THE CARING TREE
CHILD & FAMILY COUNSELING

New Patient Paperwork
Ages 18+
Today's Date:_____

Patient Name:_____ **DOB:**_____

Patient Information

Patient's Legal Name:_____ Preferred Name:_____ DOB:_____
Address:_____APT:_____ City, State & Zip:_____
Phone Number:_____ Initial if ok to leave voice message:_____
Email:_____ Initial if ok to email:_____
Preferred Contact Method:_____ Best time to contact:_____
Birth Sex:_____ Gender Identity (Please Circle): Male Female Other Preferred Not to Say
Race (Please circle): American Indian Alaska Native Asian African American/Black
Hispanic Latino Native Hawiian/Pacific Islander White Preferred Not to Say
Languages:_____ Do you need an interpreter (Please circle)? Yes or No
How did you hear about The Caring Tree?_____

Responsible Party Information: *Please bring a valid I.D. to initial appointment for the responsible party.*
Name:_____Relationship to patient:_____ Emergency Contact? Yes or No
DOB:_____ Address:_____ APT:_____ City, State & Zip_____
Main Phone:_____ Other Phone:_____ Initial if ok to leave voicemail:_____
Email:_____ Initial if ok to email:_____
Preferred Contact Method:_____ Best time to contact:_____
Employer:_____

Insurance Information

Primary Insurance:_____ Member I.D. #:_____ Policy Group:_____
Employer:_____Plan Name:_____ Insured Party:_____
Client SSN:_____

Secondary Insurance:_____ Member I.D. #:_____ Policy Group:_____
Employer:_____ Plan Name:_____ Insured Party:_____
Client SSN:_____

Emergency Contact Information

Name:_____ Relationship to patient:_____ DOB:_____
Address:_____ APT:_____ City, State & Zip:_____
Phone Number:_____ Email:_____

Name:_____ Relationship to patient:_____ DOB:_____
Address:_____ APT:_____ City, State & Zip:_____
Phone Number:_____ Email:_____

**Please note an ROI must be on file to communicate information regarding services received with another individual.*

Patient Name:_____ **DOB:**_____

Payment Policy, Financial Acknowledgment, and Insurance Assignment

The Client is responsible for costs of services provided. This may include the client, the client's spouse, or the client's parent or legal guardian.

The Caring Tree or Balance for Growth policy is to pursue the collection of all monies due to facility from third-party sources, the client, or any other responsible party. Accounts greater than 90 days from the date of service are considered delinquent at which time it is the counselors discretion whether or not the counselor will continue to see the patient. Failure to make monthly payments or failure to make payment arrangements will cause collection efforts, which includes calls, emails, postal mail, etc. If collection efforts are unsuccessful the account will be sent to collections at 180 days after the date of service. If collection efforts are unsuccessful the account will be turned over to a collection agency thereafter all services provided may be on a cash only basis.

The Caring Tree will make every attempt to collect from your insurance company. Please check your insurance policy or discuss your coverage with your employer or insurance agent. The Caring Tree accepts Mastercard and Visa for payment services.

Forward Health covers most outpatient services. Clients are required to pay their copayment at the time of their service. If you have any questions please call The Caring Tree at 715-301-0667 or email info@caringtree.us. You have the right to request a copy of this paperwork.

Please complete the following……

I request and authorize The Caring Tree-Children's Counseling Center to release to:

Primary Insurance_____ **Secondary Insurance**_____

Information from my records necessary to pre-certify/authorize services and process my claim for insurance benefits, Medicaid payment, for services provided by The Caring Tree. This includes mental health, alcohol/drug, developmental or other medical diagnoses, discharge summaries and clinical notes to include physician's orders, treatment plans (where required), and test results. The purpose of this authorization is to enable the recipient to pre-certify/authorize and process my claim. I understand I have the right to inspect and receive a copy of this form and the material to be disclosed as required under SS. DHS 92. 05 and 92. 06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this consent at any time except to the extent that action has been taken in reliance on it (45 CFR 164. 508 (c) (2) (I). This consent unless expressly revoked earlier is valid for one year from signature date.

I authorize and request payment directly to The Caring Tree-Children's Counseling Center of all benefits otherwise payable to me for services provided by The Caring Tree, not exceeding its regular charges. I understand that, as a patient, I'm financially responsible for all charges regardless of whether paid by the insurer. This assignment cannot be revoked without written consent of The Caring Tree.

Also, if needed, to initiate or facilitate enrollment/recertification in the medical assistance program, I authorize The Caring Tree to contact and share information with the County Department of Social Services.

I understand the Caring Tree will attempt to collect payment from this patient's insurance as a courtesy.
I,_____ (printed name)**, DOB** _____**, understand that I am financially responsible for services provided today.**

Signature:_____ **Date:**_____

Patient Name:_____ DOB:_____

Animal Waiver

I, _____ (printed name), agree to release, discharge, indemnify, and hold harmless The Caring Tree, its contractors, and employees for any and all claims, demands, losses, costs, liabilities, settlement agreements, damages, expenses and suits at law or in equity to my personal property or the property of my child that arise out of my child handling animals used by The Caring Tree. I recognize handling animals poses a risk of injury, including but not limited to, personal physical harm. I hereby release, discharge, indemnify and hold harmless The Caring Tree, it's contractors and employees for any and all claims, demands, losses, costs, liabilities, settlement agreements, damages, and expenses connected with my participation whether caused directly or indirectly by any negligence (active or passive) attributable to The Caring Tree, its employees and contractors.
I acknowledge that I have read and fully understand the terms and conditions of the foregoing. **If a patient, employee or contractor is injured, an Accident/Injury Report must be completed as soon as possible following the injury.*

Patient's full name (printed):_____ DOB:_____

Signature:_____ Date:_____

_____ Initial here if you prefer **Not** to have animals in your child's session. *Please note that as a patient of The Caring Tree, you may still have brief contact with our animals and animal dander.*

Consent for Outpatient Services

I understand that during enrollment for outpatient services and/or following an assessment/treatment, complete and accurate information has been/will be provided regarding each of the following areas:

- Results of the assessment
- Treatment Alternatives
- Possible outcomes and side effects of treatment recommended in the treatment plan.
- Treatment recommendations and benefits of the treatment recommendations.
- Approximate duration and desired outcome of treatment recommended in the treatment plan.
- The rights of receiving outpatient services, including the consumer's rights and responsibilities in the development and implementation of an individual treatment plan.
- The fees that the consumer or responsible party will be expected to pay for the proposed services.
- How to use The Caring Tree's Grievance Procedure.
- The means by which clients may obtain emergency mental health services during periods outside the normal operating hours of the clinic.
- Outpatient services discharge policy including circumstances under which a patient may be involuntarily discharged for inability to pay or for behavior reasonably the result of mental health symptoms.
- This consent is effective for 15 months from the time the consent is given.

I have read and understand the above information, I have had an opportunity to ask questions about this information, I understand that I can have a copy of this consent form, and I consent to an assessment and/or treatment. I understand that I have the right to ask questions of my outpatient service provider about the above information at any time.

Client Name (printed):_____

Client Signature:_____ Date:_____

Practicum and Internship Acknowledgement

The Caring Tree Child & Family Counseling Center is committed to providing quality counseling services. Part of this commitment is to enhance the quality of the field by allowing master's level providers and counseling students (interns) to practice and implement counseling services while under supervision. Interns providing services at the Caring Tree……..

- Are expected to follow the ethical guidelines for the Counseling profession and are required to follow the policies and procedures implemented by The Caring Tree Child & Family Counseling Center and their
- Follow and implement HIPPA standards.
- Counseling students are in their final stages of their masters education and are preparing to enter the counseling field. Counseling students have been approved by their education institution to practice their clinical skills by completing the necessary coursework and demonstrating competency in providing counseling services to clients while under direct supervision of a licensed professional.
- The intern will continue to receive guidance, evaluation and education while practicing their clinical skills. At times the intern will be accompanied in sessions by post graduate licensed professionals who can help assist in growth of clinical skills.
- Supervision of interns is conducted by a fully licensed professional counselor. At the Caring Tree this service is provided by the Clinical Director, Trena Loomans.
- In order to continue to enhance their skills. Interns may be required to record occasional sessions for supervision purposes only. These recordings are kept in accordance with HIPPA standards by being stored on password protected devices and are destroyed at the termination of therapy.
- Clients and their guardians can refuse or revoke consent at any time with the understanding that services will need to be transferred to another provider within The Caring Tree, and may cause a pause or disruption to treatment services.

If you have any questions regarding engaging in services that may be provided by an intern please contact The Caring Tree at 715-301-0667 or email at info@caringtree.us and someone will be able to provide you further information.

I, _____(printed name), **acknowledge that I am voluntarily engaging in services with a counseling student (intern) at The Caring Tree Child & Family Counseling Center. I have read the above information and understand the purposes of treatment and factors surrounding services provided.**

Printed Name:_____

Signature:_____ Date:_____

Receipt of Privacy Notice Acknowledgment

Your signature on this form acknowledges that you have been given the option of receiving a copy of The Caring Tree's Privacy Notice, which explains how your health information will be handled in different situations.

Printed Name:_____ DOB:_____

Signature:_____ Date:_____

Patient Name:_____ **DOB:**_____

Patient Bill of Rights & Responsibilities

You have the right to all of the following:

Personal Rights **Initial:**_____

- Be cared for in a safe and clean environment by competent healthcare professionals.
- Be free from chemical and physical restraints and involuntary seclusion unless medically necessary.
- Be free from abuse, neglect, and harassment. This includes physical, mental, emotional and financial abuse.
- Have staff make fair and reasonable decisions about your treatment and care.
- Participate in religious services and social, recreational, and community activities to the extent possible.
- Be paid, with some exceptions, for any work you do.
- Make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18 and have not been found legally incompetent.
- Be given the change to exercise, and go outside for fresh air regularly and frequently, except for health and safety concerns.
- Receive treatment in a safe, psychologically, and physically humane environment.
- Be treated with dignity. We will respect your cultural and personal values, beliefs, and preferences.
- Not have your care affected by your race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, illness, handicap or ability to pay.
- Contact with a family member or representative and your personal physician to notify them of your admission, or have a staff member do so on your behalf. You may refuse to have others contacted.

Treatment Rights **Initial:**_____

- Staff involved in your care will introduce themselves to you and explain what they are going to do.
- You must be provided prompt adequate treatment, rehabilitation and educational services appropriate to you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives and possible side effects and/or risks of treatment or medications.
- You have the right to refuse treatment or medication unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders that. If you have a guardian however, your guardian may consent to treatment and medications on your behalf.
- You may not be given unnecessary or excessive medication.
- You have the right to leave against physician's orders unless under legal hold.
- You may not be subject to electroconvulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed, in writing, of any cause of your care or treatment for which you or your relative may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.
- You have the right to formulate Advanced Directives.

Communication and Privacy Rights **Initial:**_____

- You may call or write to public officials or your attorney
- You may not be filmed or taped or photographed unless you agree to it.
- You may use the telephone when you wish.
- You must be provided privacy when you are in the bathroom and receiving care for personal needs.
- You may use and wear your own personal articles and clothing.
- Your treatment information is kept confidential unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records.

Patient Responsibilities **Initial:**_____

The care you receive depends partially on you. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities are presented in the spirit of mutual trust and respect.

The patient and family are responsible:

- To provide accurate and complete information concerning his or her present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For reporting perceived risks in his or her care and unexpected changes in his or her condition to the responsible practitioner.
- For following the treatment plan established by his or her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- For keeping appointments and for notifying the center when he or she is unable to do so.
- For his or her actions should he or she refuse treatment or not follow his or her therapist's orders.
- For ensuring that the financial obligations of his or her care are fulfilled as promptly as possible.
- For following the organization's policies and procedures.
- For being considerate of the rates of other patients/clients and staff.
- For being respectful of his or her personal property and that of other persons.
- For asking questions about the patient's condition, treatments, procedures, lab and other diagnostic test results.
- For asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- For immediately reporting any concerns or errors they may observe.

You have the right to address any concerns, complaints, file a grievance or learn more about the grievance procedure used by The Caring Tree. Please contact the Clinical Supervisor/Compliance Officer, Trena Loomans, 715-301-0667. You may also choose to communicate concerns directly to the state of Wisconsin Department of Health Services, Division of Quality Assurance, PO Box 2969 Madison, WI 53701-2969, or call 608-265-8481.

Patient Name:_____ **DOB:**_____

Health Questionnaire

Please Identify Concerns Below. Circle all that apply.

Emotional Distress		Functional Problems		Safety Concerns	
Depression	Anger	Poor Hygiene	Irresponsible	Alcohol	Drug Use
Moodiness	Sadness	Employment	Concentration	Lying	Theft
Anxiety	Panic Attacks	Mobility	Physical Pain	Physical Aggression	Verbal Aggression
Worries	Ruminates	Recent Injury	High Energy	Impulsive	Breaking the Law
Tearful	Cries Easily	Low Energy	College grades	Suicidal thoughts	Homicidal thoughts
Withdrawn	Irritable/on edge	Poor Organization	Hearing Concerns	Self-Injurious Behaviors	
Rage	Perfectionist	Trouble Listening	Speech Concerns	Past Attempts to harm self or others	
Unmotivated	Fearful	Communication	Social Relationships	Problems recognizing danger	
Phobias	Recent death/loss	Memory Concerns	Sleep Concerns		
Nightmares	Recent Divorce	Lack of Coordination	Sensory Problems	**Other/Not listed Concerns**	
Recent move	New Job	Fine Motor Concerns	Eating/Food	_____	
Psychotic-like symptoms		Adjusting to changes	Time Management	_____	
Guilt		Money Management	Learning Problems	_____	
		Cognitive Problems	Problems Socializing	_____	
		Difficulties with sexual matters			
		Avoidance	Increased stress		

Developmental History

Mother's age at time of your birth:_____ **Fathers age at time of your birth:**_____

Length of pregnancy: Full Term or Premature birth at how many weeks:_____

Were there any known complications with your mother's pregnancy with you or during delivery? Yes or No

(If yes please briefly describe)_____

_____

_____

Any known developmental milestones or delays you experienced as a child:_____

_____

_____

_____

Medical History

Name of Primary Physician & Clinic:_____

Date of last physical exam:_____

Medical Diagnoses:_____

Have you ever been medically hospitalized? Yes or No (If yes please provide date, procedure and any complications)

_____

_____

Have you experienced any of the following medical conditions? (Check all that apply)

- ☐ High or unexplained fever
- ☐ Head Injury
- ☐ Concussion
- ☐ Loss of consciousness
- ☐ Tics of abnormal body movements
- ☐ Thyroid or endocrine issues
- ☐ Strep throat
- ☐ Chronic ear or sinus infections. Were Tubes required? Yes or No
- ☐ Seizure Type: Partial Partial Complex Generalized
- ☐ Diabetes or Blood sugar issues
- ☐ Meningitis or Encephalitis
- ☐ Bronchitis or pneumonia
- ☐ Upper respiratory issues/asthma
- ☐ Allergies
- ☐ Other congenital conditions:_____
- ☐ Lead or other toxin exposure

Was hospitalization required for any of the above concerns? Yes or No
Please list date of hospitalization, and any treatment or procedures required to address concern:_____
_____
_____

Current Medications	Dose (mg, mL or IU).	Frequency Prescribed	Frequency taken currently	Date Started	Prescribed for….. (Reason)

Have you had past medications that produced ineffective or negative reactions? Yes or No
(If Yes, please list the name of medication, dose, frequency prescribed, date started and discontinued and what it was prescribed for).
_____
_____
_____

Current Medical Conditions/Illnesses:
Auditory Conditions: No Concerns Conductive Impairment Sensory-Neural Impairment Hearing Devices used
Vision Conditions: No Concerns Nearsighted Farsighted Uses Glasses Uses Contacts Legally Blind
Other:_____
Speech Conditions: No Concerns Speaks Words but no sentences Words difficult to understand Stutters

(If any of the above are circled) **Are you receiving services to treat circled above conditions outside of the primary provider?** Yes or No (If yes, please list clinic and name of treating providers):
_____
_____

Sleep Duration (in hours) **per night:**_____
Sleep Concerns: Check all that apply

- ☐ No concerns
- ☐ Requires naps
- ☐ Midnight awakenings
- ☐ Early awakenings
- ☐ Difficulty falling asleep
- ☐ Nightmares; Frequency:_____
- ☐ Other:_____

Eating Concerns: Check all that apply

- ☐ No concerns
- ☐ Obsessed with food; age of onset:_____
- ☐ Increased appetite; since when:_____
- ☐ Decreased appetite; since when:_____
- ☐ Drooling
- ☐ Food falls from mouth
- ☐ Gags
- ☐ Eats limited types of food
- ☐ Has taste or texture sensitivity
- ☐ Weight gain; amount and time frame:_____
- ☐ Weight loss; amount and time frame:_____

Psychiatric History

Psychiatric hospitalizations: Yes or No

1. When & Where:_____
2. When & Where:_____

Has been diagnosed previously with any type of developmental conditions?

☐ **ADHD/ADD**
Date of Diagnosis:_____ Type:_____ By Whom:_____

☐ **Autism Spectrum Disorder (circle one):** Autism PDD NOS
Date of Diagnosis:_____ Type:_____ By Whom:_____

☐ **Learning Disability**
Date of Diagnosis:_____ Type:_____ By Whom:_____

☐ **Cognitive Impairment (circle one):** Mild Moderate Severe
Date of Diagnosis:_____ Type:_____ By Whom:_____

☐ **Speech Impairments (circle one):** Receptive Expressive Mixed
Date of Diagnosis:_____ Type:_____ By Whom:_____

☐ **Other Mental Health Diagnoses:**
Date of Diagnosis:_____ Type:_____ By Whom:_____

Allied Health Professionals

Past mental health professional(s) (Psychologist, Psychiatrist, Neurologist, or other). Please include name, time frame and dates of treatment:_____

_____

Had previous psychological or neurological testing? Yes or No
(If yes, by whom and when):_____

Current mental health professional(s) (Psychologist, Psychiatrist, Neurologist, or other). Please include name, time frame and dates of treatment:_____

_____

Currently have a case manager? Yes or No (if yes please list name and through whom. I.e. social services or NCHCC):

_____

Patient Name:_____ **DOB:**_____

Substance Use

Please indicate any substance used currently or in the past and effect (please mark an X for any that apply & circle any effects).

Substance	**Past**	**Current Use**	**Any Effects** (Please circle if any apply)		
Alcohol					
Marijuana					
Cocaine			Black outs	Cravings	Nausea
Heroin			Dizziness	Trembling	Sweats
Ecstasy			Pass Out	Paranoia	Lethargy
Huffing (gas, aerosol, etc)			Slurred Speech	Rage	Depressed Mood
Other:_____			Hyper	Extreme Thirst	Unstable gait

Has your substance use caused any problems in your functioning at home, work or relationships? Yes or No
(If you answered yes then please complete the following questions).

Preferred Drug of Choice?_____

Problems related to use (Please circle areas that apply): Recreational Work Financial Legal Other:_____

Age of first use:_____

Have you ever attended a substance use treatment program? Yes or No (If yes please list dates and location):_____

_____

Periods of sobriety: 30 Days 2-3 Months 6 Months 1 year+

Family Dynamics

Current Living situation (please circle all that apply):

Single Never Married Legally Married Committed Relationship Divorced
Separated Widowed Renting Apartment Staying with Family or Friends Owns home

Family and Important Relationships (Please list all important relationships, if someone has passed please put year passed by name).

Relationship	**Name**	**Living in Home Y/N**	**Age**	**Quality of Relationship (Good, Fair, Poor)**

Patient Name:_____ **DOB:**_____

Family History

Please check any following if there is a family history. (Please include relationship(s) to the patient).

- ☐ Attention:_____
- ☐ Learning Difficulties:_____
- ☐ School Problems:_____
- ☐ Behavior Problems:_____
- ☐ Depression:_____
- ☐ Anxiety:_____
- ☐ PTSD:_____
- ☐ Drug/Alcohol Abuse:_____
- ☐ Legal Issues:_____
- ☐ Hallucinations/Delusions:_____
- ☐ Bipolar/Depression:_____
- ☐ Eating:_____
- ☐ Epilepsy:_____
- ☐ Mental Retardation:_____
- ☐ Dementia/Alzheimers:_____
- ☐ Traumatic Brain Injury:_____
- ☐ Autism:_____
- ☐ Heart & Lung Problems:_____
- ☐ Speech/Language Problems:_____
- ☐ Genetic Disorders:_____

Significant Trauma

Please check any trauma experienced

- ☐ Injured or in an accident
- ☐ Physical Abuse (victim or perpetrator)
- ☐ Sexual Abuse (victim or perpetrator)
- Emotional Abuse (victim or perpetrator)
- Neglect
- Removed from home

Please describe nature of trauma and age at time of incident:_____

_____

_____

Legal

Please detail any contacts you have/had with the courts, police, etc:

_____

_____

_____

Academic

Highest education completed:_____ **Age:**_____

Academic Performance (Please circle & complete all that apply)

Received A's & B's Received B's & C's Received C's & D's Graduated High School Obtained Diploma

Obtained GED Received Special Education Certificate Home Schooled

Dropped out of high school, age:_____ & grade:____ Currently attending college classes Completed some college

Graduated College

As a child was school ever stopped or paused due to (please circle) Not applicable, Held back, Suspended, or Expelled

(if circled anything other than 'not applicable' please provide a brief explanation)_____

_____

_____

If currently attending or completed college please complete the following……..

College name:_____

Focus of study:_____

Degree Obtained (if still attending please put NA):_____

Did you ever utilize Special education support services? Yes or No (if yes please provide a brief description of the services received). _____

_____

Patient Name:_____ **DOB:**_____

Employment

Have you ever been employed? Yes or No

Current Job Status (please circle all that apply):

Currently Employed Full-Time Part-Time Casual Temporary Seasonal

Self-Employed Laid Off Retired Disabled Other

Have you ever had employment terminated? Yes or No (if yes please provide details):_____

_____

Jobs held (Please briefly current and previous jobs including employer, title, reason for leaving)

_____

_____

_____

Have you served in the Military? Yes or No (*If yes complete the following questions)

Branch served:_____ **Dates:**_____

Discharge:_____ **Date of discharge:**_____

Personal Information

Please briefly list some of your strengths and positive characteristics:_____

_____

_____

Please list any hobbies or interests:_____

_____

_____

Please list what you like to do for self-care:_____

_____

_____

Any additional information you would like the provider to know:_____

_____

_____

_____

_____

Patient Printed Name:_____

Patient Signature:_____ **Date:**_____

Therapist Review Signature:_____ **Date:**_____

Thank you!

Please return completed packet to the clinic