Integrity Counseling

Intake Questionnaire – Adult

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person providing information _____ Date:_____

Please complete ENTIRE form

Clients Personal Information

Full Name (w/ M.I.)_____ Prefer to be called _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Gender: □M □F Social Security No._____

Home Phone (___)_____ Work Phone (___)_____ Cell (___)_____

Best time to contact me _____ □a.m. □p.m. on my □Home phone □Work phone □Cell phone

Marital Status: □ Single □ Married □ Widowed □ Separated □ Divorced □ Other _____

Email address _____

Employer _____ City _____ Phone _____ □Pt □Ft □Ret

Name of school (if applicable) _____ City/State _____

Referred by _____ **Emergency #**_____ **Phone #**_____

Guardian Information □ **N/A**

Guardian name _____ Phone _____
(Please provide a copy of guardianship documents)

Responsible Party (who will receive the statements?)

Name _____ DOB _____ SS # _____

Drivers License # _____

Phone (___)_____ Relationship to Client □ Self □ Spouse □ Parent □ Other _____

Address _____ City/State _____ Zip _____

Employer _____ Phone (___)_____ State _____

HIPAA

I, _____ acting on my own behalf, do hereby give permission and authority to Integrity Counseling LLC, to discuss my bill/statements with only the person or persons listed below regardless of who makes payment on this account.

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Name _____ Telephone# _____ Relationship _____

Primary Insurance Information (Who is the Policy Holder?)

Name of Insured _____ DOB _____ SS# _____

Address _____ City/State _____ Zip _____

Phone (___)_____ Relationship to Client □ Self □ Spouse □ Child □ Other _____

Employer _____ Address _____ Phone _____

Insurance Co _____ Subscriber# _____ Group# _____

Secondary Insurance Information (Who is the Policy Holder?)

Name of Insured _____ DOB _____ SS# _____

Address _____ City/State _____ Zip _____

Phone (___)_____ Relationship to Client □ Self □ Spouse □ Child □ Other _____

Employer _____ Address _____ Phone _____

Insurance Co _____ Subscriber# _____ Group# _____

Race

□ White / Caucasian
□ American Indian or Alaska Native
□ Native Hawaiian or Pacific Islander
□ Asian
□ Black / African American
□ Two or more races Unknown

Ethnicity

□ Hispanic or Latino
□ Non-Hispanic or Non-Latino

Language of Choice

□ English □ Spanish □ Hmong □ German
□ Russian □ French □ Laotian □ Other _____

Religious Affiliation

□ Catholic □ Muslim □ Protestant (including Lutheran, Methodist, etc)
□ Jewish □ Amish □ Non-Denominational
□ Mennonite □ No Affiliation □ Other _____

Do you have a disability? □ Yes □ No If yes, please specify _____

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below

_____
_____
_____

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please check all that apply)

☐ Marriage or relationship	☐ Problems with children	☐ Grieving
☐ Family problems	☐ Peer problems	☐ Abuse or trauma
☐ Depression	☐ Eating disorder	☐ Sexual functioning
☐ Mood swings	☐ Alcohol/drug use	☐ Anger
☐ Behavior	☐ Physical problems	☐ Anxiety or worry
☐ Self-confidence	☐ Work related	☐ Other (explain below)

Please explain briefly, items checked above _____
_____
_____
_____

2. How long have you had this/these problem(s)? _____

3. Have you received treatment for this problem or any other problem in the past? □ Yes □ No
If yes, when, where and with whom? _____
_____
_____

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? □ Yes □ No
If yes, please explain _____
_____

2. Do you or another family member have a history of alcohol or drug problem? □ Yes □ No
If yes, please explain _____
_____

3. Please describe your current alcohol consumption _____
_____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?
□ Yes □ No If yes, please describe the circumstances _____
_____

5. Have you or any other family member experienced any type of abuse? □ Yes □ No
If yes, please explain _____
_____

6. Please check the appropriate box if anyone in your **family** has experienced any of these problems

□ Eye disease, injury, poor vision	□ Cancer
□ Ear, disease, injury, poor hearing	□ Bowel problems
□ Nose, sinus, mouth, throat problems	□ Hemorrhoids, rectal bleeding
□ Head injury	□ Loss of consciousness
□ Convulsions or seizures	□ Frequent or severe headaches
□ Memory problems	□ Sleep disturbances
□ Extreme tiredness or weakness	□ Neck stiffness, pain, swelling
□ Thyroid disease or goiter	□ Marked weight changes
□ Skin disease	□ Circulatory problems
□ Heart disease	□ Allergies or asthma
□ Back, arm, leg or joint problems	□ Diabetes
□ Blood disease	□ Encephalitis
□ Stomach problems	□ Meningitis
□ Premenstrual Syndrome (PMS)	□ Pregnancy not carried to term / stillbirths
□ Eating disorder	□ High blood pressure
□ Liver, gallbladder disease	□ Chest pain or angina pectoris
□ Other _____	

LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole)

_____

_____

CURRENT FAMILY INFORMATION

1. Please provide the following information

Name (First and Last)	Date of Birth	Lives with You?
Spouse/Significant Other:		□ Yes □ No
Children:		□ Yes □ No
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No
Others Living in Household:		

2. Highest educational level achieved _____

3. Military service □ Yes □ No

4. Occupation _____

5. Current employer _____

PERSONAL MEDICAL HISTORY

1. Primary Care physician / pediatrician _____

   Would you like us to coordinate with your Primary Care Physician? □ Yes □ No

2. Please check the appropriate box if **you** have experienced any of these problems

□ Eye disease, injury, poor vision
□ Ear, disease, injury, poor hearing
□ Nose, sinus, mouth, throat problems
□ Head injury
□ Convulsions or seizures
□ Memory problems
□ Extreme tiredness or weakness
□ Thyroid disease or goiter
□ Skin disease
□ Heart disease
□ Back, arm, leg or joint problems
□ Blood disease
□ Stomach problems
□ Premenstrual Syndrome (PMS)
□ Eating disorder
□ Liver, gallbladder disease
□ Other _____

□ Cancer
□ Bowel problems
□ Hemorrhoids, rectal bleeding
□ Loss of consciousness
□ Frequent or severe headaches
□ Sleep disturbances
□ Neck stiffness, pain, swelling
□ Marked weight changes
□ Circulatory problems
□ Allergies or asthma
□ Diabetes
□ Encephalitis
□ Meningitis
□ Pregnancy not carried to term / stillbirths
□ High blood pressure
□ Chest pain or angina pectoris

Please explain anything checked above _____
_____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly

Medication	Dosage / Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones) _____
_____
_____
_____

GOALS

1. What are your strengths? _____
_____

2. What are your weaknesses? _____
_____

3. What goals would you like to see reached as a result of your involvement with us?_____
_____
_____
_____

4. How will you know when these goals have been reached? _____
_____
_____
_____

Anything else you would like us to know? _____
_____
_____
_____

☐ I understand t**he HIPAA authorization is in effect until I revoke it in writing.**

Client Signature _____ Date _____

Guardian Signature (if applicable)_____ Date _____

Therapist Signature _____ Date _____

Therapist Review

Signature _____ Date _____

Integrity Counseling

INFORMATION FOR CLIENTS and CONSENT FOR TREATMENT

The mission of Integrity Counseling, LLC is built on the foundation of empathetic and compassionate professionals who believe in the inherent strengths and well-being of those with whom we have the privilege to work. We view ourselves as partners with you and respect your values and experience and will work diligently to assist you as you confidently move forward in your life journey. Vision: Our vision is to help you see the value in the person you already are.

This packet contains important information about our policies and procedures. Please read it carefully. Ask your therapist to answer any questions you may have.

Eligibility:

Eligibility for Integrity Counseling programs is based on the existence of a presenting problem. You may be referred to another community resource if you (1) do not meet the eligibility criteria; (2) there is not enough staff time available to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insurance company has another counseling resource for you.

After you begin working with Integrity Counseling services may continue: (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals.

The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Appointments:

Appointments are scheduled with individual therapists. A counseling or psychotherapy hour consists of a one 45-60 minute interview with your therapist. If you need to cancel an appointment, please do so at least 24 hours in advance. **You**, not your insurance, will be billed for missed appointments.

Waiting Room Courtesy:

Be mindful of all clients while you are in the waiting room by keeping noise to a minimum. Creating noise in the waiting room can be disruptive to other clients in the waiting area and those clients that are in session.

Additionally, children under 12-years-old should **not** be unsupervised in the waiting room or other common areas within the building. Parents must stay in the building while your child is in session in case you are needed.

Hours:

The agency is open Monday through Friday 8:00a.m. to 5:00 p.m. Evening/Weekend hours are available by appointment.

Consultants:

Your therapist collaborates with other licensed therapists in his/her clinical work. Your therapist also has a Clinical Supervisor who may be contacted if you have questions or concerns. The Clinical Supervisor will meet with you when necessary or at your request. The Clinical Supervisor at Integrity Counseling, LCC is Kim Charniak MSW, LCSW. She can be reached by calling (920) 385-1420.

Confidentiality:

All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Integrity Counseling, without your written consent. The primary exception to this rule is a situation in which reporting is mandatory under Wisconsin law (e.g., child abuse, child neglect, sexual abuse, etc.). In addition, please note that your signature on this agreement gives the agency permission to release information necessary for the processing of claims for payment.

Electronic Communication

Please note that our therapists will only respond to text messages during normal business hours. Texting as form of communication is up to the therapist and you may discuss this option with them during your sessions. Texting is not a form of communication that can be used to report a crisis. Numbers for the crisis lines are listed under Emergencies.

Secure electronic messaging is always preferred to unsecure email/text communication for more sensitive PHI, but under specific circumstances, unsecure email/text communication containing protected health information (PHI) may take place between the provider(s) at Integrity Counseling, LLC and the patient.

This email/text communication may be used if both parties agree on this communication method and this form is completed and signed by the patient or the patient's personal representative/guardian (if appropriate).

A copy of this form and all email/text communication will be filed in the patient's Medical Record and a hard copy of this form will be provided to the patient, if requested. This agreement is limited to communications using the email/text addresses listed below:

Patient Email Address: _____Patient Text Messaging #: _____

Provider Awareness:
Standard email/text is not a secure means of communication, so as the provider I will use the minimum necessary amount of protected health information when responding to your questions or communicating information to you.

Provider Email Address: office@integritycounselingllc.net Main Organization Email

Other Provider Email Address: _____

Patient Awareness:
Please note that most standard email/text does not provide a secure means of communication. There is some risk that any protected health information contained in email/text may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is always an alternative that is available to you.

By completing this form, the provider and I understand and are willing to accept the risks involved with unsecure email/text communication of my protected health information.

Email/text communication is NOT appropriate forms to communicate a crisis. If patient is in crisis, patient should only contact the crisis hotline.

Emergencies:

Our normal hours are Monday through Friday 8:00 a.m. – 5:00 p.m. If there is an emergency, please call 911. If you are in crisis and need immediate attention and it is outside of our normal business hours, please contact the crisis line at:

Winnebago County Crisis: (920) 233 – 7707
Outagamie County Crisis: (920) 832 – 4646
Suicide & Crisis Lifeline - Call or text 988 or chat: **988lifeline.org**

You may call the office 24 hours, 7 days a week at (920) 385-1420 and leave a message. Your message will be passed along to your therapist within one business day. They will return your call within 24 hours, during normal business hours.

Informed Consent:

It is the policy of Integrity Counseling that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive through the agency. You will be asked to read and sign the Informed Consent Policy form prior to beginning work with your therapist.

Grievance Procedure:

Integrity Counseling shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Rights Brochure.

Program staff shall be familiar with client rights and with this agency procedures.
The program staff and their supervisor will forward the complaint to the local Client Rights Specialist.

No sanctions will be threatened or imposed against any client who files a grievance or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filling a grievance or participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.

If you have a concern about the services you are receiving, you are encouraged to discuss it with your therapist. If this does not resolve the issue, you may present a written complaint to the Clinical Director. If you are still not satisfied, please request a written copy of the Grievance Procedure.

My signature below indicates that I have been notified of my right to receive a copy of the "Client Rights" brochure and the "Integrity Counseling Joint Notice of Privacy Practices". For clients age 12-17, you have the right to receive a copy of the "Rights of Children and Adolescents in Outpatient Mental Health Treatment"

Client Access To Records:

Under Wisconsin law, you have a right to review your treatment record. Ask your therapist for the procedures used in sharing your file with you. If you feel that it contains incorrect information, ask your therapist for the procedure used to request a change in record information.

Fee Policy:

A fee is charged for professional services provided by the therapists at Integrity Counseling. If you have private insurance or medical assistance, we will bill for services at the established rate. If you do not have insurance, or if your insurance does not pay in full, you will be responsible for paying the rate established on your Fee Agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If you are receiving services under managed care, health insurance, medical assistance, or an EAP, the agency will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes Integrity Counseling to release any information necessary to process insurance claims.

Consent to Evaluate/Treat:

I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Integrity Counseling, LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment
b. Alternative treatment modes and services
c. The manner in which treatment will be administered
d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

Benefits to Evaluation/Treatment:

Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

Charges:

Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles and/or No Show fees. Fees are available to me upon request.

Confidentiality, Harm, and Inquiry:

Information from my evaluation and/or treatment is contained in a confidential record at Integrity Counseling, LLC, and I consent to disclosure for use by Integrity Counseling, LLC staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

Discharge Policy:

There are circumstances under which I may be involuntarily discharged. The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Right to Withdraw Consent:

I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

Expiration of Consent:

This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Date: _____ Patients' Name (print name): _____

Patients' Signature:_____
(14 years and older, PLEASE sign)

Guardian's Name (if applicable) (print name): _____

Guardian's Signature: _____

Integrity Counseling

Billing Authorization and Payment Policy

Please read, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please come prepared to pay your co-payment at each visit.

3. **Non-covered services**. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services, in full, at the time of visit.

4. **Proof of insurance**. All patients must complete a patient information form before seeing their counselor and provide us with an up to date copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes**. If your insurance changes, please notify us **BEFORE** your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45days, the balance will automatically be billed to you.

7. **Non-payment.** If your account is over 90 days past due or your balance exceeds $200 you will not be able to schedule another appointment until appropriate payment arrangements are made. Any account that continues to be unpaid beyond the 90 days may be subject to collections.

8. **Missed appointments**. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

9. **Statements.** Account statements will be sent monthly if a balance is due. Payments are due within 10 days of receipt. Payments may be made via check, credit/debit card or paid online. Statements are sent to the responsible party noted on the Intake Questionnaire.

☐ **I have read and understand this Billing Authorization and Payment Policy terms and agree to abide by these guidelines.**

Signature:_____ Date:_____

Print Name:_____

Credit Card Authorization / Decline

☐ I **do not** wish to authorize credit/debit card payment at this time, therefore I will be making payments at the time of service. Please mail my statement to me monthly, or anytime there is a balance due. If you select this option, **please date and sign here.**

Signature:_____ **Date**:_____

Print Name:_____

To provide credit card information for use by this office, please check the authorization option that applies, sign and date below.

By authorizing payment via credit/debit/HSA card, I acknowledge that charges will be applied to my card, to the maximum indicated below, at the time they become due.

☐ I authorize Integrity Counseling, LLC to charge my credit card an amount not to exceed $ _____ per charge. Please notify me prior to applying these charges. **Please complete the credit card information and email address below, date and sign**.

-OR -

☐ I authorize Integrity Counseling, LLC to charge my credit card an amount not to exceed $ _____ per charge. No prior notification is necessary prior to applying these charges. **Please complete the credit card information and email address below, date and sign.**

Charge notifications and/or credit/debit card receipts will be emailed to the address provided below

Email: _____

Patient Name: _____

What kind of account: ☐HSA ☐Debit ☐Credit ☐Other_____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Name on Card: _____**Expiration Date**: _____**CVV Code**: __ __ __

Billing Address for above cardholder: ☐ Same as Mailing Address

Street:_____

City:_____State:_____Zip Code:_____

☐ **This credit/debit authorization is in effect until I revoke it in writing.**

☐ **I have read and understand this credit/debit/HSA card authorization and agree to abide by its guidelines.**

Signature:_____ **Date**:_____

Print Name:_____