



# Integrity Counseling

(920) 385-1420  
office@integritycounselingllc.net  
[www.integritycounselingllc.net](http://www.integritycounselingllc.net)

Welcome to Integrity Counseling,

In this packet of information for Adult Patients, you will find instructions to our online system and several additional forms that need to be printed and completed 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](http://www.integritycounselingllc.net)

1. Go to the tab “Meet Our Counselors”
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:**

- c. Click on Update contact or insurance information and complete that
- d. Click on Complete a biographical information form and complete that in its entirety
- 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.

### **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

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

- 1) Demographic – Please **Complete ENTIRE form**
- 2) Information For Clients and Consent For Treatment
- 3) Credit Card Auth
- 4) Patient Supplemental Intake Questionnaire
- 5) Electronic Communication Form
- 6) Hipaa & Payment Policy
- 6) Hipaa - Payment Policy

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.



## Demographic

Please complete 7@F; D7 form

Intake Date: \_\_\_\_\_

### Client's Personal Information:

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F Social Security No.: \_\_\_\_\_

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

Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_  Pt  Ft  Ret

Name of school (if applicable): \_\_\_\_\_ City/State: \_\_\_\_\_

Referred by: \_\_\_\_\_ **Emergency:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### Parent/Guardian Information ffl Client is a Minor

Parent / Guardian's Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Responsible Party

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Relationship to Client:  Self  Spouse  Parent  Other: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ State: \_\_\_\_\_

Drivers Lic #: \_\_\_\_\_

### Primary 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 # \_\_\_\_\_

### 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 # \_\_\_\_\_



# Integrity Counseling

## **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.

### **Waiting Room Courtesy:**

Be mindful of all clients while you are in the waiting room by keeping noise to a minimum. Creating noise in the waiting room can be disruptive to other clients in the waiting and those clients that are in session. Additionally, children under 12-years-old should not be unsupervised in the waiting room or other common areas within the building. Parents be stay in the building while your child is in session in case you are needed.

### **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 Clinical Supervisor who may be contacted if you have questions or concerns. The Clinical Supervisor will meet with you when necessary or at your request. The Clinical Supervisor at Integrity Counseling, LCC is Dr. Renae Swanson. She can be reached by calling (920) 385-1420.

### **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

### **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. 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

Outagamie County Crisis: (920) 832 – 4646

### **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 (Rena Swanson, Ph.D., LPC, NCC). If you are still not satisfied, please request a written copy of the Grievance Procedure.

**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"**

**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.

**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. 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.

**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

## Credit Card Auth

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:** \_\_\_\_\_

**What kind of account:**  HSA  Debit  Other \_\_\_\_\_

**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

\_\_\_\_\_ 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

Email: \_\_\_\_\_

\_\_\_\_\_ Please mail my statement to me monthly, or anytime there is a balance due.



## Supplemental Intake Questionnaire- Adult

(please fill out if you have completed the Biographical Information on your patient account online)

Patient Name:

Patient Date of Birth

How were you referred to Integrity Counseling?

What is the primary problem for which you are seeking help? Please summarize below:

How long have you had the above problems?

Is there anyone to whom you would like us to include in your treatment, or anyone who you would like us to be discussing your care with? If so please list below and request that we obtain a release of information form from you to allow us to do so. Please list their names below:

If you feel that your 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:



Do you have a disability that you would like us to be aware of?

- Yes
- No

If so, please specify:

---

Do you have any current legal issues? If so please describe below:

Have you had any past legal issues? If so please describe below:

---

**The below questions are optional**

Race (optional)

- White/Caucasian
- American Indian or Alaska Native
- Asian
- Black/African American

Ethnicity (optional)

- Hispanic or Latino
- Non-Hispanic or Non-Latino

Language of Choice

- English
- Hmong
- Spanish

Religious Affiliation: (optional)

- Catholic
- Jewish
- Protestant (including Lutheran, Methodist, etc.)
- No Affiliation
- Muslim
- Amish
- Non Denominational
- Other



# Integrity Counseling

## 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](mailto: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 not 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:** \_\_\_\_\_



# Integrity Counseling

## HIPAA

I, \_\_\_\_\_ ACTING ON MY OWN BEHALF, OR ON THE BEHALF OF A MINOR CHILD (UNDER THE AGE OF 14), OF WHOM I HAVE LEGAL CUSTODY, DO HEREBY GIVE PERMISSION AND AUTHORITY TO, INTEGRITY COUNSELING, LLC, TO DISCUSS MY BILL/STATEMENT WITH ONLY THE PERSON OR PERSONS LISTED BELOW, REGARDLESS OF WHO MAKES PAYMENT ON THIS ACCOUNT.

<u>Name</u>	<u>Telephone #</u>	<u>Relationship</u>	<u>Purpose we can communicate</u>
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS
			BILL/STATEMENTS

THIS AUTHORIZATION IS IN EFFECT UNTIL I REVOKE IT.

Client Signature \_\_\_\_\_ DATE: \_\_\_\_\_

Parent/Guardian Sign \_\_\_\_\_ DATE: \_\_\_\_\_



# Integrity Counseling

## Payment Policy

Thank you for choosing Integrity Counseling LLC. We are committed to providing you with quality and affordable services. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. Proof of insurance. All patients must complete our patient information form before seeing their counselor and provide us with an up to date copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due or your balance exceeds \$250 you will not be able to schedule another appointment until appropriate payment arrangements are made.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Responsible Party Signature/Date

I have read and understand the payment policy and agree to abide by its guidelines