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.

We Care Counseling, Inc.

- **Cancellation of appointments 24 hours in advance** Appointments missed without 24-hour notice may be billed at the regular fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. (Unless therapist agrees that you were unable to attend due to circumstances beyond your control.)
- Participation of your parents/guardians/family when determined necessary by you and your therapist.
- **Notification of changes** in your income, insurance, living situations, etc.
- **Emergencies/Messages:** In the event of an emergency call 911, or one of the local crisis hotlines **330-452-6000,** or go to the nearest hospital emergency room. During office hours, you can leave a message with one of the front office receptionists. For non-emergencies ask for your therapist's confidential voice mail.

Discontinuation of Services:

We Care Counseling Inc. reserves the right to discontinue services for reasons such as:

- Treatment goals have been met to your satisfaction
- Refusing to be an active participant in the treatment process
- Cancelling or failing to show for 2 appointments without a valid reason

FINANCIAL:

Current Clinical Counseling Rates:

Diagnostic Assessment	$150.00 (45-50 min.)
Individual Outpatient Sessions	$125.00 (45-50 min.)
Phone Consultations	$ 50.00 /15 min. increments – billed to responsible party

Current Clinical Counseling Rates for Legal:

Court Appearance	$1,400.00/Half Day, $2,800.00/Full Day ($350.00/Hr.) - billed to responsible party
Legal Phone Conferences	$250.00/Hr. billed to responsible party
Legal Consultations & Meetings	$250.00/Hr. billed to responsible party
Legal Reports	$250.00/ Hr. billed to responsible party
Legal Written Correspondence	Billing in $25/15 min. increments—billed to responsible party
Phone Consultation	$ 50.00 /15 min. increments—billed to responsible party

- For your convenience, we accept cash, checks, money order, Visa and Master Card.
- Please note there will be a rush fee of $100.00 for all legal documents requested without a week's notice.
- Court appearance and legal sessions/meetings must be paid in full seven days prior to requested dates. If payment is not received, Client agrees to forfeit appearance of Licensed Clinical Counselor or Parent Coordinator.
- Court appearance, court phone consultation, and time charged for any miscellaneous and/or legal reports are not billable to insurance companies; do not count toward any deductible, nor applicable to co-pay.
- WCCI reserves the right to limit balances carried over to no more than $200. Any balance above that amount, WCCI reserves the right to temporarily delay rescheduling of services.
- Collections - In the event that WCCI is unable to collect payment for the balance due, WCCI has the opportunity of using legal means to secure the payment. This may necessitate involving a collection agency or going through small claims court, which would require WCCI to disclose certain aspects of your confidential information, such as client name, date of service and balance due. If legal action becomes necessary, all costs involved will be added to your balance due. Please note that the collection agency will report your delinquent amount to the credit bureau and thus your credit rating may be affected. In case of divorce or separation, if payment is not made on the account, collection will pursue both parents of a minor client. Regard list of the financial distribution stated in the divorce decree.

_____**Please Initial –** I have received, for my records, a copy of part two of the Consent for Treatment called Notice of Privacy Practices for Protected Health Information.

By signing below, I verify that I have read part 1 & 2 of the Consent for Treatment guidelines and agree to them as stated. I hereby authorize WCCI to treat myself and/or the named minor child for whom I claim legal responsibility as parent/guardian.

______________________________	______________________________	____/____/_______
Client Signature	Parent/Guardian Signature	Date

______________________________	____/____/_______
Staff Signature	Date

_____Please Initial **– Refusal to Consent:** I refuse to consent to treatment. I understand that my refusal to consent means that treatment, including the diagnostic assessment, will not be provided to me.

______________________________	______________________________	____/____/_______
Client Signature	Parent/Guardian Signature	Date

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.

<u>Your Rights Under The Privacy Rule</u>

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.

<u>How We May Use or Disclose Protected Health Information</u>

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.

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.

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

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