(Client Read and Keep)

CLIENT INFORMATION SHEET

PURPOSE AND GOALS OF THERAPY

Your decision to begin psychotherapy is an important one. When individuals enter this type of treatment with a good understanding of what they are about to undertake, they are likely to achieve more favorable results. The following information will help you understand the responsibilities of both the client and therapist. Read it, and then ask any remaining questions you may have.

In psychotherapy, you and a trained mental health professional will work out strategies for handling some issues of daily living. Problems that are frequently dealt with include: low-self esteem, anxiety, depression, interpersonal difficulties, spiritual depletion, marital difficulties, the effects of divorce on children, guilt, grief, unrealistic expectations of self and others, financial problems, addictions and other self-defeating behaviors.

Psychotherapy can lead to personal growth through clarification of thoughts, feelings and behaviors about yourself, others and events in your life. Treatment can involve individual, couple, family or group therapy, depending on the nature of the issues. Methods may focus on your childhood and past, while at other times the emphasis may be on the present. At times this process may involve the stirring up of uncomfortable or painful thoughts, feelings and/or decisions. Overall, the gains you achieve through therapy will generally outweigh the potential risks.

The length of treatment will vary depending on the client, therapist and the nature of the presenting issues. After your therapist has identified specific issues to address, the two of you will discuss a treatment plan involving goals, estimated length of treatment and methods to accomplish those goals.

CLIENT RESPONSIBILITIES

It is important for you to attend all scheduled appointments on time. If you are late, you will not have the benefit of a full session. Equally important are the responsibilities you have to be as active, open and honest as possible with your therapist. Your most important responsibility is to yourself and working on achieving your treatment goals.

If you are physically abusive or threaten staff members, you will be discharged from the clinic. You may utilize the Grievance Procedure at this time if you wish. If you wish to discontinue therapy, please discuss this with your therapist at least one session prior to ending. If at any time your therapist believes he/she can no longer be of assistance to you, another appropriate professional will be suggested.

Fees: Please see Financial/Insurance Form.

*** CONFIDENTIALITY

All information gained through the therapy process is considered confidential. Information will not be released to any outside person or agency unless one or more of the following applies:

1. We have a written/verbal signature on a consent/release form.
2. If we suspect that a situation involves child or elder abuse, we are required to report it to the proper authorities.
3. If we feel that you are a danger to yourself (suicidal) or others (homicidal), we must take appropriate action to protect people from harm.
4. If a court orders us to present records, we are obligated to comply.
5. If you commit a crime on the premises.
6. If you have a medical emergency while at this agency.

MINORS

It is the policy of this clinic to release all information pertaining to minors to their parent./legal guardian unless it would seriously affect the minor's therapeutic process. The parent/legal guardian is also responsible for financial obligations incurred by the minor for services at Affiliated Counseling Center, INC (ACC). All minors under the age of 12 must be accompanied by a guardian that will stay on the premises throughout the minors' scheduled appointment.

Affiliated Counseling Center, INC

RIGHTS OF CLIENTS

The client may seek additional information concerning the following:

1. **Alternative treatment methods.**
2. **Consequences of not receiving proper treatment.**
3. **The right to withdraw from treatment at any time.**
4. **Recording, photographing or filming of treatment-Signature is required.**

Clients may receive a copy of these rights and responsibilities and procedures and a signed copy of the Registration/Agreement Contract if requested.

GRIEVANCE PROCEDURE FOR VIOLATION OF RIGHTS

Anyone who is receiving treatment in a state certified facility for mental health, developmental disability or alcohol and drug abuse may utilize the grievance procedure when they believe their rights are being violated. The following procedure applies to all clients:

FILING A COMPLAINT: A complaint can be filed in writing and given to your therapist or another staff member in a sealed envelope at 1807 N. Center Street, Beaver Dam, WI 53916. The complaint must be filed within 45 days of the time the client learned of the situation The client will be informed of the decision in a written report. If the client is not satisfied with this decision, the client may choose to appeal. A copy of the Program's Grievance Procedure is available upon request.

DOCTOR REFERRAL

We feel it is important at appropriate times to communicate with your regular physician. We would appreciate your permission/signature to allow us to have this opportunity. If you do not have a regular physician we would like to consult with the Affiliated Counseling Center, INC doctor.

INTAKE FORM

If you have not done so already, please complete the Client Self Assessment Forms. Your therapist will then review them for treatment planning purposes.

*** EMERGENCIES

In the event of an emergency, you may contact us through our emergency telephone number which is *(920) 296-6559*, which is also given on our answering machine message when we are out of the office. The "on-call" therapist will return your call as soon as possible. Please only use this phone number for emergencies.

*** SCHEDULING/CANCELLATIONS

Please be responsible for your appointments. If you are late or do not cancel your appointment by 9AM the day of your appointment (except in the case of emergencies, sick or severe weather), you agree to pay $75 the first two times and $100 thereafter. If you reach 3 late cancellations/no shows, we can and will start the process to terminate you from the clinic. Charges for missed appointments are NOT covered by insurance and will be your personal responsibility and will be due in full before your next visit. This policy is to utilize our professional services at the most productive level and promptly provide services to those in need. To cancel or reschedule an appointment, simply call ACC or leave your message on our answering machine. Appointment reminders are sent via text, phone and/or email for all appointments and receipt of all reminders can be verified by staff members.

CLIENT RIGHTS

When you receive any type of service for mental health, alcoholism, drug abuse, or a developmental disability, you have Personal Rights, Treatment and Related Rights, Record Privacy and Access, and Grievance Procedure and Rights. Further information about these rights are under Wisconsin Statue sec. 51.61(1) and HFS 94, Wisconsin Administrative Code. A copy of these codes are available upon request.

Affiliated Counseling Center, INC.

Welcome to Affiliated Counseling Center (A.C.C.). We appreciate your taking this time to read over the enclosed material and fill out this Registration/Agreement form. The Client/Therapist relationship is unique, highly personal and at the same time a business contract. It is important that all parties have a clear understanding and agreement about the services involved. Please discuss any questions you may have.

REGISTRATION/AGREEMENT FORM

Client Name:_____ Birthdate:_____ Age:_____

Address:_____ City:_____ Zip:_____

Home Telephone: (_____)_____ Cell Phone: (_____)_____

Work Telephone: (_____)_____ Can we contact you at work? _____Yes _____No

Social Security Number:_____ Sex:Male/Female/Other:_____

Race :_____ Emergency Contact: _____

Email Address:_____ Emergency Contact Phone Number:_____

Were you referred to us? ____Yes____No If yes, by whom?_____

List other immediate family member (s):

1.Name_____ Birthdate_____ Age_____ Relation_____

2. Name_____ Birthdate_____ Age_____ Relation_____

3. Name_____ Birthdate_____ Age_____ Relation_____

4. Name_____ Birthdate_____ Age_____ Relation_____

(Additional Members can be listed on the back of this packet)

Person responsible for payment of services please complete if different than client:

Responsible Party:_____ Birthdate_____ Age_____ SS#_____

Address_____ City_____ Zip_____ Sex:M/F_____

Home Telephone: (_____) _____ Cell Phone:(_____) _____

Work Telephone: (_____) _____ Can we contact you at work ____Yes____No

If more than one person is responsible for payment of services other than the client please complete:

Responsible Party:_____ Birthdate_____ Age_____ SS#_____

Address_____ City_____ Zip_____ Sex:M/F_____

Home Telephone: (_____) _____ Cell Phone:(_____) _____

Work Telephone: (_____) _____ Can we contact you at work ____Yes____No

1807 N. Center Street, Ste 204
Beaver Dam, Wisconsin 53916
Phone: (920) 887-8751
Fax: (920) 887-3977

INSURANCE INFORMATION

Do you wish to use insurance? _____Yes_____No

Do you wish us to prepare and submit your insurance forms (at no charge) _____Yes_____No

*******All clients are responsible for checking with their employer or insurance company to know their insurance coverage.** It is understood that benefits can be verified by telephone but are never guaranteed. If your insurance requires a special claim form, please provide us with that form.

PRIMARY INSURANCE CO._____

CLAIMS ADDRESS_____CITY_____ZIP_____

TELEPHONES (____)_____ (____)_____

FULL NAME OF INSURED _____CLIENT_____

INSURED'S ADDRESS (IF DIFFERENT THAN CLIENT) _____

SUBSCRIBER/I.D. #_____GROUP/FILE#_____

INSURED SOCIAL SECURITY #_____ INSURED DATE OF BIRTH_____

INSURED EMPLOYER_____

DESCRIPTION OF BENEFITS_____

SECONDARY INSURANCE CO.

CLAIMS ADDRESS_____CITY_____ZIP_____

TELEPHONES (____)_____ (____)_____

FULL NAME OF INSURED _____CLIENT_____

INSURED'S ADDRESS (IF DIFFERENT THAN CLIENT) _____

SUBSCRIBER/I.D. #_____GROUP/FILE#_____

INSURED SOCIAL SECURITY #_____ INSURED DATE OF BIRTH_____

INSURED EMPLOYER_____

DESCRIPTION OF BENEFITS_____

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FEE/FINANCIAL AGREEMENT **January 2021 Updated Affiliated Counseling Rates Are:**

	Psychiatrist	Psychologist	Therapist
Initial Evaluation	**$450.00**	**$350.00**	**$325.00**
53-60 Min Session	**$425.00**	**$290.00**	**$290.00**

Medication Check for Cash Clients <15 min $200.00 or >15 min $275

Therapy Sessions for Cash Clients are $325 for Intake & 100 Each Session Afterwards

These rates are based on a 53-minute hour, which is in compliance with state code and considered "usual & customary" fees by most insurance company standards. When sessions run longer, additional minutes are prorated and charged based on the above fees.

If your mental healthcare is provided through a managed care system such as HMO of Wisconsin, CNR Health, United Behavioral System, Physician's Plus, sessions are limited to 45 minutes. Managed Healthcare systems base their rates on sessions of this length.

Brief phone calls (less than 10 minutes) are included in the above regular treatment charge. Extended phone treatment/consultation will be pro-rated and charged according to the above fees. Any services provided in other circumstances about your case, i.e., consultation with another mental health professional, physician, lawyers or in legal testimony, will be pro-rated and charged to the above fees.

Many insurance companies require a co-payments or deductible. If this is applicable to you, it is agreed that you pay your co-payment and/or deductible at the time of your session.

I agree that I will pay my co-payments at the time of service.

Checks returned for non-sufficient funds will be assessed with an additional $50 return fee.

I have read the Client Information sheet and received information on my rights and responsibilities. I understand and agree to the terms described (informed consent). I know that I am financially responsible for all charges we have agreed upon, whether or not paid by insurance. I agree to pay the full session fee (stated above) if cancellation of scheduled appointment is less than 24 hours (emergencies exempt). I authorize Affiliated Counseling Center to release medical information necessary to process any of my insurance claims and to receive payments of medical benefits (assignment) for services rendered. A photocopy of this contract is to be considered as valid as an original.

_____ _____

(Client Signature) **(Date)**

_____ _____

(Clinician Signature) **(Date)**

AFFILIATED COUNSELING CENTER, INC

1807 N. Center Street, Ste 204
Beaver Dam, WI 53916
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Fax: (920) 887-3977

Intake Questionnaire for Parents/Guardians of Children age 12 or Under

Name of Child: _____

Preferred Name (if different from first name): _____

Date of Birth: ____/____/_____

Person filling out form: _____

Relationship to patient / client: _____

1. PRESENTING PROBLEM (What problem(s) bring you to seek help for your child now?):

_____
_____
_____
_____
_____

2. PAST PSYCHIATRIC HISTORY: Please list the mental or behavioral health-related treatments and evaluations that your child has received in the past.

Type of Treatment	Problems at the time	Name of Therapist and/or Facility	When & for how long?
Outpatient			
In-Patient			
Testing			

Psychiatric inpatient admission(s) within the last 12 months	YES	NO
History of self-harming, suicidal, aggressive, or assaultive behavior	YES	NO
Past/recent statements or expressions of suicidal thoughts or wishing to be dead	YES	NO
Past suicide attempt(s)	YES	NO

Past medication(s) for depression, anxiety, "nerves", Attention-Deficit / Hyperactivity Disorder (ADD or ADHD), insomnia, or other emotional or mental illness. Please include both wanted benefits and unwanted side effects, even if the benefit was only partial. Current medications are listed in a separate section.

Name of Medication / Dosage	When and for how long?	Results

3. SOCIAL AND BRIEF EDUCATIONAL HISTORY

Current living and custody arrangements, as applicable:

_____

_____

Past and current foster or group home placement(s) as applicable:

_____

_____

Name of school, City / Town: _____

Grade Level: _____

Primary Teacher and/or teachers of academic subjects:

_____

_____

Special educational or school services, if applicable:

_____

_____

Special education teacher, if applicable: _____

Please bring copies of report cards for the last two semesters or last three quarters, the most recent IEP, and/or school psychologist's evaluation(s), as applicable.

4. Medical Review:

a. Current pediatrician or family doctor: _____

b. Has your child been seen by another pediatrician or family doctor aside from the current one? Please includean address or phone number if the doctor(s) do not practice in Beaver Dam:

_____

_____

c. Is he/she being seen, or has been seen, by another medical specialist(s)? ____ If yes, please try to provide the address and phone number:

_____

d. Allergies: Is the patient allergic to any medication, or has he/she had any previous bad reaction(s) to a medication?

Name of Medication: _____

Type of Reaction (what happened)? _____

e. Illnesses/Conditions: Please list any non-mental / medical illnesses or conditions, both past and current, that your child has:

_____

_____

f. Has he/she ever had any seizures or epilepsy?: ____ How about any head injuries? ___

g. Has he/she been hospitalized for any reason **not** related to mental health?:

_____

h. What are your child's **current medications**? Please list all medications, including over-the-counter medications as well as any herbal remidies that you are giving to him/her.

Name	Dose	When/How often Taken	Prescribing M.D.	Side Effects	Helpful?
					YES / NO
					YES / NO
					YES / NO

Name of pharmacy, City / Town: _____

5. Developmental History (Questions pertaining to pregnancy may be skipped by father)

a. Regarding the pregnancy with the patient, how long did you carry him/her (how many weeks or months)? _____. Were there any medical obstetric problems or complications during the pregnancy itself? _____. If yes, please specify:

_____

_____

b. Did you ise or have any of the following during pregnancy? (Please mark with an "X")

[ ] Smoking during pregnancy?

[ ] Alcohol during pregnancy?

[ ] Drugs during pregnancy? Details: _____

[ ] Medication during pregnancy? Details: _____

_____

c. Please provide details about labor and delivery.

Was it: [ ] Not induced or [ ] Inducted? Was it: [ ] Normal/Vaginal, [ ] Cesarean, or [ ] Breach? About how long where you in labor? _____

Birth weight: _____pounds, _____ ounces

How many days was he/she in the hospital? _____

d. Were there any complications during the delivery or soon after the birth? ____ If so, please explain as best you can: _____, If there were complications, what treatment was given? _____

e. On the following items, please include as much detail as possible. With regards to the "milestones" in the early part of his/her life (birth and pre-school), were there any **delays** in:

(1) gross motor skills such as turning over, crawling, walking, running, or skipping?

_____

(2) fine motor skills such as handling silverware, dressing, coloring, or cutting with scissors? _____

(3) language such as babbling, speaking words, putting words together, use of non-verbal communication or gestures? _____

f. Social interaction / attachment: Please describe your feelings of attachment or bonding to your child. _____

What is his/her response to cuddling or other forms of touching?

_____

How did he/she behave when he/she got hurt: _____

Describe his/her ability to appropriately play with toys and with peers:

_____

g. Was there anything else unusual about your child when he/she was younger?

_____

_____

h. Have there been any stressful times in the life of your family and/or your child either in the distant past or recently? If so, please describe these and when they took place.

_____

_____

_____

6. Family History: Please provide the following information as they pertain to the child.

Mother's name: _____ Age: _____

Education level: _____ Occupation: _____

Father's name: _____ Age: _____

Education level: _____ Occupation: _____

Parents' status: [ ] Married [ ] Never married [ ] Separated [ ] Divorced

Year married: _____, Year divorced: _____, If divorced, is either one remarried? _____

If the patient was adopted, please include whatever information you may have about the biological parent(s), as well as yourself/yourselves.

Siblings' names and ages:

_____

_____

Half and Stepsiblings' names and ages:

_____

_____

The word "family" in the following question refers to "blood relation' or individuals who are biologically related. This can include mother and father's sides of the family, grandparents, aunts, uncles, first cousins, siblings (not step-siblings), and either parent.

Is there a family history of:

Substance Abuse:

a. Alcohol:

b. Illegal substances, including but not limited to cocaine, crack, marijuana, PCP, mushrooms, LSD, narcotic pain killers, amphetamines / speed, or ecstasy?:

c. Other substances not commonly considered substance of abuse, such as inhalants, gasoline, and prescription medication?

Mental Illness, including but not limited to depression, anxiety, phobias, ADD/ADHD, bi-polar (or manic-depressive)disorder, schizophrenia, developmental disorders (mental retardation, autism), psychiatric hospitalizations, or mental health commitments?:

Suicide / Suicide Attempts? :

Violence toward others:

Any other **physical or medial illness**, including seizures, thyroid disease, or other heritable illnesses?

7. Other Comments:

Thank you for filling out this questionnaire. The hope is that it will help us focus on the present issues at your first appointment, but without sacrificing the gathering of background information that any clinician will need to render good mental health and medical care.

Individual filling out form: **Date:**

Therapist, as applicable: **Date:**

Psychiatrist, as applicable: **Date:**

Affiliated Counseling Center, INC_____

CHILD/ADOLESCENT SYMTOMS CHECKLIST

CLIENT: _____ DATE: _____

DIRECTIONS: Check all that apply to your child

___ often loses temper
___ refuses to do chores
___ defies rules

___ swears/uses obscene language
___ ran away once without returning on his/her own
___ often blames others for his/her mistakes
___ is often angry or resentful
___ has stolen on more than one occasion
___ has run away from home overnight at least twice
___ has deliberately destroyed others property/materials
___ has been cruel to animals
___ has broken into someone else's house or car
___ often talks excessively
___ often interrupts
___ often fidgets with hands and feet/squirms in seat
___ is easily distracted
___ often loses things necessary for tasks and activities at school (e.g., toys, pencils, books, assignments)

___ complains of headaches or tired
___ fails to finish chores
___ has difficulty sustaining attention on tasks or play
___ insists on following routines in precise detail
___ spins, finger flicks, head bangs
___ aggressive behavior towards peers
___ talks about hurting/killing others
___ harms self (cuts or burns self)
___ picks at skin
___ attachment to unusual objects (e.g., carries around a piece of string)
___ has difficulty sleeping
___ irritable
___ cries easily
___ poor concentration
___ sad
___ talks about dying or suicide
___ restless
___fear of dying

___ often argues with adults
___ refuses adult requests
___ often deliberately does things to annoy others
___ had difficulty awaiting his/her turn
___ is often spiteful or vindictive
___ is often touchy or easily annoyed by others
___ butts into other children's games
___ often truant from school
___ has deliberately set fires
___ has forced someone into sexual activity
___ has been physically cruel to people
___ has difficulty playing quietly
___ has stolen with confrontation
___ intrudes on others
___ impulsive/dangerous play
___ prefers solitary play
___ complains of stomach upset
___ does not come for comfort even when ill, hurt

___ often shifts from one task to another
___ stiffens when held
___ gets upset over minor changes
___ wets clothing or bed
___ soils clothing (feces)
___ mouths objects
___ refuses to talk/mutism
___ becomes frustrated easily
___ difficult to get to bed
___ appetite has decreased
___ worries excessively
___ lacks energy
___ feelings are easily hurt
___ appetite increased/overeats
___ shy
___ complains of dizziness

Any issues not listed above: _____

_____

Affiliated Counseling Center, INC

(CLIENT READ AND KEEP)

HIPAA NOTICE OF PATIENT PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

This Notice of Privacy Practices describes how we may use and disclose your protected health informatio n (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your pro tected health information. "Protected health information" is information about you, including demographi c information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may beused and disclosed by our organization, our office staff and others outside of our office that are inv olved in your care and treatment for the purpose of providing health care services to you, to pay your heal th care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health c are with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the phy sician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health ca re services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order t o support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducti ng or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility.

We may use or disclose your protected health information in the following situations without your authorization as follows:

As Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compe nsation. Required Usesand Disclosures: Under the law, we must make disclosures to you and when requir ed by the Secretary of the Department of Health and Human Services to investigate or determine our com pliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent,

1807 North Center Street, Ste 204
Beaver Dam, Wisconsin 53916
Phone: (920) 887-8751
Fax: (920) 887-3977

Authorization or Opportunity to Object, unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the auth orization.
Your Rights: Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and prote cted health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involvedin your c are or for notification purposes as described in this Notice of Privacy Practices.
Your request must state the specific restriction requested and to whom you want the restriction to apply.
Our organization is not required to agree to a restriction that you may request. If our organizationbelieves it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.
You may have the right to have our organization amend your protected health information. If we deny yo ur request for amendment, you have the right to file a statement of disagreement with us and we may prep are a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You t hen have the right to object or withdraw as provided in this notice.
Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe yo ur privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questio ns concerning or objections to this form, please ask to speak with our Executive Director in person or by phone at 920-887-8751.
Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.
We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services

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Affiliated Counseling Center, INC

Acknowledgement
For
Receipt of Notice of Patient Privacy

This form is a receipt noting that you have received the Affiliated Counseling Center, INC, Notice of Privacy Practices and that you have read the terms of the notice.

_____
Client Name

_____
Signature

_____
Date

*If the client is a minor or otherwise unable to sign the acknowledgement, please provide the name and signature of the Parent/Gaudian/Representative

_____
Printed Name of Parent/Gaudian/Representative

_____
Signature

_____
Date

_____
Authorized Representative

_____
Date

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Affiliated Counseling Center, INC_____

INFORMED CONSENT

As an individual receiving treatment in a state certified clinic, you are entitled to receive information regarding fees, confidentiality, individual rights, treatment, and the grievance procedure if you think your rights are being violated. Affiliated Counseling Center, INC provides you with this information through the Client Information, Rights of Individuals, and Grievance Procedure forms. **Additionally, your therapist will explain and answer any questions you have about treatment. Your signature on this informed consent indicates that you agree with the items checked below.**

X **I have received a copy of the Client Information form. I understand and agree with the financial obligation outlined on the Client Information form.**

X **I have received a copy of the Rights of Individuals Receiving Treatment in a State Certified Clinic.**

X **I have received a copy of or have access to a copy of the Grievance Procedure.**

X **I consent to the treatment proposed at Affiliated Counseling Center at this time. I understand that I have the right to withdraw my consent for treatment at any time in writing.**

X **I have received a copy of this *Informed Consent.***

X **I have received a copy of or have access to a copy of the Policies and Procedures for Affiliated Counseling Center**

These 7 areas have been discussed with me and I consent to treatment.

1. **The benefits of the proposed treatment and services;**
2. **The way the treatment is to be administered and the services are to be provided;**
3. **The expected treatment side effects or risks of side effects which are a reasonable possibility, including side effects or risks of side effects from medications;**
4. **Alternative treatment modes and services to include TeleHealth**
5. **The probable consequences of not receiving the proposed treatment and services;**
6. **The period of time for which the informed consent is in effect; which shall be no longer that 15 months from the time the consent is given; and**
7. **The right to withdraw informed consent at any time, in writing**

X _____ X _____

Client Signature **Date**

_____

Therapist/Physician **Date**