LIVING WELL
CHRISTIAN FAMILY CLINIC

Client Intake Info Sheet

Enclosed are informational forms for you to review and complete. This will expedite your therapist's assessment and evaluation of the concerns that prompted your requesting Christian counseling services.

For Your Review:

Please review these enclosures carefully and be prepared to discuss any questions you may have at your initial intake session.

- ☐ **Informed Consent to Treatment**- detailed information about our services and treatment
- ☐ **Privacy Practice Notice**- information on your privacy rights (HIPAA).
- ☐ **Fee and Insurance Information**
- ☐ **Client Rights and the Grievance Procedure brochure**
- ☐ **Mission Statement**

To Be Completed:

Attached to this document are several intake forms to fill out and bring with you to your first appointment. The intake forms are fillable documents, so if preferred you may fill them out electronically and then bring the printed forms with you. If attending therapy as a couple or family, each person attending therapy will need to fill out the forms.

- ☐ **Confidential Contact Form**- (only one form needed if client is a couple or family)
- ☐ **Intake Form**
- ☐ **Health Report**
- ☐ **Cross Cutting Symptom Measure**
- ☐ **Substance Use History Report**

Please arrive 10-15 minutes early to fill and sign any remaining forms at your first session.

Financial Arrangements:
Methods of payment include check, cash, or health insurance. Please bring your insurance card with you to your first session if you would like us to file a claim for services received. If you are planning to use your Employee Assistance benefits (EAP), please bring your authorization information to the first session.

We are pleased to be of service to you. We pray that you will benefit from your contact with Living Well Christian Family Clinic. Please feel free to contact our office with any questions at 608-783-1452.

LWCFC INFORMED CONSENT TO TREATMENT INFORMATION

Welcome to the Living Well Christian Family Clinic Counseling, LLC (LWCFC). Thank you for choosing LWCFC to assist you. We pray that the matters you bring are resolved to the glory of our loving Lord.

LWCFC, founded in 2008, is a state certified outpatient mental health clinic committed to providing quality counseling services by professionally trained therapists in a supportive, Christ-centered environment. It is our prayer that your relationship with your therapist will help you and/or your family members to gain better insight into your daily living and to grow towards a healthier more satisfying Christian life. This requires mutual effort by both you and your therapist, along with the strength of our gracious Lord. Living the Christian life is both a joy and a challenge for all of us.

The following is important information about our services and your treatment. Please read it carefully and feel free to ask questions about anything that you do not understand.

CONFIDENTIALITY

The therapy relationship is confidential. Your therapist cannot release any information about the therapy process without your written permission. This includes the fact that you are a client here. Confidentiality is governed by Federal and State law and LWCFC will abide by the law. When a couple seeks marital therapy, the therapy notes are "owned" by the couple. The signatures of both participants will be required to release information to third parties such as attorneys.

However, confidentiality does have its legal and ethical limitations. A therapist may break confidentiality if, in his/her clinical judgment, it is necessary to protect the safety or welfare of you (the client) or another person. If you threaten to hurt yourself or someone else, or raise suspicion of child abuse or neglect, your therapist is bound by law to report it to the proper authorities.

In addition, your therapist may discuss your case with other LWCFC professional staff and contracted consultants for purposes of effectively coordinating treatment and/or to meet state mandated requirements.

THE PROCESS OF THERAPY

Depending on the personalities of the client and therapist and the issues that the client brings, therapy may vary. There are different approaches to address different problems. The currently acceptable treatment modes to help you with your specific situation will be discussed with you. Be assured that the specific approach agreed upon to help you will be a God pleasing one. Psychotherapy requires an active effort on your part. Together with the therapist you will choose how to approach your concerns. To be successful you will have to work toward goals both during sessions and at home.

Psychotherapy has both benefits and risks. Psychotherapy has been shown to reduce feelings of distress, create better relationships and resolve specific problems. Risks include experiencing increased uncomfortable feelings such as sadness, guilt, anxiety, anger, loneliness, and helplessness that may be part of the process of change. Relationships may also be affected. Side effects or risks of side effects from any psychotropic medications should be discussed with your physician.

Assessment and Treatment Planning

There are two main steps in psychotherapy. The first step is assessment. You and your therapist will spend time evaluating your needs, goals, and gathering pertinent information. A treatment plan will be completed and will include an initial assessment, diagnosis (as appropriate), your treatment goals, and intervention techniques to accomplish these goals. You will then need to decide whether to continue the therapy process. If you choose not to work with your therapist, your therapist will refer you to another mental health professional in your area. Therapy involves a commitment of time, energy, and money, and any questions you have about the process should be discussed whenever they arise. Should you choose to not pursue therapy or discontinue prematurely against your therapist's advice, your symptoms may return and/or worsen.

The second step is the actual therapy. While the first step usually takes 1 to 2 sessions, the actual number of sessions needed to accomplish goals for clients will vary greatly. Some matters are quite complex and considerable time is needed to accomplish the goals. Other situations take less time to resolve. Your therapist will make every effort to be as time and cost efficient as possible to help you resolve your concerns.

After the initial intake, psychotherapy typically occurs in 45 or 60 minutes blocks of time. A session usually occurs once per week to begin with and then, as progress toward your goals for therapy is being made, the time between your sessions is spread out. This is tailored to the needs/agreement between client and therapist.

Treatment goals will also be reviewed with you whenever requested, and after 90 days or 6 sessions (whichever covers the longer period). This allows you to discuss progress, approaches, and goals moving forward, or to determine successful completion of your goals.

SCHEDULING AND REMINDERS

LWCFC business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday. Please call during these hours, especially when you are making or changing appointments, have questions regarding your bill, insurance, etc.

LWCFC uses an appointment reminder call service. Please be sure you have given staff your preferred phone number for this service. However, be aware the responsibility to attend or cancel appointments is the client's, even if a reminder call does not come.

CANCELLATION POLICY

Due to the nature of therapy, your commitment to the therapy process is important and includes keeping your scheduled appointments. **Our cancellation policy requires a 24-hour notice of any cancellations (except for emergencies or other circumstances beyond your control). If such notice is not given, a $75.00 fee will be charged to you and not to your insurance. Also, after 2 incidents of no show or late cancellation, any future appointments already scheduled will be cancelled. You will need to contact your therapist to discuss scheduling your next appointment.** It is also important for you to be prompt for your sessions; the charge will not be reduced if you are late.

E-MAIL

Even when utilizing a HIPAA compliant email service, **there are risks associated with privacy when using e-mail communication**. LWCFC cannot guarantee that e-mail communication will be confidential; therefore clients are urged to be mindful of the information communicated with staff.

E-mail may be used to arrange administrative related tasks such as scheduling or cancelling appointments**. E-mail is NOT an appropriate form of communication for emergencies**, especially as staff cannot guarantee e-mails will be monitored or responded to in a timely fashion. Therapists will not conduct therapy via e-mail but may provide follow up information or resources for clients, or for other purposes as agreed upon in therapy sessions.

FEES AND INSURANCE

Therapy is typically conducted in 45 or 60 minute sessions. The therapy is billed using CPT codes. The fees for a master level therapist in training are the same as that for a licensed therapist. A therapist in training works under the supervision of a qualified supervisor. The current fees for therapy at LWCFC (and the corresponding CPT Codes) are available upon request.

LWCFC billing is divided into two categories:

1. Non-insured services - Payment for services is due on the day of the scheduled appointment. Checks are to be made out to LWCFC. Major credit cards are also accepted.

2. Insured services - Your health insurance may cover all or a portion of the fee. We cannot guarantee payment from your insurance company. To avoid disappointment, we strongly suggest that clients contact their insurance

company to make certain that their mental health insurance assumptions are correct. As you know, most insurance companies pay only a portion of the provided services. Further, clients must realize that professional services are rendered to a person, not to the insurance company. Hence, the insurance company is responsible to the client and the client is responsible to us. We cannot render services on the assumption that the charges will be paid by the insurance company. Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute is between you and your insurance carrier. Our office will not be involved in the settlement of such disputes. The final responsibility for the services provided to you is yours.

You will be asked to sign a form giving LWCFC your permission to release sufficient personal health care information to file the claim with your insurance company.

It is our practice to receive payment for co-pays, co-insurance, and deductibles at the time of your visit.

Payment methods include check, credit card, or cash. If the check is not cleared at the bank due to insufficient funds and LWCFC incurs a fee from the bank, you are responsible for paying $25 in addition to what you may already owe.

You will receive monthly statements that will notify you of any balance on your account. Unless prior arrangements are made, past due balances may be submitted to a third party, such as a collection agency or attorney, for collection. Past due is defined as being 30 days delinquent from the date of billing. LWCFC reserves the right to determine when a past due account is referred to a third party for collection.

EMERGENCY SERVICES

When the Clinic is closed, an outgoing voice mail message will provide the consumer the options to call 911, contact their pastor, or go to the nearest hospital for help. For consumers currently being served by LWCFC and are at risk to hurt themselves, the consumer's provider will work with the consumer to develop a specific action plan to follow when emergency services are needed by consumer.

LEGAL MATTERS

In the event that a therapist is subpoenaed to testify in court and the consumer does not want their privileged and confidential information released to the court and will not sign a release of information form to allow this, all legal costs to prevent the release of information, including attorney's fees to represent the Clinic, will be the responsibility of the consumer. Also, all costs incurred for deposition and court testimony including travel time, cost for travel, preparation time including time spent with legal representation for the Clinic, time waiting to testify, and testifying time will be the responsibility of the consumer. Time spent in communicating with the consumer's attorney, either written (e.g. drafting a letter) or verbal, will be the responsibility of the consumer. Time will be billed at $180 per hour. Mileage will be billed at fifty cents per mile. Paper copies of records will be billed at the following rates: $1 per page for the first 25 pages; 75 cents per page for pages 26 to 50; 50 cents per page for pages 51 to 100; and 30 cents per page for pages 101 and above. A retainer of $1200 is due in advance of giving testimony or communicating with an attorney regarding testimony. A Minimum non-refundable charge for a court appearance, including time waiting to testify, is $1200. If the case is rescheduled without a minimum of 72-hour notice, the client will be charged an additional $500 (in addition to the $1200). Any payment owed above and beyond the retainer is due within 30 days of service.

ALCOHOL / DRUGS

If, in the judgment of the consumer's therapist, the consumer appears intoxicated due to alcohol and / or drugs, the therapist may choose to discontinue the session. The normal fee for the session will be billed to the client and not to insurance, if applicable.

INVOLUNTARY DISCHARGE

A consumer may be involuntarily discharged by the Clinic because of the consumer's inability to pay for services or behavior that is a safety risk for staff or other consumers of the Clinic. Before the Clinic involuntarily discharges a consumer, the Clinic will do the following: notify the consumer in writing of the reasons for the discharge, the effective date of the discharge, sources for further treatment, and the consumer's right to have the discharge reviewed by the subunit of the Department that certifies Clinics.

CLIENT RIGHTS AND SATISFACTION

If you consider the services you received are unsatisfactory or think your rights have been violated, you have the right to use a grievance procedure. Please contact the LWCFC office for an information packet on the procedures to follow. Include your name, address, and phone number. Also, the State of Wisconsin has established a Patient Bill of Rights. (Statute Section 51.61). These rights are posted in our waiting room.

CLIENT ACKNOWLEDGMENT

You will be asked to sign our client acknowledgement document at your first session, and then yearly if applicable. Your signature on this form indicates that:

1. you have received the **Informed Consent to Treatment Information** (this document) and you agree to abide by its stated terms regarding the cost/charges for care and treatment services during your professional relationship with your therapist;
2. you have received the **Privacy Practice Notice**,
3. you consent to enable us to use and disclose your personal health information for purposes of treatment, payment and health care operations;
4. you have received a brochure describing your rights and the grievance procedure; and
5. you have received the handout describing the Mission of LWCFC and Statement of beliefs.

The time period for this informed consent shall be one year. At the end of this time frame this material will be shared with you again and your informed consent obtained. You have the right to withdraw informed consent at any time, in writing. This will, in effect, terminate therapy.

LIVING WELL CHRISTIAN FAMILY CLINIC
PRIVACY PRACTICE NOTICE

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

We respect the privacy of your personal health information. We are committed to maintaining the confidentiality of our clients' personal health information. This notice applies to all information and records related to your care that our Clinic has received or created. It extends to information received or created by our staff and counselors. This notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and our obligations regarding your personal health information.

We are required by law to do the following:

- Maintain the privacy of your protected health information;
- Provide to you this detailed notice of our legal duties and privacy practices relating to your personal health information;
- Abide by the terms of the notice that is currently in effect.

The Living Well Christian Family Clinic ("LWCFC" or "Clinic") participates in an organized health care arrangement. As such, we may share your health information and the health information of others we service with each other as needed for treatment, payment or health care operations relating to our organized health care arrangement.

I. WITH YOUR CONSENT WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

You will be asked, as part of the "Consent for Treatment", to consent to enabling us to use and disclose your personal health information for purposes of treatment, payment and health care operations. We have described these uses and disclosures below and provide examples of the types of uses and disclosures we may make in each of these categories.

FOR TREATMENT: We will use and disclose your personal health information in providing you with treatment and services. We may use and disclose your personal health information to other healthcare personnel in order to treat you or to assist in your treatment. For example, we may consult with the agency's supervising psychiatrist and/or psychologist regarding the course of your treatment

FOR PAYMENT: We may use and disclose your personal health information so that we can bill and receive payment for the treatment and services you receive at our clinic. Unless you object, we may use and disclose your personal health information in order to bill and receive payment for the treatment and services from your health insurance plan. For example, we may contact your health insurance plan to verify that you are eligible for benefits and for what range of benefits.

FOR HEALTH CARE OPERATIONS: We may use and disclose your personal health information in connection with our health care operations. These uses and disclosures are necessary to manage the clinic and to monitor our quality of care. Health care operations include:

- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
  Medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer services, and resolution of internal grievances.

For example, we may use personal health information to evaluate our clinic services, including the performance of our staff.

II. WE MAY USE AND DISCLOSE PERSONAL HEALTH INFORMATION ABOUT YOU FOR OTHER SPECIFIC PURPOSES

APPOINTMENT REMINDERS: We may use or disclose personal health information to remind you of appointments.

TREATMENT ALTERNATIVES: We may use or disclose personal health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

AS REQUIRED BY LAW: We will disclose your personal health information when required by law to do so. Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, certain physical injuries, or respond to a court order.

FOR PUBLIC HEALTH ACTIVITIES: We may be required to report your health information to authorities to help prevent injury. This may include using your health record to report information related to child abuse or neglect.

FOR HEALTH OVERSIGHT ACTIVITIES: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.

FOR ACTIVITIES RELATED TO DEATH: We may disclose your health information to the State Department of Health and Family Services so they can carry out their duties related to deaths associated with a psychotropic medication or suicide.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY: As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to you or the public's health or safety.

FOR MILITARY, NATIONAL SECURITY, OR INCARCERATION/LAW ENFORCEMENT CUSTODY: If you are involved with the military, national security, or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

FOR WORKERS' COMPENSATION: We may disclose your health information to the appropriate person(s) in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OR DISCLOSURES OF PERSONAL HEALTH INFORMATION

You may give us written authorization to use your personal health information or to disclose it to anyone for any purpose. If you give us an Authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your Authorization while it was in effect.

Unless you give us a written Authorization, we cannot use or disclose your personal health information for any reason except those described in this notice.

A NOTE ON OTHER RESTRICTIONS

Please be aware that state and federal law may have more requirements than HIPAA on how we use and disclose your health information. If there are more specific restrictive requirements, even for some of the purpose listed above, we may not disclose your health information without your written permission as required by such laws. We are also required by law to obtain your written permission to use and disclose your information related to treatment for a mental illness, developmental disability, or alcohol or drug abuse.

There may be other restrictions on how we use and disclose your health information than those listed above. We believe state and federal laws discussing such restrictions are Wisconsin Statutes Sections 146.82, 51.30, 895.50 and 905.04; Wisconsin Administrative Code HFS 92 and 124.14; and 42 C.F.R. Part 2 and 45 C.F.R. Parts 160 and 164. If you would like a copy of these laws, please contact the Clinic.

IV. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

While your health records are the physical property of the Clinic, the information contained in the health record ultimately belongs to you. You have the following rights regarding your personal health information that we maintain about you:

CONFIDENTIAL COMMUNICATIONS: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a confidential communication, submit a written request to the Clinic, specifying the requested method of contact or the location where you wish to be contacted. Our Clinic will accommodate reasonable requests. You do not need to give a reason for your request.

REQUEST RESTRICTIONS: You have the right to request a restriction in our use or disclosure of your personal health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we limit our disclosure of your personal health information to individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You may verbally request that we restrict our disclosure of your personal health information, however, we may request you submit your request in writing to the Clinic. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our Clinic's use, disclosure or both; and (c) to whom you want the limits to apply.

ACCESS: You have the right to inspect and obtain a copy of your personal health information that we use to make decisions about you, including medical records and billing records, except as excluded by law such as psychotherapy notes. Submit your request in writing to the Clinic in order to inspect or obtain a copy of your personal health information. We may charge a reasonable fee for our costs in copying and mailing your requested information. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to personal health information, in some cases you will have a right to request review of the denial. This review would be performed by a licensed health care professional designated by the Clinic who did not participate in the decision to deny.

AMENDMENT: You have the right to request that we amend your personal health information if you believe it is incorrect or incomplete as long as the information is kept by or for our Clinic. You may ask to amend your health information. You must make your request in writing, and it must

explain why the information should be amended.

We may deny your request for amendment if the information:

- Was not created by our Clinic, unless the originator of the information is no longer available to act on your request;
- Is not part of the personal health information kept by or for the Clinic;
- Is not part of the information to which you have a right to access; or
- Is already accurate and complete, as determined by the Clinic.

If we deny your request for amendment, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted to amend.

If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting" of our disclosures of your personal health information. This is a listing of certain disclosures of your personal health information made by the Clinic for purposes other than (a) treatment, payment and health care operations, (b) as consented and/or authorized by you, and (c) for certain other activities, as of April 14, 2003. To request an accounting of disclosures, you must submit a request in writing to the Clinic. An accounting will include, if requested: the disclosure date; the name of the person or entity that received the information; a brief description of the information disclosed; and a brief statement of the purpose of the disclosure or a copy of the request. The first accounting within a 12-month period will be free; for further requests, we may charge you a reasonable cost-based fee.

RIGHT TO A PAPER COPY OF THIS NOTICE: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of the notice at any time. To obtain a paper copy of this notice, contact the Clinic.

V. COMPLAINTS

If you have concerns that we may have violated your privacy rights, or you disagree with a decision we made about access to your personal health information or in response to a request you made to amend or restrict the use or disclosure of your personal health information, you may file a complaint in writing with the Clinic. To file a complaint with the Clinic, contact Kim Stein, Client Rights Specialist, at 715-832-1678.

You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to privacy of your personal health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in the Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all personal health information already received and maintained by the Clinic as well as for all personal health information we receive in the future. We will post a copy of the current Notice in the Clinic. We will provide a copy of the revised Notice to all Clients and/or their representatives.

VII. FOR FURTHER INFORMATION

This Notice takes effect April 14, 2003 and will remain in effect until we replace it. If you have any questions about this Notice of our Privacy Practices or would like further information concerning your privacy rights, please contact Joshua Lipps, Clinic Administrator, at 608-783-1452.

LWCFC Fees and Insurance Information- Therapy

Therapy is typically conducted in 45 or 60 minute sessions. The therapy is billed using CPT codes. The fees for a master level therapist in training are the same as that for a licensed therapist. A therapist in training works under the supervision of a qualified supervisor.

The current fees for therapy at LWCFC (and the corresponding CPT Codes) are as follows:

90791	**Psychiatric Diagnostic Evaluation (Initial Intake Session)**	**$225.00**
90832	Psychotherapy with patient or family member, 30 minutes (*16-37 minutes*)	$75.00
90834	**Psychotherapy with patient or family member, 45 minutes (*38-52 minutes*)**	**$150.00**
90837	**Psychotherapy with patient or family member, 60 minutes (*53-60 minutes)***	**$200.00**
90846	Family or couple psychotherapy, without patient present	$175.00
90847	**Family or couple psychotherapy, with patient present**	**$175.00**
90853	Group Psychotherapy (*not family*)	$50.00
CANCELLED	Late Cancellation (less than 24-hour notice given)	$75.00
MISSED	Missed Appointment (no show, no contact)	$75.00

LWCFC billing is divided into two categories:

1. Non-insured services - Payment for services is due on the day of the scheduled appointment. Checks are to be made out to LWCFC.

2. Insured services - Your health insurance may cover all or a portion of the fee. We cannot guarantee payment from your insurance company. To avoid disappointment, we strongly suggest that clients contact their insurance company to make certain that their mental health insurance assumptions are correct. As you know, most insurance companies pay only a portion of the provided services. Further, clients must realize that professional services are rendered to a person, not to the insurance company. Hence, the insurance company is responsible to the client and the client is responsible to us. We cannot render services on the assumption that the charges will be paid by the insurance company. Should there be a dispute related to the service provided or the charge for that service, the settlement of that dispute is between you and your insurance carrier. Our office will not be involved in the settlement of such disputes. The final responsibility for the services provided to you is yours.

You will be asked to sign a form giving LWCFC your permission to release sufficient personal health care information to file the claim with your insurance company.

It is our practice to receive payment for co-pays, co-insurance, and deductibles at the time of your visit.

Payment methods include check, credit card, or cash. If the check is not cleared at the bank due to insufficient funds and LWCFC incurs a fee from the bank, you are responsible for paying $25 in addition to what you may already owe.

You will receive monthly statements that will notify you of any balance on your account. Unless prior arrangements are made, past due balances may be submitted to a third party, such as a collection agency or attorney, for collection. Past due is defined as being 30 days delinquent from the date of billing. LWCFC reserves the right to determine when a past due account is referred to a third party for collection.

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional, or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability, or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting, and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped, or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation, and educational 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 to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, or **a court orders it.** [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject 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 any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

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

- 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 or medications. 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 records 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.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.

- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Care and Treatment Services (DCTS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Care and Treatment Services or designee. Send your request to the DCTS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:

Kim Stein
3410 Oakwood Mall Drive, Ste 700
Eau Claire, WI 54701
(715) 832-1678

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or DHS 94, Wisconsin Administrative Code is available upon request.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
www.dhs.wisconsin.gov
P-23112 (09/2016)

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

LIVING WELL CHRISTIAN FAMILY CLINIC

Mission Statement

The mission of Living Well Christian Family Clinic is to build and strengthen marriages and families and encourage individuals toward positive change and growth in their emotional, personal, and spiritual lives.

Statement of Beliefs

We believe in the Triune God, one God eternally existent in three persons: Father, Son, and Holy Spirit (Matt. 28:19)

We believe that the Bible is the inspired (2 Pet. 1:21), inerrant (1 Cor. 2:13), infallible (Jn. 10:35), and completely authoritative (2 Tim. 3:16) Word of God.

We believe that all people are sinners by nature and activity (Ps. 51:5) and unable to reconcile themselves to God by any human efforts (Eph. 2:1, Rom. 3:9-18).

We believe that salvation is by God's grace and action alone (Eph. 2:8-9) accomplished through His Son, Jesus Christ (Jn. 3:16, Acts 4:12, Gal. 4:4-5).

We believe that Jesus Christ is the eternal Son of God, who became man, lived the perfect life that God requires, died a substitutionary death, and rose again from the dead to atone for the sins of the whole world (Col. 2:9, Acts 2:23-24, 1 Pet. 3:18).

We believe that it is by the working of the Holy Spirit through the Means of Grace that people receive faith in Jesus as their Lord and Savior (1 Cor. 12:3). The Holy Spirit gives believers the wisdom and strength to walk according to His will (Phil. 2:13, Gal. 5:16-25, Is. 41:10).

We believe that Jesus shall return visibly and bodily to judge all people. While unbelievers will be condemned to an eternity in hell, those who believe in Jesus will live with Him forever (Mk. 13:26, Jn. 5:27-29).

LIVING WELL CHRISTIAN FAMILY CLINIC --CONFIDENTIAL CONTACT FORM

Client Name: _____

Cell Phone _____ **E-mail** _____

Home Phone _____ **Address**_____

Other Phone _____ _____

Please describe any restrictions on the means and/or location you want us to use (e.g.- do not leave a message on home telephone number): _____

_____

_____

Appointment Reminders

As a courtesy, our office sends out appointment reminders prior to scheduled appointments. Our cancellation policy requires 24-hour notice for cancelling an appointment.

I prefer to receive my appointment reminders using:

text message ☐ _____

e-mail ☐ _____

I do **NOT** want to receive appointment reminders: ☐

Balance Notifications

Our office is transitioning to electronic notification of balances due on your account. This saves the expense of office printing and mailing paper statements.

These balance notifications contain a link sent to text message or e-mail. You must provide us the cell number and or e-mail you would like to use.

Upon clicking the link in your notification, you are taken to a payment portal where you can log in to see more information about your charges and payments.

I prefer to receive my balance notifications using:

text message ☐ _____

e-mail ☐ _____

I do **NOT** want to receive balance notifications, please mail me a paper statement: ☐

Signature: _____ **Date:** _____

If this request is by a personal representative on behalf of the individual (e.g.- minor child), complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Please refer to LWCFC Privacy Practice Notice for more information on confidential communication and HIPAA
10/22

LIVING WELL CHRISTIAN FAMILY CLINIC, LLC
INTAKE FORM

REFERRAL SOURCE Insurance ☐ Friend ☐ Pastor ☐ Teacher ☐ Phone book ☐ Web ☐ Other ☐

CLIENT

Name: _____ D.O.B _____ Race: _____
First MI Last
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____ How long: _____
Church: _____ Past Military Experience: _____

SPOUSE / PARENT (if client is a minor child)

Name: _____ D.O.B _____ Race: _____
First MI Last
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____ How long: _____
Church: _____ Past Military Experience: _____

PARENT (if client is a minor child)

Name: _____ D.O.B _____ Race: _____
First MI Last
Street: _____ City: _____ Zip: _____
Home phone: _____ Cell: _____ Work: _____
Education (highest level): _____
Employer: _____ Occupation: _____ How long: _____
Church: _____ Past Military Experience: _____

MARITAL INFORMATION

Date married: _____ Present Status: _____
Prior marriages

Husband From _____ to _____ Death ☐ Divorce ☐
Husband From _____ to _____ Death ☐ Divorce ☐
Husband From _____ to _____ Death ☐ Divorce ☐

Wife From _____ to _____ Death ☐ Divorce ☐ Previous name: _____
Wife From _____ to _____ Death ☐ Divorce ☐ Previous name: _____
Wife From _____ to _____ Death ☐ Divorce ☐ Previous name: _____

Children/(Siblings, Step-Siblings)

Name	Age	Grade	Describe relationship with this child
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

LIVING WELL CHRISTIAN FAMILY CLINIC, LLC

HEALTH REPORT

Name: _____ Age: _____

What childhood diseases did you have? _____

_____

What serious illnesses have you had? _____

_____

What operations have you had? _____

_____

List present ailments: _____

_____

What allergies do you have? _____

Please list any prescription or over-the-counter medications you are currently taking and why:

Medication	Dosage (ie: 15ml)	Frequency (ie: 2 times a day)	Purpose

When was your last physical check-up?_____ Results: _____

_____

How is your appetite? _____Have you lost weight in the last three months? _____Gained? _____

If you have gained or lost weight, how much? _____

Do you exercise? _____ If so, what do you do? _____ How often?_____

How many packs of cigarettes do you smoke each day? _____

How many cups of coffee or tea do you drink each day? _____ Sodas? _____ Alcoholic drinks? _____

Is there a history in your family of any of the following? (Check)

☐ High Blood Pressure ☐ Obesity ☐ Gallbladder Disease ☐ High Cholesterol ☐ Diabetes

☐ Neurological Disease ☐ Cancer ☐ Hypoglycemia ☐ Arthritis ☐ Schizophrenia

☐ Upper respiratory problems ☐ Stroke ☐ Heart Disease ☐ Mental Retardation ☐ Dementia

Other health issues: _____

Name of your Personal Physician: _____ Phone: _____

Clinic Name: _____Clinic Address: _____

City: _____ State: _____Zip: _____ May we contact your Physician? ◯ Yes ◯ No

PRESENTING PROBLEM:

Why are you seeking therapy/counseling? _____

_____

_____

_____

_____

MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT HISTORY:

Please list any prior mental health treatment or counseling (include any hospitalizations or substance abuse treatment):

Dates	Location	Provider	Reason/Outcome

What did you like/dislike about your former experiences with counseling? _____

_____

_____

_____

EDUCATIONAL/VOCATIONAL ISSUES:

Highest Grade Completed: _____ Did you have any learning or behavioral problems while in school?

_____

_____

Are you experiencing any issues related to your job/schooling due to the concern you are being seen for today?

_____

_____

_____

FAITH / SPIRITUALITY:

Do you have any concerns related to your spirituality or faith and the reason you are being seen today that you believe may impact your care? _____

_____

_____

_____

STRESSORS:

Please list any changes in your life that you would consider to be significant in the past several years: _____

_____

_____

_____

Have any of these had a negative or positive effect on your daily life? _____

_____

_____

Completed by: _____Date:_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

LIVING WELL CHRISTIAN FAMILY CLINIC, LLC

SUBSTANCE USE HISTORY REPORT

Name: _____ Age: _____

Please list any mental health or substance use concerns within your family of origin:

_____

_____

_____

Chemical Use History in past **ONE** year:

Type of Substance	Not in lifetime	Age of first use	Route of Administration	Rarely	1-3 times a month	1-5 times a month	Daily-Almost Daily	Last Date of Use
Alcohol								
Cannabis								
Cocaine (powder)								
Crack Cocaine								
Methamphetamine								
Heroin								
Other Opiates								
Sedatives/Barbituates								
Mushrooms								
Tobacco								
Other:								

Have you experienced a blackout Describe: _____

Experienced injuries as a result of use Describe: _____

Increased tolerance since first use Describe: _____

How often do you spend more time than you planned using or obtaining substances: _____

Withdrawal symptoms in past year Describe: _____

Longest period of sobriety _____

What made previous attempts at sobriety unsuccessful: _____

_____

Reason for use: _____

_____

PLEASE COMPLETE REVERSE SIDE

What supports do you feel you need for recovery _____

_____

Do you have support to assist you with recovery Describe: _____

_____

Have you felt guilty/embarrassed about substance use Describe: _____

_____

Additional information/comments _____

_____

_____

Substance Use Treatment History

Date(s)	Clinic	Therapist/Counselor	Outcome

Abuse/Trauma History

Have you been a victim or at risk for emotional, physical or sexual abuse

Describe: _____

Other trauma/losses: _____

Social/Peer Relationships

Are you satisfied with your current social life Describe: _____

_____

Do most of your friends use substances

Were there relationship issues as a result of use If yes, please describe: _____

_____

How would you describe your social tendencies?

Completed by: _____Date:_____