

Wise Change counseling LLC

Evelyn Wise 208-614-3070

Client Information

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

Date _____ Referred by _____

Name _____ Birth Date _____

Address _____ City _____ Zip _____

Sexual orientation _____ pronouns _____

Is this your mailing address as well? Yes No

Primary phone _____ Work phone _____

Email _____ Okay to correspond via email? ☐ Yes ☐ No

Occupation/ Employer _____

Relational Status: ☐ Married/cohabitating ☐ separated ☐ divorced ☐ widowed ☐ single ☐ engaged

Spouse/partner's name _____

Children's names/ages _____

Emergency contact

Name _____ Phone # _____

Address _____

Email _____

PRIVATE PAYMENT CONTRACT

I _____ (client/guardian), am entering into a financial agreement with Evelyn Wise to ensure payment for counseling services rendered thru insurance and private payment.

This amount will be due the time of service unless covered by insurance. If there are any concerns or questions, it is the responsibility of the client to share them with Evelyn Wise.

Client Signature_____

Date_____

Counselors Signature_____

Date_____

Welcome to Wise Changes Counseling LLC.

Informed Consent and Client Rights

Evelyn Wise is the sole owner and Counselor. This document contains important information regarding my services, therapeutic approach, confidentiality, your rights, and business policies. If you have any questions, please ask for further information. Counseling is a professional relationship designed to empower diverse individuals, families, and groups to accomplish mental health, wellness, education, relationship, and career goals. According to the U.S. Dept. of Human Services, the primary purpose of counseling is to empower you to deal adequately with life situations, reduce stress, experience personal growth, and make well-informed rational decisions. Wise Changes Counseling is here to help you achieve positive changes through Counseling. I am a graduate in Mental Health Counselor from Adams State University. I have gotten my MA in Mental Health Counseling and am Licensed in Idaho. I have an LPC # 9029 and I am a National Certified Counselor. I am trained in EMDR.

Counseling Process.

The counseling process will begin with the creation of personalized therapy goals. We will work together to create goals that are attainable and help you change by finding what works for you. Goals for therapy tend to center on symptom reduction, improved relationships, gained insight and processing, and learning necessary skills to manage the challenges of life. I will help you reprocess and let go of negative thoughts, and memories. Once therapeutic goals are created, the counseling process continues with ongoing sessions focusing on the exploration of feelings, thoughts, motivations, and relationship dynamics. As the counseling process progresses, gradual shifts in thoughts, feelings, and behaviors typically occur and often substantial therapeutic progress is made.

Counseling Risks and Benefits.

There are times when a session or sessions can be emotional and draining. Complete therapeutic success largely depends on the individual. If you remain committed, open, honest, and positive, outcomes are likely. Feeling comfortable with your counselor is also important. While benefits of counseling are expected, specific results cannot be guaranteed. If you feel as though progress is not being made, you should discuss this with Evelyn Wise. I will give as many referrals as needed. A client should feel comfortable with their counseling to create change. When change is achieved, these changes could impact your relationships with significant others in both positive and negative ways. At times, counseling can involve remembering unpleasant events and may bring up strong emotional feelings. The benefits of counseling may include improved ability to relate with others, a clearer understanding of self, values, goals, increased academic or work productivity, and an ability to deal with everyday stress more effectively. Taking personal responsibility for working through these issues may lead to greater growth and positive changes.

Counseling Sessions, Cancellation Policy, Counseling sessions are normally 60 minutes in length. Typical office hours for scheduling regular appointments are between 11am and 8pm, Wednesday – Friday Saturday from 12-6. Sessions are typically scheduled once a week depending on the need. Every individual has different issues, so the number of sessions vary greatly. Counseling sessions may include just the individual adult or teen or a parent and child, or a family/parent consultation session to support the individual teen client. We will create a counseling schedule to support your specific needs. Changes to scheduled appointments, including cancellations, must be done 24 hours in advance and can be done by text or calling 208-614-3070. Clients will be subjected to a \$50 charge for failure to give 24hr notice. Sudden sickness is excused at no charge. Failure to give notice for two consecutive appointment cancellations (no-shows) may result in the termination of the counseling relationship. If ongoing cancellations become problematic, a discussion of the therapeutic treatment will occur, and a decision will be made to support the client and counselor in the best possible way.

Emergency Procedures I will give notice of any planned time away and will create a plan with you to address your counseling needs during extended vacations or professional conferences during my absence. If you are in crisis or have an emergency, you may call the crisis line (208-788-3596), contact your local mental Health hotline 988, or go to your nearest emergency room. Documentation is maintained regarding the counseling services you receive. You have the right to access your counseling records with written request. There will be small fee for copying these records. If in my professional opinion, I find that releasing your counseling records may cause you substantial harm, endanger your life or physical safety, or pose a significant risk of harm to you or another individual, it will be strongly recommended to receive a treatment summary of these records. Given their inclusion of professional language, case notes are typically not released to anyone even when specifically requested.

Documentation. Records are kept for 5 years and will be destroyed after that time. Documentation in written form will be stored at the office in a HIPPA compliant manner and in accordance with relevant laws and statutes. Client information is managed and stored through an EHR system that is HIPPA compliant. **Diagnosis** If a third party, such as an insurance company, is paying for part of your bill, I am

normally required to give a diagnosis to that third party to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. This will be determined during our initial sessions and may be changed or be amended throughout the counseling process. Professional Standards: I am required by the State of Idaho to adhere to the ACA Code of Ethics. A copy of this can be provided upon request.

Therapeutic Relationship. Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals. At times, this process may feel very intimate. Our relationship is a professional one in which I am providing clinical services for an agreed upon fee. Our contact will be limited to the agreed upon schedule, except in the case of emergency. Invitations to events, offering of gifts, or interactions outside of our agreed upon treatment schedule will be talked about between you the client and myself the professional. In most cases, offers and invitations will be declined due to any possible effect it may have on my objectivity, clinical judgment, and therapeutic effectiveness provided to you the client. Progression towards your goals will best be served if our sessions and communication concentrate exclusively on your goals and clinical concerns. Sexual intimate relationships are NEVER appropriate with client or client relatives and should be reported to the Idaho Bureau of Occupational Licenses immediately. Social Media and Electronic Communication Counselors may maintain both a Personal and Professional presence in social media. Counselors will not respond to any request and/or comment placed by individuals that may disclose confidential information. Counselors maintain appropriate boundaries with clients and clients' families regarding social media and electronic presence. You may choose to engage in electronic communications with me by text and phone for scheduling and paperwork purposes. It is important for you to know that it is not a confidential means of communication. I do not use an encryption program on my phone, although I do use a secure private phone. Confidentiality In general, the law protects the confidentiality of all communications between a client and counselor, and I can only release information to others about your counseling with your written permission (in the form of a Release of Information). However, there are some exceptions where information may be shared without your written permission. The Confidentiality In general, the law protects the confidentiality of all communications between a client and counselor, and I can only release information to others about your counseling with your written permission (in the form of a Release of Information). However, there are some exceptions where information may be shared without your written permission. The limitations of confidentiality are as follows:

- Client reports a serious and foreseeable danger to self / others
- Client reports a contagious, life threatening disease
- Child or Elder being abused / neglected
- Individual unable to care for themselves is being abused / neglected
- Client is below 18 years of age; parents have rights to therapeutic information.
- Client requests release of information
- Court orders
- Subordinates who process client information and papers
- Clinical supervision/consultation
- Legal and clinical consultation situations
- Third Party Payers requests relevant clinical information.

When working with minor children, it is important to respect their confidentiality as well. When working with teens and parents, I will encourage the teen to speak with parents openly. If any type of imminent danger is disclosed to the counselor, this will be immediately disclosed to the parent and authorities. I may share information about the case while leaving out identifying information about you. EHR (electronic health records) online software as well as Square, Inc, is used for payments. A Business Associate agreement is in place with both, and they also maintain your information under HIPPA compliance.

Questions/Concerns All complaints should be addressed directly to your counselor. You have the right to make complaints regarding ethical concerns to the Bureau of Occupational Licenses. If a client files a complaint or lawsuit, the counselor may disclose relevant information regarding the client in order to defend themselves.

The Idaho Bureau of Occupational Licenses 700 West State Street, Boise, ID 83702 (208) 334-3233 or <http://ibol.idaho.gov/IBOL>.

Fees and Services

Diagnosis	70-90 minutes	\$180.
Sessions	55-60 minutes	\$120.
Cash payment same day as appointment.		

Group sessions	90 minutes	\$40.
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Insurance is billed at the maximum amount aloud per contract. Appointment are 55-60 minutes.

Client Rights and Responsibilities

Client Rights: -

- You have the right to privacy and confidentiality.
- You have the right to not be discriminated against or treated unfairly due to race, ethnicity, nationality, gender, sexual orientation, or religion, age, mental of physical disability, medical condition, medical history, claims experience, evidence of insurability, or source of payment.
- You have the right to be a participant in treatment decisions.
- You have the right to seek a second opinion.
- You have the right to file a complaint without retaliation. –
- You have the right to refuse treatment and/or any services or treatment modalities and be advised of the consequences of refusal. –
- You have the right to obtain clear information about your records. –
- You have a right to participate in the ongoing counseling plans. Client Responsibilities: -
- You are responsible for attending appointments as scheduled or giving 24-hour notice if you cannot attend. –

- You are responsible for participating in treatment and following through with homework or other tasks assigned by your counselor
- You are responsible for expressing concerns or complaints that you have to your counselor. –
- You are responsible for maintaining personal boundaries and respecting boundaries that may be set by your counselor.
- Clients have rights protected by State and/or Federal law, and Professional ethical standards. For information contact: Idaho Bureau of Occupational Licenses Physical Address: 700 West State Street, Boise, ID 83702. Mailing Address: PO Box 83720, Boise, Idaho 83720-0063

Please sign this sheet to indicate you have read the informed consent information and understand your rights as a client. By signing you are stating you were given the opportunity to ask any questions regarding the above presented information and you have agreed to receive counseling services with Evelyn Wise at Wise Changes Counseling

I _____ Client Name (Printed) Counseling

Client/Parent/Legal Guardian Signature

Date

Counselor Signature _____ - Date _____

BIOPSYCHOSOCIAL HISTORY

Name: _____ Date: _____

Date of Birth: _____

REASONS YOU ARE SEEKING COUNSELING?

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

Never Sometimes Often

- **Diminished pleasure/joy** ☐ ☐ ☐
- **Arguments/fighting** ☐ ☐ ☐

- **Difficulty getting out of bed** ☐ ☐ ☐
- **Anger management issues** ☐ ☐ ☐
- **Substance use** ☐ ☐ ☐
- **Aggressive behavior** ☐ ☐ ☐
- **Nightmares** ☐ ☐ ☐
- **Difficulty concentrating** ☐ ☐ ☐
- **Changes in eating habits** ☐ ☐ ☐
- **Impulsivity** ☐ ☐ ☐
- **Easily distracted** ☐ ☐ ☐
- **Feelings of anxiety** ☐ ☐ ☐
- **Increased sexual behaviors** ☐ ☐ ☐
- **Property damage** ☐ ☐ ☐
- **Oppositional behavior** ☐ ☐ ☐
- **Thoughts of self-harm** ☐ ☐ ☐
- **Suspiciousness** ☐ ☐ ☐
- **Physical harm to others** ☐ ☐ ☐
- **Chronic illness** ☐ ☐ ☐
- **Irritability** ☐ ☐ ☐
- **Insomnia or hypersomnia** ☐ ☐ ☐
- **Sexual dysfunction** ☐ ☐ ☐
- **Fixation or obsessive thoughts** ☐ ☐ ☐
- **Over-sexualized behavior** ☐ ☐ ☐
- **Physical pain or aches** ☐ ☐ ☐
- **Worry or fears** ☐ ☐ ☐
- **Grief** ☐ ☐ ☐
- **Panic attacks** ☐ ☐ ☐
- **Feelings of guilt** ☐ ☐ ☐

History of Trauma, Abuse, or Loss: Have you (or your child) experienced any significant trauma, abuse (including being a perpetrator of abuse), or loss? No Yes If yes, please briefly describe:

Treatment History: Additional or past outpatient counseling/therapy (Counseling, OT, Speech, Feeding, Physical, Equine etc.)? No Yes If yes, who have you seen? Prior provider name Dates Seen? Beneficial?

Family Therapy History: Has any family member had outpatient counseling/therapy? If yes, who/why (list all):

Prior Psychiatric Hospitalization(s)? No Yes If yes: _

Psychiatric Hospitalization History: Has any family member been in a psychiatric hospital? *If yes, who/why (list all):* What was the name of the facility? Psychiatric Hospital Name Month/Year Attended _

Current Mental Health Medications: If yes: No Yes Medication Dosage Frequency Physician Side effects

Medical History: Describe current physical health: ☐ Good ☐ Fair ☐ Poor

List name of primary care physician: ☐ None Name Phone List name of psychiatrist: (if any): ☐ None Date of last physical: _____ Name _____ Phone _____ List Current and Past Physical Illnesses:

List current non-mental health medications (give dosage & reason):

_____ Describe any serious hospitalization or accidents: List any known allergies: ☐ NKA ☐ Peanut Allergy Year _____ Age _____ Reason _____ Other: Year _____ Age _____ Reason _____

SUBSTANCE USE HISTORY Family alcohol/drug abuse history: Previous Substances Abuse? _____ Current Substance Use _____

HIPAA Consent Form

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you

- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.

Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for five years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to **200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures How do we typically use or share your health information? We typically use or share your health information in the following ways.

Run our organization.

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information

see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research; We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director We can share health information with a coroner, medical examiner, or funeral director when an individual die

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena. **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing.

You may change your mind at any time. Let me know in writing if you change your mind. Please sign below to indicate that you have reviewed the HIPAA Notice of Privacy Practices and understand that you may request a copy of the HIPAA Notice of Privacy Practices at any time.

Client Printed Name _____

Client (Parent/Guardian) signature _____

Date _____

Counselors signature _____ Date _____