Red Oak Counseling, Ltd.

Client Master Record

Client Name: _____

Date of Birth: _____ Age: _____ Assessment Date: _____

Address: _____

City: _____ State: _____Zip: _____

Gender: □ Male □ Female

Relationship Status: □ Married □ Separated □ Partnered
□ Divorced □ Widowed □ Single/Never Married

Race: □ African American □ Caucasian □ Hispanic
□ Native American □ Asian □ Other

Contact Information:

Cell: _____ Work: _____

Home #: _____ Email address: _____

Is it ok to leave a message at these numbers? (*Circle One*) Yes or No

SS Number: _____ Number of Family supported by income: _____

Estimated Income per year: _____ Employer: _____

Referred By: _____ Phone Number: _____

Emergency Contact Information

Emergency Contact: _____Relationship to Client: _____

Home Phone: _____ Work Phone: _____

In case of an emergency, I give permission for the staff at Red Oak Counseling, Ltd. to call the person listed above and/or (911) for medical assistance and to release any information that will allow for proper medical care.

Client or Parent/Guardian Signature:_____Date:_____

Staff Signature: _____Date:_____

Red Oak Counseling, Ltd.
12970 W. Bluemound Road, Suite 200
Elm Grove, WI 53122
(262) 780-1020 ♥ Fax: (262) 780-1022

Payment Agreement

The following agreement states your financial obligations for psychotherapy and counseling provided by Red Oak Counseling, Ltd.

I understand that:

1) I am responsible for all the fees incurred. Individual, couples, and family sessions are based on a 45-50 minute session. The remaining 10 minutes of the session are used to plan for the next appointment or to follow-up on issues important to your treatment. A sliding fee scale is available to individuals without insurance.

   Initial Assessment: $225
   Individual/Family Therapy: $200
   Group session: $120
   Correspondence fee: $50 per letter

2) All fees are due at the time of service. Red Oak Counseling, Ltd. reserves the right to attempt to collect any unpaid bills by reasonable means. If your account balance is not paid in full your account may be turned over to a collection agency and a collection fee up to 50% may be assessed to any unpaid balance. Non-payment of fees can be cause for termination from treatment.
3) We offer complimentary benefit checks for both in and out of network levels of care. Please keep in mind that the information you receive from us regarding your insurance benefits is what we are quoted from your insurance company & we cannot guarantee the accuracy of the information until we begin receiving the explanation of benefits. If we are informed by your insurance company that you have an unmet deductible, a co-payment and/or a coinsurance as part of your plan, that amount will be due at the time of service.
4) Our contracted rates with the insurance companies that we work with are subject to change at any time and may result in an increase to your out of pocket responsibility. We may not be aware of this change until the explanation of benefits is received.
5) Appointments cancelled without 24-hour notice will be billed at the session rate for that date up to $200 maximum and minimum of $90. I am personally responsible to pay that amount at or before my next appointment. I am aware that insurance plans will not reimburse me for late cancellations or for not showing for appointments and it is my responsibility for payment.
6) I am authorizing Red Oak Counseling, Ltd. to bill my insurance company or other sources of reimbursement for services incurred. In doing so, I also understand that my insurance company, managed care organization, or other source of reimbursement may require direct clinical management in the treatment process. This involvement will directly impact the confidentiality of my records.

Fee Statement

I authorize Red Oak Counseling, Ltd. to release information to my insurance company (or other reimbursement source) in order to process claims for services provided. Please fill out insurance verification form.

Name of insurance Company or Reimbursement Source: _____

Please check options that apply:

□ I am self-paying and agree to pay: $_____ for the assessment $_____ for individual/couples/family $ _____ for group therapy

□ I am utilizing my EAP benefits.

□ I am utilizing my Insurance coverage.

I have carefully reviewed all of the above statements and accept all of the above conditions as indicated. If there are any changes in my insurance benefits I will immediately inform Red Oak Counseling, Ltd. Failure to report changes I agree to all charges.

Client Signature: _____Date:_____

Parent/Guardian Signature: _____Date: _____

Staff Signature: _____Date:_____

RED OAK COUNSELING, LTD.
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Elm Grove, WI 53122
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Health Information

Client Name: _____

Date of Birth:_____ Today's Date:_____

Medical History

Current Primary Care Physician: _____

Address: _____ Phone Number: _____

When was your last visit to your Primary Care Physician? _____
Please list any hospitalizations _____
Please list any serious injuries _____
Please list any chronic medical conditions _____

Current Medications:

Physician Prescribing Medication:_____

Name of Medication	Dosage	Reason for Medication

Have you ever been told that you have Tuberculosis (TB)? □ No □ Yes
Have you ever been told that you have HIV/AIDS? □ No □ Yes
Have you ever been told that you have a STD? □ No □ Yes
Are you currently pregnant? □ No □ Yes # of months: _____
Do you drink coffee or caffeinated soda? □No □Yes Amount: _____
Do you smoke cigarettes/cigars/chewing tobacco? □ No □ Yes Amount: _____
Do you exercise on a regular basis (at least 3x per week)? □ No □ Yes

Nutrition Screen

Have you noticed any appetite changes? □ No □ Yes
If yes, describe _____
Describe your weight. □ Stable □ Weight Gain □ Weight loss
How much did you gain or lose? _____
Have you been in counseling/psychotherapy in the past? □ No □ Yes
If yes, how long ago? _____Where? _____
Did you find it helpful? □ N □ Yes Explain: _____
_____

(Page 2)
Family History:

Mother's Name _____ Age_____Health/Mental Health Problems _____
Father's Name _____ Age_____ Health/Mental Health Problems _____
Spouse's Name _____ Age _____ Health/Mental Health Problems _____

Who raised you? □ Both Parents □ One Parent □ Grandparents □ Other _____
Number of Brothers: _____ Number of Sisters: _____
Number of children you have: _____Ages: _____

Symptoms: Please check all that apply. Please be honest in identifying the symptoms so that appropriate care can be arranged.

o Avoidant	o Abandonment	o Abuse	o Affair	o Alcohol
o Anxiety	o Appetite	o Blended Family	o Body Image	o Children
o Codependent	o Compulsions	o Conduct	o Crisis	o Depression
o Disability	o Disorganized	o Distractible	o Divorce	o Drugs
o Enabling	o Family conflict	o Fear	o Grades	o Grief
o Hyperactive	o Idealization	o Inactivity	o Inattentive	o Inhibition
o Jealousy	o Legal problems	o Marital	o Medical	o Memory Loss
o Oppositional	o Pain	o Panic	o Rage	o Rationalization
o Resistance	o Ruminative	o School problems	o Self-absorption	o Self esteem
o Shame	o Social skills	o Sleep	o Stress	o Trauma

Please provide any additional information that you feel is important to your care:

_____
_____
_____
_____

Please list your goals for therapy:

_____
_____
_____
_____

Client signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Consent for Treatment

The Mission of RED OAK COUNSELING, LTD, is to enhance the well-being of individuals and families in a way that blends traditional and innovative approaches. Creating an atmosphere of dignity and respect while fostering hope and encouragement for our clients.

For the best results and for your own welfare, it is very important that you take the time to read and understand what it means to be receiving psychotherapeutic services from RED OAK COUNSELING, LTD. Please read the brief description below. If you understand it and you choose to receive therapeutic services from RED OAK COUNSELING, LTD. as described here, sign and date this form and return it to your intake interviewer. If you have any questions or concerns, you are urged to talk about them with your intake interviewer.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you solve problems that may be limiting your satisfaction in life, and to help you cope better with the feelings and challenges that you encounter in your daily life.

2. The most common method of psychotherapy involves you talking about your feelings, your problems or concerns, and your experiences and your situation. Other common methods involve using your imagination, keeping personal records of your experiences, and trying new and/or different ways of thinking, acting or feeling. These methods may be used within treatment sessions or you may be asked to do them at home.

3. The length of psychotherapy often depends on your individual needs and the rate of your progress toward the agreed upon goals in your treatment plan. Many therapists use periodic reviews as means of evaluating your needs, progress and satisfaction, and treatment plans are reviewed every three months at RED OAK COUNSELING, LTD.

4. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your psychotherapist. If you feel that your therapist has attempted to violate you in any way – financially, physically, sexually or otherwise – you should inform the state agency responsible for professional licensing. You are also encouraged to contact the Clinical Director at the agency at any time with any concerns or feedback you may have about your therapist.

5. You always have the right to choose whether or not to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist or the Clinical Director at the agency should be able to offer information on possible referrals. Local mental health agencies are listed in the telephone book and they may also offer helpful information. Sometimes it is helpful to participate in different kinds of counseling in addition to or instead of psychotherapy. Some different kinds of counseling are self-help or support groups, therapeutic reading and different forms of religious or pastoral counseling. The agency strongly supports your making the decision to participate in therapy that feels right for you. We will help you to the best of our ability acquire appropriate care.

6. Communication is essential to successful psychotherapy. You are urged to ask questions, express concerns, and share information about your personal life with your therapist. This information must be kept private (confidential) by your therapist unless you grant permission to release it. The only exceptions to this protection of your privacy are dictated by laws and are explained in the Limits of Confidentiality form that will be reviewed with you. If you do not understand the limits of confidentiality you are urged to discuss them with the intake counselor or your therapist.

7. RED OAK COUNSELING, LTD's mental health providers are a diverse group from various disciplines. They include psychiatrists, psychologists, professional counselors, social workers, marriage and family therapists as well as graduate school interns from a number of graduate programs in the state. All of the graduate student interns receive supervision, meaning they consult with mental health professionals about their clients without divulging the clients' names or identifying information. All the other providers are licensed professionals or are actively working toward their licensure through continuing education and supervision. If you have any questions about your therapist, please do not hesitate to ask him or her, or the Clinical Director.

Your signature below indicates that you have read and understood the above description of psychotherapy. Your signature also indicates that you are consenting to be in psychotherapy with the understanding that you retain the right to review and revise the decision at later points in time.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

_____

Staff Signature Date

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AUTHORIZATION TO RELEASE INFORMATION FOR ASSIGNMENT OF INSURANCE/EAP BENEFITS

Please Indicate Your Preference By Signing Either A Or B Below:

A. I hereby authorize Red Oak Counseling, LTD. to release to my insurance company, EAP, and/or associate professionals any information from my medical records which may be necessary to determine benefits payable under my policy and/or expedite treatment. This information may be transmitted electronically with appropriate assurances for confidentiality. I further authorize payment directly to Red Oak Counseling, LTD. for the benefits otherwise payable to me for the amount which covers but does not exceed charges for services delivered. I hereby guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits. I am also aware that any co-payments are expected at the time of service.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouse, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standard and my health information may be re-disclosed without my authorization.

Please Note: If consent has been given to release information to my insurance company, I understand that some communications may be transmitted by facsimile ("fax") or electronically. Although every attempt is made to ensure confidentiality of these transmissions, the nature of this method cannot absolutely guarantee confidentiality.

CLIENT SIGNATURE:_____ DATE:_____

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____

STAFF SIGNATURE_____DATE: _____

B. I **DO NOT** authorize my insurance company/EAP company to be billed and I **DO NOT** authorize any information from my medical records to be released to my insurance company. I understand that I am solely responsible for private payment of all charges incurred with Red Oak Counseling, LTD.
I am aware that payment for service is expected at the time of service.

CLIENT SIGNATURE:_____ DATE:_____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

STAFF SIGNATURE_____DATE: _____

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A Mental Health and AODA Clinic

Confidentiality of Alcohol and Drug Abuse Client Records

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by the Clinic. Generally, the clinic may not say to a person outside the clinic that a client attends the clinic, or disclose any information identifying a client as an alcohol or drug abuse client unless:

(1) The client consents in writing;
(2) The disclosure is allowed by court order;
(3) The disclosure is made to medical personnel in a medical emergency.

Violation of the Federal law and regulations by the clinic is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the clinic or against any person who works for the Clinic or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate State or local authorities.
(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal regulation.)

Confidentiality of Mental Health Client Records

All information concerning your identity and all treatment information in your files at the Red Oak Counseling, Ltd. shall remain confidential. Your records shall be released without your written informed consent **ONLY** as provided under sections 46.21, 46.215, 51.30, and 146.81, et seq., of the Wisconsin Statues, 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 of the federal statues, 42 C.F.R. Part 2 of the federal regulations, or as otherwise allowed or required by state or federal law. They may also be released to other persons with your written informed consent or the written informed consent of a person authorized by you. Feel free to request additional information or have your Therapist/Counselor explain the circumstances under which your records may be released if you wish further clarification.

You are not required to give the Red Oak Counseling, Ltd. any specific information. However, all information that you give will help us gain funds for the services you may receive.

All information that you give will also help your Therapist/Counselor provide you (and your family) with the best care possible. Feel free to have your Therapist/Counselor explain further if you wish clarification.

You have the right to review your file with staff present and to contest the accuracy of any statement in your file with which you disagree.

I have read and understand the above confidentiality policies of client records. I understand that my records may be released to other persons without my informed consent only as provided by State and Federal law, or to other persons with my informed consent or the informed consent of a person authorized by me.

Client Signature: _____Date:_____

Parent/Guardian Signature: _____Date:_____

Staff Signature: _____ Date:_____

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Acknowledgement of Receiving "Notice of Privacy Practices"

I, _____acknowledge
(Please print your name)
that I have received the written "Client Rights and the Grievance Procedure for Community Services" Notice of Privacy Practice as explained by staff of Red Oak Counseling, Ltd. I understand the "Client Rights and the Grievance Procedure for Community Services" and acknowledge the understanding of the process by signing this acknowledgement.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

_____

Staff Signature Date

Red Oak Counseling, Ltd.
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Grievance Procedures Outline

Red Oak Counseling, Ltd. is devoted to providing competent mental health and AODA Treatment to our clientele. The agency would also like every client to know that he/she does have a voice in the kind of care received. Grievances involve complaints about service, breach of confidentiality or abuse. The following instructions are steps to be taken should a client feel the need for resolution of a situation. If level one does not provide satisfactory results, the client should proceed to the next level, and so on.

Level One

One of the most important tools in psychotherapy is the relationship between the therapist and the client. If a client has a discrepancy with the therapist, those issues should first be discussed directly with the therapist. The two parties will discuss the matter and come to an agreeable resolution. If the therapist is a student intern, the student should bring the issue to the attention of the Clinical Director.

Level Two

Clients of **Red Oak Counseling, Ltd.** have a right to speak directly with the Clinical Director if speaking with the therapist has not helped the situation. The Clinical Director will attempt to mediate the difficulties between the therapist and client.

Level Three

At this level, clients should place all grievances and steps that have been taken to remedy the situation in writing using the "Grievance and Complaint Summary Form" within one month of the meeting with the Clinical Director. This form may be obtained from the Client Rights Specialist/Director. The Director will review the situation and meet with the parties involved to discuss a resolution. A letter outlining the agency's position will be mailed to the parties involved within two weeks of the meeting.

Level Four

Clients of **Red Oak Counseling, Ltd.** may present their case to the Advisory Board of **Red Oak Counseling, Ltd.** if the first three steps have proved unsatisfactory. The client may present their grievances to the Board at the next scheduled meeting. The client must submit the written "Grievance and Complaint Summary Form" to attend the Advisory Board meeting which will outline the issues involved two weeks before the board meeting to make space on the agenda or be scheduled for the following meeting. The Advisory board will review the situation in a closed session and decide on an appropriate method of resolution. The Advisory Board's decision will be mailed to all parties involved.

_____

Client Signature Date

_____

Parent/Guardian Signature Date

_____

Staff Signature Date

Red Oak Counseling, Ltd.

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Client Rights

• You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.

• If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.

• You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.

• You have a right to a copy of this signed authorization.

• If you choose not to agree with this request, your benefits or services will not be affected.

Client Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified client. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

This consent expires in twelve (12) months from the date of my signature below unless otherwise stated herein.

Red Oak Counseling, Ltd is authorized to release protected health information related to the evaluation and treatment of:

_____

Client Name Date of Birth

Primary Care Physician Name Primary Care Physician Phone Number

Primary Care Physician Address City State Zip Code

2nd Provider Name 2nd Provider Phone Number

2nd Provider Address City State Zip Code

Disclosure may include the following verbal or written information: (check all that apply)

☐ Client Master Record	☐ History & physical	☐ Laboratory/diagnostic testing results	☐ School information
☐ Discharge summary	☐ Medication records	☐ Behavioral health/psychological consult	☐ Psychosocial assessment
☐ ER record report	☐ Psychiatric evaluation	☐ Psychological evaluation testing results	☐ Other_____
☐ Substance abuse treatment record		☐ Summary of treatment records & contact dates	

___ I hereby refuse to give authorization for any release of information

(Signature of Client, Parent, Guardian or Authorized Representative) (Date)

(Therapist Signature) (Print Therapist Name) (Date)

Office Use Only

Red Oak Counseling, Ltd.

Coordination of Care between Health Care Providers and Release of Information

I want to inform you that _____was seen by me for the treatment
(Client Name)

DSM-V and/or medical diagnosis: _____

Date of appointment: _____

Summary of treatment: _____

_____

_____

_____

_____

The treatment plan consists of the following modalities:

___ Individual Psychotherapy ___ Group Psychotherapy ___ Family Psychotherapy
___ Other (specify) ___ Medication Management (see below)

Current Medication(s) Prescribed at Our Clinic (Dosage, Frequency and Delivery): _____

_____

_____

_____

The following medication was or will be started (indicate medication and dosage): _____

_____

_____

Estimated length of treatment: _____

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug clients.

Client Name: _____

RED OAK COUNSELING, LTD.
ALCOHOL AND DRUG SCREEN SELF-REPORT

❖ **In order to better understand your general health and functioning, please answer the following eleven questions about your alcohol and drug use by checking yes or no. Your responses will be kept confidential. These questions will be reviewed with you and your interviewer as part of the assessment process.**

1. In the last 12 months, has using alcohol or other drugs occasionally caused you to miss work or school, perform poorly at work or school, neglect your children, or fail to perform household duties? □ Yes □ No

2. In the last 12 months, while under the influence of alcohol or some other drug, have you occasionally driven a car, operated dangerous machinery (such as a power mower), or participated in potentially hazardous sports (such as swimming or rock climbing)? □ Yes □ No

3. In the last 12 months, have you been arrested for driving while intoxicated, disorderly conduct, or any other substance related offense? □ Yes □ No

4. In the last 12 months, have you continued drinking or using drugs despite fights or arguments with people close to you expressing concern about your drug or alcohol use? □ Yes □ No

5. In the last 12 months, have you been consuming more alcohol or drugs than you originally intended to at a given time, or does your drinking and drugging go on longer than you originally intended? □ Yes □ No

6. In the last 12 months, have you been wanting to cut down, or have you tried to stop or cut down, and not been able to? □ Yes □ No

7. In the last 12 months, has your tolerance increased - does it take more alcohol or drugs than it used to take to get you high, or achieve the desired effect? Or does a given amount have less effect than it used to? □ Yes □ No

8. In the last 12 months, have you had any withdrawal symptoms? For instance, have you felt shaky the morning after drinking, or thick headed after smoking marijuana, or paranoid after using cocaine? □ Yes □ No

9. In the last 12 months, have you spent a significant amount of time procuring alcohol or drugs, using alcohol or drugs, or recovering from their effects? □ Yes □ No

10. In the last 12 months, have you been spending more time drinking or drugging and less time with friends and family, in work or school-related activities, or pursuing hobbies, sports or other interests? □ Yes □ No

11. In the last 12 months, have you experienced any emotional or physical side effects - such as depression, anxiety, liver damage, or stomach trouble - but continued to use drugs or alcohol anyway? □ Yes □ No

AODA Screen Outcome: _____

(Red Oak Staff Only!)

Staff Signature_____ Date_____

RED OAK COUNSELING, LTD.
12970 W. Bluemound Road, Suite 200
Elm Grove, WI 53122

CLIENT BILL OF RIGHTS AND GRIEVANCE PROCEDURES

When you receive any type of service for mental health or substance abuse you have the following rights under Wisconsin Statute sec. 51.61 (1) and HFS 94, Wisconsin Administrative Code:

Personal Rights

- You must be treated with respect and dignity, free from verbal, physical, emotional, or sexual abuse.
- Staff must make fair and reasonable decisions about your treatment and care.
- No one may treat you unfairly because of your race, national origin, sex, age, religion, disability, or sexual orientation.
- You may not be made to work for the clinic or clinic staff.
- You may use your own money as you choose.
- You may make your own decisions about personal things like getting married, voting, and writing a will.

Treatment and Related Rights

- You must be provided prompt and adequate treatment, rehabilitation, and education services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives and possible side effects of medications.
- No treatment or medication may be given to you without your consent unless it is needed in an emergency to prevent serious harm to you or others, or a court orders it.
- If you have a guardian, he or she can consent to treatment and medications on your behalf.
- You must not be given unnecessary or excessive medication.
- You cannot be subjected to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of costs of your care and treatment services.

Privacy Rights

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

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

Right Of Access To Courts

- You may sue someone for damages or other court relief if they violate any of your rights.

Grievance Resolution Process

- If you feel that your rights have been violated, you may file a verbal or written grievance.
- You cannot be threatened or penalized in any way for filing a grievance.
- The service provider or facility must inform you of your rights and how to use the grievance process.
- You may, at the end of the grievance process, or at any time during it, choose to take the matter to court.

Client Copy

Red Oak Counseling, Ltd.
12970 W. Bluemound Road, Suite 200
Elm Grove, WI 53122
(262) 780-1020 Fax: (262) 780-1022

Notice of Privacy Practices for Protected Health Information

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information, i.e., protected health information, used or disclosed to us in any form, electronically, on paper, or orally, be kept confidential. This federal law gives you, the client, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

OUR RESPONSIBILITIES

Red Oak Counseling, Ltd., understands your privacy is important. We are required by law to maintain that privacy and to provide you with this Notice of Privacy Practices. This Notice is provided to tell you about our duties and practice with respect to your information. We are required to abide by the terms of this Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we use and disclose your health information without your written permission.

- **For Treatment.** We may use health information about you to provide you with diagnosis, treatment or related services and to manage or coordinate your treatment or related services. We may disclose your health information to therapists, case managers or other employees involved in your treatment.

- **For Payment.** We may use and disclose your health information to bill and collect for the treatment and related services we provide to you. We may send your health information to an insurance company or to the third party for payment purposes. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to find out if your plan will cover the treatment.

- **For Behavioral Health Care Operations.** We may use and disclose your health information for behavioral health care operations. These uses and disclosures are necessary to run Red Oak Counseling, Ltd., to make sure you receive competent, quality care, and to maintain and improve the quality of services we provide. We may also provide your health information to various governmental or certification entities to maintain our license and certification.

- **As Required by Law.** We will disclose your health information when required to do so by federal, state or local law.

- **About Victims of Abuse.** We may disclose your health information to notify the appropriate government authority if we believe an individual has been the victim of abuse or neglect. We will only make the disclosure if you agree or when required or authorized by law.

- **Judicial Purposes.** We may disclose your health information in response to a court order.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following right regarding health information we maintain about you:

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or behavioral health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the clinic director. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- **Right to Inspect and Copy.** You have the right to examine and copy your health information and/or billing information.

To examine and copy your file, you can submit your request in writing to the clinic director. To examine and copy billing information, you can submit your request in writing to the billing department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Amend**. You have the right to ask us to amend your health and /or billing information for as long as the information is kept by us.

If you believe the health and /or billing information we have about you is incorrect you can request an amendment. To request an amendment to your health information, your request must be made in writing and submitted to the clinic director. To request an amendment to your billing information, your request must be made in writing to the billing department. Your letter should include your full name, address and telephone number. Your letter should also explain why you believe the health and/or billing information is inaccurate. If we agree with you, we will correct the health and/or billing information and notify you of the correction.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason (s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the health and/or billing information you believe is correct. It should also include the reason (s) why you disagree with our decision to correct the information in our files. We will file your statement with the disputed health and/or billing information. We will include your statement any time we disclose the disputed information.

We may deny your request for an amendment if it is not in writing and does not include a reason to support the request.

- **Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures that we have made of your health information.

To request this list of disclosures, you must submit your request in writing to the clinic director. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a twelve-month period will be free. For additional lists, during the twelve-month period, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

An accounting will not include the following types of disclosure of my heath information:

- Disclosures for purposes of my treatment, payment for treatment and/or the behavioral health care operations of this organization;
- Disclosures made to you or your legal representative;
- Disclosure made under an Authorization signed by you or your legal representative;
- Disclosures permitted under law to be made to other persons directly involved in your care.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact our Privacy Officer at (262) 780-1020.

WHO THIS NOTICE APPLIES TO

This Notice describes Red Oak Counseling, Ltd. services, including Mental Health and AODA treatment.

All of these services follow the terms of this Notice. In addition, these services may share health information with each other for treatment, payment or operations purposes described in this Notice.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in a clear and prominent location to which you have access. The Notice is also available to you upon request. The Notice will contain the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer at (262) 780-1020. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

If you have any questions about this Notice, please contact:
Red Oak Counseling's Ltd. Privacy Officer at (262) 780-1020

Biographical Information Form Instructions

We ask that our new/current clients who are able to enter their information in online please do so. This information is helpful to your therapist and will allow you to cover more in your initial session. Below are the instructions, do not hesitate to let me know if you have any issues or questions.

Here are the instructions:

1.) Go to http://www.therapyappointment.com

2.) Click on the "Find Your Therapist" link in the upper right side of the screen.

3.) Search for your therapist by last name or city (Elm Grove, WI). Click on their name to get to the next step.

4.) Once you click on your therapist's name it will bring you to a login screen. Please login using your first initial and last name for the login name and password temp1234. Example: John Doe would be login name: jdoe and password: temp1234. If you are the parent of a minor and they are the client the information will reflect their name.

5.) Once logged in a list of options will appear, please select the "complete a biographical information form" option and submit when finished.

If you would like to edit your basic information, edit insurance information, change your password, or edit how you would like to be notified for appointment reminders please follow steps 1-4 and then you can edit the information there. Login name and password will be the same as above.

Thank you for your help and we look forward to meeting with you!