INTAKE INFORMATION

Client's Name: _____ Today's Date: _____

Client's Date of Birth: _____/_____/_____ Client's Age: _____ Male_____ Female_____

Client's Race/Ethnicity: _____ Dominant Hand (circle one): Right Left Ambidextrous

Client's Address: _____

City: _____State: _____ Zip Code: _____

Client's Social Security Number: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email Address:_____

We may contact you by (check all that apply): Phone ____ Voicemail ____ Text ____ Email ____

Who referred you or how did you find us?: _____

Client's Education:_____

Client's Occupation/School: _____ Employer: _____

Marital Status: _____ Spouse/Partner's Name: _____

Children's Names and Ages: _____

Parent's Names (if client is a minor): Mother _____ Father _____

Are the parents of the client divorced?: Yes _____ No _____

If Yes, and both parents hold legal authority, does each parent/guardian consent to psychological services: Yes _____ No _____

Person responsible for payments: _____; Relation to Client: _____

Emergency Contact Person: _____; Phone Number: _____

INSURANCE INFORMATION:

Primary Policy Holder (if different than client): _____

Date of Birth: _____/_____/_____ Social Security Number: _____

INTEGRATIVEPSYCHE

HEALTH ASSESSMENT

For Therapy and Evaluations

Client's Name: _____ Date of Birth: ____/____/_____

Please briefly explain client's reason for seeking services with our clinic:

_____

_____

Has client seen a psychologist or counselor in the past?: YES_____ NO_____

If Yes, with Who?: _____ When?: _____

Reason: _____

Has client had a (neuro)psychological evaluation in the past?: YES_____ NO_____

If Yes, with Who?: _____ When?: _____

Findings: _____

Is client currently under the care of a psychiatrist? YES _____ NO_____

If Yes, with Who?: _____ Where?: _____

Please list currently prescribed medications and dosages:

_____

_____

Please list any major health problems:

_____

_____

Client's primary care physician or pediatrician: _____

Date of last exam: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

INFORMED CONSENT
CONFIDENTIALITY AND DENIAL OF RIGHTS
For Evaluations

Thank you for choosing to receive psychological services from Integrative Psyche, LLC. This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician and/or their supervisor. This clinic is a training facility. Our students are under the supervision of a licensed psychologist with expertise in (neuro) psychological, educational, and cognitive assessment. In order to ensure the best possible service, your testing clinician will be discussing your testing results with her/his supervisor(s). It is possible that some of your/your child's responses will be audio recorded, which will remain confidential. Your signature below represents your informed consent for audio recordings.

Through the use of a variety of standard psychological tests, we will attempt to answer the questions that have brought you for this assessment. These questions generally concern learning disabilities, academic functioning, personality functioning, or coping styles. Throughout the assessment process you have the right to inquire about the nature or purpose of all procedures. You also have the right to know the test results, interpretations, and recommendations. The assessment process generally involves an informational interview followed by the administration of one or more (neuro) psychological tests (i.e., cognitive, achievement, personality, memory, attention/concentration/executive functioning, behavioral functioning, projective- social/emotional functioning). Although it is sometimes possible to complete the testing procedure in one sitting, it is common for people to be asked to return for another session to finish the assessment battery. Once testing is completed, the data will be analyzed and a report will be written. You will then have the opportunity to meet with your clinician to discuss the results and receive a copy of the report. Because we are a training clinic, our general turnaround time for completed reports is about 5 weeks.

You/your child will be tested or evaluated by a person with the following credentials:

- Licensed Psychologist
- Practicum Student – a practicum student is a graduate student who is pursuing a doctoral degree, and is gaining their first experiences in the field of (neuro) psychological assessment. All practicum students have had other types of clinical training, including assessment courses, supervision, and client interaction. Practicum students receive extensive and close supervision with a licensed psychologist who remains responsible for the client's well-being and the results of the evaluation.
- Post-Doctoral Intern – a post-doctoral intern has received their doctorate degree in clinical psychology, and has passed rigorous comprehensive and clinical competency examinations. They are earning their post-doctoral hours before becoming a licensed psychologist. Post-doctoral interns are supervised by a licensed psychologist who is responsible for the client's well-being and the results of the evaluation.

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

INFORMED CONSENT
CONFIDENTIALITY AND DENIAL OF RIGHTS
For Evaluations
Continued

Additionally, I understand that if Integrative Psyche staff deems that additional or alternative testing be necessary, the Clinic will describe the reasons for this testing and will advise client and/or client's guardian(s) of any additional costs. I understand that I have the right to discontinue the evaluation process at any time. However, I understand that the treating clinician(s) may be unable to provide feedback of the test results if testing is terminated, and that I will still be responsible for payment of any testing, scoring, and evaluation time provided up until that point.

Information obtained during this evaluation is confidential and will not be discussed without your release of that information. However, Wisconsin Law requires that therapists break this confidentiality under the following conditions: 1) when there is a court order to do so; 2) there is a serious threat of harm to oneself or another person; or 3) if a child or older adult (over the age of 60) is being endangered through abuse or neglect. In the rare event of any of these situations, the treating clinician(s) would attempt to discuss their intentions with the client/client's guardian(s) before an action is taken, and disclosure of confidential information would be limited to the minimum necessary to insure safety.

There may be times in which it may be necessary to consult with other professional colleagues about your care. Should it be useful or necessary for the rendering provider to do so, your personal information will be kept confidential so that no identifying information will be shared without your consent. Insurers sometimes require the release of certain information before they will authorize payment. In such instances, only the minimal information required for reimbursement will be released.

It is important to understand that Integrative Psyche, LLC does not perform custody evaluations for children, which is a highly specialized field. In addition, the Clinic does not perform forensic psychological evaluations (to examine and evaluate a patient in anticipation of prosecution or litigation). If you are considering using the results of an evaluation for a custody dispute or for legal purposes, please consult with experts in those areas.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMED CONSENT/CONFIDENTIALITY AND DENIAL OF RIGHTS FORM AND AGREE TO ITS TERMS.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

CONSENT TO PSYCHOLOGICAL CARE

For Evaluations

I, having legal responsibility and authority and knowing that I am/my child is in need of outpatient diagnostic and/or (neuro) psychological testing, do authorize Integrative Psyche, LLC, including assistants, students and other staff to perform and prescribe treatment and other related care under the supervision of a licensed psychologist and/or licensed clinicians. I understand that administrative support staff, students, assistants, and other staff members may not be employed by this agency. It is also understood and agreed upon that, at times, students may deliver, observe, and contribute to services in other ways under the supervision of authorized agency personnel such as licensed psychologists and other licensed professionals. I understand that some providers are not licensed and are accruing hours toward licensure or as a part of their educational requirements. These providers are under the care and supervision of licensed psychologists and/or other licensed clinicians.

I understand that Integrative Psyche, LLC has a training component which serves important educational functions. I also understand that without using my name or other identifying information, students may use material from my file for educational purposes. I approve the use of information from my file for educational purposes so long as my identity and privacy is protected.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE CONSENT TO PSYCHOLOGICAL CARE FORM AND AGREE TO ITS TERMS.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

FINANCIAL POLICY

For Evaluations

Please understand that when you come for psychological services, you and your treating clinician(s) automatically contract with one another. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits. Any charges not covered by your insurance company are your responsibility. This includes deductibles, co-pays, co-insurance, lapses in coverage, or any private pay arrangements agreed upon between you and your therapist. Payments are due 30 days from the date of the statement. After three consecutive months, failure to make payment in full, or to make payment arrangements with office staff, will result in your account being turned over for collections. If this occurs, a 25% collection charge will be added to your bill.

We reserved the right to charge a $25 fee for failure to cancel any appointments 24 hours in advance.

Cost of Treatment:

Psychological Evaluation:..... $300 per hour

Neuropsychological Evaluation:..... $350 per hour

Fees for psychological and neuropsychological evaluations and therapy will vary according to each situation. The exact charges will be based on the number and type of tests administered, the time needed for scoring and interpreting, the time for written report, consultations with other parties involved in the evaluation process, and type and length of sessions. Please note that time spent on scoring, interpreting, reviewing records, and report writing will be billed accordingly, and may not be reflected on the day(s) of your actual office visit(s).

- I have read and understand this Financial Policy as indicated above. _____Initial
- I authorize the use of my and/or my child's personal identifying information and release of information for insurance submissions. _____ Initial
- I understand that payments for services rendered are non-refundable, except and only under specific circumstances determined by insurance companies and/or Integrative Psyche, LLC/ my treating clinician(s). _____ Initial

BY SIGNING THIS FORM, I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR PAYING, IN FULL, FOR MY AND/OR MY CHILD'S PSYCHOLGICAL SERVICES. THIS INCLUDES PAYMENT OF PRIVATE PAY FEES AND/OR ANY PORTIONS OF THE BILL THAT ARE NOT COVERED BY MY AND/OR MY CHILD'S INSURANCE COMPANY.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

INTEGRATIVEPSYCHE

RELEASE OF INFORMATION

For Evaluations

Client: _____ DOB: _____ Today's Date: _____

I hereby authorize Integrative Psyche, LLC to disclose information to and/or obtain information from the following individual(s) regarding my/my child's care:

❒ By checking this box, I decline consent for the release of information with the Primary Care Physician.

❒ By checking this box, I accept consent for the release of information with the Primary Care Physician.

Name and Relationship to Client: Primary Care Physician (PCP)_____
Address: _____
Phone/Fax Number: _____
Email Address: _____

For the following information:

- ❒ Release of evaluation notes/results
- ❒ Progress Notes
- ❒ Collaboration
- ❒ Other, please specify _____

For the purposes of:

- ❒ Continuity of care
- ❒ Employment
- ❒ Other, please specify _____

Upon fulfillment of the above stated purposes, this consent will automatically expire one year following the date of signature without my express revocation unless otherwise specified here:

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND AND AGREE THAT CONFIDENTIAL INFORMATION AND/OR PROTECTED HEALTH INFORMATION REGARDING THE IDENTIFIED CLIENT MAY BE DISCOLOSED TO THE IDENTIFIED INDIVIDUALS IDENTIFIED ABOVE.

Printed Name of Client: _____
Signature of Client: _____ Date: _____
Printed Name of Parent/Guardian/Legal Representative (if applicable): _____
Signature of Parent/Guardian/Legal Representative (if applicable): _____
Relationship to Client: _____ Date: _____
Witness Signature_____ Date: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

INTEGRATIVEPSYCHE

RELEASE OF INFORMATION

For Evaluations

Client: _____ DOB: _____ Today's Date: _____

I hereby authorize Integrative Psyche, LLC to disclose information to and/or obtain information from the following individual(s) regarding my/my child's care:

❒ By checking this box, I decline consent for the release of information with others.

❒ By checking this box, I accept consent for the release of information with others.

Name and Relationship to Client: _____
Address: _____
Phone/Fax Number: _____
Email Address: _____

For the following information:

- ❒ Release of evaluation notes/results
- ❒ Progress Notes
- ❒ Collaboration
- ❒ Other, please specify _____

For the purposes of:

- ❒ Continuity of care
- ❒ Employment
- ❒ Other, please specify _____

Upon fulfillment of the above stated purposes, this consent will automatically expire one year following the date of signature without my express revocation unless otherwise specified here:

YOUR SIGNATURE BELOW INDICATES THAT YOU UNDERSTAND AND AGREE THAT CONFIDENTIAL INFORMATION AND/OR PROTECTED HEALTH INFORMATION REGARDING THE IDENTIFIED CLIENT MAY BE DISCOLOSED TO THE IDENTIFIED INDIVIDUALS IDENTIFIED ABOVE.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

Witness Signature_____ Date: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTHCARE 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 I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health Information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health related to health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed to others outside of my office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, and any other use required by law.

Treatment: I will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, I would disclose your protected health information, as necessary to another health agency or health care provider that provides care to you to ensure that they had necessary information to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. Healthcare Operations: I may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Child abuse, physical neglect and/or sexual abuse; Adult and Domestic abuse of an incapacitated or vulnerable adult.

Health Oversight: Wisconsin Board of Psychological Examiners conducting an investigation.

Judicial and Administrative Proceedings: if you are involved in a court proceeding and a request is made for information about professional services I have provided.

Serious Threat to Health or Safety: if I believe there is an imminent risk of harm to yourself or others.

Worker's Compensation: it may be necessary to comply with laws relating to worker's compensation or other similar programs.

Other Permitted and Required Uses and Disclosures will be make only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that I have taken an action in reliance on the use or disclosure indicted in the authorization.

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

HIPAA NOTICE OF PRIVACY PRACTICES

CONTINUED

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 protected 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 me 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 involved in your care 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. I am not required to agree to a restriction that you may request. If I believe 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 choose another Healthcare Professional.

You may have the right to request an amendment of your protected health information. If I deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare 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. I reserve the right to change the terms of this notice and will inform you in person of any change. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to Nicole Klepp, Psy.D., HIPAA Officer, if you believe your privacy rights have been violated. I will not retaliate against you for filing a complaint.

This notice is effective April 14, 2003. I am required by law to maintain the privacy of, and provide individuals with, this notice.

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

HIPAA NOTICE OF PRIVACY PRACTICES

CONTINUED

I have read the information contained within this consent form and HIPAA notice of privacy practices. My signature below indicates my consent/assent to psychological services as well as my understanding and agreement to the terms contained within this consent form and HIPAA notice. I have been provided with a copy of the HIPAA form. I have also been provided with an opportunity to discuss any concerns that I may have.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

Witness Signature_____ Date: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

As a convenience to me, I hereby request that Integrative Psyche, LLC and/or my treating providers communicate with me regarding my treatment by Integrative Psyche staff via electronic communications (e-mail, phone calls, voicemail, and text message). I understand that this means Integrative Psyche staff may transmit my protected health information such as information about my appointments, diagnosis, medications, progress, psychological evaluation report, and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, phone calls, or voicemail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted or password protected. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Integrative Psyche, LLC and/or my treating providers shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information between Integrative Psyche staff and me.

Please note that your provider may route your email, text, or voicemail messages to other staff members for informational purposes or for expediting a response. As such, designated staff may receive your electronic messages. During emergencies you should contact 911.

This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I understand that in the event I no longer wish to receive electronic communications from Integrative Psyche, LLC, I may revoke this authorization by providing written notice to Integrative Psyche, LLC at 10150 W. National Avenue, Suite 390, Milwaukee, WI 53227, or via fax at 414-545-4454.

I HAVE BEEN PROVIDED NOTICE OF THE RISKS INHERENT IN THE USE OF ELECTRONIC COMMUNICATIONS. I HEREBY AUTHORIZE INTEGRATIVE PSYCHE STAFF TO COMMUNICATE ELECTRONICALLY WITH ME.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

Printed Name of Parent/Guardian/Legal Representative (if applicable): _____

Signature of Parent/Guardian/Legal Representative (if applicable): _____

Relationship to Client: _____ Date: _____

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454

One-Time & Repeat Payment

Credit Card Authorization Form

CARDHOLDER INFORMATION

Name: _____

Billing Street Address: _____

City: _____ State: _____ Zip Code: _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

PATIENT INFORMATION

Patient Name: _____

❒ I authorize a one-time charge against my credit card for the following amount $ _____

❒ I authorize a recurring charge against my credit card for the following amounts:

$_____once every ❒ ____ day(s) ❒ ____ week(s) ❒ ____ month(s) ❒ ____year(s)

Beginning Date: _____ and ending after _____ payments.

CARDHOLDER INFORMATION

Credit Card Type: ❒ MasterCard ❒ Visa ❒ American Express ❒ Discover Card

Number: _____

Expiration Month: _____ Expiration Year: _____

Cardholder Signature: _____ Date: _____

Security Code: _____

❒ Check if this is an HSA Credit Card Account

10150 WEST NATIONAL AVENUE, SUITE 390 | MILWAUKEE, WI 53227 | P: (414) 545-4430 | F: (414) 545-4454