Dear Parent/Guardian,

The packet of information you are receiving is for your student to receive one to one counseling services at his or her school. Two agencies are providing counseling services at Wausau East:

- Bridge Community Health Clinic (Barbie Bunnell, LCSW)
- Peaceful Solutions Counseling (Carla Jones, LCSW & Amy Kluetz, LPC)

School staff have recommended counseling for your child and may also have suggested one of these therapists to you based on your child's particular needs.

In order for your child to receive these services, you will need to complete our intake form, just as you would if you were actually coming into our agency requesting services for your child. We also have the same privacy laws to follow even though your child will be seen in school. We will need you to sign a release of information for us to talk with school staff about your child's needs, and even to acknowledge your child is seeing us for counseling. The release of information will be helpful for communication between therapist and the school and in coordinating care for your child, but it is NOT a requirement for your child to receive counseling with us at school.

Our therapist will be following up with you to gather information about your child's needs and their history and will talk with you about setting up appointments in the school, progress your child is making, and to answer questions you may have. There may be times that our therapist asks for your presence at a session, and we will do our best to make that work with your schedule.

Our agencies will provide the same counseling services your child would receive at our agencies. We accept most all insurances, and if there is a concern regarding the cost of the services beyond what your insurance can cover due to high deductibles or insufficient insurance coverage, please contact us and we will help identify possible options to get your child the counseling that has been recommended for them.

- Bridge Clinic Financial Information contact: 715-848-4884; please ask for a Patient Financial Advocate
- Peaceful Solutions Counseling Financial Information contact: 715-675-3458

We look forward to working with you and your child!

Sincerely,

Dakota Kaiser
Behavioral Health Program Director
Bridge Community Clinic
715-848-4884

Michelle Gleason
Executive Director
Peaceful Solutions Counseling
715-675-3458

Peaceful Solutions Counseling

BILL OF RIGHTS FOR MENTAL HEALTH/AODA SERVICES
At Peaceful Solutions Counseling

1. You have the right to prompt and adequate treatment.
2. You have the right to be informed in writing about the costs of treatment.
3. You have the right to confidentiality of conversations and records.
4. You have the right to participate in the development of your treatment plan, including benefits, effects and method of treatment.
5. You have the right to be informed about alternatives to treatment.
6. You have the right to refuse any treatment unless a court orders you to receive treatment.
7. You may not be given any medication at our clinic as none of our staff are licensed physicians.
8. You may not be subjected to any drastic treatment measure without your express written, informed consent.
9. You have the right to be treated with dignity and respect, free from verbal or physical abuse.
10. You may not be videotaped, photographed or audio taped without your written consent.
11. You must be treated in the least restrictive manner.
12. You may not be discriminated against because of your race, gender, faith, age disability, sexual orientation or ethnicity.
13. You have the right to complain about your services. A copy of the state's laws about this is available upon request.
14. You have the right to be informed of the expected duration of treatment.

If you believe that one of your rights may have been violated, the agency's clients rights specialist will investigate that matter and attempt to find a resolution if the complaint is validated.

I am encouraged to contact my therapist regarding any concerns I may have during my treatment. I understand that my therapist may be consulting with a supervising mental health practitioner regarding my case and that I may request a meeting with the mental health practitioner.

My signature below indicates that I have been given a copy of the "Information for Clients" sheet, the "Client Rights and the Grievance Procedure for Community Services" brochure and the "Peaceful Solutions Counseling Privacy Notice".

Client Signature: _____ **Date:** _____

Guardian/Parent Signature (if applicable): _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Peaceful Solutions Counseling

INFORMED CONSENT FOR TREATMENT

I. Treatment method:

Treatment services will be provided through individual, couple, group and family therapy sessions as deemed appropriate and mutually agreed upon by you and your therapist. Collateral contacts with significant others and other involved health care providers may also occur with mutual agreement, as deemed appropriate.

II. Alternative treatment approaches:

Mental Health/AODA therapy incorporates a broad array of theories and techniques for assisting in the resolution of psychological, emotional, and behavioral problems. You always have the option of seeking information from other health care providers regarding their approach or style of therapy.

III. Potential benefits of proposed treatment:

a. Reduction or alleviation of emotional pain related to presenting problem
b. Modification or elimination of self-defeating behaviors
c. Strengthening of self esteem
d. Enhancement of coping, communication, and problem-solving skills
e. Increased satisfaction with interpersonal relationships
f. Improved quality of life

IV. Potential side effects of proposed treatment:

a. Increased awareness of own role in the presenting problem with possible accompanying temporary dip in mood
b. Disruption in one or more key relationships or termination of such relationship(s)
c. Some degree of increased stress and frustration associated with changing long-standing beliefs and behaviors

V. Potential consequences for not receiving proposed treatment:

a. Continuation or worsening of emotional pain related to presenting problem
b. Continuation or further entrenchment of self-defeating behaviors
c. Weakening of self-esteem
d. Continued or increased dissatisfaction with interpersonal relationships
e. Diminished quality of life

VI. Duration of consent validity

a. Your consent to treatment, as indicated by your signature, is considered to be valid and in effect for 12 months from the date signed
b. You have the right to withdraw your consent, in writing at any time

I hereby give my consent to treatment at Peaceful Solutions Counseling according to the agreed upon treatment plan.

Consumer/Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Peaceful Solutions Counseling, Inc.
731 N 1st Street, Suite 5000
Wausau, WI 54403
Phone: (715) 675-3458
Fax: (715) 675-7238

Billing Information

Date: _____

Client Name: _____ Age: _____ Date of Birth: _____

Sex: _____ Social Security Number: _____

Phone: _____ Alternative Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Payment Method: _____ Insurance _____ Medical Assistance _____ Self Pay
Fee Amount $_____.00

Insurance Name: _____

Phone Number on Card: _____

Subscriber's Name: _____

Subscriber's Address: _____

Date of Birth (for subscriber): _____ Relationship to Client: _____

Identification Number: _____ Group Number: _____

Address to Mail Claims: _____

Person Responsible for Billing (if different from client):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Relationship to Client: _____

Dr. Name and Location: _____

Peaceful Solutions Counseling

Billing Agreement

It is the policy of Peaceful Solutions Counseling to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family/household size and annual income. Please complete the following information and bring to your first appointment to determine if you are eligible for a discount. The discount will apply to all services received at this clinic. This form must be completed every 6 months or if your financial situation changes.

If you have private insurance you will be responsible for satisfying any amount left on your deductible. If your insurance does not pay in full once the deductible has been met, you will be responsible for the amount not paid by your insurance company **or** the amount established at the bottom of this fee agreement, whichever is the lesser amount. Provisions exist for reducing or waiving fees below the amount listed on the sliding fee scale, if you request a special waiver. Please note that a request does not change your fee until the Clinic Director approves the waiver.

A mental health or substance abuse initial assessment is $190.00 and ongoing services are billed at the rate of $165.00 per session. If you have Medicaid, Medicare or private insurance we will bill your insurance company for services at the established rate. Please note that a sliding fee scale cannot be used for court related alcohol/drug assessments.

MISSED APPOINTMENTS: With the exception of MA clients, if appointments are not canceled 24 hours in advance, you will personally be billed for the reserved time, for the amount established as your fee. Also note, after 3 no show/no call appointments, services will be terminated. If you arrive for your appointment 15 minutes or more past the scheduled time you will be asked to reschedule your appointment.

Please complete chart below. *Note: Include income from all sources including gross wages, tips, social security, disability, annuities, veteran's payments, alimony, child support, military, and public aid.*

Patient Name:	

Number Living in Household: _____	Household Income
Self (Income)	_____Yearly/Monthly/Bi-Weekly *(Circle which one)*
Other Adult (s) (Income)	_____Yearly/Monthly/Bi-Weekly *(Circle which one)*
Dependent children under age 18 (Income)	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*
Total:	_____ Yearly/Monthly/Bi-Weekly *(Circle which one)*

OFFICE USE ONLY

Based on this information the sliding fee will be: $_____per session

Current primary method of payment:
Insurance ____ MA ____ FEE____

I certify that the family size and income information above is correct, and that I agree to pay the established fee based on my co-insurance, co-pays and deductibles (if applicable). I also authorize Peaceful Solutions Counseling to release any information necessary to process insurance claims to: _____.

If requested, I am entitled to a list of entities to which my information has been disclosed. This agreement will remain in place for one year of signing this document unless revoked prior to that. I further acknowledge that this information has been reviewed with me and that I have received a copy.

Client or Parent/Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Peaceful Solutions Counseling

Sliding Fee Scale

For services provided by therapists: Initial Session $190.00, Ongoing $165.00

Household Size	Gross Annual Income Levels - Not To Exceed										
1	6,245	12,490	15,613	18,735	21,858	24,980	31,225	37,470	43,715	49,960	56,205
2	8,455	16,910	21,138	25,365	29,593	33,820	42,275	50,730	59,185	67,640	76,095
3	10,665	21,330	26,663	31,995	37,328	42,660	53,325	63,990	74,655	85,320	95,985
4	12,875	25,750	32,188	38,625	45,063	51,500	64,375	77,250	90,125	103,000	115,875
5	15,085	30,170	37,713	45,255	52,798	60,340	75,425	90,510	105,595	120,680	135,765
6	17,295	34,590	43,238	51,885	60,533	69,180	86,475	103,770	121,065	138,360	155,655
7	19,505	39,010	48,763	58,515	68,268	78,020	97,525	117,030	136,535	156,040	175,545
8	21,715	43,430	54,288	65,145	76,003	86,860	108,575	130,290	152,005	173,720	195,435
Discount	95%	90%	85%	80%	75%	70%	60%	50%	40%	30%	20%
Adj Fee	**$ 8.25**	**$ 16.50**	**$ 24.75**	**$ 33.00**	**$ 41.25**	**$ 49.50**	**$ 66.00**	**$ 82.50**	**$ 99.00**	**$ 115.50**	**$ 132.00**

Client Demographics Form

THIS SECTION FOR OFFICE USE ONLY:

Intake date: _____

Marathon County Lincoln County

Other:

SAFE, AODA, Trauma, Mental Health,

CHOICES/County Social Worker

Ins Self Pay MA EAP

1. **Client Name:** _____

2. **Client Gender:**

( ) Female ( ) Male

3. **Client Age:**

( ) 0 - 6 years ( ) 18 – 24 years

( ) 7 –12 years ( ) 25 – 54 years

( ) 13 – 17 years ( ) 55 – 64 years ( ) 65+ years

4. **Client Zip Code:** _____

5. **Client's Race/Ethnicity:**

( ) White/Caucasian
( ) American Indian/ Alaska Native
( ) Native Hawaiian/Pacific Islander
( ) Hispanic or Latino
( ) Asian
( ) Black/African American
( ) Other race/two or more races
( ) Unknown

6. **Annual Household Income:**

( ) Less than $9,500
( ) $9,501 - $12,500
( ) $12,501 - $15,000
( ) $15,001 - $20,000
( ) $20,001 - $25,000
( ) $25,001 - $30,000
( ) $30,001 - $35,000
( ) $35,001 - $40,000
( ) $40,001 - $45,000
( ) $45,001 - $50,000
( ) $50,001 - $55,000
( ) $55,001 - $60,000
( ) $60,001 – more

7. **How many people reside in your household?**

( ) 1
( ) 2
( ) 3
( ) 4
( ) 5
( ) 6
( ) 7
( ) 8

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Peaceful Solutions Counseling

INTAKE QUESTIONNAIRE – CHILD

Your responses 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: _____ Age: _____

Address: _____ Gender: _____

_____ Relationship Status: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Social Security Number: _____ Household Income: $_____

Emergency contact: Name: _____ **Phone:** _____

Relationship: _____

How did you hear about Peaceful Solutions Counseling (PSC)?

- ☐ Church/Religious Affiliation
- ☐ County Department of Social Services/Heath Services/Human Services
- ☐ Department of Corrections/Legal System/Court
- ☐ Employee Assistance Program (EAP)
- ☐ Employer/Co-worker
- ☐ Facebook/Twitter
- ☐ Friend/Relative
- ☐ Hospital/Doctor/Mental Health Provider
- ☐ School
- ☐ United Way's 2-1-1
- ☐ Insurance Company
- ☐ Internet Search
- ☐ PSC Client
- ☐ PSC Employee/PSC Program
- ☐ PSC Website/Brochure
- ☐ Other Social Service Agency
- ☐ Phone Book
- ☐ Self – Returning PSC Client
- ☐ Other: _____

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, how can the office accommodate your needs?

_____

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 ISSUE (current situation and history)

1. What is the primary issue for which you are seeking help?

	Length of time for issue	Received treatment in the past from:
☐ Parent/Child issues	_____	_____
☐ Over-activity	_____	_____
☐ Grieving	_____	_____
☐ Sibling issues	_____	_____
☐ Peer problems	_____	_____
☐ Abuse or trauma	_____	_____
☐ Behavior problem at home	_____	_____
☐ Eating issues	_____	_____
☐ Anger issues	_____	_____
☐ Depression/Sadness	_____	_____
☐ Sleep Issues	_____	_____
☐ Divorce/Custody issues	_____	_____
☐ Mood swings	_____	_____
☐ Alcohol/drug use	_____	_____
☐ LBGT	_____	_____
☐ Behavior problem at school	_____	_____
☐ Physical Problems	_____	_____
☐ Anxiety or worry	_____	_____
☐ Self-confidence issues	_____	_____
☐ Academic Performance	_____	_____
☐ Harming self (ex: cutting)	_____	_____
☐ Sexual Acting Out	_____	_____
☐ Suicidal Thoughts/Attempts	_____	_____
☐ Other: _____	_____	_____

Additional comments:

_____

2. Is your child currently being seen by another mental health therapist or substance abuse therapist?

☐ Yes ☐ No If yes, who? _____

It is often advantageous for all your behavioral health clinicians to have the ability to collaborate/communicate.

Do you consent to allow this collaboration? ☐ Yes ☐ No

3. **Has your child ever been a victim of a crime ? (whether reported or not) (*Some examples might include: Sexual or physical abuse, bullying, etc.)*** ☐ Yes ☐ No

CURRENT FAMILY INFORMATION

1. Does the child live with parent(s)? ☐ Yes ☐ No

2. If no, where does the child live and with whom? (Names/relationship): _____

_____

3. Has the child lived with anyone else in the past? ☐ Yes ☐ No

4. If yes, with whom and where? _____

_____

5. Who has legal guardianship of the child? _____

6. Parent Information

Father's Name		Phone			
Address		DOB		Age	
Occupation		Education			
Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Step-Father's Name		Phone	

Address		DOB		Age	
Occupation		Education			
Step-Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Foster Father's Name		Phone			
Address		DOB		Age	
Occupation		Education			
Foster Mother's Name		Phone			
Address		DOB		Age	
Occupation		Education			

Guardian/Other Name		Phone			
Address		DOB		Age	
Occupation		Education			

List all other adults living in the home (i.e. aunts, uncles, grandparents, significant others, friends, etc.):

_____

_____

_____

6. Please provide information about the child's brothers and sisters and any other children living in the home:

Name	Gender	DOB	Relationship (full, half, step, foster)	Lives with child?	If no, lives where?
	M F			Yes No	
	M F			Yes No	
	M F			Yes No	
	M F			Yes No	

7. In your current family/household is there a history of: (check all that apply)

☐ Eating disorders ☐ Mental illness ☐ Suicide (attempts or actual) ☐ Physical abuse

☐ Sexual abuse ☐ Emotional abuse ☐ Domestic violence ☐ Custody issues

☐ Incarceration ☐ Gambling ☐ Sexual Addiction ☐ Spending issues

If checked, please explain:

_____

_____

_____

8. The family's strengths are:

_____

_____

_____

9. The family's weaknesses are:

_____

_____

_____

10. The primary disciplinarian in the home is: _____

11. The kind of discipline used with the child is:

_____

_____

12. Are there any family circumstances you would like us to be aware of?

_____

_____

SOCIAL DEVELOPMENT

1. My child gets along with peers:

☐ Poorly ☐ Sometimes ☐ Most of the time ☐ Almost Always

2. My child gets along with adults:

☐ Poorly ☐ Sometimes ☐ Most of the time ☐ Almost Always

3. My child spends the most time with (check closest answer)

☐ Younger children ☐ Same age children ☐ Older children ☐ Adults ☐ Self

4. My child's hobbies and interests are: _____

_____

_____

WORK AND ACADEMIC INFORMATION

1. What school does the child currently attend? _____
2. What grade is the child in? _____
3. School Contact Person/Role: _____
4. Number of schools the child has attended: _____
5. Locations of the schools the child has attended: _____
6. Does the child have a written IEP? ☐ Yes ☐ No
7. Is the child in special education classes? ☐ Yes ☐ No
8. If yes, what type? _____
9. The child is a ☐ Good Student ☐ Average Student ☐ Poor Student
10. Attitudes towards School

☐ Truancy	☐ Argumentative	☐ Fighting with Peers	☐ Poor Effort
☐ Disruptive	☐ Attentive	☐ Repeated Grades	☐ Expulsions
☐ Suspensions	☐ Detentions	☐ Difficulty keeping Friends	☐ Noncompliant
☐ Cooperative	☐ Motivated	☐ Complies with expectations	☐ Interested

11. Is your child currently employed? ☐ Yes ☐ No
12. If yes, where and number of hours per week: _____

ALCOHOL & DRUG HISTORY

Do you suspect/know your child has used drugs or alcohol before or during school? ☐ Yes ☐ No

Do you suspect/know if your child has missed school because of use or just to use? ☐ Yes ☐ No

My child avoids non-users. ☐ Yes ☐ No

Do you suspect/know if your child uses more than one drug to get intoxicated or high? ☐ Yes ☐ No

Is there a history of problems with alcohol or drugs in your family? ☐ Yes ☐ No

If checked yes, please explain: _____

_____

My child is using the following:			How much each time?	How often?
Alcohol	☐ Yes	☐ No		
Tobacco	☐ Yes	☐ No		
Marijuana	☐ Yes	☐ No		
Cocaine/Crack	☐ Yes	☐ No		
Heroin	☐ Yes	☐ No		
Meth	☐ Yes	☐ No		
Tobacco	☐ Yes	☐ No		
Hallucinogens: (MDMA, LSD, Psilocybin, Mushrooms, Ecstasy, Ketamine)	☐ Yes	☐ No		
Opioids: (Oxycontin, Morphine, Codeine, Vicodin, Tramadol)	☐ Yes	☐ No		
Amphetamines: (Adderall, Ritalin, Concerta)	☐ Yes	☐ No		
Benzo's: (Xanax, Clonazepam, Ativan)	☐ Yes	☐ No		
Party Drugs: (GHB, Rohypnol)	☐ Yes	☐ No		
Synthetics: (Bath Salts, K2, Spice, 2-C-T-I)	☐ Yes	☐ No		
Other (Specify) _____				

Interventions:

A. My child has been involved in a 12 step/AA program? ☐ Yes, currently ☐ Yes, but not currently ☐ No

B. My child has received outpatient AODA treatment? ☐ Yes, currently ☐ Yes, but not currently ☐ No

C. My child has received inpatient AODA treatment? ☐ Yes, currently ☐ Yes, but not currently ☐ No

LEGAL HISTORY

Has your child ever:			When?	For what?
Been arrested	☐ Yes	☐ No		
Been convicted	☐ Yes	☐ No		
Been on probation	☐ Yes	☐ No		

My child is currently:			For what?	For how long?
On probation	☐ Yes	☐ No		
			When?	For how long?

Registered as a sexual offender ☐ Yes ☐ No _____ _____

Complete if applicable:

Name of child's social worker _____ Phone number: _____

Name of child's PO _____ Phone number: _____

DEVELOPMENTAL HISTORY

1. Pregnancy

Smoking during pregnancy ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Alcohol during pregnancy ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Drugs during pregnancy ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently

Medication during pregnancy ☐ Yes ☐ No (If yes, list all medications)

_____

2. Labor

☐ Spontaneous ☐ Induced Duration in hours: _____

Complications during pregnancy _____

Birth weight: _____ Infant days in hospital: _____

3. Did the child reach developmental milestones at a normal age?

MEDICAL HISTORY

1. Please check the appropriate box if your child has 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
☐ Suicide Attempt
☐ 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
☐ Cancer
☐ Bowel problems
☐ Hemorrhoids, rectal bleeding
☐ Loss of consciousness
☐ Chest pain or angina pectoris
☐ 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: _____

_____

_____

_____

2. Please provide information about medication(s), prescription or over-the-counter, which your child takes regularly:

Medication	Dosage/Frequency	Prescribing Physician	For what condition?

3. Does your child have a pediatrician or primary care physician? ☐ Yes ☐ No

If yes, who? _____

It is often advantageous for your treatment for your physician and your therapist to have the ability to collaborate/communicate. Do you consent to allow this collaboration? ☐ Yes ☐ No

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

_____

_____

COMMUNITY RESOURCES

1. Are you currently receiving any services from any community resources? (i.e., support groups, social services, church groups, school based services, food pantries, etc.)

_____

_____

GOALS

1. What are the child's strengths? _____

_____

2. What are the child's weaknesses? _____

_____

3. What goals would you like to see reached as a result of your involvement with Peaceful Solutions Counseling?

_____

_____

_____

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

_____

_____

_____

Custody Agreement/Court Order

In order to comply with Wisconsin state law, it is our policy at Peaceful Solutions Counseling that any child who is mentioned in a court order or custody agreement cannot begin counseling until a copy of that order is given to and reviewed by the clinician. Please answer the following questions regarding the custody of and legal right to consent to mental health treatment for this child.

1. **Are you the biological/adoptive parent of this child with full legal rights?** ☐ Yes ☐ No

   If YES: *Do you have medical rights to seek treatment for this child?* ☐ Yes ☐ No

   If NO: *Please bring the document stating your rights to make medical decisions to the first counseling appointment (a copy of the most recent custody agreement or divorce decree). If you do not bring these documents or do not have legal rights to consent, we will be unable to provide counseling services to the child.*

2. **Is this child named in any kind of court order or custody agreement?** ☐ Yes ☐ No

   If YES: *Please bring a copy of these documents to the first counseling appointment.*

   ** If you do not bring these documents, we will be unable to provide counseling services to the child.*

I, _____, parent/guardian of _____,

hereby confirm that the above answers are both true and correct concerning custody and court orders involving this child. I also agree that the orders provided are current as filed with either the county or state authorities. Lastly, I agree that if any new orders or custody agreements are made during the time that this child is in services, I will present these papers to the clinician at Peaceful Solutions Counseling upon my receipt of the orders or custody agreements.

_____ _____

Parent/Guardian Date

_____ _____

Witness Date

Peaceful Solutions Counseling

731 N 1st Street Suite 5000 – Wausau WI 54403
(715) 675-3458 Fax: (715) 675-7238

Authorization for Release of Information

Client Name: (Child name)_____ D.O.B.: _____

(1) I/We, (Parent/Guardian Name) _____, hereby request and authorize Peaceful Solutions Counseling to: (select which apply)

_____ Disclose to _____ Receive from _X_ Exchange with

Agency/Name: WAUSAU EAST HIGH SCHOOL

Address/city/state/zip: 2607 N. 18TH STREET, WAUSAU, WI 54403

Phone Number: (715)261-0650 Fax Number: _____

(2) The information to be provided covers the time period of: _____

(3) Disclosure of this information is for the purpose of: (select which apply)

☐ Diagnosis, assessment, treatment or provision of services
☒ Continuation of care
☒ Other: (please specify) GUIDANCE, ATTENDANCE, STUDENT'S TEACHERS
☐ Legal purposes
☐ Insurance eligibility

(4) Because a general authorization for the release of medical or other information is not sufficient for all purposes, the following specific information is requested. The specific information to be released is as follows: (select which apply)

_____ AODA Findings
_____ Physical/Medical Findings
_____ Psychiatric Assessment and Recommendations
_X_ Psychological Assessment and Recommendations
_X_ Recommendations
_____ Legal
_X_ Educational Assessment and Recommendations
_X_ Psycho/Social Assessment and Recommendations
_X_ Progress Notes and Findings
_X_ Treatment Plan/Treatment Plan Reviews
_X_ Discharge Summary
Other: (specify) ATTENDANCE; VERBAL EXCHANGE OF INFORMATION

(5) This authorization will expire in one (1) year, unless an earlier date is specified as follows: _____

Your Rights, Regarding This Authorization:

Right to receive a copy of authorization: You have a right to receive a copy of this authorization.

Right to refuse to sign this authorization: You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain treatment.

Right to withdraw this authorization: You have a right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your withdrawal will not be effective until received by Peaceful Solutions Counseling and will not be effective regarding the uses or disclosures made prior to the cancellation.

Right to inspect or receive a copy of the information: You have a right to review and/or receive a copy (at a reasonable fee) of the information you authorized to be used or disclosed by this authorization. (There are certain legal restrictions to this that may be applicable, for example, a minor's records cannot be released to parents who have been denied physical placement of the minor). You may arrange to inspect your file or obtain copies of this information disclosed by Peaceful Solutions Counseling.

Prohibition of re-disclosure: I understand that information regarding my alcohol and / or drug treatment is protected by federal law under the Drug Abuse Prevention, Treatment, and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and their implementing regulations. See generally 42 C.F.R. Part 2; 45 C.F.R. Parts 160, 164. I understand that my health information specified above will be disclosed pursuant to this authorization, that the recipient of the information may re-disclose the information and federal law under HIPAA may no longer protect it. Federal law governing confidentiality of alcohol and drug abuse patient information, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from re-disclosure.

Client's Signature: _____ Date: _____

AND/OR

Person Authorized to Sign for Client: _____ Date: _____

Specify Relationship to Client: _____

Witness: _____ Date: _____