Thank you for your interest in becoming a teletherapy client at Counseling Associates.

Contained in this packet are the necessary materials that Counseling Associates will need to proceed in scheduling an appointment for you.

We will need these materials completed and returned to us before proceeding in scheduling your appointment. Any questions can be address our contact form on counselingassociateslax.com or calling (608) 785-0827. For your convenience we have the following checklist:

[ ] Consent for teletherapy consultation signed and dated

[ ] Client information form completed and signed and dated by BOTH X.

[ ] Copy of insurance card. If not able to copy, please fill in the appropriate section on the client information card.

[ ] Personal history form completed.

[ ] Review the Informed Consent Notice. This does not need to be returned and is for your information only.

[ ] Review the Client Privacy Rights. This does not need to be returned and is for your information only.

The completed materials can be forwarded to Counseling Associates via one of the following:

Scan and send to counselingassociateslax@gmail.com
Fax: 1-608-785-0273
Mail: Counseling Associates
115 5th Avenue S, Suite 301
La Crosse WI 54601

We look forward to serving you!

Counseling Associates, LLC
115 5th Avenue S. Suite 301
La Crosse, WI 54601
Ph: 608-785-0827
Fax: 608-785-0273

CONSENT FOR TELETHERAPY CONSULTATION

Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. Teletherapy based services may not be as complete as face-to-face services.

1. I understand that my therapist wishes me to engage in a teletherapy consultation.
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information apply to teletherapy and my rights are detailed in the form CLIENT PRIVACY RIGHTS.
4. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunication equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the therapist to do the same on their end.
5. I understand there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be interrupted by unauthorized persons.
6. There are risks that services could be disrupted or distorted by unforeseen technical problems.
7. I understand that I may benefit from teletherapy, but results cannot be guaranteed or assured. I understand that there are risks and benefits associated with any form of psychotherapy, and despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may get worse.
8. Teletherapy does not provide emergency services. If I am experiencing a medical emergency I understand I can call 911 or proceed to the nearest hospital emergency room for help.
9. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

I have read, understand and agree to the information provider regarding teletherapy.

Client's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

COUNSELING ASSOCIATES CLIENT INFORMATION FORM

Purpose: We are usually quite successful in helping people cope with stress and difficulties, although no one can solve your problems for you. Your counselor will listen and be helpful to the fullest extent of his/her professional capabilities. It is by discussing your thoughts and feelings that we can work as a team to obtain the best results. All counseling sessions are completely confidential. No information will be released without your consent. **Please print legibly.**

TODAY'S DATE:_____

CLIENT NAME:_____ BIRTHDATE: _____ ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____ PHONE#_____ COUNTY OF RESIDENCE:_____ SEX: [ ] MALE [ ] FEMALE [ ] OTHER	RESPONSIBLE PERSON (if not the client): NAME:_____ RELATIONSHIP TO CLIENT:_____ ADDRESS:_____ CITY:_____STATE:_____ ZIP:_____PHONE#_____ COUNTY OF RESIDENCE:_____

CELL PHONE:_____ EMAIL:_____

HOME PHONE:_____ WORK PHONE:_____

IS IT OK TO LEAVE A MESSAGE AT HOME PHONE? [ ] YES [ ] NO

CLIENT MARITAL STATUS: [ ] SINGLE [ ] DIVORCED [ ] WIDOW(ER) [ ] MARRIED
[ ] SEPARATED [ ] DOMESTIC PARTNER

EMPLOYED: [ ] FULL TIME [ ] PART TIME [ ] SHELTERED EMPLOYMENT [ ] RETIRED
[ ] HOMEMAKER [ ] UNEMPLOYED [ ] DISABLED [ ] STUDENT

EMPLOYER:_____

IN CASE OF EMERGENCY CONTACT: NAME:_____
PHONE:_____ RELATIONSHIP:_____

CLIENT'S CURRENT MEDICATIONS:

_____

_____

ANY ALLERGIES? _____

PHYSICIAN: _____ PHONE # _____
PERMISSION TO CONTACT PHYSICIAN? [ ] YES [ ] NO

HAS THE CLIENT EVER HAD COUNSELING? [ ] YES [ ] NO WHEN? _____
BY WHOM? _____ WAS IT HELPFUL? _____

Financial Agreement

____ **Self-Pay**: I will be paying for the services I receive at this clinic. I will make a full payment of $_____ each time I come unless other approved arrangements have been made.

NOTE: If you choose this option, this clinic will not bill any insurance company at a later date.

____ **Insurance payment**: I will give all insurance information required to the staff and request that they submit the charges to my insurance company for payment. I understand my insurance may not pay in full or may deny my services. I understand that I am financially responsible for all charges. This includes my deductible and/or copay. I authorize this clinic to furnish to my insurance company all information that may be required in order to process the claims for me and/or my dependents.

Please present your insurance card at the time of the initial appointment. If you **do not have your insurance card** please fill out the following **thoroughly**:

Name of Insurance: _____

Address of Insurance Company: _____

Policy/ID#:_____ **Group#:** _____

Name of Policy Holder:_____ **Employer:** _____

All counseling appointments are scheduled in advance. We reserve a specific time period to each client. It is important that you realize that a block of time has been set aside for you. We request notification 24 hours prior to appointment if at all possible. If an appointment is not cancelled you may be responsible for a 50.00 No-Show charge.

Assignment of Benefits

I hereby instruct and direct my insurance company to pay for my services by electronic payment of check made out and mailed to: Counseling Associates, LLC, PO BOX 185, Winona, MN 55987
If my current policy prohibits direct payment to provider, I hereby also instruct and direct my insurance company to make the check out to me and mail it to the above address for the professional or medical expenses allowable for the professional or medical expenses allowable, and otherwise payable to me under my current policy as payment toward the total charges for services rendered. This is a direct assignment of my rights and benefits under this policy. I have agreed to pay any balance of said charges for professional services over and above this insurance payment. A copy of this assignment shall be considered as effective and valid as the original.

X **Client signature** (Parent if Minor): _____ **Date:** _____

Therapist: _____ Witness: _____

INFORMED CONSENT

By my signature, I am indicating I have read and understood the Informed Consent Notice and the notice of Privacy Practices. I am requesting professional services from Counseling Associates, LLC. I understand that I can discuss any questions or concerns I have regarding my treatment, or these policies with my counselor or their supervisor. I also understand I may withdraw this consent and terminate counseling at any time for any reason, but it must be in writing and signed by myself or my legal guardian.

X **Client signature** (Parent if Minor): _____ **Date:** _____

Therapist signature _____ Date: _____

Consent effective no longer than 15 months from date signed.

COUNSELING ASSOCIATES, LLC

Personal History Form

CLIENT NAME: _____ **Preferred Pronoun:** _____ **DATE:** _____

BIRTHDATE: _____ **AGE:** _____ **REFERRAL SOURCE:** _____

Form completed by: [ ] Client [ ] Other: _____

Phone number: _____ **Email:** _____

OK to leave message? [ ] Phone [ ] Email

PRESENTING PROBLEM(S) (Issues you are seeking therapy for):

- How long have you had the current problem(s)?
- How stressful is this to you? Minimal----------Mild----------Moderate----------Severe
- How have you attempted to cope with this problem?

What are your symptoms? [ ] sleep disturbance [ ] low interest/motivation [ ] energy level

[ ] concentration problems [ ] appetite problems [ ] hopelessness [ ] thoughts of self-harm/suicide

[ ] anxiety [ ] panic attacks [ ] nightmares [ ] flashbacks [ ] OCD symptoms [ ] Others:

What effect do these symptoms have on your life? Minimal----------Mild----------Moderate----------Severe

Do you regularly use alcohol? No Yes In a typical month, how often do you have 4 or more drinks? _____

How often do you engage in recreational drug use? Never----Rarely----Monthly----Weekly----Daily

Do you consider this alcohol/drug use a problem? No Yes Unsure

Are there cultural considerations that need to be taken into consideration in your treatment?

[ ] No [ ] Yes Specify:

What is your current living situation, employment/school status, marital status?

WHAT ARE YOUR PAST/CURRENT/IMPENDING STRESSORS?

[ ] Deaths	[ ] Divorce	[ ] Frequent relocations
[ ] Physical/sexual abuse	[ ] Alcohol/drug abuse	[ ] Psychiatric illness
[ ] Attempted/completed suicide	[ ] Financial crisis/unemployment	[ ] Legal problems
[ ] Debilitating injuries/disabilities	[ ] Serious illness	[ ] Other: _____

HAVE YOU EXPERIENCED ABUSE? [ ] None [ ] Unsure [ ] Emotional [ ] Physical [ ] Sexual

- At what age?
- By whom?

FAMILY OF ORIGIN (parents, siblings, relationships, places lived, family mental health history, substance abuse issues):

In general, how would you describe your childhood? Very happy---Mostly happy---Average---Unhappy---Very unhappy

Why?

Who do you consider a source of support for you?

Medical History: (Current health, allergies, current medications, medical hospitalizations, injuries)

Psychiatric History: (Hospitalizations, outpatient treatments, previous medications)

Other agency/Legal involvement: (Probation, arrests, current court issues, case management)

What do you hope to achieve through treatment?

How optimistic are you that your concern(s) can be addressed? Not at all---Mildly---Moderately---Highly

Informed Consent Notice

Counseling Associates, LLC

This notice describes how medical information about you may be used and disclosed, your rights as a client, risks and benefits of treatment, and the administration of treatment within this agency. Our commitment is to serve our clients with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

RISKS AND BENEFITS

When receiving treatment for health problems there are usually both risks and benefits. It is the same for mental health treatment and counseling. Risks or side effects may include discomfort from sharing personal information, or discomfort from trying/applying treatment strategies to your daily living routine. There also may be times of strong, sometimes unpleasant feelings. However, this is a normal part of the counseling process and can be discussed with your therapist at any time. Although there are possible risks to counseling, the possible benefits can be even more substantial. These benefits include an increase in ability to cope with life stressors, decrease in mental health symptoms, better relationships, increased self-understanding and acceptance, and an overall feeling of being understood and unconditionally accepted. These are a few examples of potential benefits. As the client, or guardian of the client, you have numerous rights (refer to Client's Bill of Rights). One of which is the right to refuse or decline any proposed treatment methods or services. However, your refusal may have a number of consequences including: symptoms or problems may become chronic or intensify; symptom relief may take longer to achieve; your treatment options may decrease; et cetera.

CONFIDENTIALLY

During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples or instances where information may be shared:

- For payment purposes, we may use the services of a billing service
- During health care operations, we may need a second opinion
- Health Insurance companies may request additional information
- Therapists receiving supervision will need to consult with their supervisor to ensure you are receiving the best clinical services possible
- If you are receiving treatment from other resources, collaborating with those professionals to provide the best and most consistent care

Other reasons that confidentially may be broken include the following:

- In certain situations, involving suicide or threatening another person's life
- The possibility of abuse or neglect of a child or vulnerable adult
- Court ordered release of records

The professionals at Counseling Associates are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above

are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

TREATMENT

When attending counseling sessions, there is usually an order to the process. On the day of your first session you will be asked to fill out forms that provide us with your personal information such as: name, address, age, why you are seeking counseling, et cetera. You will also provide information pertaining to your preferred method of payment. During your first session with your therapist you will be asked to discuss your current issues. You may also be asked questions regarding your family, current or past relationships, previous counseling, current and past medications, et cetera. The information you provider will be kept confidential, as mentioned previously. Gathering information about your past and present circumstances is necessary for planning and providing the best possible treatment. Depending on your given situation, you may receive a diagnosis. Again, this allows the counselor to create the most appropriate treatment plan. A multitude or treatment models exist in the counseling field. The most common ones used at this agency are Cognitive-Behavioral Therapy, Dialectical Behavior Therapy, Gestalt, Choice Therapy, and Relaxation/Anxiety Reduction. It may take time and several strategies to find the best method for you as an individual. Discussing your goals for treatment and requesting alternative strategies is an important part of your active participation in the counseling process.

CLIENT'S BILL OF RIGHTS

- Receive respectful treatment
- Refuse treatment or a particular intervention strategy
- Ask questions at any time
- Have full information about fees, method of payment, insurance reimbursement, etc.
- Choose your own lifestyle and to have that choice respected by your counselor.
- Have full information regarding counselor qualifications to practice, including licensure or registration, training, experience, etc.
- Consult as many counselors as you choose
- Talk about any part of your counseling with anyone you choose
- Withdraw informed consent at any time
- Decline any referrals the therapist may suggest
- Inspect and receive a copy of any material to be disclosed to another individual or agency/organization

CLIENT PRIVACY RIGHTS

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. In general, this consists of medical and billing records. To inspect and copy medical information that may be used to make decisions regarding your care, you must submit your request in writing to the Counseling Associates, LLC professional who is treating you. If you request a copy of this information, we may charge a fee for the costs of copying, mailing, or other supplies associates with your request.

We may deny your request to inspect and copy your records in certain very limited circumstance. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the clinic will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Counseling Associates, LLC. To request an amendment, your request must be in writing and submitted to the Counseling Associates, LLC professional who is treating you. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

-Was not created by us, unless the person or entity that created the information kept by or for Counseling Associates, LLC.
-Is not part of the information which you would be permitted to inspect and copy; or
-Is accurate and complete

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of other agencies that have requested information from your medical history at Counseling Associates, LLC. To request this list or accounting of disclosures, you must submit your request in writing to the Counseling Associates, LLC professional who is treating you. Your request should indicate in what form you want the list (e.g. Paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operation. You also have the right to request a limit on the information we disclose about you to someone who is involved in your care or the payment for your care. To request restrictions, you must make your request in writing to the Counseling Associates, LLC professional who is treating you. 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 wish the limits to apply.

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 with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Counseling Associates, LLC professional who is treating you. We will not ask the reason for your request. Your requests must specify where you wish to be contacted.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to provide you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are also entitled to a paper copy of this notice.

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 CAREFULLY: If you have any questions about this notice, please contact the Counseling Associates LLC professional who is treating you.

WHO WILL FOLLOW THIS NOTICE: This notice describes Counseling Associates' practice, how all clinics, sites, and locations will follow the items of this notice. These clinics, sites, and locations may share information with each other for the purpose of treatment, payment, and operations.

OUR PLEDGE REGARDING MEDICAL INFORMATION: We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at this center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Counseling Associates LLC whether made by personnel or your therapist.

We are required by law to:
-Make sure that medical information that identifies you is kept private
-Give you this notice of our legal duties and privacy practices with respect to medical information about you.
–Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of use or disclosure, we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use information about you to provide you with treatment or services. We may disclose information about you to doctors, therapists, nurses, case managers, medical students, or other personnel who are involved in taking care of you.

For Payment: We may use and disclose information about you so that the treatment and services you receive may be billed to and payment collected from an insurance company, you, or a third party.

Family and Friends: We may use or disclose information to a family member, a personal representative, or another person responsible for your care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Health Care Operations: We may use and disclose information about you for our agency's operations, to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine information from other mental health care facilities

to decide if additional services should be offered and what services may be needed. We may also disclose information to doctors, therapists, nurses, medical students, and office staff for review and learning purposes.

Appointment Reminders: We may use and disclose information to contact you as a reminder that you have an appointment.

Treatment Alternatives: We may use and disclose information to tell you about health-related benefits and services that may be of interest to you.

Research: Under certain circumstances, we may use and disclose information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who one treatment to those who received another for the same condition. All research projects, however, are subject to a special process. Before we use or disclose medical information for research, the project will have been approved through a research approval process, but we may, however, disclose information about you to people preparing to conduct a research project so long as the information they review does not leave Counseling Associates, LLC. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

As Required by Law: We will disclose information about you when required to do so by federal, state, or local law. For example, Ombudsman, Child Protection, and a Valid Court Order.

To Avert a Serious Threat to Health or Safety: We may use or disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Special Situations:

Military and Veterans: If you are a member of the armed forces, we may release information about you required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release information about you for workers' comp or similar programs. These programs provide benefits for work related injuries or illnesses.

Public Health Risks: We may disclose medical information about you for public health activities. These activities generally includes the following:

- To prevent or control discuss
- To report birth, deaths, and serious injuries
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law and Disputes: If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by law enforcement officials:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime if, under certain limited circumstance, we are unable to obtain the person's agreement.

- About the death we believe may be the result of criminal conduct.
- About criminal conduct at Counseling Associates.
- In emergency circumstances to report a crime, the location of the crime or victims, the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We may release information to a coroner, medical examiner, or funeral director. This may be necessary to identify a deceased person or determine the cause of death.

National Security and Intelligence Activity: We may release information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose medical information about you to authorized general officials so they may provide protection to the President, other authorized persons, or foreign heads of state or conduct special investigations.

Inmates: If you are and inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety of the correctional institution.

Business Associates: We may disclose your health information to a business associate whom we contract with to provide services on our behalf. To protect your health information, we require for business associates to appropriately safeguard the health information of our clients.

Changes to this Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical 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 the Agency. The Notice will contain the effective date. In addition, each time you register for healthcare services as an outpatient, we will have available a copy of the current notice in effect.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Counseling Associates, LLC or with the Secretary of the Department of Health and Human Services at 612-296-3971. To file a complaint with Counseling Associates, contact Mario Einsman, Director, at 608-785-0827. All complaints must be submitted in writing. **You will NOT be penalized for filing a complaint. You may not be intimidated, threatened, coerced, discriminated against, or subjected to retaliatory action for the exercise of any right established, or for the participation in any process provided.**

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.