# Child Pre-Treatment Questionnaire

Child's name: _____ Date of birth: _____
Child's Preferred Name:_____
Sex: _____Gender:_____ School: _____Grade: _____
Parent/Legal Guardian Name and Address: _____
_____
Phone Numbers: Home: _____ Work: _____ Cell: _____
Email address for appointment reminders: _____
Emergency Contact:_____ Phone:_____
Please list any lengths of time your child has been out of school for any reason including major illness, home schooling, suspension, expulsion, etc.

_____
People in household with child:_____
_____
If child is not living with one or both birth parents, what is the reason? _____

Visitation Schedule:_____

Is your child currently under a physician's care? Yes No
Physician/medication(s): _____
_____

Has your child received prior counseling or related services? If yes, please explain:
_____
_____

Outcome: (circle one):

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|
| Much worse | | | | Stayed the same | | | | | Much better |

Please list any psychiatric hospitalizations for the child, including reason, dates, and facility:
_____
_____
_____

Please check any of the reasons listed below that led you to seek treatment for your child, **circling the most important**:

____
__ Depression or anxiety
__ Worry about drinking or drug use
__ Communication problems
__ Child arguing with parent(s)
__ Child arguing with brothers/sisters
__ Sexual orientation questions
__ Problematic or too much anger
__ Feel alone/trouble making friends
__ Trouble controlling impulses
__ Difficulty with loss or death
__ Trouble staying organized
__ Refusing to attend school
__ Withdrawn
__ Learning/memory problems
__ Worry that he/she is suicidal
__ Child's behavior is out of control
__ Abuse (physical/sexual/emotional/verbal)
__ Trauma other than abuse (natural disaster, accident, crime witness, etc.)
__ Trouble concentrating
__ Getting in trouble at school
__ Learning problems
__ Trouble following directions
__ Clingy/tearful
__ Verbally or physically aggressive
__ Trouble getting child to bed at night
__ Other: _____

Were there any difficulties with the pregnancy, birth, or early development of your child?
If so, please explain.

_____
_____

Is there anything else you want the therapist to know?

_____

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## If child has requested therapy, please allow them to answer the following questions , helping if needed.

Please check any of the reasons below that led you to seek treatment. **Circling the most important**.

__ Depression or anxiety
__ Bullying
__ Communication problems
__ Arguing with parent(s)
__ Arguing with brothers/sisters
__ Sexual orientation questions
__ Problematic or too much anger
__ Feel alone/trouble making friends
__ Trouble controlling impulses
__ Difficulty with loss or death
__ Trouble staying organized
__ Trouble concentrating
__ Thinking of hurting myself or someone else
__ Learning/memory problems
__ Family problems
__ Abuse (physical/sexual/emotional/verbal)
__ Trauma other than abuse (natural disaster, accident, crime witness, etc.)
__ Trouble sleeping
__ Family member wants me here
__ Getting in trouble at school
__ Learning problems
__ Trouble following directions
__ Other: _____

Regarding the most important reason, please rate the following:

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

What do you like to do for fun/what are your interests?_____
_____

What are you good at/what are your strengths?_____
_____

What questions do you have/hope will be answered?_____

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Is there anything else you want the therapist to know?_____
_____

Child signature:_____Date:_____

Parent/Guardian signature:_____Relationship:_____

# Notice of Privacy Practices

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of our practice. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And we are legally required to follow the privacy practices described in this Notice. However, we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI on file with us already. Before we make any important changes to our policies, we will promptly change this Notice and post a new copy of it in our office and on our website. You can also request a copy of this Notice, or you can view a copy of it in our office.

III. HOW WE MAY USE AND DISCLOSE YOUR PHI.

We will use and disclose your PHI for many different reasons. For some of these uses or disclosures, we will need your prior written authorization; for others, however, we do not. Listed below are the different categories of our uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. We can use your PHI within our practice to provide you with mental health treatment, including discussing or sharing your PHI with trainees and interns. We can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, we can disclose your PHI to your psychiatrist to coordinate your care.
2. To Obtain Payment for Treatment. We can use and disclose your PHI to bill and collect payment for the treatment and services provided. For example, we might send your PHI to your insurance company or health plan (if you use that as a payment source) to get paid for the services that we have provided to you. We may also provide your PHI to our business associates, such as billing companies, claims-processing companies, and others that process our health care claims.
3. For Health Care Operations. We can use and disclose your PHI to operate our practice. For example, we might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. We may also provide your PHI to accountants, attorneys, consultants, or others for audit purposes.
4. Patient Incapacitation or Emergency. We may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as we try to get your consent after treatment is rendered, or if we try to get your consent but you are unable to communicate (for example, if you are unconscious or in severe pain) and we think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.

We can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, we may have to make a disclosure to applicable governmental officials when a law requires us to report information to government agencies and law enforcement personnel about victims of abuse or neglect.
2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, we may have to use or disclose your PHI in response to a court or administrative order. We may also have to use or disclose your PHI in response to a subpoena.
3. When law enforcement requires disclosure. For example, we may have to use or disclose your PHI in response to a search warrant.
4. When public health activities require disclosure.
5. When health oversight activities require disclosure. For example, we may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
6. To avert a serious threat to health or safety. For example, we may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.
7. For specialized government functions. If you are in the military, we may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.
8. To remind you about appointments and to inform you of health-related benefits or services. For example, we may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that we offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object. Disclosures to Family, Friends, or Others: We may provide your PHI to a family member, friend, or other person that you indicate and approve is involved in your care or the payment for your care, unless you object. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, we will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to

disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action in reliance on such authorization) of your PHI.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on Uses and Disclosures.

You have the right to request restrictions or limitations on our uses or disclosures of your PHI to carry out treatment, payment, or health care operations. You also have the right to request that we restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests in writing. We will consider your requests, but are not legally required to accept them. If we do accept your requests, we will put them in writing and will abide by them, except in emergency situations. However, be advised that you may not limit the uses and disclosures that we are legally required to make.

B. The Right to Choose How We Send PHI to You. You have the right to request that we send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide information as to how payment for such alternate communications will be handled. We may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of your PHI, but you must make the request to inspect and receive a copy of such information in writing. If we don't have your PHI but know who does, we will tell you how to get it. We will respond to your request within 30 days of receiving your written request. In certain situations, we may deny your request. If this happens, you will receive in writing our reasons for the denial and explain your right to have the denial reviewed.

D. The Right to Receive a List of the Disclosures We Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which we have disclosed your PHI. The list will not include disclosures made for treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before Dec. 12, 2013. We will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. Your request can relate to disclosures going back as far as six years. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge each year, but there may be a charge for more frequent requests.

E. The Right to Amend Your PHI.

If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail, or read it on the web.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Department of Health and Human Services, please contact Jeanne Kolker, 2021 Atwood Ave., Madison, WI 53704

VII. EFFECTIVE DATE OF THIS NOTICE: December 12, 2013

## Acknowledgment of Receipt of Notice of Privacy Practices

*You may refuse to sign this acknowledgment*

I hereby acknowledge that I have received a copy of, read and understand this office's Notice of Privacy Practices.

Printed name: _____ Signature/date: _____

This form must also be signed by a parent or legal guardian.

Printed name: _____ Signature/date: _____

# Client Rights and Informed Consent

**TREATMENT**

1. Psychotherapy can have benefits and risks. Alternatives to treatment include medication and/or coping with life's stressors without the aid of a therapist.
2. Possible outcomes and side effects, if you should choose to continue treatment, vary from person to person. As counseling service progresses, clients may find themselves feeling worse rather than better. Understand that this is a common problem, or side effect, experienced by many. If you experience this, it is important to talk about this openly with your counselor. Your counselor will help you manage these feelings in a supportive manner. The probable consequences of not receiving treatment vary from person to person, but may include the continuation or even worsening of symptoms.
3. Your therapist will make recommendations and describe the benefits of treatment, which may include healthier relationships and improved functioning.
4. Your therapist will review the approximate duration of treatment, which may range from as little as 2 to 3 sessions up to a year or more. At the end of treatment, you and your therapist will review your goals to ensure that you have achieved the desired outcome of treatment.
5. Services that will be offered include talk therapy with a focus on holistic health in a supportive, strengths-based, client-centered environment.

**NON-NEGOTIABLE CLIENT RIGHTS**

1. To know the name, identity, and professional status of all persons providing services to you and to know the staff member who is primarily responsible for your family's services.
2. To receive complete and current information concerning your assessment and/or treatment service plan in terms that you can understand.
3. To accept or refuse any treatment offered, and to be informed of the consequences of any such refusal.
4. To receive and review the Notice of Policies and Practices to Protect the Privacy of your Health Information. To receive the Client Rights/Grievance Procedure information from your therapist.

**DISCLOSURES, TERMINATION, EMERGENCY SERVICES, AND GRIEVANCE PROCEDURE**

1. Due to ethical and legal guidelines, all staff members are mandated to report any indications, belief, or suspicion of harm to oneself, harm to others, or intent to harm self or others. This includes suspicions of child abuse or neglect and elder abuse or neglect.
2. If you have been referred by another agency, Insight Counseling & Wellness will obtain a release of information to share treatment progress, plan, and participation in services with the referring agency.
3. At any time, Insight Counseling & Wellness or you may terminate services. The clinic may discharge a consumer for inability to pay or for behavior reasonably the result of mental health symptoms, such as behavior that threatens the safety of staff or other consumers of the clinic.
4. Services will automatically be terminated after six months of no contact with the client.
5. Clients have the right to access services in case of an emergency. The therapists are available between 8 a.m. and 5 p.m. After hours, should an emergency arise, call 911 for imminent issues. For all other crisis calls, you may contact the office in order to obtain the after-hours number listed on the voicemail.

6. Clients have the right to a fair and efficient process for resolving disputes and differences with provider. Clients are given a grievance pamphlet or referred to Maria Hanson, Client Right Specialist, at 608-446-8957.

# Informed Consent Signature

I acknowledge that I have read the Client Rights, the Insight Counseling & Wellness informed consent and privacy notices, and have had the opportunity to receive a copy of the same.

I give permission to Insight Counseling & Wellness to file any insurance claim with 3rd party payer sources and provide/receive information necessary to complete these transactions. Insight Counseling & Wellness has the ability to appeal any denial of claims for services rendered on my behalf. I assign all payment to Insight Counseling & Wellness, LLC for services rendered and claims filed.

I understand that while Insight Counseling & Wellness will seek reimbursement through insurance or other payer sources, I (or parent/guardian) am ultimately responsible for payment for these services, or may be responsible for a co-pay as designated by the payer source. I agree that my responsibility to provide accurate and updated information regarding alternative payer sources (such as primary insurance) or changes in payer sources to Insight Counseling & Wellness in order to assist with filing claims for services rendered and appealing these claims, as necessary. In the event that a claim is denied, I understand that I may be responsible for the full payment for the services rendered.

If insurance reimbursement is not an option, I agree to pay $_____ per session, and to pay at the end of each session. I agree to pay for appointments that I do not cancel within 48 hours. The only exceptions are unforeseen or unavoidable situations arising suddenly. I understand the clinic's cancellation policy and agree to pay $75 if I cancel my appointment within 48 hours. I agree to pay $100 if I do not contact the clinic and fail to attend my scheduled appointment. My initials here _____ indicate that my therapist has explained the cancellation policy and that I have agreed to its conditions. With enough knowledge, and without being forced, I enter into treatment with this therapist. I understand that I have the right to withdraw my consent for treatment at any time by providing a written request to the clinician. I understand that this consent to treat will expire 15 months from the date of signature.

I understand that Insight Counseling & Wellness makes every attempt to coordinate my mental health treatment and care with my primary care physician. By signing this document, I understand that Insight Counseling & Wellness will notify my primary care physician that I am receiving services at Insight Counseling & Wellness. Additional treatment information, such as treatment plan, updates, progress, medical records, recommendations, and medications will only be released upon my expressed, written permission to Insight Counseling & Wellness.

By signing this form, I consent to the care and treatment as is prescribed by Insight Counseling & Wellness for myself; if I am the parent/guardian of a minor child under the age of 18, by signing this form, I consent to the care and treatment as is prescribed by Insight Counseling & Wellness. I understand that the purpose of treatment practices will be explained to me and is subject to my agreement.

Client printed name: _____

Client (or Parent or Guardian) signature: _____ Date: _____

Therapist signature: _____ Date: _____