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_____

Home Telephone _____ Work Telephone _____

Birthdate_____ Age_____Gender_____SID /DL #_____

Spouse/Guardian_____Phone _____

Address_____City_____State_____Zip_____

Birthdate _____ Age_____SID/DL #_____

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_____ Secondary Insurance_____
Phone_____ Phone_____
Contract/ID_____ Contract/ID_____
Group/Acct_____ Group/Acct_____
Subscriber_____ Subscriber_____
Subscriber Date of Birth_____ Subscriber Date of Birth_____
Client relationship to Subscriber Client relationship to Subscriber
Self_____Spouse_____Child_____Other_____ 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 Anxiety	☐ Substance abuse
☐ Sleeping problems		

☐ Other _____
☐ Other _____

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

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

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:_____

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.

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** _____

Nicklaus Counseling Center, S.C.

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.
    - o 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.

- ✓ At sixty (60) days the person responsible for payment will be the one accountable for all monies not paid by insurance or thrid-party payers.
- ✓ After sixty (60) days you are put on notice if no payment or alternate payment arrangementsare 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.
    - o 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.

Clients are responsible for co- 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, late or cancellations of appointments less than 24 hours prior to the appointment are charged $50.00. We can be reached at 715-732-6868 during office hours Monday –Thursday 9am to 5pm. We have confidential voicemail that time stamps all messages left during or 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_____

Nicklaus Counseling Center, S.C.

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.

I_____have read and understand my rights as a client
Printed Name of client or Name Guardian

Person responsible for account:_____Date_____

Co-Responsible party:_____Date_____

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 willbe used.

Policy changes: You will be given any changes in policy in writing

I_____have read and understand my rights to receive information.
Printed Name of client or Name Guardian

Person responsible for account:_____Date_____

Co-Responsible party:_____Date_____

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.

I_____have read and understand my client responsibilities.
Printed Name of client or Name Guardian

Person responsible for account:_____Date_____

Co-Responsible party:_____Date_____

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 ofself-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

I_____have read and understand the ethical obligation of the Center.
Printed Name of client or Name Guardian

Person responsible for account:_____Date_____

Co-Responsible party:_____Date_____

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. 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.

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, your provider may be under supervision of Christine Nicklaus MS, MS-Ed, NCC, LPC (WI & MI). 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 overto a collection 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 donot 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.**

Nicklaus Counseling Center, S.C.

No-Show, Late, and Cancelation Policy

Definitions

- **"No Show"** shall mean any client who fails to arrive for a scheduled appointment.
- **"Same-Day Cancellation"** shall mean any client who cancels an appointment less than 24 hours before their scheduled appointment.
- **"Late Arrival"** shall mean any client who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of this practice to monitor and manage appointment no-shows and late cancellations. Nicklaus Counseling Center, S.C.'s goal is to provide excellent care to each client in a timely manner. If it is necessary to cancel an appointment, clients are required to call or leave a message at least 24 hours before their appointment time. Notification allows the practice to better utilize appointments for other clients in need of our in-demand care.

Procedure

I. **Established client:**
   a. Appointment must be cancelled at least 24 hours prior to the scheduled appointment time. If this does not occur, it will result in a $50.00 missed appointment fee. This fee must be paid prior to rescheduling any appointments.
   b. In the event a client arrives late as defined by "late arrival", they will be charged a $50.00 same day-cancelation fee that must be paid prior to rescheduling any future appointment.
   c. In the event a client has incurred two (2) documented "no-shows" and/or "same-day cancellations," the client may be subject to dismissal from Nicklaus Counseling Center, S.C. The client's chart is reviewed and dismissals will be determined without exceptions, in accordance with Nicklaus Counseling Center, S. C.'s guidelines. A written notice of dismissal will be sent that includes a list of area counselors.

II. **New clients:**
   a. Appointment must be cancelled at least 24 hours prior to scheduled appointment time.
   b. In the event of a no-show, Nicklaus Counseling Center, S.C., will require a $50.00 fee to schedule another appointment.
   c. In the event a client arrives late as defined by "late arrival" it will be considered a same-day cancellation, and they will have to reschedule. If this happens, Nicklaus Counseling Center, S.C., will require a $50.00 fee to schedule another appointment.

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 belowconfirms that I understand all of these policies and agree to comply with all of them:

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

Printed Name:_____

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

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:_____

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

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 tome 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'salcohol 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 restrictany use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. State lawsmay also protect the confidentiality of the client's records.