Welcome
To
Nicklaus Counseling Center

Come as You Are
And
Leave a Better You

1557 Cleveland Avenue ▪ Marinette, WI 54143 ▪ Phone: 715-732-6868 ▪ Fax: 715-732-6866

Updated 06/27/2019

Nicklaus Counseling Center, S.C.

PLEASE PRINT CLEARLY SHEET MUST BE FILLED IN COMPETELY

Today's Date_____

Client First Name_____ Last Name_____ MI_____

Address_____ City_____ State _____ Zip_____

Birthdate _____ Age_____Gender_____State ID or Driver's License #_____

Home Telephone _____ Work Telephone _____

Spouse/Guardian _____ Phone _____

Address_____ City_____ State _____ Zip_____

Birthdate _____ Age_____ State ID or Driver's License #_____

Person Responsible for Payment _____
(Please Print)

Signature of Person Responsible for Payment_____
(Must be signed for services to begin)

EMERGENCY CONTACT INFORMATION

Name_____ Relationship_____Phone _____

Address_____ City_____ State _____ Zip_____

Physician_____Phone _____

Address_____ City_____ State _____ Zip_____

Psychiatrist_____Phone _____

Address_____ City_____ State _____ Zip_____

Employment Information (If client is a minor, provide parent/guardian employment)

Name of Employer_____Phone _____
Client/Guardian

Address_____ City_____State _____ Zip_____

Name of Employer_____Phone _____
Spouse

Address_____ City_____ State _____ Zip_____

Insurance Information

Primary Insurance_____
Phone_____
Contract/ID_____
Group/Acct_____
Subscriber_____
Subscriber Date of Birth_____
Client relationship to Subscriber
☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance_____
Phone_____
Contract/ID_____
Group/Acct_____
Subscriber_____
Subscriber Date of Birth_____
Client relationship to Subscriber
☐ Self ☐ Spouse ☐ Child ☐ Other

Nicklaus Counseling Center, S.C.

Mental Health Screening Form

Name: _____ Date: _____
Last First MI

1. Do you have any history of treatment from mental health professionals due to emotional or behavior problems? ☐ No ☐ Yes If yes:
   a. Are you currently seeing a mental health professional? ☐ No ☐ Yes
   b. How many years total have you received mental health services? _____

2. Have you ever been hospitalized for mental health reasons? ☐ No ☐ Yes

For what purpose(s): _____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

3. Do you have any history of taking medications for mental health? ☐ No ☐ Yes

4. Check any of the following symptoms that are concerns for you.

☐ Suicidal thoughts	☐ Aggression	☐ Concentration
☐ Crying spells	☐ Depression	☐ Fatigue
☐ Fears	☐ Hallucinations	☐ High energy
☐ Hopelessness	☐ Hyperactivity	☐ Impulsive behaviors
☐ Irritability	☐ Intrusive thoughts	☐ Lack of pleasure
☐ Low motivation	☐ Nightmares	☐ Obsessive thoughts
☐ Panic attacks	☐ Restlessness	☐ Substance abuse
☐ Sleeping problems	☐ Anxiety	☐ Trembling

☐ Other_____
☐ Other_____

5. Check any areas in which mental health concerns are affecting your functioning.

☐ Emotionally	☐ Marriage/family
☐ School	☐ Sexually
☐ Work	☐ Physically
☐ Socially	☐ Other_____

Nicklaus Counseling Center, S.C.

Name: _____ Date: _____
Last First MI

1. Current Medications Prescribed and Over the Counter

Name	Amount	How Often	Reason

7. Physician/Psychiatrist Prescribing Medications

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

By signing this, I confirm that all the information on this mental health screening and medication list is true and accurate:

Signature: _____ Date: _____

Printed Name _____

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Nicklaus Counseling Center, S.C.

INFORMED CONSENT

Client (full name legibly printed)

Last **First** **MI**

I, the undersigned, hereby confirm that I have voluntarily entered into treatment, or give my consent for the minor person under my legal guardianship mentioned above, at Nicklaus Counseling Center, S.C., Marinette, Wisconsin, herby referred to as the Center. Further, I consent to have treatment provided by a social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me, I understand that the therapy may be discontinued at any time by either party. **The Center encouraged that this decision be discussed with the treating professional, to help facilitate a more appropriate plan for discharge**.

Recipient's Rights:
I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content.

Non-voluntary Discharge from Treatment:
A client may be terminated from the Center non-voluntarily if:

A. The client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic.
B. The client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, misses 2 appointments without notice, or does not make payment or payment arrangements in a timely manner.

The client will be notified of the non-voluntary discharge by letter. The client may appeal the decision with the Center Director or request to reapply for serves at a later date.

Client Notice of Confidentiality:
The confidentiality of patient records maintained by the Center is protected by federal and/or state laws and regulations. Generally, the Center may not say to a person outside the Center that a client attends the program or disclose any information identifying the client as an alcohol or drug abuser unless:

A. The client consents **in writing**
B. The disclosure is allowed by a court order or
C. The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Signature of Client/Legal Guardian _____ Date _____

Printed Name of Client/Legal Guardian _____

Client Protections:

- Violation of federal and or state law and regulations by treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities.
- Federal and or state laws and regulations do not protect any information about a crime committed against any person, or about any threat to commit such a crime by a client at the Center.
- Federal and or state regulations do not protect information about suspected child (or vulnerable adult) abuse, or neglect from being reported to appropriate state or local authorities.
- Health care professionals are required to report admitted parental exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim when a significant threat of harm has been made.
- In the event of a client's death, the spouse or parents of a deceased client have the right to access their child/spouse's records.
- Parents or legal guardian of non-emancipated minor have the right to access the client's records.

When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client but will not clinical information.

My signature below indicates that I have been offered a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Nicklaus Counseling Center, S.C.

Signature of Client/Legal Guardian _____ Date _____

Printed Name of Client/Legal Guardian _____

Payment Contract for Services

The staff at Nicklaus Counseling Center, S.C., (hereafter referred to as the Center) is committed to providing a caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all clients. The financial policy is designed to clarify the payment policies as determined by the management of the Center.

- ✓ The person responsible for payment of the account is required to sign a Payment Contract for Services which includes an explanation of the fees and collection policies for the Center.
- ✓ Your insurance policy, if any, is a contract between you and the insurance company; we at the Center are not part of this contact.
- ✓ As a service to you, the Center will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered, nor are we responsible for the collection of such payments from these companies.
    - In some cases insurance companies or other third-party payers may not cover certain services, or deem them as not reasonable, or necessary. In such cases the person responsible for payment of the account is responsible for these services fees.

We charge our clients the usual and customary rates for the area, and the client or person responsible for payment on the account is accountable regardless of any insurance company's arbitrary determination of usual and custom rates.

- ✓ After sixty (60) days the person responsible for payment will be the one accountable for all moneys not paid by insurance or third-party payers.
- ✓ At 60 days you are put on notice if no payment has been made or alternate payment arrangements are made with Nicklaus Counseling Center's Director of Finance. All sessions scheduled will be cancelled until the account is in good standing.
- ✓ Payments not received after one hundred twenty (120) days are then subject to collections.

- ✓ Insurance co-pays, are due at time of service.
- ✓ All co-insurance or deductible payments are due no later than 30 days after the statement date.
    - Although it is possible that mental health coverage deductibles amounts may have been met elsewhere (ex. If there were previous visits to another mental health provider since the beginning of the deductible year collected by another provider prior to your first session at the Center), this amount will be collected by the Center until deductible payment verification is made by the insurance company or third-party provider.

Nicklaus Counseling Center, S.C.

Clients are responsible for payments at the time of service. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. **Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at time of service.**

Missed appointments or cancellations less than 24 hours prior to the appointment are charged $25.00. We can be reached at 715-732-6868 during office hours Monday –Thursday 9am to 5pm and Friday 10am-3pm. We have an answering machine that time stamps calls that is available after office hours.

Payment methods include check, cash, or the following charge cards: VISA/MASTERCARD/ Discover/Diners Club/American Express. **CLIENTS USING CHARGE CARDS MAY EITHER USE THEIR CARD AT EACH SESSION OR SIGN A DOCUMENT ALLOWING THE CLINIC TO AUTOMATICALLY SUBMIT CHARGES TO THE CHARGE CARD AFTER EACH SESSION.**

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account:_____ Date_____

Co-Responsible party:_____ Date_____

Co-Responsible party Printed Name:_____

Co-Responsible party Address:_____

City_____ State_____ Zip_____

Co-Responsible party Telephone_____

Co-Responsible party Birth Date:_____

Co-Responsible party State ID or Driver's License #_____

Recipient's Rights Responsibilities and Notifications

As a recipient of service at our facility, we would like to inform you of your rights as a patient. The information contained in this notification explains your rights and the process of complaining if you believe your rights have been violated.

YOUR RIGHTS AS A CLIENT

- ✓ **Complaints**: We will investigate all complaints.
- ✓ **Suggestions:** You are invited to suggest changes in any aspect of the services we provide.
- ✓ **Civil Rights:** Your civil rights are protected by federal and state laws.
- ✓ **Cultural/Spiritual/Gender Issues:** You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
- ✓ **Treatment :** You have the right to take part in formulating your treatment plan.
- ✓ **Denial of Service:** You may refuse services offered to you and be informed of any potential consequences.
- ✓ **Record restrictions:** You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
- ✓ **Availability of records:** You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records, If so, we will discuss the decision with you.
- ✓ **Amendment of records:** You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
- ✓ **Medical/Legal advice:** You may discuss your treatment with your doctor or attorney, but we may not communicate with them without your written permission.
- ✓ **Disclosures**: You have the right to receive an account of disclosures of your protected health information that you have not authorized.

YOUR RIGHT TO RECEIVE INFORMATION

- ✓ **Cost of Service:** We will inform you of how much you will need to pay with monthly invoices.
- ✓ **Termination of services at our Center:** You will be informed as to what behaviors or violations could lead to termination of services at our Center
- ✓ **Confidentiality:** You will be informed of the limits of confidentiality and how your protected health information will be used.
- ✓ **Policy changes:** You will be given any changes in policy in writing

CLIENT RESPONSIBILITIES

- ✓ You are responsible for knowing your insurance policies for mental health coverage.
- ✓ You are responsible for your financial obligations to the Center as outlined in the Payment Contract for Service.
- ✓ You are responsible for upholding the policies of the Center.
- ✓ You are responsible to treat staff and fellow clients in a respectful, cordial manner in which their rights are not violated.
- ✓ You are responsible to provide accurate information about yourself.

Nicklaus Counseling Center, S.C.

OUR ETHICAL OBLICATION

- ✓ We dedicate ourselves to serving the best interest of each client.
- ✓ We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
- ✓ We maintain an objective and professional relationship with each client.
- ✓ We respect the rights and views of other mental health professionals.
- ✓ We will appropriately end services or refer clients to other programs when appropriate.
- ✓ We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
- ✓ We respect various institutional and managerial policies but will help improve such policies if the best interest of

INSURANCE POLICY

Your provider utilizes a third-party billing company to file their insurance claims. Clients are advised that they are ultimately responsible for communications with their insurance company to determine eligibility of coverage, benefits, and any co-pays, co-insurance or deductible.

TRAINING FACILITY

Nicklaus Counseling Center has made it part of our mission to provide culturally competent, holistic, and wellness focused services that promote social-emotional development, prevent development of mental health challenges, and address social-emotional problems that currently exist. We strive to be a training facility for future counselors; therefore your case may be supervised by Felicia Finley MA.LPC, CSAC, NCC. This supervision measure is to ensure proper training and or the ability to consult to ensure the highest level of client care.

COLLECTIONS PROCESS

After 120 days, when all efforts to collect outstanding client balances have been exhausted, accounts may be turned over to a collections bureau. If this occurs, the collection bureau becomes the primary way a client can clear any outstanding balance. Please be advised that bureaus have the authority to impose long-term financial ramifications on clients who do not settle outstanding balances. **If you are sent to collections you will not be able to schedule appointments at our facility even after you have paid your balance off in full.**

RESCHEDULING/CANCELATION POLICY

- ✓ Insurance companies do not reimburse your provider for any client missed or cancelled appointments, regardless of the circumstances.
- ✓ It is required that if a client has to reschedule or cancel an appointment with a provider for any reason whatsoever, they must give **AT LEAST 24 BUSINESS HOURS** notice prior to their scheduled appointment time. This will allow your provider the ability to service other clients.
- ✓ Any appointments cancellations (including no contact no show for an appointment) or rescheduling requests that occur on the same day as the scheduled appointment will have a fee imposed of $25.00, for each missed session.
- ✓ **After 2 missed appointments without calling you will be provided a community services referral list and you will be removed from the schedule as to make room for clients on a waitlist.**

To cancel or reschedule your appointment please call Nicklaus Counseling Center at 715-732-6868 and leave a confidential voicemail message with the details of your request. This voicemail is available 24 hours a day 7days a week and provides a time stamp to ensure accuracy.

I have carefully read the above Rights and Responsibility policies for Nicklaus Counseling Center. My signature below confirms that I understand all of these policies and agree to comply with all of them:

Client Signature Parent/Legal Guardian Signature:_____ Date:_____

Printed Name_____

Nicklaus Counseling Center, S.C.

Consent for the Release of Information to Coordinate Care with Primary Physician

CLIENT INFORMATION

Client Name_____
Last First MI

Address_____
Street City State Zip

DOB:_____
mm dd yyyy

PRIMARY PHYSICIAN INFORMATION

Primary Physician Name and/or Clinic

_____

Office Address

_____
Street

_____
City State zip

PROVIDER INFORMATION

Nicklaus Counseling Center, S.C.
1557 Cleveland Avenue
Marinette, WI 54143
Phone 715-732-6868 Fax 715-732-6866

The above individual has sought mental health treatment services at Nicklaus Counseling Center. The following is his/her diagnosis and treatment plan.

_____
Date of Assessment **Diagnosis**

_____
Current Symptoms

_____
Treatment Plan Includes:

☐ **Individual Therapy** ☐ **Family Therapy** ☐ **Couples Therapy** ☐ **Other**

The undersigned authorizes the provider and primary physician to release/obtain the following medical records and information concerning the client. The purpose of such release is to allow for a coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions.

☐ **I do not place any restrictions on the information provided, leaving this to the discretion of staff.**

☐ **I request that the information be limited to the following:**

☐ **Admission notes** ☐ **Psychological Testing** ☐ **Immunization Records** ☐ **Discharge Summary**

☐ **Laboratory Records** ☐ **Genetic Evaluation Services** ☐ **Other**_____

I have been informed of the type of information being released; the benefits and disadvantages (if any); and I understand that treatment services are not contingent upon my decision concerning the signing of this release. I understand that my records are protected as confidential under state and federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with state and federal law and regulations. This consent is valid for sixty 12 months from date of signature, or if patient is hospitalized, for the duration of the hospitalization, whichever is longer. However, I may revoke this consent at any time (which must be in writing) except to the extent that action has already been taken.

_____ _____ _____
Signature of Client/Legal Guardian **Client/Legal Guardian Printed Name** **Date**

_____ _____ _____
Signature of Adolescent Client **Adolescent Printed Name** **Date**

_____ _____ _____
Witness Signature **Witness Printed name** **Date**

Nicklaus Counseling Center, S.C.

Appointment Reminders from Reception

I would like you to ☐ Text or ☐ Call for appointment reminders using:

- ☐ Email Address _____
- ☐ Home Number: _____
- ☐ Work Number: _____
- ☐ Cell Number: _____

Signature: _____ Date: _____

Messages from Therapists

I would like you to call

Home _____ Work _____ Cell Number: _____

If unable to reach me:

- ☐ You may leave a detailed message.
- ☐ Please leave a message asking me to return your call.
- ☐ Other _____

The best time to reach me is _____ between (times) _____

Signature: _____ Date: _____

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Updated 05/04/2020

Nicklaus Counseling Center, S.C.

Medical Information Release Form

(HIPAA Release Form)

Client Name: _____ Date of Birth: _____

I have been given the opportunity to read Nicklaus Counseling Center's Privacy Practices Pamphlet.

☐ I took a copy of Nicklaus Counseling Center's Privacy Practices Pamphlet. Initial _____

☐ I did not take a copy of Nicklaus Counseling Center's Privacy Practices Pamphlet. Initial _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Other _____
First Name Last Name Relationship/Organization

Other _____
First Name Last Name Relationship/Organization

Other _____
First Name Last Name Relationship/Organization

Other _____
First Name Last Name Relationship/Organization

Information is not to be released to anyone.

This authorization is valid until I revoke it in writing, or 60 days after I have completed treatment, whichever is sooner.

Signed: _____ Date: _____

Witness: _____ Date: _____

The person signing this authorization is entitled to a copy.
TO PERSON RECEIVING THE CONFIDENTIAL INFORMATION
PROHIBITION OF REDISCLOSURE
Federal and state law protects the confidentiality of the information disclosed to you related to the individual's alcohol and drug abuse treatment. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations.
Disclosure is limited to the purpose and persons included on the authorization form. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State laws may also protect the confidentiality of the client's records.