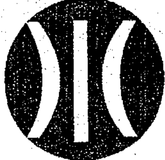


CAMBRIDGE COUNSELING CLINIC INC.

120 East Main Street - P.O. Box 548 - Cambridge, WI 53523

Adult Client Information Sheet

(*Diag. Code*________)

Name of Patient______________________________ Phone ____________________

Address____

City____________________________________ State________ Zip___________

Date of Birth__________________ Male___ Female___

Single___ Married___ Divorced___ Widowed___ Separated___ Child____

Employed _____ Full Time Student _____ Part-Time Student ______

Employer/School Name____

Responsible Party (if different from above)
Name
____

Address______________________________ City__________ State____ Zip________

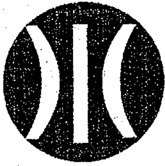
Informed Consent and Authorization

State and federal law requires that you be informed about the information to be released from your records. Permission for this release of information must be given in writing.
Communication with your physician: Our clinic policy is to keep your physician generally informed about your treatment progress because this affects your overall health.
Communication with insurance companies: Insurance companies are required to pay for services only for certain diagnoses and conditions. It is the policy of the clinic to release a minimum amount of information necessary to successfully process your claim; often this is just the diagnosis code and dates of visits but in some cases, more information is necessary.
Medicare authorization (if applicable): I request that payment of authorized Medicare benefits be made to me or on my behalf to Cambridge Counseling Clinic, Inc. for any services furnished by the clinic. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.
Payment of Medical Benefits: I authorize payment of medical benefits I am entitled to under the terms of my health care coverage to Cambridge Counseling Clinic, Inc. and agree to be responsible for services not paid, in whole or in part, by my health care payer. This includes balances beyond the usual and customary reimbursement by insurance companies.

**By signing below I am authorizing the Cambridge Counseling Clinic, Inc. to release information and request payments as stated above for the duration of my treatment. I understand that this consent may be revoked by me at any time by giving written notice to the directors of the Cambridge Counseling Clinic, Inc.
A photocopy of this consent will be considered as valid as the original.**

EXPLANATION OF MENTAL HEALTH TREATMENT

Mental health practitioners at Cambridge Counseling Clinic and contracted practitioners administer services to referred members. Mental health services are provided based on a determination of the medical necessity and appropriate clinical interventions. Services are goal-oriented and usually of brief duration. Psychiatric consultations for medication are available as necessary through a referral by the therapist.



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If I feel suicidal or assaultive while participating in treatment, I agree to tell my therapist immediately. In an emergency, I agree to call 911 or the emergency number provided to me by my therapist. I agree to use the mental health crisis line for emergency matters only. I will call the mental health clinic I receive my care from during regular business hours (8:00 a.m. to 5:00 p.m. Monday through Friday) for non-emergency questions.

I understand that I will be responsible for mental health services not authorized and/or not covered by my insurance. I agree to notify the mental health clinic at least twenty-four hours in advance if I must cancel a scheduled appointment.

I may stop treatment at any time. If I wish to begin treatment with another therapist, I may/request this by contacting the clinic I receive care from. If I have a complaint about my therapist, I understand that I can communicate this to my therapist directly or to your Client Rights Specialist: Maria Hanson, P. O. Box 14533, Madison, WI 53714, Telephone: (608) 446-8957.

Privacy Policy

I understand that Cambridge Counseling Clinic is committed to protecting patient confidentiality and that information concerning my treatment will be kept confidential in accordance with organizational policies and procedures. I have a right to inspect my own medical records following Cambridge Counseling Clinic's policies and procedures. Mental health records are confidential and will not be disclosed to anyone outside of Cambridge Counseling Clinic without my consent except in circumstances mandated by law. I understand that medical and mental health practitioners are required to report child physical or sexual abuse to Child Protective Services authorities in the county within which they practice. I understand that confidentiality privileges are waived if I present a threat to my own safety or to that of others. I understand that under limited circumstances my records may be subject to court subpoena and that my therapist may be subpoenaed to testify. If I am attending therapy as a result of a court order or condition of probation or parole, my records will be available to the supervising authority.

CLIENT RIGHTS:

In Wisconsin, clients in outpatient mental health clinics like Cambridge Counseling Clinic, Inc. have many important rights. These are enumerated in the Notice of Privacy Rights found in the waiting room. Please read them at your convenience. The Client Rights may be summarized around three issues, which include the following:

INFORMED CONSENT: The right to know the nature of your treatment – its benefits, possible consequences and available alternatives. You have the right to refuse your treatment or any treatment contact at Cambridge Counseling Clinic, Inc.

CONFIDENTIALITY: The right to privacy regarding all conversations and records unless you authorize, i.e., your insurance carrier, your doctor, and anyone else you authorize to become aware of your work at Cambridge Counseling Clinic, Inc. In specific situations involving allegations of child abuse or threat of danger to yourself or others Cambridge Counseling Clinic, Inc. is required to report to authorities. This information is released with our knowledge and preferably with your consent.

GRIEVANCES: The rights to file a grievance if you believe our Client Rights have been violated. The grievance procedure is initiated by contacting any Cambridge Counseling Clinic, Inc. staff person with your concerns. If the grievance cannot be resolved at that time, the staff person will arrange a meeting for you with the Director's of Cambridge Counseling Clinic, Inc. If resolution of the grievance does not occur at this informal level, a meeting with Cambridge Counseling Clinic, Inc.'s Clients Rights specialist will be arranged.

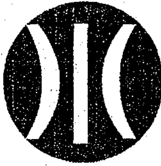
CLIENT PAYMENT INFORMATION

SERVICES:

Cambridge Counseling Clinic, Inc. provides evaluations and psychotherapy services conducted by licensed psychiatrists, psychologists, and licensed clinical social workers. These services may include individual, couple, family or group therapy, various intelligence and personality tests as well as an Admission Evaluation. The Court Ordered Evaluation may result in a referral to other facilities for ongoing treatment.

FEE PAYMENT:

Therapy costs are the responsibility of the client. (In the case of a child, the child's parent or legal guardian is responsible. In the case of a divorce or like situation, the parent seeking therapy services and signing this document will be solely responsible for payment of charges incurred at this facility.) **Please bring billing concerns to the attention of your therapist or office staff so your questions may be answered in a timely manner.**



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Cambridge Counseling Clinic, Inc. is not responsible for collection of claims or the negotiation of a disputed claim. **If you are using insurance, any portion of your bill not paid by your insurance or health reimbursement account, is your responsibility.** In the event that Cambridge Counseling Clinic, Inc. needs to use collection or legal service to obtain payment, it is understood that copies of bills, work or home telephone numbers, and Social Security numbers will be provided to the professionals involved.

FEE SCHEDULE:

Co-Pays Due On Day of Service

Court Ordered Evaluation (including testifying or report writing)	
Psychiatrist	$250.00 per hour
Licensed Psychologist	$210.00 per hour
Clinical Social Worker	$130.00 per hour
Initial Assessment with a	
Psychiatrist	$240.00 per hour
Licensed Psychologist	$210.00 per hour
Clinical Social Worker	$195.00 per hour
Individual Therapy with a	
Psychiatrist	$200.00 – 50 minutes/hour
Licensed Psychologist	$140.00 – 50 minutes/hour
Clinical Social Worker	$130.00 – 50 minutes/hour
Family Therapy with a	
Licensed Psychologist	$180.00 – 50 minutes/hour
Clinical Social Worker	$165.00 – 50 minutes/hour
Medication Management	$120.00 per 15 minutes
Psychological Testing	$125.00 per 50 minutes
Group Therapy	$ 60.00 per 90 minute session

Fees Not Billable To Insurance: Fees Due At Time Of Service

Missed Appointments	$ 130.00 up to full hourly charge
Late Cancellations (less than 24 hours)	$ 130.00 up to full hourly charge
Correspondence, forms, specific reports	Regular rate pro-rated according to time spent
Telephone calls/consultations	Regular rate pro-rated according to time spent
Copies of Records	$ .30 per page

I have received/ reviewed and agreed to the privacy policy, fee schedule, mental health treatment explanation and client's rights.

Client Name(print)____________________________________ **D.O.B.**________

Client Signature (Parent/guardian for minor)____________________________

Witness (must be 18 or over)________________________________ **Date**________

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What motivated you to seek our services? What is your presenting concern or problem?

____

____

____

How have you tried to deal with this issue in the past? Were you successful or not?

____

____

____

When did the issue(s) begin? ______________________________

____

____

Approximate age of onset: ____________ years old

History of presenting problem(s):

- Has the issue changed (improved or worsened) over time?
- Is it a consistent problem or is it only in certain situations?
- Was there a certain event that caused the problem(s) to surface?

____

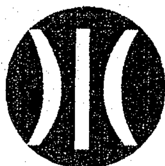
____

____

____

____

Phone: 608-423-4700 Fax: 608-423-7751 EMAIL: info@cambridgecounselingclinic.com



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ADULT INTAKE ASSESSMENT

HEALTH PROFILE

Client Name: ______________________________ DOB: __________

Primary Care Physician ______________________________

Clinic Name and City ______________________________

Clinic Phone # ____________________

Are you currently under the care of this doctor for any physical or emotional condition? ☐ Yes ☐ No

Client Health History

List any hospitalizations within the last 3 years.

LOCATION	REASON	YEAR

List all prior mental health services received:

FACILITY OR THERAPIST	REASON	YEAR

Circle any support groups you have attended: AA AO NA ALANON OA OTHER _____

Health Concerns/ Conditions

Check all that apply to your health.

( ) Allergies
( ) Asthma/ Breathing
( ) ADD
( ) ADHD
( ) Bullying/ Being Bullied
( ) Cancer
( ) Chronic Pain
( ) Dental Health
( ) Diabetes
( ) Emotional Problems
( ) Epilepsy/ Seizures
( ) Hay Fever
( ) Headaches
( ) Hearing Problems
( ) Heart Disease
( ) High Blood Pressure
( ) Hypoglycemia
( ) Irritable Bowel Syndrome
( ) Overweight/ Obese
( ) Sleep Disturbances
( ) Vision Problems

If you indicated allergies, what causes an allergic reaction? ______________________________

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Please check any area that applies to you; past or present:

( )	Abuse / Assault Survivor	( )	Gang Involvement	( )	School Attendance
( )	Aggression Physical or Verbal	( )	Grief and Loss	( )	School Achievement
( )	Alcohol or Drug Use	( )	Interpersonal Relationships	( )	Self-Harming Behavior
( )	Anger Management	( )	Joint Custody	( )	Sexual Identity
( )	Anxiety	( )	Making/ Keeping Friends	( )	Sexualized Behavior
( )	Computer/Internet Use	( )	Mood Swings	( )	Social Skills
( )	Cruelty to Animals	( )	Parenting Skills	( )	Stress
( )	Depression	( )	Personal Responsibility	( )	Suicide Ideation/ Attempt
( )	Domestic Violence	( )	Poor Self-Concept	( )	Temper Tantrums
( )	Failure to Respond to Prior Treatment	( )	Problem Solving Skills	( )	Theft
( )	Family Issues	( )	Refusal to comply	( )	Truancy/ School Refusal
( )	Fire Setting	( )	Runaway	( )	Vandalism

Other significant history: ______________________________

Legal Status and History

Have you ever been arrested? No Yes

If yes, please explain . ______________________________

Have you ever been on probation? No Yes

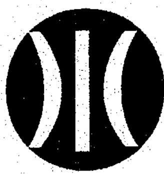
If yes, please explain. ______________________________

Are you currently involved in litigation regarding a physical injury at work? No Yes

If yes, please explain. ______________________________

Are you currently involved in a court action for any other reason? No Yes

If yes, please explain. ______________________________



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Substance Use and Risky Behavior History

***AOD= Alcohol or other drugs**

Have you ever been concerned about your AOD* use? No Yes

Have others expressed concern over your AOD* use? No Yes

Has using AOD* caused any problems for you? No Yes

If AOD*, have you had prior treatment for it? No Yes

Approximate age of first AOD* use: Alcohol? ____________ Drugs? ______________

Last date of use and amount of alcohol/drugs consumed:

____

Circle any of the following you would identify as a problem:

Gambling Pornography Computer/Internet Use

Compulsive Eating Unhealthy Sexual Activity

Your Childhood Developmental History

My mother's pregnancy with me was: Routine Problematic Don't Know

My mother used alcohol/ tobacco/ drugs/ medications while pregnant with me. No Yes Don't Know

My delivery was: Routine Problematic Don't Know

As an infant/ child I experienced significant illness, injury, or major surgery. No Yes

If yes, please explain: ____

As a child, my behavior and personality made parenting and care: Easy Challenging

Significant Childhood/ Adult Stressors (Check any that apply to you.)

Death of a Parent when I was __________ years old.

Death of a sibling when I was __________ years old.

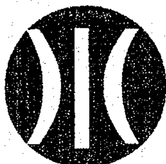
Parents divorced when I was __________ years old.

Physical/Sexual Abuse when I was __________ years old. Duration of the abuse: ________________

Domestic physical violence when I was __________ years old.

Family Alcoholism/ Drug Abuse or Dependency ___ One Parent ___ Both Parents ___ Other

Family Mental Health/ Psychiatric Illness: ____



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Current Health Status

List any prescription medications currently being taken. Use the back of the sheet if necessary.

MEDICATION	DOSE	REASON	DOCTOR/ PRESCRIBER

Are you currently having problems with physical pain? Yes No

From what? ______________________________

If yes, how severe is it? (1 2 3 4 5 6 7 8 9 10)

Health Impacting Behaviors

Briefly describe your:

Eating habits (i.e., frequently overeat, erratic eating pattern, on a diet) ______________________________

____

Sleep/rest patterns (how much, restful or fitful sleep) ______________________________

____

Physical exercise/ activity (how much, what type) ______________________________

____

Hobbies, Sports, & Interests: ______________________________

____

Religious Affiliation/ Spirituality ______________________________

How do you rate your overall physical health?

( ) Excellent ( ) Good ( ) Fair ( ) Poor

Client: ______________________________ D.O.B. ______________ Date: ______________
(Please Print)

Signature: ______________________________
(Client or Guardian)

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Special Care Situations of Childhood (Check any that apply to you.)

Adoption- Age ________

Resided with relatives: Age ________ Duration ________________________________

Foster Care placement: Age ________ Duration ________________________________

Inpatient placement: Age ________ Duration ________________________________

History of past or current involvement with Protective Services or County Human Services staff.

Academic Information:

How many different schools did you attend during your K-12 academic career? ________________________

Did you have attendance problems? No Yes

Did you have a history of behavior problems? No Yes

Did you receive additional academic support? No Yes- Special Education

Tutoring/ Mentoring

Other Services

Family Members:

Name	Relationship	Age	City of Residence	Nature of Current Relationship

Are there any people living in your home at this time that are not listed above? ________________________

____

____