## **Patient Demographic Information**

|  |  |
| --- | --- |
| **Patient Name:** | **Social Security #:** |
| **Street Address:** | **Date of Birth:** |
| **City, State, Zip Code:** | **Home Phone:** |
| **Gender:** | **Work Phone:** |
| **Email Address:** | **Mobile Phone:** |
| **Primary Physician:** | **Psychiatrist (if any):** |
| **Emergency Contact Person:** | **Emergency Contact Phone:** |
| **How did you hear about us?** | **Marital Status:** |

**Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)**

|  |  |
| --- | --- |
| **Responsible Party:** | **Home Phone:** |
| **Street Address:** | **Work Phone:** |
| **City, State, Zip Code:** | **Mobile Phone:** |
| **Relationship to Patient:** | **Responsible Party SSN:** |

**Insurance Information**

|  |  |
| --- | --- |
| **Primary Insurance:** | **Policy Holder Name:** |
| **Company Address:** | **Policy Holder Date of Birth:** |
| **City, State, Zip Code:** | **Identification Number:** |
| **Company Phone:** | **Policy/Group Number:** |
| **Employer:** | **Policy Holder SSN:** |
| **Secondary Insurance:** | **Policy Holder Name:** |
| **Company Address:** | **Policy Holder Date of Birth:** |
| **City, State, Zip Code:** | **Identification Number:** |
| **Company Phone:** | **Policy/Group Number:** |
| **Employer:** | **Policy Holder SSN:** |

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

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

**HEALTH ASSESSMENT**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Please briefly explain client’s reason for seeking services with our clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has client seen a psychologist or counselor in the past?: YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_

If Yes, with Who?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is client currently under the care of a psychiatrist? YES \_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_

If Yes, with Who?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list currently prescribed medications and dosages:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any major health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s primary care physician or pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party (if client is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_

Relationship (if other than client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature** **Date**

**INFORMED CONSENT**

**CONFIDENTIALITY AND DENIAL OF RIGHTS**

Thank you for choosing to receive services from Albright Art Therapy and Counseling. In keeping with the State Statute section 51.61 and HSS 94, we are required to inform you of your rights when seeking art therapy and counseling services. I provide individual therapy, group therapy, and family therapy for children and adults. These services are beneficial only to the extent that the client(s) are actively participating in delivery of services.

1) The benefits from psychotherapy may include, but are not limited to, being better able to meet your needs, improve communication skills, more satisfying intimate relationships, and better understanding of your personal goals and values.

2) Psychotherapy is conducted in individual and family contexts with a therapist for purposes of determining and resolving problems or concerns.

3) Psychotherapy may include the risk of remembering unpleasant events and can arouse intense emotions such as sadness, fear, and anger. Feelings of anxiety, depression, frustration, loneliness, and helplessness may also be aroused.

4) The therapist may suggest alternative treatment modes and will make referrals when appropriate or necessary.

5) If you forgo psychotherapy, it is possible that your problems may not resolve, or become worse than they are at the present time.

6) This informed consent will be in effect until such time that you are discharged from treatment either by mutual agreement with your therapist, your own decision, or your therapist’s clinical decision that services with another provider or agency are more appropriate for your treatment needs.

7) You have the right to withdraw this informed consent at any time. Your request must be in writing.

8) Benefits of art therapy and counseling may include greater emotional regulation, reductions in anxiety or depression, increased coping strategies, and a decline in maladaptive behaviors or survival skills.

Information discussed with a clinician is confidential and will not be discussed without your release of that information. However, Wisconsin Law requires that therapists break this confidentiality under the following conditions: 1) when there is a court order to do so; 2) there is a serious threat of harm to oneself or another person; or 3) if a child or older adult (over the age of 60) is being endangered through abuse or neglect.

As your clinician, there are times in which it may be necessary to consult with other professional colleagues about your treatment. Should it be useful or necessary for me to do so, your personal information will be kept confidential so that no identifying information will be shared without your consent.

Insurers sometimes require the release of certain information before they will authorize payment. In such instances, only the minimal information required for reimbursement will be released.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party (if client is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Relationship (if other than client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health Information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health related to health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed to others outside of my office that are involved in your care and treatment for providing health care services to you, to pay your health care bills, and any other use required by law.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, I would disclose your protected health information, as necessary to another health agency or health care provider that provides care to you to ensure that they had necessary information to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. Healthcare Operations: I may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Child abuse, physical neglect and/or sexual abuse; Adult and Domestic abuse of an incapacitated or vulnerable adult.

Judicial and Administrative Proceedings: if you are involved in a court proceeding and a request is made for information about professional services I have provided.

Serious Threat to Health or Safety: if I believe there is an imminent risk of harm to yourself or others.

Worker's Compensation: it may be necessary to comply with laws relating to worker's compensation or other similar programs.

Other Permitted and Required Uses and Disclosures will be make only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that I have taken an action in reliance on the use or disclosure indicted in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask me not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction that you may request. If I believe it is in your best interest to permit use ar disclosure of your protected health information, your protected health information will not be restricted. You then have the right to choose another Healthcare Professional.

You may have the right to request an amendment of your protected health information. If I deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. I reserve the right to change the terms of this notice and will inform you in person of any change. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to Dr. Jennifer G. Albright, DAT, ATRL, LPC/AODA HIPAA Officer, if you believe your privacy rights have been violated. I will not retaliate against you for filing a complaint.

This notice is effective November 1, 2017. I am required by law to maintain the privacy of, and provide individuals with, this notice.

I have read the information contained within this consent form and HIPAA notice of privacy practices. My signature below indicates my consent to treatment as well as my understanding and agreement to the term contained within this consent form and HIPAA notice. I have been provided with a copy of the HIPAA form. I have also been provided with an opportunity to discuss any concerns that I may have.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Dated

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, name and signature of parent, guardian, or legal representative. Dated
By signing on this line, I declare that I am the parent, guardian, or legal
representative of the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Dated

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $25 if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of $35 if I fail to show for my appointment.

3. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is \_\_\_\_\_\_; my deductible amount per year is \_\_\_\_\_\_\_\_\_\_\_. Have you met your deductible for this year? □YES □ NO If no, how much more do you have to pay towards your deductible?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**FINANCIAL POLICY**

Please understand that when you come for psychological services, you and your therapist automatically contract with one another. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits. Any charges not covered by your insurance company are your responsibility. This includes deductibles, co-pays, lapses in coverage, or any private pay arrangements agreed upon between you and your therapist.

**Cost of Treatment:**

Initial Intake Interview: $150 per 45-60 minute session

 Individual Psychotherapy: $100 per 45-50 minute session

 $125 per 60-75 minute session

 Family Therapy: $100 per session, no client present

 $125 family session with client

I understand that, by signing this form, I am financially responsible for any portion of the bill which will not be covered by my insurance company.

I authorize the use of my personal identifying information and release of information for insurance submissions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name Date

**RELEASE OF INFORMATION**

Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Dr. Jennifer G. Albright, DAT, ATRL, LPC/AODA to disclose information to and/or obtain information from the following individual(s) regarding my/ my child’s care:

Name and Relationship to Client:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Phone/Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

For the following information:

\_\_Progress Notes

\_\_Discharge/Treatment Summary

\_\_Collaboration

\_\_Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the purposes of:

\_\_Continuity of care

\_\_Treatment Planning

\_\_Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Upon fulfillment of the above stated purposes, this consent will automatically expire one year following the date of signature without my express revocation unless otherwise specified here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Your signature below indicates that you understand and agree that confidential information and/or protected health information regarding the identified client may be disclosed to the identified individual above.*

Printed Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian/Legal Representative (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian/Legal Representative (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_