



**CONSENT FOR TREATMENT** – (please print)

**This is a two-part document:** *Part-one* contains important information about the professional services and business policies of We Care Counseling, Inc, (here after refed to as WCCI). *Part-two*, (Client’s copy), contains information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and healthcare operations.

Client’s Name:

Date of Birth:  /  /

Guardian:

**WHAT CLIENTS CAN EXPECT FROM WCCI:**

**Informed Consent:** You have a right to make informed decisions about your care and will be provided information about the services that you receive, as well as those services that may be recommended. You have a right to refuse recommended service and to discontinue service at any time. You have a right to ask for a different service provider if you are not comfortable with your current provider.

**Confidentiality:** Your personal information will be protected by WCCI according to HIPPA. No information will be released without your written or verbal consent, (part-two defines exceptions to confidentiality).

- ID Number will be given to Client on the first visit. Please protect this number and give it only to those you want to have access to your personal information. This number will be required when yourself or others call WCCI. When this number is given WCCI staff will assume you have given your permission to use or disclose personal information. Parents are required to communicate to both parents this number so both parents have equal access to child’s information.
- Preferred Appointment Notification - As a courtesy, WCCI will send you a reminder of your appointments. This is an option, and if you choose this option you are giving WCCI permission to notify you through a text message and/or email you provide:

- Cell Phone Number:
- Cell Phone Provider:
- E-mail Address:

**Insurance Card:** Billing your insurance company is a service WCCI provides after receiving a current copy of your insurance card (front and back), driver license, social security numbers of the person who is on the insurance policy and social security number of all minor clients. However, if your deductible has not been met, full payment is due when each session is rendered. Co-pay is due after deductible is met and at the beginning of each session.

- Client’s social security number:
- Insured’s social security number:

**Legal Documentation for Minors of Divorced/Separated Parents:** (*children will not be seen without this paperwork*) Parents initiating counseling for their minor child must provide a copy of the divorce decree, custody papers, and distribution of financial responsibility. The parent initiating the counseling will be held 100% responsible for any balance due on the account.

**Complete New Client Registration Package:** Paperwork must be completed before seeing a counselor.

- Release of Information Form: Giving permission to use or disclose information to those individuals client has identified as needing consultation or updates to their treatment, (e.g. medical doctors, previous mental health providers, educators, attorneys, court).
- Health History: Please fill out completely.
- Bio- background for all Minors: Given to parents on first visit. Please complete and return to therapist on second visit.

**WHAT WCCI EXPECTS FROM THEIR CLIENTS:**

- **Inform therapist** of distress symptoms, thoughts of harm to self and/or others and all important information related to your reasons for seeking services.
- **Actively participate** in services being provided and attend scheduled appointments during business hours of M, T, W, & F from 9:00 a.m. –5:00 p.m., Th from noon—8:00p.m.



## **Part Two**

### ***Notice of Privacy Practices for Protected Health Information, Client Rights:***

*This is part two of a two part document. This notice describes how your identification number and your protected health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.*

Protected health information (PHI), is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI based on the American Counseling Association's Code of Ethics and under the HIPAA Privacy Rule. This notice describes your rights to access and control your PHI. It also describes how we follow applicable rules when using your information, disclosing or sharing this information with other healthcare professionals involved in your care and treatment, when obtaining payment for services you receive, managing our healthcare operations, and for other purposes that are permitted or required by law.

#### **ACA Guidelines for Confidentiality and Privacy**

We Care Counseling, Inc. (WCCI) recognizes that trust is a cornerstone of the counseling relationship. The counselors at WCCI aspire to earn the trust of our client's by creating an ongoing relationship, which includes establishing and upholding appropriate boundaries and maintaining confidentiality. WCCI makes it a priority to communicate the parameters of confidentiality in a culturally competent manner.

WCCI strives to maintain:

- Awareness and sensitivity regarding cultural meanings of confidentiality and privacy.
- Respect of differing views toward disclosure of information.
- Holding ongoing discussions with the Client as to how, when, and with whom information is to be shared.
- Respect of the privacy of the Client.
- Requesting PHI from the Client when it is beneficial to the counseling process.
- Disclosing PHI with appropriate consent or with sound legal or ethical justification.

#### **ACA Guidelines for Exceptions to Confidentiality and Privacy**

Throughout the counseling process, your counselor will inform you of the limitations of confidentiality and seek to identify situations where confidentiality may be broken. To the extent possible, the Client is informed before confidential information is disclosed and involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, limited essential information is revealed.

WCCI may breach confidentiality when:

- Disclosure is required to protect the Client or identified others from serious and foreseeable harm.
- Legal requirements demand that confidential information must be revealed.
- The Client discloses that they have a disease commonly known to be both communicable and life threatening, and an identifiable third party is known to be at serious and foreseeable risk of contracting the disease.
- When in response to a court or administrative order, or in response to a subpoena.

#### **Your Rights Under The Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with your counselor or office staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices for Protected Health Information** - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. The notice will be posted on our website.

**You have the right to authorize other use and disclosure** - You may authorize any use or disclosure of PHI that is not specified within this notice. For example, WCCI would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization at any time in writing except to the extent that your healthcare provider, or our practice, has taken an action in reliance on the use or disclosure indicated in the authorization. WCCI strives to make every effort to ensure that privacy and confidentiality of your PHI is maintained by:

- Subordinates, including employees, supervisees, students, clerical assistants, and volunteers.
- Interdisciplinary or treatment teams involved in the Client's care.
- Discussing confidential information in settings which ensure the Client's privacy.
- Third-party insurance payers.
- Transmitting PHI through the use of any medium.
- Legal requirements and documented preferences of deceased clients.

**You have the right to request an alternative means of confidential communication** – You may ask WCCI to contact you about private health matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by WCCI, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI within the guidelines of our ACA Code of Ethics** - You may obtain a copy of your health record, excluding counseling notes, under the counselors discretion to do no short or long-term harm. Clinical progress notes must be clinically interpreted by the counselor, thus you may request a clinical report of progress of treatment. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines. If the Client is a minor or adult who lacks the capacity to give voluntary consent to release confidential information, WCCI will seek permission from an appropriate third party to disclose information. In such instances, WCCI will inform the Clients consistent with their level of understanding and take appropriate measures to safeguard the Client's confidentiality.

**You may have the right to request an amendment to your PHI** - You may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability** - You may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

**You have the right to receive a privacy breach notice** - You may receive written notification if WCCI discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

### **How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your PHI that WCCI are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

- **Treatment** - WCCI may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment.
- **Special Notices** - WCCI may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. WCCI may contact you by phone, text, email or other means to provide information regarding your care. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.
- **Payment** - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits.
- **Healthcare Operations** - WCCI may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, legal services, auditing functions and Client safety activities.
- **Health Information Organization** - WCCI may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

- **To Others Involved in Your Healthcare** - Unless you object, WCCI may disclose to an individual or individuals that you identify, your PHI that directly relates to that persons involvement in your healthcare. If you are unable to agree or object to such a disclosure, WCCI may disclose such information as necessary if determined that it is in your best interest based on our professional judgment. WCCI may use PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.
- **Other Permitted and Required Uses and Disclosures** - WCCI is also permitted to use or disclose your PHI without your written authorization for the following purposes, including but not limited to:
  - If the Client is a minor.
    - A non-residential parent of a child is entitled to access, under the same terms and conditions as the residential parent, to any record that is related to the child and to which the residential parent of the child legally is provided access, unless the court determines that it would not be in the best interest of the child for the non-residential parent to have this access.
  - If a danger of harm to yourself and/or others is present
  - Reporting suspected abuse, neglect or domestic violence.
  - Preventing disease.
  - Workers compensation claims.
  - If WCCI receives a court order issued by a judge.
  - Law enforcement purposes or with a law enforcement official.
  - Health oversight agencies for activities authorized by law.
  - WCCI Audits and Compliance Reasons; your records may be accessible to any of the following:
    - Mental health board auditors
    - Funding source auditors and authorized agency personnel
    - For the purpose of ensuring that quality care is provided to you and that the services provided are in compliance with accrediting entities, funding sources (including insurance companies) and professional standards.
  - Special government functions such as military, national security, and presidential protective services.
  - If requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

### **Privacy Complaints and Grievances**

You have the right to air grievances regarding access, use or disclosure of PHI to WCCI's HIPAA Coordinator, who can be contacted at: (330) 305-9100, or aired directly to the Department of Health and Human Services, for which contact information can be found at: [www.hhs.gov/ocr](http://www.hhs.gov/ocr).

## **HEALTH HISTORY**

Client Name: \_\_\_\_\_

Contact information: Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number of Children in Household: \_\_\_\_\_

Religious/Spiritual Involvement: \_\_\_\_\_

Reason I came to counseling is: \_\_\_\_\_

**EMPLOYMENT INFORMATION:**

Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Years Worked: \_\_\_\_\_

Insurance: Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact information: Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Have you (the client) had any of the following symptoms in the past 60 days? Please check all that apply.

<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Speech Problems
<input type="checkbox"/>	Breathing Difficulty	<input type="checkbox"/>	Falling	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Unsteady Gait	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Confusion	<input type="checkbox"/>	Hair Change	<input type="checkbox"/>	Oral Health/Dental	<input type="checkbox"/>	Vision Changes
<input type="checkbox"/>	Consciousness Loss	<input type="checkbox"/>	Lightheadedness	<input type="checkbox"/>	Penile Discharge	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Memory Problems	<input type="checkbox"/>	Shakiness	<input type="checkbox"/>	
<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Sleep Problems	<input type="checkbox"/>	

Any Health Problems?	Now	Past	Never	Treatment Received and Date	Family History? Relation
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Blood Pressure (high or low)					
Bone/Joint Problems					
Brain Tumor					
Cancer					
Cirrhosis/Liver					
Depression					
Diabetes					

Eating Disorder					
Epilepsy/Seizures					
Eye Disease/ Blindness/Glaucoma					
Fibromyalgia/Muscle Pain					
Head Injury/TBI					
Heart Disease					
Hepatitis/Jaundice					
HIV/AIDS					
Hyperactivity (ADD or ADHD)					
Kidney Disease					
Learning Problems					
Lung Disease/Emphysema					
Schizophrenia					
Sexually Transmitted Diseases					
Stomach/Bowel Problems					
Stroke					
Thyroid					
Tuberculosis					
Other					

**CURRENT MEDICATIONS:** (Dosage/Frequency)

---



---

**PREVIOUS PSYCHOTROPIC MEDICATIONS:** (Reason Discontinued)

---



---

**ALLERGIES:** (Medical or Environmental)

---



---

**HOSPITALIZATIONS:** (Place, Date, and Reason)

---



---

**PRIMARY CARE PHYSICIAN:**

Date Last Seen/Reason for Visit: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Initial if permission given to consult with Primary Care Physician \_\_\_\_\_  Release Signed

**PSYCHIATRIST:**

Date Last Seen/Reason for Visit: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Initial if permission given to consult with Psychiatrist \_\_\_\_\_  Release Signed

**MENTAL HEALTH TREATMENT HISTORY:**

Outpatient: Yes No Inpatient: Yes No

Agency/Facility: \_\_\_\_\_ Reason: \_\_\_\_\_

Clinician: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Agency/Facility: \_\_\_\_\_ Reason: \_\_\_\_\_

Clinician: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous or Current Diagnosis if known: \_\_\_\_\_

**SUICIDAL IDEATION/ATTEMPTS:**

Past Attempts (Date and Treatment Received): \_\_\_\_\_

Current Thoughts, Plans, or Intent of Harm to Self or Others? Yes No

**DEVELOPMENTAL CONCERNS:** (Please mark those that apply)

	Premature birth	Prenatal exposure to substances	Lack of eye contact	Fussiness, incessant crying, inconsolable
	Abuse or neglect	Prolonged separation from primary caregiver	Dislike being touched	Prolonged gaze, not moving between objects
	Low birth weight	Chronic sleeping or feeding disturbances	Failure to grow	Exaggerated startle

Please explain marked if not explained elsewhere:

**ACADEMICS:**

Highest level of education completed: \_\_\_\_\_

IEP or 504? \_\_\_\_\_

Any specialized testing (Type, Date, Findings): \_\_\_\_\_

**PREGNANCY HISTORY:** (For women only)

Currently pregnant? Yes No If yes, expected delivery date: \_\_\_\_\_

Receiving prenatal health care? Yes No If yes, indicate provider: \_\_\_\_\_

History of pregnancies: # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_ # of miscarriages or terminated pregnancies \_\_\_\_\_

**SUBSTANCE USE:**

	None	Past	Current		None	Past	Current		None	Past	Current
Alcohol/ Beer/Wine				Sleep Medications				Cocaine/ Crack			
Marijuana				Tranquilizers				Heroin			
Hashish				Hallucinogens				Pain Medication			
Stimulants				Inhalants				Other:			

If presently yes, how much and how often are you (the client) using? \_\_\_\_\_

Have you had any substance abuse treatment? Yes No Please indicate if current, past, or both: \_\_\_\_\_

Family history of use of substances? \_\_\_\_\_

**HABITS:**

Sleep Routine:  No sleep schedule/pattern

Time to Bed: \_\_\_\_\_ Wake Up Time: \_\_\_\_\_ Average number of hours slept per night: \_\_\_\_\_

How many times do you wake up through the night? \_\_\_\_\_



Smoking: Yes No

Number daily: \_\_\_\_\_ How long? \_\_\_\_\_ When stopped? \_\_\_\_\_

Caffeine Use: Yes No

# Cans of soda: \_\_\_\_\_ # Cups of coffee: \_\_\_\_\_ # Energy Drinks: \_\_\_\_\_ Other: \_\_\_\_\_

**EXERCISE ROUTINE:** Yes No

What? \_\_\_\_\_ # of times this past week? \_\_\_\_\_

Eating or Diet Concerns: Yes No Explain if yes: \_\_\_\_\_

Cutting: Yes No Onset: \_\_\_\_\_ Frequency: \_\_\_\_\_ Known Triggers: \_\_\_\_\_

**SEXUAL ACTIVITY:** Never Currently Active Past Activity

Partners: Male Female Both

Number of Partners: Last 6 months \_\_\_\_\_ Last Year \_\_\_\_\_ Last Two Years \_\_\_\_\_ Lifetime \_\_\_\_\_

**FAMILY OF ORIGIN HISTORY:**

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Relationship: Good Fair Poor Mental Health Diagnosis: Yes No \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

Relationship: Good Fair Poor Mental Health Diagnosis: Yes No \_\_\_\_\_

Parent's Marital Status: Married Separated Divorced Widowed

Biological Siblings:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: Good Fair Poor

Current Household:

Spouse/Partner's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Years in Relationship: \_\_\_\_\_

Biological Children:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

Extended Family Psychiatric History: \_\_\_\_\_

**MILITARY STATUS:**  None Reported

Duty Status: \_\_\_\_\_ Branch: \_\_\_\_\_ Rank: \_\_\_\_\_ Discharge Status: \_\_\_\_\_

Deployment Details: \_\_\_\_\_

**LEGAL ISSUES:**  None Reported

Legal Status: \_\_\_\_\_ Incarcerations: \_\_\_\_\_

Current Civil Protection Order: Yes No Indicate current or past: \_\_\_\_\_

Child Protective Service Involvement: Yes No Case Worker: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

Divorce/Separation of Biological Parents: **\*Please provide all court documents including divorce decree, custody orders, and current court orders.**

Is counseling court ordered? Yes No

Case number: \_\_\_\_\_ Judge/Magistrate: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

GAL Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

Step Father:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Occupation: \_\_\_\_\_ Relationship: Good Fair Poor

Mental Health Diagnosis: Yes No \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Step Mother:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Occupation: \_\_\_\_\_ Relationship: Good Fair Poor

Mental Health Diagnosis: Yes No \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Step Children:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: Good Fair Poor

\_\_\_\_\_  
Print Name of Person Completing Questionnaire

\_\_\_\_\_  
Signature of Person Completing Questionnaire

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date Completed

\_\_\_\_\_  
Staff Signature and Credentials

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date