

UPLANDS COUNSELING ASSOCIATES  
INFORMATION FORM

CLIENT INFORMATION

Today's Date: \_\_\_\_\_ DX: \_\_\_\_\_

New Client  Returning Client (Use "Returning" if it has been more than 3 months since your last visit)

Name: (L, F, MI) \_\_\_\_\_

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

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Phone Numbers: *Okay to call you here* *Okay to leave a message*  
Home: \_\_\_\_\_  Yes  No  Emergency Only  Yes  No  Emergency Only  
Work: \_\_\_\_\_  Yes  No  Emergency Only  Yes  No  Emergency Only  
Cell: \_\_\_\_\_  Yes  No  Emergency Only  Yes  No  Emergency Only

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Female  Male SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Legally Separated  Widowed

Student:  Yes  No School: \_\_\_\_\_ Grade: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Clinic (if applicable): \_\_\_\_\_

Who Referred You To Us?  Doctor: \_\_\_\_\_  Friend  Other

Is condition for which you are seeking treatment related to:  Employment  Auto Accident  Other Accident

**RESPONSIBLE PARTY** (Complete if primary client is under eighteen and you must also sign the financial agreement)

Name: (L, F, MI.) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: (if different than client) \_\_\_\_\_

Phone Number: *Okay to call you here* *Okay to leave a message*  
Home: \_\_\_\_\_  Yes  No  Emergency Only  Yes  No  Emergency Only  
Work: \_\_\_\_\_  Yes  No  Emergency Only  Yes  No  Emergency Only  
Cell: \_\_\_\_\_  Yes  No  Emergency Only  Yes  No  Emergency Only

Sex:  Female  Male Relationship to Client: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**\*\*PRIMARY INSURANCE COMPANY:** \_\_\_\_\_

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

Subscriber or ID #: \_\_\_\_\_ - \_\_\_\_\_ Group/File #: \_\_\_\_\_

Full Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Home address if different than client: \_\_\_\_\_

Deductible: \_\_\_\_\_ Co-Payment: \_\_\_\_\_ Mental Health Coverage Limits: \_\_\_\_\_

Is referral/pre-authorization required:  Yes  No Has pre-authorization been obtained:  Yes  No

Terms of the referral: \_\_\_\_\_

**\*\*SECONDARY INSURANCE COMPANY:** \_\_\_\_\_

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

Subscriber or ID #: \_\_\_\_\_ - \_\_\_\_\_ Group/File #: \_\_\_\_\_

Full Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Home address if different than client: \_\_\_\_\_

Deductible: \_\_\_\_\_ Co-Payment: \_\_\_\_\_ Mental Health Coverage Limits: \_\_\_\_\_

Is referral/pre-authorization required:  Yes  No Has pre-authorization been obtained:  Yes  No

Terms of the referral: \_\_\_\_\_

**– INFORMATION FORM CONTINUED –**

<b>Other Persons in Household:</b> Name	Sex (M/F)	Birth date (mo/day/yr)	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**SUMMARY OF THE CONTENTS OF THE WISCONSIN NOTICE FORM**

- Your protected health information (PHI) may be used or disclosed with your consent for purposes of Payment, and Health Care Operations. Your signature on our patient registration indicates your consent for the release of information, for the above underlined purposes ONLY.
- The use or disclosure for purpose of Treatment or for purposes outside those underlined above, is permitted ONLY with your written authorization on a separate form designated for this purpose.
- Uplands Counseling Associates may disclose information without your consent or authorization under circumstances of Child Abuse, Adult and Domestic Abuse, Health Oversight, Judicial or Administrative Proceedings, Serious Threat to Health or Safety, or Worker’s Compensation.
- Your rights and my duties are summarized in this document.
- You have received and reviewed the following policy: Wisconsin Notice Form

**SUMMARY OF THE CONTENTS OF THE BILL OF RIGHTS**

**I acknowledge that:**

- I have been informed of my rights as a client of Uplands Counseling as outlined in the Client Bill of Rights.
- I have received and reviewed the Uplands Counseling Client Bill of Rights and Client Information Form.
- I consent to treatment as outlined by my therapist and in accordance with the Client Bill of Rights.
- I have been informed of the cost of treatment.
- Unless otherwise Specified, I give permission to contact my primary care physician, as well as to communicate with my insurance company and/or managed care provider for the purpose of billing and/or treatment.
- I understand that I am responsible for obtaining current referral on HMO policies. I understand that I am responsible for co-pay portions of benefits, for cost incurred during any period in which you do not have a current referral, and for services which are not covered by insurance, such as school consultation, telephone therapy, correspondence, report writing, marital counseling, psychological testing, and case management.  
*Ultimately – I am responsible for my entire bill.*
- My signature gives the insurance company permission to make payment directly to my account at Uplands Counseling Associates. Any payment received will be applied directly to my account. Uplands Counseling Associates reserves the right to seek legal means to secure reimbursement. This may include releasing names and information to collection agencies, attorneys or the Court.
- I have read and understand the missed appointment and bad check fees/policies of Uplands Counseling.

CLIENT NAME : \_\_\_\_\_  
(PLEASE PRINT)

Signed: \_\_\_\_\_  
Client Signature

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

\_\_\_\_\_  
Responsible Party Signature

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

\_\_\_\_\_  
Witness – Therapist Signature

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

<p><b>CONSENT TO TREAT A MINOR AUTHORIZATION</b> I give _____ permission (Therapist)</p> <p>to give psychiatric treatment to _____ DOB: _____ (Client)</p> <p>Because client is <input type="checkbox"/> Minor <input type="checkbox"/> Incompetent <b>Legal Authority</b> <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Legal Guardian</p> <p>Signature: _____ Date: _____</p>
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## WISCONSIN NOTICE FORM

### Notice of Mental Health Providers' Policies and Practices to Protect the Privacy of Your Health Information

#### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another Mental Health Provider.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “*Use*” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

#### II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

#### III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to suspect that a child seen in the course of my professional duties has been abused or neglected, or have reason to believe that a child seen in the course of my professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, I must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If I believe that an elder person has been abused, or neglected, I may report such information to the relevant county department or state official of the long-term care ombudsman.
- **Health Oversight:** If the Wisconsin Department of Regulation and Licensing requests that I release records to them in order for the Psychology Examining Board to investigate a complaint, I must comply with such a request.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release the information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance, if this is the case.
- **Serious Threat to Health or Safety:** If I have reason to believe, exercising my professional care and skill, that you may cause harm to yourself or another, I must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings.

- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release records relevant to that claim to your employer or its insurer and may be required to testify.

#### **IV. Patient's Rights and Mental Health Provider's Duties**

##### **Patient's Rights:**

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### **Discharge Policy:**

Clients may be discharged if there is no contact for at least three (3) months and/or client and clinician agree to terminate. Involuntary discharge from service may occur due to unsafe client behavior in the clinic, repeated missed appointments, lack of cooperation in working out a payment plan, or lack of cooperation with recommended treatment that is significantly interfering with safety or treatment.

You have the right to have an involuntary discharge review prior to the effective date of the discharge by contacting the Behavioral Health Certification Section, Division of Quality Assurance, whose address is PO Box 2969, Madison, WI 53701-2969, and fax number (608) 261-0655.

##### **Mental Health Provider's Duties:**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you either by mail or in person

#### **V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Vaughn Brandt at 608-234-8734.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

#### **VI. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on May 16<sup>th</sup>, 2003

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by either mail, by posting in the waiting room, or in person.

#### **VI. Emergency Services**

Current Uplands Counseling clients can obtain emergency mental health services after hours by calling (608) 283-5858. If there is a life-threatening emergency call 911.

# UPLANDS COUNSELING ASSOC. - CLIENT BILL OF RIGHTS

Our services are available to clients without regard to race, color, religion, sex, age, national origin, disability, or sexual orientation. When you receive service for mental health, you have the following rights under Wisconsin Statute Section 51.61(1) and HSS 94 Wisconsin Administrative Code.

## **RIGHTS REGARDING ENTRY INTO TREATMENT**

You have the right to:

- Information prior to treatment about services available, their cost, and any limitation on their availability.
- Full Information – oral and written – about your rights.

## **RIGHTS WHILE IN TREATMENT**

You have the right to be treated with dignity and respect in a humane environment. You have the right to:

- Receive prompt and appropriate treatment or be referred elsewhere if this cannot be made available.
- Have staff make fair and reasonable decisions about your treatment and care.
- Treatment by qualified and competent staff members
- To have access at all times during treatment to records of any medications prescribed and to have access to the treatment record after formally terminating treatment.
- Consultation with the supervising psychiatrist or psychologist if desired
- Refuse or stop treatment at any time by withdrawing Informed Consent in writing.
- Refuse to take any medication prescribed by our medical staff if you so choose.
- Be allowed to participate in the planning and reviewing of your treatment. This would include:
  - δ Names and qualifications of all professional staff responsible for your care
  - δ Plans established for your treatment
  - δ Benefits and risks associated with all treatment and medication as well as side effects of medications
  - δ Alternatives to the recommended treatment, consequences of not receiving treatment.

## **CONFIDENTIALITY OF CLIENT INFORMATION**

All treatment records are confidential. Uplands Counseling Associates may not disclose any information about you without your written authorization with the following exceptions:

- 1). As mental health providers we are mandated by law to report any cases of suspected neglect, physical, or sexual abuse of children.
- 2). In the event that a client poses a threat, either to themselves, or to another person, at the clinicians discretion, necessary acts will be taken to protect him/her or the potential victim. Information may be released to another Health Care Provider or Law Enforcement Officials in the case of an emergency.
- 3) If you provide written authorization to Uplands Counseling Associates to disclose or receive information.

Treatment records are the property of the individual attending therapist. Our policy is that, unless there are extenuating circumstances, you may review your clinical record in the presence of your therapist. After reviewing your record with your therapist and upon payment of fees for photocopying, you may obtain copies of your record. If you believe something in your record is incorrect, you can challenge its accuracy by putting your own version in your record.

Information from your clinical record may be reviewed among the staff at Uplands Counseling Associates for the purpose of consultation, periodic review, and as required for state certification.

## **GRIEVANCE RESOLUTION PROCESS**

If you have a grievance with your counselor, or the way you are being treated, you have the right to the following:

- Informal Discussion - Speak with your counselor and/or staff.
- Grievance Investigation/Formal Inquiry – You may file an inquiry with the Client Right’s Specialist (CRS), and they will investigate your grievance and attempt to resolve it.
- State Grievance Examiner – You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level.

Your Client Rights Specialist is:

Vaughn Brandt  
608-234-8734

# UPLANDS COUNSELING ASSOCIATES - CLIENT INFORMATION

**CERTIFIED CLINIC STATUS** – Uplands Counseling Associates, Inc. is a certified clinic under Wis 632-89, which means that we are eligible for the mental health insurance benefits mandated for most group health insurance plans. In order to comply with state regulations, supervision must be provided for your therapist, by a psychiatrist.

**RESPONSIBLE PARTY** (if child is a minor): When the primary client is your child, the parent or guardian bringing the child in for services is responsible for paying for the services. If you have a financial agreement (such as a divorce agreement/judgment) for your child's medical expenses with the other parent, you will be expected to pay for your child's services and arrange for your own reimbursement with the other party. We would be happy to provide any billing information to the other party.

**INSURANCE – You are responsible for your entire bill.** However we will submit claims to your health insurance company as a courtesy to you. Please provide our billing department with your insurance information and present your insurance ID before your first appointment. Before your first appointment, please make sure that you understand the mental health benefit provided by your insurance plan. You should understand the amounts of your co-payments (the portion of the charge your insurance company expects you to pay) and deductibles (the amount your insurance company requires you to pay before they pay benefits). You should be aware of plan restrictions and benefit limits. *If you need assistance in verifying benefits with your insurance company, please ask our billing department.*

**Many insurance plans require pre-authorization of mental health services. Some insurance plans place restrictions on the type of services covered and/or on the frequency or number of appointments covered. You must let our billing department and your therapist know about these requirements and restrictions before your first appointment.**

## **PROFESSIONAL FEE FOR SERVICE:**

### LCSW FEE SCHEDULE

Initial Evaluation	\$ 185.00
45-50 Minute Psychotherapy Session	\$ 120.00

### CSAC (AODA) FEE SCHEDULE

Initial Evaluation (for Psychotherapy)	\$ 185.00
45-50 Minute Psychotherapy Session	\$ 120.00

### Ph.D. (Psychologist) FEE SCHEDULE

Initial Evaluation	\$ 210.00
45-50 Minute Psychotherapy Session	\$ 135.00

### M.D. (Psychiatrist) FEE SCHEDULE

Initial Medication Evaluation	\$ 220.00
20-30 Minute Medication Management	\$ 110.00

For specialized assessment and treatment services, other fees may apply. Consult your therapist.

Payment/Co-Pay/Deductibles are due at the time of the session unless other arrangements are made with your therapist. We reserve the right to charge interest on unpaid accounts over 60 days old at the rate of 1.5% or 18% annually. If you have any questions about your account, contact our Business Manager.

**Appointments that are missed or cancelled with less than 24 hours notice with therapists will be billed to you directly at \$45 (\$25 for 1 hour AODA group). Late cancellations and missed appointments cannot be billed to your insurance.**

**Late Cancellation and Missed Appointment Fees for the Psychiatrist are as follows:**

**Initial Appointment - \$105    Follow-up Med Check 20 Minutes - \$55    Follow-up Med Check 20-30 Minutes - \$85**

**Our bank charges a fee of \$40.00 for any returned check.** This fee along with the original amount of the bad check is payable only in cash, money order, or cashier's check. At this point you will be required to pay only by these means for any future balances.