Red Oak Counseling, Ltd.

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

8825 S. Howell Avenue, Suite 200
Oak Creek, WI 53154
(414) 215-7554 *Fax:(414)215-7644

Client Master Record

Client Name: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Gender: □ Male □ Female □ Other

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

SS Number: _____ Number of Family Members 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 Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Staff Signature: _____ Date: _____

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 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
   Record Requests Fee: Up to $30

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 & 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. 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 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 canceled without 24-hour notice for therapists will be billed at the session rate for that date up to $200 maximum and minimum of the contracted insurance rate (Contracted rates differ based on the insurance company). I am aware that insurance plans will not reimburse me for late cancellations or for not showing up for appointments and it is my responsibility for payment at or before my next appointment.
6) I am authorizing Red Oak Counseling, Ltd. to bill my insurance company or other source 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 my 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 the individual/couples/family,
and $_____for group therapy.
□ I am utilizing my EAP benefits
□ I am utilizing 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.
If I fail to report changes I agree to all charges
Client Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____
Staff Signature: _____Date: _____

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

_____

_____

_____

Are you currently pregnant? □ No □ Yes # of Months _____
Do you drink coffee of caffeinated soda? □ No □ Yes Amount: _____
Do toy 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? □ No □ Yes
Explain: _____

_____

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: _____

Family History Continued:

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: _____
Parent/Guardian Signature: _____ Date: _____
Staff Signature: _____ Date: _____

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 of 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 help you cope better with the feelings and challenges that you encounter in 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 involved using your imagination, keeping personal records of your experience 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 a 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 exception 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 client's names or identifying information. All the other providers are licensed professionals or are actively working towards 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.

AUTHORIZATION TO RELEASE INFORMATION FOR ASSIGNMENT OF INSURANCE/EAP BENEFITS

Please Indicate Your Preference By Checking 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 of otherwise payable to me for the amount which covers but does not exceed changes for services delivered. I hereby guarantee payment of any and all changes 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 organizations listed above are not health care providers, health plans or a health care clearing house, 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 be facsimile ("fax") or electronically. Although every attempt is made to ensure confidentiality of these transmissions, the nature of this method cannot absolutely guarantee confidentiality.

☐ **B.** I **DO NOT** authorize my insurance/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 charged incurred with Red Oak Counseling, Ltd.

I am aware that payment for service is expected at the time of service.

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 of 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 personal 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 to 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 abut any threat to commit such 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 regulations.

Confidentiality of Mental Health Client Records

All information concerning your identity and all treatment information in your files at 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 Wisconsin State Statues, 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3. of the federal state statutes, 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 Red Oak Counseling, Ltd. any specific information. However, all information that you give will help us gain fund 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.

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 is psychotherapy is the relationship between the therapist and the client. If a client has a discrepancy with the therapist, those issues should 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 the right to speak directly to the Clinical Director if speaking with the therapist has not helped the situation. The Clinical Director will attempt to mediate the difficulties between 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 resolution. A letter outlining the agency's position will be mailed to the parties involved within two weeks of the meeting.

Acknowledgement of Receiving "Notice of Privacy Practices"

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

I acknowledge that I have received the written "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 this process by signing this acknowledgement.

I have read and understand the above confidentiality policy 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 persons with my informed consent or the informed consent of a person authorized by me.

Client Name Printed	Date
Client Signature	Date
Parent or Guardian Signature	Date
Staff Signature	Date

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. The 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 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 _____ Second 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/Physical Consult	□ Psychological Assessment
□ ER Record Report	□ Psychiatric Evaluation	□ Psychological Evaluation Testing Results	□Other _____
□ Substance Abuse Treatment Record		□ Summary of Treatment Records & Contract 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**

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 substances related defense?
□ Yes □ No

4. In the last 12 months, have you continued to drink or use other 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 have 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 interest?
□ 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 continues to use drugs or alcohol anyway?
□ Yes □ No

AODA Screen Outcome: _____
(Red Oak Staff Only!)

Staff Signature: _____ Date: _____

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!

Credit Card Authorization Form

Clinic Name: **Red Oak Counseling, Ltd.**

Name: _____ Date: _____

Card Number: _____Exp. Date: _____

CVV/CVC Code: _____

Card Type (Circle One):

● Master Card ● Visa ● Discover Card ● American Express

Signature: _____

☐ I authorize Red Oak Counseling, Ltd. to use this card for all future sessions and/or missed appointments.

☐ I authorize Red Oak Counseling, Ltd. to use this care for a one-time payment only.
Amount: _____