at home? ☐ Yes ☐ No If yes, please explain: ____________________

2. What are the child's strengths? ____________________

3. What are the family's strengths? ____________________

4. What are the child's weaknesses? ____________________

5. What are the family's weaknesses? ____________________

6. What kind of discipline is used with the child? ____________________

   Who is the primary disciplinarian? ____________________

7. Are there any family circumstances you would like us to be aware of? ____________________

8. What goals would you like to see reached as a result of your child's involvement *[Your Organization's Name]*?
____
____
____
____

9. How will you know when these goals have been reached (describe changes in behavior or functioning)?
____
____
____
____

THERAPIST REVIEW

Signature: ______________________________ Date: ____________________

Integrity Counseling, LLC

Electronic Communication Form

Agreement to Communicate by Electronic Messaging

Secure electronic messaging is always preferred to insecure email/text communication for more sensitive PHI, but under specific circumstances, insecure email/text communication containing protected health information (PHI) may take place between the provider(s) and Integrity Counseling, LLC and the patient.

This email/text communication may be used if both parties agree on this communication method and this form is completed and signed by the patient or the patient's personal representative (if appropriate).

A copy of this form and all email/text communication will be filed in the patient's Medical Record and a hard copy of this form will be provided to the patient. This agreement is limited to communications using the email/text addresses listed below:

Patient Email Address:____

Patient Text Messaging #:____

Provider Awareness:

Standard email/text is not a secure means of communication, so as the provider I will use the minimum necessary amount of protected health information when responding to your questions or communicating information to you.

Provider Email Address: office@integritycounselingllc.net Main Organization Email

Other Provider Email Address: ____

Patient Awareness:

Please note that most standard email/text does not provide a secure means of communication. There is some risk that any protected health information contained in email/text may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is always an alternative that is available to you.

By completing this form, the provider and I understand and are willing to accept the risks involved with insecure email/text communication of my protected health information.

**Email/text communication is <u>not</u> appropriate forms to communicate a crisis.
If patient is in crisis, patient should only contact the crisis hotline.**

Date: ______________________

Patient's Name (print name):____

Patient's signature : ____

Guardian's Name (if applicable) (print name):_______________________________________

Guardian's Signature:____