Wings of Eagles Counseling Clinic

We will nurture a partnership of hope, health, and wholeness in the people we serve using evidenced based practices to improve families and communities.

Intake Questionnaire (Children & Adolescents)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide us will be confidential as required by state and federal law.

Date: _____ **Social Security Number**: _____

Name: _____ **Date of Birth**: _____ **Age**: _____

Home Address: _____ **City/State/Zip code**: _____

Home Phone: _____ **Cellular/Alternate Phone**: _____

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

How long has this been going on?

What made you come in at this time?

What do you hope to gain from this evaluation and/or counseling?

If you had difficulties in the past, what have you done to cope? Was it helpful?

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not feeling rested in the morning

Average hours of sleep per night: _____

- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed Mood
- ☐ Feeling Numb
- ☐ Rapid mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities or specific things
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)
- ☐ Outbursts of anger

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight? _____
- ☐ Weight gain: _____ lbs
- ☐ Weight loss: _____ lbs.

- ☐ Difficulty catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling "jumpy"
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don't have
- ☐ Racing thoughts
- ☐ Intrusive memories

- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else

- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses, or images
- ☐ Unusual visual experiences such as flashes of light, shadows
- ☐ Hear voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or the radio is communicating with you

- ☐ Difficulty problem solving
- ☐ Dependency on others
- ☐ Inappropriate expression of anger
- ☐ Difficulty or inability to say "no" to others
- ☐ Sense of lack of control
- ☐ Abusive relationship
- ☐ Concerns about your sexuality
- ☐ Difficulty meeting role expectations
- ☐ Manipulation of others to fulfill your own desires
- ☐ Self-mutilation/cutting
- ☐ Ineffective communication
- ☐ Decreased ability to handle stress
- ☐ Difficulty expression emotions

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?
☐ No ☐ Yes If so:

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

Name of therapist: _____ Dates of Treatment
Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**	**Has it been helpful?**

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**How long have you been taking it?**

Have you been on **PSYCHIATRIC** medication in the past? ☐ No ☐ Yes If YES, please list:

Medication	**Dosage**	**First/Last time you took it**	**Effect of Medication**

Have you been hospitalized for psychiatric reasons? ☐ No ☐ Yes If YES, describe:

Hospital	**Dates**	**Reason**

Have you ever attempted suicide? ☐ No ☐ Yes If YES, describe:

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes If YES, describe:

List any PRIOR illnesses, operations and accidents

FAMILY HISTORY

Father: Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HIS age at time of his death____ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with him: --_____ Are you/Have you been close to him? _____

Mother: Age: ☐ Living ☐ Deceased Cause of death:
If deceased, HER age at time of his death___ YOUR age at time of his death_____
Occupation: _____ Health: _____
Frequency of contact with him: --_____ Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

During your childhood, have you lived any significant period of time with anyone other than your natural parents?

☐ No ☐ Yes If so, please give the persona's name and relationship to you

Name: _____ Relationship to you:_____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems						
Depression						
Hyperactivity						
Counseling						
Psychiatric Medication						
Psychiatric Hospitalization						
Suicide Attempt						
Death by Suicide						
Drinking Problem						

SOCIAL HISTORY

Education

Highest grade level completed so far:_____

Have you had any disciplinary problems in school? --_____

If yes, please explain: _____

What kinds of grades do you get in school? _____

Legal

Have you been arrested or had any contact with the police? --_____

If yes, please describe: _____

Religion

Do you have a religious affiliation? --

If yes, what is it? _____

What kind of social activities do you participate in? _____

_____

Who do you turn to for help with your problems? _____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe:

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol? -- If yes, age of first use _____

How much do you drink? _____

How often do you drink? _____

Do you use tobacco (cigarettes, dip)? _____

If yes, how often? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				

Is there anything else you would like us to know about you?

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Informed Consent Form

1. **Consent to Evaluate/Treatment**: I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Wings of Eagles Counseling Clinic 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 modalities in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, 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.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, 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.

3. **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. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry**: Information from my evaluation and/or treatment is contained in a confidential record at Wings of Eagles Counseling Clinic, and I consent to disclosure for use by Wings of Eagles' 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.**

5. **Discharge Policy**: There are circumstances under which I may be involuntarily discharged. I have read and understand the Involuntary discharge agreement for the clinic.

6. **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.

7. **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.

_____	_____
Signature of client ages 14 or order	***Date***
_____	_____
Signature of parent or guardian if under 18 years of age	***Date***
_____	_____
Witness (therapist or staff)	***Date***

217 N Madison Street, Green Bay WI 54301
Phone: 920-227-7078 or 920-455-0301 Fax: 920-273-8847 www.wingsofeagles1.com

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INSURANCE AUTHORIZATION

CLIENT NAME: _____ DOB: _____

If insurance provider is from government (forward health/medicaid/badger care) please provide network you are placed in: _____

Policy Holder Information (complete section below **IF** policy holder is not client – **AND/OR** - copy of card is not present):

Policy Holder Name: _____ DOB: _____

Relationship to client: ○ Self ○ Spouse ○ Child ○ Other

Under employer's Health Plan? ○ Yes ○ No Insured SS #: _____

Employer Name: _____

Ins Co Name: _____ Phone#: _____

Group Number: _____ ID Number: _____

I authorize payment of medical benefits
Signature of client /Guardian _____ ***Date:*** _____

I authorize the release of any medical or other information necessary to process this claim or any further claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.
Signature of client /Guardian _____ ***Date:*** _____

***********please provide a copy of insurance card*********

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NOTICE OF PRIVACY PRACTICES

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

Wings of Eagles Counseling Clinic, LLC is required by law to maintain the privacy of your health information. We are also required to provide you with a notice that describes our legal duties and privacy practices and your privacy rights with respect to your health information. We will follow the privacy practices described in this notice. If you have any questions about any part of this Notice or if you want more information about our privacy practices, please contact *Privacy Officer, 217 N Madison Street, Green Bay WI 54301*

We reserve the right to change the privacy practices described in this notice if the practices need to be changed to be in compliance with the law. We will make the new notice provisions effective for all the protected health information that we maintain. If we change our privacy practices, we will have them available upon request. It will also be posted at the location of service and on our website at www.wingsofeagles1.com

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

For Treatment. We may use or disclose your health care information in the provision, coordination, or management of your health care. For example, one mental health practitioner may ask another for consultation about your care. Our communications to you may be by telephone, cell phone, e-mail, patient portal, or by mail.

Payment. We may use or disclose your health care information to obtain payment for your health care services. For example, we may use your information to send a bill for your health care services to your insurer.

Health Care Operations. We may use or disclose your health care information for activities relating to the evaluation of care, evaluating the performance of health care providers, business planning and compliance with the law. If the activities require disclosure outside of Wings of Eagles Counseling Clinic, LLC, we will request your authorization before disclosing that information.

Health Information Exchange. We may make your protected health information available electronically through an information exchange service to other health care providers, health plans, and health care clearinghouses that request your information. Participating in an exchange service also let us see their information about you.

How We May Use or Disclose Your Health Information Without Your Written Authorization

The following categories describe the ways that we may use and disclose your health information without your authorization:

1. **Required by Law.** We may use and disclose your health information when that use, or disclosure is required by law. For example, we may disclose medical information to report child abuse or to respond to a court order.
2. **Public Health.** We may release your health information to local, state or federal public health agencies subject to the provisions of applicable state and federal law for reporting communicable diseases, aiding in the prevention or control of certain diseases and reporting problems with products and reactions to medications to the Food and Drug Administration.

3. **Victims of Abuse, Neglect or Violence.** We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly.

4. **Health Oversight Activities.** We may disclose your health information to health agencies authorized by law to conduct audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system.

5. **Judicial and Administrative Proceedings.** We may disclose your health information in the course of an administrative or judicial proceeding in response to a court order. Under most circumstances when the request is made through a subpoena, a discovery request or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

6. **Law Enforcement.** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, or missing person, or complying with a court order or other law enforcement purposes. Under some limited circumstances we will request your authorization prior to permitting disclosure.

7. **Coroners and Medical Examiners.** We may disclose your health information to coroners and medical examiners. For example, this may be necessary to determine the cause of death.

8. **Research.** Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct medical research which may involve an assessment of whether a certain treatment is working better than another.

9. **To Avert a Serious Threat to Health of Safety.** We may disclose your health information in a very limited manner to appropriate persons to prevent a serious threat to the health or safety of a particular person or the general public. Disclosure is usually limited to law enforcement personnel who are involved in protecting the public safety and/or to the target of the threat.

10. **Specialized Government Functions.** Under certain and very limited circumstances, we may disclose your health care information for military, national security, or law enforcement custodial situations.

11. **Workers' Compensation**. Both state and federal law allow the disclosure of your health care information that is reasonably related to a worker's compensation injury to be disclosed without your authorization. These programs may provide benefits for work-related injuries or illness.

12. **Health Information.** We may use or disclose your health information to provide information to you about treatment alternatives or other health related benefits and services that may be of interest to you.

    a. **Caregivers.** We are permitted to release your information to your spouse, parent, adult child, or sibling if they are directly involved in your care. Without your permission this information is limited to a summary of diagnosis and prognosis, a list of medication, and a copy of your treatment plan. Alcohol and drug treatment records can NOT be released under this provision.

When Wings of Eagles Counseling, LLC is Required to Obtain an Authorization to Use or Disclose Your Health Information. Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. For example, uses and disclosures made for the purpose of psychotherapy, marketing and the sale of protected health information require your authorization. If your provider intends to engage in fundraising, you have the right to opt out of receiving such communications. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Your Health Information Rights

1. **Inspect And Copy Your Health Information**. You have the right to inspect and obtain a copy of your health care information. You have the right to request that the copy be provided in an electronic form or format. If the form and format are not readily producible, then we will work with you to provide it in a reasonable electronic form or format. This right of access does not apply to psychotherapy notes, which are maintained for the personal use of a mental health professional. Your request for inspection or access must be submitted in writing to *Privacy Officer, 217 N Madison Street Green Bay WI 54301.* We may charge you a reasonable fee to cover our expenses for copying your health information.

2. **Request To Correct Your Health Information**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. For example, if you believe the date of your first visit is incorrect; you may request that the information be corrected. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make you request in writing to *Privacy Officer, 217 N Madison Street Green Bay WI 54301* You must also provide a reason for your request.

3. **Request Restrictions on Certain Uses and Disclosures**. You have the right to request restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. We are not required to agree in all circumstances to your requested restrictions. However, we must comply with your request to refrain from billing your insurance or health plan if the services are paid in full out-of-pocket. If you would like to make a request for restrictions, you must submit your request in writing to *Privacy Officer, 217 N Madison Street Green Bay WI 54301*.

4. **Receive Confidential Communications Of Health Information**. You have the right to request that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests. To request confidential communications, you must submit your request in writing to *Privacy Officer, 217 N Madison Street Green Bay WI 54301*

5. **Receive A Record Of Disclosures Of Your Health Information.** You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting to *Privacy Officer, 217 N Madison Street Green Bay WI 54301*. Accounting Request Forms are available from our office or the Privacy Officer. The accounting will not include several types of disclosures, including disclosures for treatment, payment or health care

operations. If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

6. **Obtain A Paper Copy Of This Notice**. You may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically. To obtain a paper copy of this Notice, ask your provider or send your written request to *Privacy Officer, 217 N Madison Street Green Bay WI 54301*

7. **Notified of a Breach.** We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.

8. **Complaint.** If you believe your privacy rights have been violated, you may file a complaint with *Privacy Officer, 217 N Madison Street Green Bay WI 54301*. You can also 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, by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/ privacy/hipaa/complaints/. **We will not retaliate against you for filing a complaint.**

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact *Privacy Officer, 217 N Madison Street Green Bay WI 54301.*

Effective Date of This Notice: September 27, 2022

Wings of Eagles Counseling Clinic

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HIPAA ACKNOWLEDGEMENT OF RECIEPT
NOTICE OF PRIVACY PRACTICE

Print Client Name: _____ DOB: _____

Wings of Eagles Counseling Clinic, LLC are required by law to maintain the privacy of our clients and provide individuals with the attached notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the notice, please ask to speak with our HIPPA Compliance office in person or by phone at main office.

I hereby acknowledge that you have reviewed the HIPPA notice of Privacy Practices with staff at Wings of Eagles Counseling Clinic.

_____ _____

Signature of client ages 14 or order ***Date***

_____ _____

Signature of parent or guardian if under 18 years of age ***Date***

_____ _____

Witness (therapist or staff) ***Date***

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Therapist Client Agreement
Office Policies/Fees/HIPAA/PRIVACY POLICY

Client Name: _____

Client Date of Birth:_____Insurance ◉ Self Pay ○

WELCOME: Welcome to Wings of Eagles Counseling Clinic. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is included in your folder, explains HIPAA and its application to your personal health information in greater detail, and our practice is in general accordance with HIPAA policies. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES: Therapy is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to create change a client. As a client in therapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. We, as therapists, have corresponding responsibilities to you. These respective rights are described in the following section. Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. To be most successful, you will have to work on things that we discuss outside of the sessions. The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work together may include. At that point, we will discuss your treatment goals and create a personalized, initial treatment plan, if you decide to continue. You should evaluate this information as well as your own assessment about whether you feel comfortable working with your therapist.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions or concerns about your therapists' procedures, ask to discuss them whenever they arise.

APPOINTMENTS: We normally conduct an evaluation that will last from 1 or 2 sessions. During this time, we can both decide if your therapist is the best person to provide the services you need to meet your treatment goals. If therapy is has begun, we will usually schedule one, 50-minute session per week at a time both client and therapist agree on, although some sessions may be longer or more frequent.

CANCELLATION: Psychological services are most effective when meeting times are regular and consistent. The time scheduled for your appointment is assigned to you alone. If you need to cancel or reschedule a session, it is required that you provide more than 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hours' notice, you must pay the appropriate fee (usually half of the session cost) for the missed session. It is important to note that insurance companies do not provide reimbursement for canceled sessions. In addition, you are responsible for coming to your session on time. If you are late, your appointment will still need to end on time.

Indicate agreement to cancellation policy with your initials here. _____

FEES, BILLING, AND PAYMENT: Psychotherapy sessions are 50 minutes to an hour and billed at $125 per hour session (initial sessions are $200; other fees are dependent upon service provided and will be arranged at the time of service). Session fees or insurance co- pays are payable at time of service. If you are a cash-paying client, you must fill out and sign the appropriate agreement. All payment arrangements must be I writing and signed by both the client and the therapist. Fees will be reevaluated periodically. You will be responsible for paying the entire fee if your insurance fails to cover your services.
Moreover, legal fees ($250 per hour of service provided) are not billable to insurance companies and will be charged to the patient directly (e.g., court evaluations, court appearances). Should a balance accrue, and no payment is received, Wings of Eagles Counseling reserves the right to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency. You may contact Wings of Eagles Counseling Clinic: 920-227-7078 217 N Madison Street, Green Bay, WI 54301

Indicate agreement to fees, billing, and payment policy by your initials here: _____

INSURANCE: We accept payment directly from insurance companies, and our therapists are participating providers on several managed care preferred provider plans. If we are not a participating provider in your managed care plane, our services are typically not reimbursable. Insurance companies sometimes require a formal diagnosis with their claims. Diagnoses are technical terms that describe the nature of your presenting symptoms and whether they are short-term or long-term concern. All diagnoses come from a book entitled the DSM-V. There is a copy in our office, and we will be glad to allow you to view and learn more about your diagnosis if applicable.

PROFESSIONAL RECORDS: We are required to keep appropriate records of the psychological services that we provide. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request; you will be charged $0.15 per page. Your records are maintained in a secure location in the office. There are occasions where we will share your records interoffice with other practitioners or therapist that make up your "treatment team"; but only within Wings of Eagles Counseling Clinic unless you sign a written authorization form that meets certain legal requirements imposed by HIPAA.

Indicate agreement to professional records policy with your initials here: _____

CONFIDENTIALITY: The confidentiality of all communications between a client and a psychologist is generally protected by law and Wings of Eagles Counseling, as your therapy center, cannot and will not tell anyone else what you have discussed or even that you are in therapy without your written permission. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. Except for certain specific situations described below, you have the right to confidentiality of your therapy. You, on the other hand, may request that information is shared with whomever you choose, and you may revoke that permission in writing at any time.
There are, however, several exceptions in which we are legally bound to take action even though that requires revealing some information about a patient's treatment. If possible, we will make every effort to inform you when these will have to be put into effect legal exceptions to confidentiality include, but are not limited, to the following:

1. If there is good reason to believe you are threatening serious bodily harm to yourself or others. If we believe a client is threatening serious bodily harm to another, we may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, we may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.
2. If there is good reason to suspect, or evidence of, abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, we are required by law to file a report with the appropriate state agency.
3. In response to a court order or where otherwise required by law.
4. To the extent necessary, to make a claim on a delinquent account via a collection agency.
5. To the extent necessary for emergency medical care to be rendered.

Finally, there are times when your therapist may find it beneficial to consult with colleagues as part of their practice for mutual professional consultation. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

CONTACTING US: Your therapist may not be immediately available by telephone. While we are usually in the office during n01mal business hours, your therapist may not answer the phone when they are with a client. If you need to reach your therapist between sessions, or in an emergency, you have the right to a timely response. You may leave a message on their confidential voicemail at any time. Your call will be retuned as soon as possible or by the next business day under n01mal circumstances. On weekends, we do not typically check voice mail. But, for any number of unseen reasons, if you do not hear from us or we are unable to reach you, it remains your responsibility to take care of yourself until such time as we can talk. If you feel unable to keep yourself safe, call the crisis liner or go to your nearest emergency room and ask to speak to the psychiatrist or psychologist on call. We will make every attempt to inform you in advance of any planned absences and provide you with a name and phone number of the therapist covering the practice.

OTHER RIGHTS: If you are unhappy with what is happening in therapy, we hope that you will talk with us so that we can respond to your concerns. Such criticism will be taken seriously and with care and respect. You may also request that we refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspect of the therapy and about our specific training and experience. You have the right to expect that we will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY: Your signature below indicates that you have read this agreement and agree to its terms. It also serves as an acknowledgment that you have received the HIPAA Notice Form described above.

Print: _____

Sign: _____ Date: _____

Virtual Mental Health Informed Consent

I hereby consent to engage in virtual mental health services with Wings of Eagles Counseling Clinic LLC. I understand that these services include the practice of health care delivery involving diagnosis, consultation, treatment, and education using interactive audio, video, and/or data communication.

I understand that I will need to download an application to use this platform. I also need to have a broadband internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. The secure, HIPPA compliant server to be used is Zoom or Microsoft Teams.

1. Unless I explicitly provide agreement otherwise, virtual therapy exchanges are strictly confidential. Any information I choose to share with my therapist will be held in the strictest confidence. My private information will not be released unless it is required to do so by law. WI law requires therapists to notify authorities if a client has the potential to physically harm someone, harm themselves, or if they are abusing or about to abuse children, the elderly or the disabled.
2. I understand that virtual therapy services are authorized in the state of WI and that the services provided are governed by the laws of WI.
3. I understand that I have the right to withdraw or withhold consent from virtual therapy services at any time. I also have the right to terminate treatment at any time.
4. While virtual therapy will be conducted primarily through secure and private videoconferencing, I understand that there are always some risks with virtual therapy services including but not limited to, the possibility that: the transmission of your medical information could be disrupted or distorted by technical failures and/or the transmission of your information could be intercepted by unauthorized persons.
5. I will work with my therapist to identify an alternative communication method (most often phone) if the videoconferencing tool fails.
6. I understand that I may benefit from visual therapy but that results cannot be guaranteed or assured. In addition, I understand that virtual mental health services may not yield those same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g., face-to-face service), I will be referred to a psychotherapist in my area who can provide such service.
7. I understand that the benefits of virtual mental health may include but are not limited to finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be greater opportunity to prepare in advance for therapy sessions.
8. I understand and accept that virtual therapy does not provide emergency services. If I am experiencing an emergency, I understand that the protocol would be to call 911 or to proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts

or making plans to harm myself, I may also call the National Suicide Prevention Lifeline at 1-800-273 TALK (8255) for free 24 hour hotline support.

9. I agree not to record virtual therapy sessions.
10. It is important to maintain a setting that is similar to being in an office together with your therapist. Maintaining the structure of the setting is critical. To have effective online therapy sessions, the following guidelines must be followed: 1) Make sure that you are in a private location where your sessions cannot be overheard by others. You are required to inform your therapist if there is anyone in the room with you and no one can be invited to session without therapist permission. 2) Try to have proper lighting so that your therapist can best communicate with you. 3) You must be appropriately attired each session. 4) Minimize background noise. Turn off televisions, music, or other sounds. Please close the door to the room you are in. 5) Minimize distractions. You should not be playing games on a device, be on social media or working on other things while in therapy. Make sure that pets, children, and household members will not be distractions from treatment.
11. I have the right to access my medical information and copies of my medical records in accordance with HIPPA privacy rules and applicable state law.
12. If your therapist is concerned about you or contact is lost with you during a session or if you fail to show for a scheduled virtual therapy session, your therapist will contact you by phone to check on your well-being. In addition, if you are showing signs of being in real trouble, your therapist will require that we have permission to contact someone to ensure your safety. We require two levels of contact:

Name: _____ Relationship: _____ Phone #_____

Name: _____ Relationship: _____ Phone #_____

Print Client's Name: _____

_____ _____

Signature of client ages 14 or order **Date**

_____ _____

Signature of parent or guardian if under 18 years of age **Date**

✂----------✂

Crisis Response Contact: 911

□ Brown County: (920)436-8888 or 988 **□ Outagamie: (920)832-4646**

□ Manitowoc (888)552-6642 **□ Oconto (920)846-3444**

□ Shawano (715)526-3240 **□National Suicide Hotline 1800-273-TALK (8255)**

Wings of Eagles Counseling Clinic

We will nurture a partnership of hope, health, and wholeness in the people we serve using evidenced based practices to improve families and communities.

CLIENT RIGHTS AND GRIEVANCE PROCEDURE

CLIENT RIGHTS:

When you receive any type of services for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free of any verbal or physical abuse from all staff.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You can decide whether you want to participate in religious services.
- You cannot be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You can make your own decisions about things like getting married, voting and writing a will (unless rights waived under Ch.55 or 880).
- You cannot be treated differently because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for you.
- You must be encouraged and 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 of medications.
- No treatment or medication may be given to you without your consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, or a court orders it. (If you have a guardian, however, your guardian can consent to treatment and medications on your behalf.)
- You cannot be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be treated with dignity and respect, free of any verbal or physical abuse from all staff.
- You must be informed of any costs of your care and treatment that you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to allow the maximum amount of personal and physical freedom necessary to meet your needs. Involuntary clients can ask a court to review the order to place them in a facility. (Note exception of clients under s.51.35(3) or 51.37, Stats., or under Ch.971 or 975, Stats.)
- You may call or write to public officials or your lawyer or advocate.
- You may not be filmed or taped unless you agree to it.
- You may use your own money as you choose, within limits. (Exception for those clients with a representative payee).
- You have access to a grievance procedure to ensure your rights. You cannot be threatened or penalized in any way for filing a grievance (See "Access to Grievance Procedure" below.)
- You have the right for your services provider to assist you in exercising and of these rights outlined or specified under Ch.51, Stats., or HSS 94.
- You have the right to receive copies of program manuals, guidelines and licensing and certification rules, if you so choose.

AT NO TIME ARE YOU REQUIRED TO WAIVE (GIVE UP) ANY OF YOUR RIGHTS UNDER CH.51, STATS., OR HSS 94 (OUTLINED IN THIS FORM) AS A CONDITION OF ADMISSION OR RECEIPT OF TREATMENT AND SERVICES.

RECORD PRIVACY AND ACCESS LAWS

Under Wisconsin Statute sec. 51.30 and HSS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential).
- Your records cannot be released without your consent, unless the law specifically allows for it
- You can ask to see your records. You must be shown any records about your physical health or medications. Staff may limit limit how much you can see of the rest of your records while you are receiving services. You must be informed of the reasons for any such limits. You can challenge those reasons in the grievance process. After discharge, you can see your entire record if you ask to do so.
- If you believe something in your records is wrong, you can challenge its accuracy. If staff will not change the part of your record you have challenged, you can put your own version in the record.

ACCESS TO GRIEVANCE PROCEDURE

Many complaints can be quickly resolved in an informal manner. If you have a complaint in regard to the above rights, please ask to speak with the Client Rights Specialist of Wings of Eagles Counseling and attempt to resolve the matter informally. If this does not work, you have the right to file a written grievance. Information and forms for filing a grievance are available upon request. You may, at the end of the grievance process, or any time during it, choose to take the matter to court.

GRIEVANCE PROCEDURE AND RIGHTS TO ACCESS TO COURT

- Before treatment is begun the service provider must inform you of your rights and how to use the grievance process. A copy of Wings of Eagles Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or at any time during it, choose to take matters to court to sue fir damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have; however, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation-Formal Inquiry

- If you want to file a grievance you should do so within 45 days of the time you become aware of a problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client right Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days for the date you filed the formal grievance. You will get a copy of the report.
- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rant them in order of importance.

Program Manger's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of receiving the program manager's decision. You may ask the program manger to forward your grievance or you may do it yourself.
- The County Agency Director must issue a written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manger's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner with i 14 days of receiving the decision from the previous appeal level. You may ask the program manger to forward the your grievance to the State Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Care and Treatment Services (DCTS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days to receipt of written decision of the State Grievance Examiner to request a final state review by the Administrator of the DCTS or designee. Send your request to: PO Box 7851, Madison WI 53707-7851.

You may talk to staff or contact your Client Rights Specialist, listed below, if you would like to file grievance or learn more about the grievance procedure used by Wings of Eagles Counseling Clinic, LLC

Client Right Specialist:

Leslie Ousley MA LPC SAC-IT, 217 N Madison Street, Green Bay WI 54301, 920-228-3199

RIGHTS OF MINORS OUTPATIENT BEHAVIORAL HEALTH TREATMENT

Information about the legal rights of children and adolescents in outpatient mental health and substance use treatment

Consent for Mental Health Treatment:

If you are younger than 14-year-old, a parent or guardian must agree, in writing, to you receiving outpatient mental health treatment.

If you are 14 year or older, you and your parent or guardian must agree to you receiving outpatient mental health treatment.

If you want treatment but your parent or guardian is unable to agree to it or won't agree to it, you (or someone on your behalf) can petition the county mental review officer for a review.

If you do not want treatment but your parent/guardian does, the treatment director for the clinic where you are receiving services must petition the mental health review officer for a review.

Regardless of your age, in an emergency, the treatment director for the clinic may allow you to receive outpatient mental health treatment, but no medication, for up to 30 days.

During the 30 days, the treatment director must get the informed written consent of your parent or guardian, or file a petition for review for admission with the Mental Health Review Officer.

Review by Mental Health Review Officer and/or Court:

Each juvenile court appoints a mental health officer for their county. Find the mental health review officer for your county at: www.dhs.wisconsin.gov/clientrights/mhros.

The juvenile court must ensure that you are provided any necessary assistance in the petition for review

If you request it and the mental health review officer believes it is in your best interest, review by mental health review officer can be skipped and the review will be done by the court (judicial review).

If the **mental health review officer** does the review, a hearing must be held within 21 days of the filing of the petition for review, and everyone must get at least 96 hours (4 days) notice of the hearing.

To approve your treatment (against your will or despite the refusal of your parent/guardian) the mental health review officer must find that all these are true:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interest.

If you disagree with the decision of the mental health review officer, you and your parent/guardian will be informed of the right to a judicial review.

If the **court** does the review, within 21 days of the mental health review officer's ruling, you (or someone acting on your behalf) can petition the juvenile court for a judicial review.

A court hearing must be held within 21days of the petition, and everyone must get at least 96 hours (4 days) notice of the hearing.

If you do not want the treatment, the court must appoint you an attorney at least 7 days prior to the hearing. If it is your parent/ guardian who does not want the treatment and you do not already have a lawyer, the court must appoint you one.

To approve your treatment (against your will or despite the refusal of your parent/guardian), the judge must find that all these are true:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

A court ruling does not mean that you have a mental illness.

The court's ruling can be appealed to the Wisconsin Court of Appeals.

Consent for Substance Use Treatment:

Any minor can consent to substance use treatment at a public facility as long as it is for prevention, intervention, or follow up.

If you are **younger than 12-years-old**, you may only get limited substance use treatment (such as detox) without a parent or guardian's consent.

If you are **12-years-old or older,** you can be provided some limited treatment (assessment, counseling, and detox less than 72 hours) without your parent or guardian's consent or knowledge.

If your parent or guardian agrees to it, you can be required to part
icipate in substance use treatment, including assessment and
testing.

Treatment Rights:

You must be provided prompt and adequate treatment.

If you are **14 years or older,** you can refuse mental health treatment until a court orders it.

You must be told about your treatment and care.

You have the right to and are encouraged to participate in the planning of your treatment and care.

You and your relatives must be informed of any costs they may have to pay for your treatment.

Record Access and Privacy Rights:

Staff must keep your treatment information private (confidential). However, it is possible that your parents may see your records.

If you want to see your records, ask a staff member.

If you are **younger than 14-years-old**, you must view your records in the presence of a parent/guardian, attorney, judge, or staff member. You may always see your records on any medications you take.

Regardless of your age, staff may limit how much you may see of your records. They must give you reasons for any limits.

If you are at least 14-years-old, you can consent to releasing your own mental health treatment records to others.

If you are at least 12-years-old, you can consent to releasing your substance use treatment records to others.

Personal Rights

You must be informed of your rights.

Reasonable decisions must be made about your treatment and care.

You cannot be treated unfairly because of your race, national origin, sex, gender expression, religion, disability or sexual orientation.

Patient Rights Help

If you want to know more about your rights or feel your rights have been violated, you may do any of the following:

- Contact patient rights staff. Their contact information should be provided to you by your treatment provider. Treatment providers should also list this information on a poster.
- File a complaint. Patient rights staff will look into your complaints. They will keep your complaints private (confidential); however, they may need to ask staff about the situation.
- Contact Disability Rights Wisconsin. They are the protection and advocacy organization for Wisconsin. Their advocates and attorneys can help you with patient rights questions. Call 608-267-0214 or 800-928-8778.

For more information, visit:
www.dhs.wisconsin.gov/clientrights/minors

GRIEVANCE PROCEDURE ACKNOWLEDGEMENT

As a client of Wings of Eagles Counseling Clinic LLC, I acknowledge have received a copy of my rights and grievance procedure and/or rights of minors for my own records.

_____ _____
Signature of client ages 14 or order ***Date***

_____ _____
Signature of parent or guardian if under 18 years of age ***Date***

_____ _____
Witness (therapist or staff) ***Date***