Beloit Psychotherapy, LLC.
Welcome Letter

New Client Information

Welcome to our Beloit Psychotherapy, LLC! We understand that the amount of paperwork presented for review and signatures during the first session can be overwhelming. We urge you to let us know if you need a break or if you have any questions as we complete the required paperwork. We thank you for your patience.

Forms

Enclosed you will find several items for your review. You may keep the following documents for your records:

- HIPAA Notice of Privacy Practices
- Summary of your Client Rights
- Information about filing a grievance
- A copy of our Informed Consent

Contact numbers

You may call the clinic at (608)346-8315 to make an appointment. Clients may also call this number to speak to someone in the case of a mental health crisis. Additional support numbers are listed under emergency coverage on the back of the Informed Consent. **Always, in the case of an emergency, dial 911.**

Fees

We at Beloit Psychotherapy, LLC are committed to providing services for all clients in need. Our standard fees follow. (Separate charges apply for any testing and/ or additional assessments.)

90-minute Initial Assessment	$ 420.00
45-minute Individual Session	$ 195.40
60-minute Individual Session	$ 210.00

You will be assessed a $75.00 charge for late cancellations and missed appointments. Exceptions to this policy will be made at the therapists' discretion.

Payment

We accept most private insurance. **Please contact your insurance company to verify coverage of our services.** We will submit claim forms to your insurance company, but we cannot guarantee that they will provide payment. You are responsible for any charges not covered. If you are uninsured or your insurance does not cover our services, payment is expected at time of service unless other arrangements are made in advance. **Co-payments are due at time of service**.

*******If you do not have insurance and you are unable to pay the full charge for services, you may ask the receptionist about applying for our discount fee and/or billing plan.*******

Clinic Hours

Clinic hours are daily 9 a.m.- 5 p.m. M-F(evening and weekend appointments are by appointment only). We look forward to working with you!

Sincerely,

Kari Bell, MSEd, LPC, CSAC, CSW, CHt

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This information is available in Spanish and Hmong. Please ask a staff member if you need a copy in either of these languages. Esta información esta disponible en español. Se usted necesita una copia en español, por favor pregunte a miembro del personl. Cov ntau ntawv no nws muaj cov pes lus hmoob. Yog tias koj xa tau ib daim ntawv uas pes lus hmoob no thov noog cov neeg ua hauj lwm.

When we refer to "you" or "your" in this Notice we refer to the person or persons receiving the services provided by Beloit Psychotherapy LLC. When we refer to disclosures of information to "you", we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from Beloit Psychotherapy, LLC

Who follows this Notice:

This Notice applies to all **protected health information** (**PHI**) maintained by Beloit Psychotherapy, LLC for services provided at any office of Beloit Psychotherapy LLC or services provided at non-office locations by any employee of Beloit Psychotherapy LLC in the course of their employment. If you have any questions after reading this Notice, please contact the Beloit Psychotherapy LLC's Privacy Officer.

Each time you receive services from Beloit Psychotherapy, LLC a record of the services provided is created. Typically this record could contain information about the type of service you have received, the dates of service and the results of the service provided. At times this will include the reason you have come to Beloit Psychotherapy, LLC for service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by Beloit Psychotherapy, LLC.

Our Pledge to Protect Your Health Information: We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices. We will abide by the terms of this Notice.

How We May Use and Share Your Health Information with Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a worker or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your worker or therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from Beloit Psychotherapy, LLC so Beloit Psychotherapy, LLC can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may disclose PHI about you for business operations of Beloit Psychotherapy, LLC. These uses and disclosures are necessary for Beloit Psychotherapy, LLC to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that require them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

Future Communications and Fundraising Activities: We may use your name, address and telephone number to contact you to provide newsletters, information about programs or other services we offer or to raise money for health programs If you do not want contact relating to fundraising efforts, you must notify us in writing. Please contact the Privacy Officer to assist you with this request.

Appointments: We may use your PHI for the purpose of sending to you appointment reminders through the mail or by telephone. Messages left for you will not contain specific health information.

Required or Permitted by Law*:* *Beloit Psychotherapy, LLC* is required by law to disclose your PHI in certain circumstances:

- For public health oversight activities

- To facilitate the functions of federal or state governmental agencies
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Prison officials if you are in custody
- Worker's Compensation officials if your condition is work-related
- If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of Beloit Psychotherapy*,* LLC we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for Beloit Psychotherapy, LLC at 136 W Grand Ave. Beloit, WI 53511.

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by Beloit Psychotherapy, LLC for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. Beloit Psychotherapy, LLC is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by Beloit Psychotherapy, LLC. Requests for amendment or correction should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom Beloit Psychotherapy, LLC may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period. The request cannot include any disclosures made before January 4th 2014. Requests for an accounting of disclosures should be made by submitting a form requesting an accounting of disclosures to the Privacy Officer. This form is available from the Privacy Officer. We will respond to your request within 60 days after you submit the request.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to Beloit Psychotherapy, LLC will be made only with your authorization. If you authorize Beloit Psychotherapy, LLC to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization, please contact your therapist or the clinic where you receive services.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with Beloit Psychotherapy, LLC contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

We reserve the right to revise or change this Notice. Each time you sign a consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.

Effective Date: January 4, 2020

How to Contact Us

Beloit Psychotherapy, LLC. Privacy Officer: (608) 346-8315
Secretary of Department of Health and Human Services: (877) 696-6775

INFORMATION FOR CLIENTS

The mission of Beloit Psychotherapy is to assist in quality living through compassionate, and culturally competent, client centered care. Beloit Psychotherapy, LLC is a private practice which provides counseling and psychotherapy for individuals and families. This sheet contains important information about our policies and procedures. Please read it carefully. Ask your therapist to answer any questions you may have.

Eligibility: Eligibility for Beloit Psychotherapy, LLC counseling programs is based on the existence of a presenting problem. **You may be referred to another community resource if you** (1) do not meet the eligibility criteria; (2) there is not enough staff time available to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insurance company has another counseling resource for you.

After you begin working with Beloit Psychotherapy LLC, services may continue: (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals.

The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Appointments: Appointments are scheduled with individual therapists. A counseling or psychotherapy hour consists of a one 45-60 minute interview with your therapist. **If you need to cancel an appointment**, please do so at least 24 hours in advance. ***You, not your insurance, will be billed for missed appointments***.

Hours: The agency is open Monday through Friday 9:00 a.m. to 5:00 p.m. Evening hours and Saturday hours are available by appointment.

Consultants: Your therapist collaborates with other licensed therapists in his/her clinical work. Your therapist also has a supervisor who may be contacted if you have questions or concerns. The supervisor will meet with you when necessary or at your request.

Confidentiality: All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Beloit Psychotherapy LLC, without your written consent. The primary exception to this rule is those situations in which reporting is mandatory under Wisconsin law (e.g., child abuse, child neglect, sexual abuse, etc.) In addition, please note that your signature on the fee agreement gives the agency permission to release information necessary for the processing of claims for payment.

Emergencies: In an emergency, you may call the office 24 hours, 7 days a week at (608) 346-8315 to speak to your/a therapist. During non-working hours our answering service takes messages for non-emergencies and at your request, will have your/a therapist return your call immediately for emergencies. Following are a list of additional numbers to call in the event of an emergency:

Rock County Crisis Intervention: (608) 757-5025

National Suicide Hotline (800) 273- 8255

Informed Consent: It is the policy of Beloit Psychotherapy LLC that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive through the agency. You will be asked to read and sign the Informed Consent Policy form prior to beginning work with your therapist. Those patients receiving medication from an agency consultant will be asked to sign an Informed Consent specific to the medication being used.

Grievance Procedure:

Beloit Psychotherapy LLC shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At any time a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Grievance and Requests for Administrative Review Policies and Procedures. Program staff shall be familiar with client rights and with these agency procedures. The program staff and their supervisor will forward the complaint to the local Client Rights Specialist.

No sanctions will be threatened or imposed against any client who files a grievance, or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filling a grievance or participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.

If you have a concern about the services you are receiving, you are encouraged to discuss it with your therapist. If this does not resolve the issue, you may present a written complaint to the Program Supervisor or the Regional Director. If you are still not satisfied, please request a written copy of the Grievance Procedure.

Client Access To Records:

Under Wisconsin law, you have a right to review your treatment record. Ask your therapist for the procedures used in sharing your file with you. If you feel that it contains incorrect information, ask your therapist for the procedure used to request a change in record information.

Clients seen at our facility who are thirteen years old and younger; both parents have access to the child's records **unless** parental rights have been terminated by court.

Fee Policy:

A fee is charged for professional services provided by the therapists at Beloit Psychotherapy LLC. If you have private insurance or medical assistance, we will bill for services at the established rate. If you do not have insurance, or if your insurance does not pay in full, you will be responsible for paying the rate established on your Fee Agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If your therapist receives a subpoena, a standard fee of $165.00 per hour will be charged to your account.

- ***A 3% fee is charged for credit card payments using our processing terminal (WorldPay)***

If you are receiving services under managed care, health insurance, medical assistance, or an EAP, the agency will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes Beloit Psychotherapy, LLC to release any information necessary to process insurance claims.

My signature below indicates that I have been given a copy of this information sheet, the "Client Rights and the Grievance Procedure for Community Services" brochure and the "*Beloit Psychotherapy,* Joint Notice of Privacy Practices". For clients age 12-17, I have been given a copy of the "Rights of Children and Adolescents in Outpatient Mental Health Treatment".

Signature (adult or minor age 12 or older): ______________________________ **Date:**______________

Signature of Guardian if signer/client is under the age of 18**:** ______________________________ ***Date*****:**______________

Therapist Signature: ______________________________ **Date:**______________

Consent for Beloit Psychotherapy, LLC Evaluation and/or Treatment

Version for Adult

Name:

Date of Birth:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Beloit Psychotherapy, LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling. We have out-of-state certified clinics from MN, IL and MI to serve our WI residents. Besides following the WI administrative code, they also follow their own state applicable law and regulation.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Beloit Psychotherapy, LLC and I consent to disclosure for use by Beloit Psychotherapy, LLC staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

______________________________ ______________

Signature of client ages 14 years or older **Date**

______________________________ ______________

Signature of witness **Date**

INTAKE QUESTIONNAIRE – ADULT

Beloit Psychotherapy, LLC.

Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.

Name of person completing form: ______________________ Date: ______________

IDENTIFYING INFORMATION (for individual receiving services)

Name: ______________________ Date of Birth: ______________

Address: ______________________ Sex: ______________

______________________ Marital Status: ______________

Home Phone: (   ) ______________ Work Phone: (   ) ______________

Email Address: ______________________ Household Income: $ ______________

Who referred you to our facility? ______________________

Race:
- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Asian
- ☐ Black/African American
- ☐ Two or more races

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino

Language of Choice:
- ☐ English
- ☐ Hmong
- ☐ Russian
- ☐ Laotian
- ☐ Spanish
- ☐ German
- ☐ French
- ☐ Other: ______________

Religious Affiliation:
- ☐ Catholic
- ☐ Muslim
- ☐ Jewish
- ☐ Amish
- ☐ Mennonite
- ☐ Protestant (including Lutheran, Methodist, etc.)
- ☐ Non-Denominational
- ☐ No Affiliation
- ☐ Other: ______________

Disability:
Do you have a disability? ☐ Yes ☐ No If yes, please specify: ______________
If you have a disability, does the office accommodate your needs? ☐ Yes ☐ No
If no, please explain: ______________________

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

____

____

____

PRESENTING PROBLEM (current situation and history)

1. What is the primary problem for which you are seeking help? (please circle)

a. Marriage or relationship	g. Problems with children	m. Grieving
b. Family problems	h. Peer problems	n. Abuse or trauma
c. Depression	i. Eating disorder	o. Sexual functioning
d. Mood swings	j. Alcohol/drug use	p. Anger
e. Behavior	k. Physical problems	q. Anxiety or worry
f. Self-confidence	l. Work related	r. Other (explain):

____

____

____

2. How long have you had this/these problem(s)? ______________________________

3. Have you received treatment for this problem or any other problem in the past? ☐ Yes ☐ No

   If yes when, where and with whom? ______________________________

   ____

FAMILY HISTORY

1. Were drugs or alcohol a problem in your family when you were growing up? ☐ Yes ☐ No

   If yes, please explain: ______________________________

   ____

2. Do you or another family member have a history of alcohol or drug problem? ☐ Yes ☐ No

   If yes, please explain: ______________________________

   ____

3. Please describe your current alcohol consumption: ______________________________

   ____

4. Was there any type of abuse (physical, sexual, domestic or emotional) in your family or home?

   ☐ Yes ☐ No If yes, please describe the circumstances: ______________________________

   ____

5. Have you or any other family member experienced any type of abuse? ☐ Yes ☐ No

   If yes, please explain: ______________________________

   ____

LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

____

____

CURRENT FAMILY INFORMATION

1. Please provide the following information:

Name (First and Last)	**Date of Birth**	**Lives with You?**
Spouse/Significant Other:		Yes No
Children: ______________________________		Yes No
______________________________		Yes No
______________________________		Yes No
______________________________		Yes No
Others Living in Household:		

2. Highest educational level achieved: ______________________________

3. Military service: ☐ Yes ☐ No

4. Occupation: ______________________________

5. Current employer: ______________________________

6. Emergency Contact ______________Phone Number ______________ Relationship to you ______________

MEDICAL HISTORY

1. Primary Care physician/pediatrician: ______________________________

2. Please check the appropriate box if you have experienced any of these problems:

- ☐ Eye disease, injury, poor vision
- ☐ Ear disease, injury, poor hearing
- ☐ Nose, sinus, mouth, throat problems
- ☐ Head injury
- ☐ Convulsions or seizures
- ☐ Memory problems
- ☐ Extreme tiredness or weakness
- ☐ Thyroid disease or goiter
- ☐ Skin disease
- ☐ Heart disease
- ☐ Back, arm, leg or joint problems
- ☐ Blood disease
- ☐ Stomach problems
- ☐ Premenstrual Syndrome (PMS)
- ☐ Eating disorder
- ☐ Liver, gallbladder disease
- ☐ Chest pain or angina pectoris
- ☐ Cancer
- ☐ Bowel problems
- ☐ Hemorrhoids, rectal bleeding
- ☐ Loss of consciousness
- ☐ Frequent or severe headaches
- ☐ Sleep disturbances
- ☐ Neck stiffness, pain, swelling
- ☐ Marked weight changes
- ☐ Circulatory problems
- ☐ Allergies or asthma
- ☐ Diabetes
- ☐ Encephalitis
- ☐ Meningitis
- ☐ Pregnancy not carried to term/stillbirths
- ☐ High blood pressure
- ☐ Other ______________________________

Please explain anything checked above: ____

____

3. Please provide information about medication(s), prescription or over-the-counter, which you take regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

4. Please list significant hospitalizations, operations, injuries (including broken bones): ____________

____

GOALS

1. What are your strengths? ____

____

2. What are your weaknesses? ____

____

3. What goals would you like to see reached as a result of your involvement with *Beloit Psychotherapy?*

____

____

____

____

4. How will you know when these goals have been reached?

____

____

____

Patient Signature____________________ **Date** ____________________

THERAPIST REVIEW

Signature: ____________________ Date: ____________________