Madison Art Therapy

Client Intake Packet

For Treatment with Madison Art Therapy

Included in this packet:

Consent for Treatment

Welcome to therapy. We are happy that you have taken the first, and often difficult step, towards investing in your well-being. We are honored and excited to empower and support you through your journey. Therapy can bring about so many wonderful moments but it is important to understand that during your therapeutic journey you may also experience a range of distressing emotions such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have benefits for individuals who undertake and invest in this journey. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

APPOINTMENTS

Appointments will be approximately 1 hour in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours notice. We understand that emergencies do arise, however, if you miss a session without canceling, or cancel with less than 24 hours notice, our policy is to charge for the missed appointment at the rate of $50 [_____ initial]. If possible, we will try to find another time to reschedule. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for the initial intake is $150 and each subsequent session is $150. You may be eligible for an out of pocket discount and/or further discounts when prepaying for sessions. You are responsible for paying at the time of your session unless prior arrangements have been made. We accept cash and checks. In order to make our services more accessible to the community, we may offer a reduced fee based on a sliding scale on a case-by-case basis.

CONFIDENTIALITY

Our confidentiality policies are further outlined in the HIPAA Notice of Privacy Practices and the Client Rights handouts. If you have any questions about these documents or confidentiality please feel free to bring it up throughout your course of treatment. There are certain exceptions to confidentiality within therapy, which you should be aware of before entering into a therapeutic relationship. Please read through these exceptions and be sure to ask your counselor if you have any questions:

- ➢ If you pose a threat of harm to yourself, another person, or the community, we will take whatever steps are required by law, or permitted by law to help prevent the potential harm from happening. This may include contacting your family or law enforcement;
- ➢ In the event of a psychiatric hospitalization
- ➢ If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect;
- ➢ A court order, issued by a judge, could require us to release information contained in your records, or could require a therapist to testify

PARENTS & MINORS
While privacy in therapy is crucial to successful progress, parent/guardian involvement can also be essential. All information pertaining to minors will be released to their parents or legal guardians upon their request, unless it would seriously affect the therapeutic process. The adult accompanying the minor to the appointment is responsible for the payment at the time of service.

I, as the legal parent or guardian agree to allow confidentiality for my minor.

_____ _____

Legal Parent / Guardian Signature Date

CONTACTING US
Phone numbers: **Mary** (608) 305-4325 & **Kelly** (608) 520-0846

We often are not immediately available by telephone. We will not answer the phone when with clients or unavailable. At these times, you may leave a message on our confidential voice mails and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear back from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe:

1. Contact the Dane County 24-Hour Mental Health Crisis Line at 608-280-2600,
2. Go to your Local Hospital Emergency Room, or
3. Call 911 and ask to speak to the mental health worker on call.

In case of an emergency with your therapist, provisions have been made and your case will be handled by either Mary Williams LLC or Kelly Toltzien LLC. Every attempt will be made to inform you in advance of planned absences, and provide you with the name and number of the therapist covering our practice.

OTHER RIGHTS
If you are unhappy with what is happening in therapy, we hope you will let us know so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request to be referred to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Client Name (please print) Date

_____ _____

Client Signature Parent / Guardian Signature (if a minor)

Client Rights

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you provided us with when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes we may leave messages on your voicemail. You have the right to request that our therapists communicate with you in a different way.

1. May we contact you at home? (circle one) **Yes or no?**
2. If yes, may we leave a message? **Yes or no?**
3. May we contact you at work? **Yes or no?**
4. If yes, may we leave a message? **Yes or no?**
5. May we contact you by cellphone? **Yes or no?**
6. If yes, may we leave a message? **Yes or no?**
7. May we contact you by email? **Yes or no?**
8. May we contact you by text message? **Yes or no?**

Right to release your medical record

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records

You have the right to inspect and obtain a copy of your information contained in our medical record. To request access to your billing or health information, contact your therapist. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the cost of copying, mailing, and supplies.

Right to add information or amend your medical records

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact your therapist. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with your family, or information that you gave us specific consent to release. It also excludes information that we are required to release. To

receive information regarding disclosure made for a specific time period no longer than 6 years and after April 14th, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on the use and disclosure of your health information

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to your therapist. However, we are not required to agree to such requests.

Right to complain

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the US Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 14, 2003

We respect our clients and their privacy and are therefore very committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collections purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent. There are some instances where we may be required to use and disclose information without your consent**.** For example, but not limited to; information you and/or your child or children report about physical or sexual abuse: then by Wisconsin state law we are obligated to report this to the Department of Child Protective Services. If you provide information that notifies us that you are in danger of harming yourself or others. Information to remind you of/or to schedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Consent for Disclosure & Acknowledgement of HIPAA

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from your therapist.

I, _____, understand that information pertaining to myself of my dependant's treatment program/therapy will be regularly discussed during staffing between Mary Williams, LLC and Kelly Tolzien, LLC. Confidentiality will be strictly maintained under the guidelines of counseling and art therapy professional ethics. I understand if my therapist is being supervised my case may be discussed during said supervision while still adhering to above stated confidentiality and ethical guidelines.

I, _____, acknowledge that I have been offered a copy of the HIPAA Notice of Privacy Practices and if I would like more information, I may visit www.hhs.gov/ocr/privacy/.

_____

Client / Guardian Date

_____

Therapist Date

Missed Appointments and Scheduling Guidelines

We do understand that life gets busy, things can be forgotten or overlooked, and emergencies or other important obligations come up. However, our time is valuable and we strive to provide as much availability to our clients as possible. Please review each guideline below, initial, and sign at the bottom showing your understanding of said guidelines.

_____If you miss a session without canceling, or canceling with less than 24 hours notice, it is our policy to charge for the missed appointment at the rate of $50 at the therapist's discretion.

_____It is within the therapist's rights to discharge a client upon missing 2 consecutive appointments without canceling or making other arrangements in advance.

_____Unless otherwise notified, we will wait approximately 20 minutes past the scheduled start time of the session but after this time we will consider this a no show and the remainder of your appointment will not be held. This means the therapist cannot guarantee remaining in the office or not filling the appointment.

_____

Client / Guardian Date

_____

Print Name

Adult Personal History (18 & Older)

Name: Date:

Address:

Phone: Email:

Date of Birth:

Primary Physician: Phone:

Please fill out as much as you feel comfortable with at this time. The more information you can provide us with the better. However, we understand that some of this information is difficult to share.

RELATIONSHIP STATUS (Circle or Check all that apply):

Unmarried In a relationship Live together Married Separated Divorced Widowed

Name of Significant other: # of years together:

Who lives in your home?

Any children or Step-children?

Number or brothers/sisters: # living: # older than you:

Family members you are close to now:

What RECENTLY HAPPENED to make you decide to seek help now?

What would you like to achieve during your treatment?

Have you ever sought treatment for Mental Health issues in the past? When?

Past reason(s) for seeking treatment:

How was it helpful or not?

CIRCLE any of the following that apply to you now or within the past month:

Depression	Increased alcohol/drug use	Nervous/anxious
Crying spells	Risky activity	Panic attacks
Hopelessness	Blackouts/memory loss	Difficulty concentrating
Relationship breakup	Withdrawal symptoms	Confusion
Loneliness	Financial worries	Mood swings
Emptiness	Loss of control in:	Racing thoughts
Loss of appetite	-alcohol	Fear of dying
Sleep disturbance	-overeating/bingeing	Job stress
Nightmares	-purging	Decreased activity
Thoughts of harming self	-yelling/breaking things	Not seeing friends
Thoughts of harming others	-hitting people	Feeling controlled
Suicide attempts/injuries	-endangering self	Feeling talked about
Hearing voices	-endangering others	Guilt/shame
Seeing things other don't	-spending	Sexual problems
Unusual or racing thoughts	-gambling	School problems
Feeling overwhelmed	Anger	Impulsivity
Other:_____		

Please explain selected items:

RELIGION/SPIRITUALITY:

What is your religious/spiritual background, if any?

Do you have any current religious/spiritual activity?

ETHNICITY:

What is your ethnic background?

Any ethnic problems or concerns?

EDUCATION: Last grade completed:_____ Degree:_____ In school now?_____

Special training or skills:

Hope/plan to go to school?

Have a learning difficulty?

EMPLOYMENT:

What do you do for a living?

Employer: Years on job:

If no, when did you last work? Looking for work now?

Any job problems now?

INTERESTS/ACTIVITIES (Circle or check):

Television	Being with friends	Shopping	Fix/repair things
Movies	Being with family	School	Sew/knit/crochet
Music	Being alone	Build/create	Play instrument
Cooking/eating	Exercise	Gardening	Singing
Going to museums	Playing sports	Photography	Dancing
Volunteer work	Watching sports	Video games	Writing
Reading	Traveling	Sex	Prayer/church
Gambling	Child-care	Camping	Drawing/artmaking
Pets/animals	Hiking	Nothing	

Other interests/activities:

Have you recently lost interest in activities you normally enjoy?_____

Do you feel you spend enough time on your interests or non-work activity?_____

ALCOHOL & DRUG HISTORY:

Do you currently use drugs or alcohol? If yes, how often and how much? If no, have you in the past?

_____

_____

_____

Have you ever wanted to reduce the amount of or frequency of your use of alcohol/drugs?_____

Has somebody else wanted you to reduce or stop your alcohol or drug use?_____

Has your use of drugs or alcohol negatively impacted your family, work, school, or other aspects of your life? If yes, which areas and how?

_____

_____

_____

PHYSICAL HEALTH:

Please circle or check each item that has applied to you in the past or now:

Allergies
Severe Headaches/migraines
Genetic disorder
Asthma
Frequent neck/shoulder pain
Accidents
Ulcers
Head injuries
Weight gain
Cancer
Physical abuse
Weight loss
Stomach problems
Sexual abuse
Hernia
Pancreatitis
Premenstrual Syndrome
Irritable bowel
Chronic pain
Sexually transmitted diseases
Diabetes
Cardiac disease
HIV/AIDS
Chronic fatigue
Respiratory problems
High or Low blood pressure
Impotence
Hepatitis
Circulation problems
Fibromyalgia
Hypoglycemia (low blood sugar)
Vision problems
Major surgeries
Thyroid problems
Broken bones
Dental problems
Liver disease
Speech problems
Hearing problems
High cholesterol
Reproductive concerns
Other_____

Please describe your selections including treatments (use back of sheet if necessary):

Please list all current medications:

Date of last physical:_____ Results:_____

Do you eat a regular balanced diet?_____ Do you skip meals? _____

Any poor eating/junk food habits? _____

Do you exercise regularly?_____ If so, how often and what do you do? _____

How many hours of sleep do you get on average?_____

Do you feel like this is too little or too much?_____

Do you have concerns about your physical health?_____

If yes, if this something you would like to address in your therapy?_____