Aalto Enhancement Center for Mind & Body Wellness: 8503 - 75th St. Ste: A, Kenosha, WI 53142

NAME		CLIENT#:		DOB:		DATE	

DEMOGRAPHICS/ INTAKE 2018 **P.1**

Where did you hear about us? [ ] Insurance [ ] WORK [ ] EAP [ ] Friend/Family [ ]Physician [ ]Our Website [ ]Other

EMAIL:

NAME:	Maiden Name:	**Gender:**	**DOB:**	**Age:**
ADDRESS:	**Phone Number**	**Zip Code:**	**Religion:**	
City: **State:**		**Social Security #**		

LIVING SITUATION (Check all that apply)

[ ] Alone [ ] w/parents [ ] w/spouse [ ]w/friend [ ]w/children [ ] fiance' [ ] partner [ ] other:

Birth City/State:	**Religion:**
	Any Current Legal Issues? [ ] No [ ] Yes IF on probation what is the name of your probation officer & number

EDUCATION: [ ] Less than H.S. [ ] H.S. graduate [ ]Tech school [ ] Undergrad degree [ ] Masters [ ] Doctorate

[ ] Currently in school@: _____

FINANCIAL/VOCATIONAL: Employment Status check all that apply

[ ] EMPLOYED: name of employer:

[ ] Retired [ ] Disabled [ ] Self Employed [ ] Other:

PAYMENT SOURCE FOR SERVICES

Staff to complete if known, otherwise client to complete **Please check for accuracy**

[ ] EAP (if EAP no need to complete section below)	NUMBER OF SESSIONS:
Name of EAP	Authorization #

RATES: SELF PAY (NO INSURANCE) : Must be paid in advance:

Initial Assessment **Therapy Session (45-50 min)** **Group:**

Copays and estimated co-insurances must be paid in advance:

Name of Primary insurance: _____

Is it: [ ] Commercial [ ]Medicare [ ] T19 -Badger card -forward health. Is is [ ] Yours, [ ] spouses, or [ ] parent's

Deductible: **COPAY/coinsurance: INITIAL VISIT:** **45-50 session:** **Group:**

Copays and estimated co-insurances must be paid in advance:

Name of secondary insurance: _____

Is it: [ ] Commercial [ ]Medicare [ ] T19 -Badger card -forward health. Is is [ ] Yours, [ ] spouses, or [ ] parent's

Deductible: **COPAY/coinsurance: INITIAL VISIT:** **45-50 session:** **Group:**

Copays and estimated co-insurances must be paid in advance:

Name of 3rd insurance: _____

Is it: [ ] Commercial [ ]Medicare [ ] T19 -Badger card -forward health. Is is [ ] Yours, [ ] spouses, or [ ] parent's

Deductible: **COPAY/coinsurance: INITIAL VISIT:** **45-50 session:** **Group:**

Do you have a POA for health care? [ ]Yes [ ]No. If yes please bring in a copy, If NO would you like information? [ ]Yes [ ]NO

For Office Use Only:	yes	no		yes	no
Info entered into therapy notes? Patient info page?			Release of info signed for Psychiatrist		
- Sex of client is correct?			Release for dr		
- Name spelled correctly?			For Emergency contacts		
- Address correct			Staff initials		

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Insurance card scanned?			

HEALTH/MEDICAL INFORMATION

Allergies: [ ]No [ ] Yes Allergic to: _____

It is important for all your health providers to share medical information to each other. **Attached are some ROI'S** (release of information) forms that we would like you to sign so that we may provide your Doctors with information regarding your diagnoses, your progress, as well as recommendations for care. **Let the receptionist know if you need another ROI**

Name of PCP or Psychiatrist	Phone Number	Fax Number	Date last seen	Signed ROI?
				__Yes __NA __Refused
Name of other Physician providing care:	**Phone Number**	**Fax Number**	**Date Last Seen**	**Signed ROI?**
				__Yes __NA __Refused
				__Yes __Refused __NA

Current Medications:	DOSE	FREQUENCY	Prescriber:

ADULT HEALTH HX	CHILDHOOD HEALTH	WOMAN'S HEALTH HX	FAMILY HEALTH HX
[ ] Usual colds/flu [ ] Heart [ ] HTN	[ ] Usual colds/flu	1st Menses Age: ___	[ ]Unknown [ ] Cardiac [ ]CANCER
[ ] Asthma [ ] Obesity [ ] CANCER [ ] Diabetes [ ]Kidney Disease	[ ]Diabetes [ ] Heart [ ]Allergies [ ]Cancer	Approx date last menses: _____	[ ]Diabetes [ ]Arthritis [ ]Asthma [ ]Allergies
[ ] Head trauma [ ]Chronic pain [ ] Fibromyalgia [ ] Arthritis [ ] Hypothyroidism [ ] HIV {] M.S.	[ ]Arthritis [ ]Asthma [ ]Stomach Aches [ ] Kidney Disease [ ] Cystic Fibrosis	# of X's PG: _____ # of births: _____	[ ]Obesity [ ]Mental Illness [ ]Gastrointestinal [ ]Fibromyalgia
[ ] Other:	[ ]Obesity [ ]Other:	→ Any complications?	[ ]Kidney Disease [ ]Alcoholism [ ]Other:

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Psychological/Social Concerns

PAST PSYCH OUTPATIENT TX: [ ]NO [ ]YES Place:_____ When: _____

PAST PSYCH INPATIENT TX: [ ]NO [ ]YES Place: _____ When:_____

SUBSTANCE USE

SUBSTANCE	CURRENT USE Yes/No	PAST use? Yes/No	AGE 1st use	DATE LAST USED	SUBSTANCE	CURRENT USE Yes/ No	PAST use? Yes/ No	AGE 1ST Use	DATE LAST USED
Caffeine					Shrooms				
Cigarettes					Heroin				
Alcohol					LSD				
Marijuana					Meth				
Ecstasy					Abuse of prescribed meds				
Cocaine					OTC drug **abuse**				
Other:					Other:				

CURRENT CONCERNS	Self score: On a scale of 0 -10, w/10 being the worst.	Approximately age or date when symptoms started or became a problem	CURRENT CONCERNS	Self score: On a scale of 0 -10, w/10 being the worst.	Approximate age or date when symptoms started or became a problem
Poor Concentration/ Easily distracted			Nervousness/Anxiety/Worries/ phobia's/fearful		
Poor Organization			Racing Thoughts		
Hyper/fidgety			Heart pounding or racing		
Frequently loses things			Disrupted sleep		
Chronic tardiness			Freq feelings of Deja Vu		
Poor listening skills			Sleeping too much		
Forgetful			Trouble getting to sleep.		
Seeing shadows or hallucinations			Excessive hand washing, checking things over & over		
Hearing voices others don't			Repetitive behaviors		
Feeling sad			Irritable		
No feelings – feel flat			Angry		
Suicidal thoughts or desires			Explosive		
Feeling hopeless			Overly happy (euphoric)		
Self harm: thoughts or behavior			Experienced Trauma		
Lack of caring about things you used to care about			Other:		

Personality Likes/ Dislikes &/or Personality Strengths/Short-comings

Likes/Interests/Hobbies	*Dislikes/ Pet Peeves*	*Personal Strengths*	*Coping Skills/strengths*	*Personal Weaknesses*

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INITIAL &/Or Updated TREATMENT PLAN

During your 1st or 2nd appointment with your therapist you will discuss (and your legal guardian if applicable) your plan of care to develop treatment goals. This treatment plan will be re-assessed every 90 days or after 6 visits whichever is longest. Please answer the following:

What do you hope coming in for therapy will help you with? Check all that apply:

- [ ] Improved coping [ ] gain insight [ ] stress management [ ] improved self esteem [ ] mood stability
- [ ] improved communications [ ] happiness [ ] less anger [ ] less anxiety [ ] better understanding of self
- [ ] less alcohol use [ ] stop consuming alcohol [ ] stop using drugs [ ] feel better [ ] talk out my problems
- [ ] psycho education [ ]Better Parenting [ ] Improved relationship with _____
- Other: _____

How often do you want to be seen: [ ] weekly [ ] every other week [ ] other:_____

What length of time for treatment do you anticipate: [ ] 1-3 months [ ] 4-6 months [ ] 6 months or longer [ ] Other: _____

Please list below the top three problems or concerns you would like help with:	**On a scale of 0-10, w/ 10 being the worst.**		
	Score how troublesome your problem are:	Using the same scale what are your goal scores?	
		Short term	At discharge
1.			
2.			
3.			

Following are the therapeutic models many therapists use. Your therapist will discuss which treatment models they use and what works best for your type of concerns.

	CBT		Integrative		Solution Focused		Psychodynamic
	DBT		Reality Therapy		Narrative		Motivational Interviewing
	ACT		Family Therapy		Humanistic (Gestalt, Existential, Client Centered)		Interpersonal
	REBT		Mindfulness		Behavioral (Exposure/desensitizing. Behavior mod)		Relaxation
	Play		Insight		Internal Family Therapy		Moral Reconation Therapy

As the consumer &/or legal guardian of services at AEC, I have had a chance to be informed of services, and their benefits, and have participated in the development of this treatment plan with my therapist.

_____

Consumer's name (Print) / Consumer's signature Date

_____

Legal guardian's name (Print) / Guardian's signature Date

_____

Legal guardian's name (Print) / Guardian's signature Date

Therapist's signature: _____ Date:_____

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FAMILY INFORMATION

MARITAL STATUS: [ ] Not Married [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] In a Committed relationship & living together [ ] In a committed relationship but not living together

Name of spouse or partner:

PARENTS: (Include step)	Status: Living/dc	NAMES of Siblings	ages	CHILDREN (Include all: step/adopted)	AGES

Following are designated persons that I give permission to **make or cancel appointments for me,** receive calls regarding my appointments and to be contacted **in case of emergency.** The only information that will be given will be billing, diagnoses (if needed for medical emergency) appointment times, and name of therapist. A release of info needs to be signed if authorizing clinical information. I can revoke this consent in writing at any time, and it will revoke current, future but not past contact.

1_____(relationship_____Ph #_____

2._____(relationship):_____ Ph #_____

3._____(relationship)_____Ph #_____

TREATMENT CONSENT/RIGHTS/RESPONSIBILITIES

Please initial and sign at bottom

____I give my consent for psychotherapy treatment for a mental health diagnoses which may or may not include alcohol and drug issues. Psychotherapy includes initial assessment, treatment plan development, individual sessions with a clinician and/or group therapy.

____As a consumer of services at Aalto I understand my clinician as required by state of Wisconsin statues will collaborate with their supervisor and other colleagues/peers at Aalto Enhancement Center.

____I have received a copy of my HIPPA rights, grievance procedure, **(they are Attached)**

____I give consent for AEC to bill my insurance company for services received, for direct payment to go to AEC, and understand insurances may or may not cover the cost for services, therefore I am responsible for any and all costs not covered by insurance.

____I agree to pay prior to each session any co-payments or co-insurance not covered by insurance.

____If I am a self pay client, in order to receive prepayment discount, I agree to pay for services prior to each session, if I do not pay in advance, then I am responsible to pay full rates.

____I understand I need to **cancel or reschedule** appointments **24 hours or more** in advance to avoid a no show or late cancellation fee of $60.00 or more.

____I understand that **frequent cancellations and/or no shows is** disruptive, counterproductive, and harmful therefore it may result in discharge from services in addition to a no show/late cancellation fee.

____I understand accounts past due may result in a pause, and/or discharge from treatment and/or your bill being sent to a collections agency.

___I understand that the law requires us to report threats of violence, injury directly to the recipient of the threat as well as to the police. We are also required to report to the law, or crisis intervention threats to harm self, and/or physical, sexual abuse and/or neglect to a minor child,

___I understand the police, or rescue squad &/ or my emergency contact may be called if I arrive under the influence of alcohol &/or a controlled substance. If I drove to Aalto I will not be allowed to leave while I am under the influence.

___I agree to have automated appointment reminders sent to me by way of: check all that apply

_____SMS (text message) and/or _____Voice message to cell phone # of:_____

_____Email message to: _____

Client Signature: _____date:_____

Guardian Signature: _____date:_____

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SERVICES / PROVIDERS / COSTS / PAYMENTS

Our counseling center offers a variety of providers who are at various levels of expertise, training, and licensing, therefore prices will vary according to the level of expertise. Following is a chart, which is subject to change as circumstances change.

1. **NON COVERED SERVICES**: The following services are not covered by health insurances.

    1. **Phone calls to your doctor or therapist**. For emergencies call 911.
       If URGENT please inform secretary of the nature of the call.
       Otherwise please schedule an appointment to talk w/ your provider about issues/concerns.

    2. **Letters, completion of reports, forms , etc.**
       Dr. $300.00 per hr. Therapists: $150.00 per hr

    1. **Court Testimony:** An estimated pre-payment is required.
       Includes drive time, consults w/ lawyers, waiting time.
       Dr: $400.00 per hr Therapists:$200.00 per hr

    1. **Court ordered &/or legal AODA EVALUATIONS/ASSESSMENTS:**
       $200.00 PER Hr. (done only by a CSAC)

Payment for services not covered by your insurance is expected to be paid in full prior to each session.

PSYCHOTHERAPY/COUNSELING

SERVICE	RATE	
PROVIDER	PhD/ PsyD	LCSW/LPC
INITIAL EVALUATION 60 min or less	$300.00	$180.00
Psychotherapy: 45-50 min.	$200.00	$150.00
Psychotherapy: 20-30 min	$150.00	$100.00

PROVIDER	PRE-PAID RATE [SELF PAY] ONLY IF PAID AT THE TIME OF SERVICE			
INITIAL EVALUATION 60 min or less	PhD/PsyD	Licensed Master LCSW OR LPC	Master Level IT	MASTER LEVEL INTERN
Psychotherapy: 45-50 min.	$160.00	$140.00	$80.00	$55.00
Psychotherapy: 20-30 min	$130.00	$90.00	$60.00	$35.00
	$100.00	$50.00	$40.00	$25.00

GROUP / CLASSES

	RATE	PRE-PAID [Self Pay]
GROUPS	$100.00	**$30.00**
CLASSES	TBA	**TBA**

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INFORMED CONSENT/HIPAA

INFORMED CONSENT(Permission to treat): Is in effect no longer than 15 months. Following is to be discussed by your provider with you:

- Benefits of treatment(s), services; how & ways services are to be provided.
- The expected side effects or risk of side effects & alternative treatment modes & services.
- The probable consequences of not receiving the proposed treatment & services.
- The right to withdraw Informed Consent at any time **in writing.**

→ Services shall NEVER involve sexual contact between therapist and client.

HIPAA requires each health care provider to provide you with information about your rights for confidential information:

- The right to have a say in how & what information can be shared. May revoke any consents in writing, at any time.
- Participate in the development of your treatment plan.
- Right to Refuse to be filmed or taped
- Right to file a grievance. (Grievances can be filed with the office manager or the clinic's administration as step one).
- Right to petition a court according to the law.

~HIPAA, does not interfere with the law which requires us to report situations of **emergency, abuse, neglect,** or **harm to self or others**, as well as cooperation with legal authorities; such as law enforcement officials, court officials, or government agencies. Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises. In the event of death, pertinent information may be released to a coroner, or medical examiner.

Medical Records: (the release of)

1. Psychotherapy notes are the property of the psychotherapist. Release is to be determined by the therapist. Therefore you will need to meet with your therapist or provider to discuss what information is needed and if release of records or a **brief summary is appropriate.**
2. A fee (which is NOT covered by your insurance) will be charged to you for this meeting, plus a fee is charged for a copy of records.
3. Records can be released to another health care provider only after a signed consent is obtained along with the facility fee.
4. Information complied for use (or anticipated use) in a civil, criminal, or administrative action or proceeding may be released to the authorities under a court order.
5. AEC (Aalto Enhancement Center) reserves the right to deny access to your medical record under other circumstances that may arise

In-house staffing's and coordination of care:

Treatment at AEC (Aalto Enhancement Center) may also include providing, coordinating, or managing health care & related services by one or more health care providers here at AEC (Aalto Enhancement Center). Consultations between health care providers may occur to insure continuity of care, discuss appropriateness of care, treatment referrals such as referral to a more restricted environment, or referrals to another health care provider. In addition, health care at AEC (Aalto Enhancement Center), may require conducting quality assessments, evaluations, protocol development, case management, medical reviews, legal services and auditing functions.

YOUR RESPONSIBILITIES:

1. Keep us informed of Your wishes for confidentiality -in writing.
2. Tell us of any changes in your medical condition, address, phone numbers, & **INSURANCE INFORMATION**
3. To show up for all appointments on time,
4. Pay for services **prior to each session.** Failure to pay may result in termination of services
5. Rescheduling or cancellation of an appointment – **MINIMUM OF 24 HOURS is needed in order to avoid a fee.**

PER YOUR INSURANCE COMPANY RULES & REGULATIONS:

Your insurance company requires us to collect from you all co-pays, co-insurances, deductibles, etc.
We are not allowed to waive these costs! Therefore:

→ Administrative Fee may be added to any amounts owed past 30 days.

→ ***Accounts past due will be turned over to collections unless a payment is received monthly.***

→ **Services may be discontinued for non payment of services.**

IN CASE OF EMERGENCY: call 911. For non emergency but urgent go to the Emergency Room or call crisis: 657-7188

- for non life threatening situations that are urgent- a therapist is on call after hours at 262 496-3586.

THIS PAGE IS FOR YOU TO KEEP!