CAMBRIDGE COUNSELING CLINIC INC.

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

Client Information (*Diag. Code_____)*

Date_____
Name of Patient_____ Home Phone_____
Address_____ Cell #_____ Mom__Dad__Self__
City_____State_____Zip_____
Social Security #_____Date of Birth_____ Male__Female__
Single__ Married__ Divorced__Widowed__Separated__
Employed___ Full Time Student___ Part-Time Student___
Employer/School Name_____
Physician Name_____Phone #_____
Name of Responsible Party & Billing Information _____
Address_____City_____State____ Zip_____

Parent/Guardian Information (for minors only)

NAME	DATE OF BIRTH	CUSTODY
Mother		Sole____ Joint____
Father		Sole____ Joint____

Family Information

Spouse_____
Siblings_____
Children_____

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 it's 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.

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

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Client Name(print)_____D.O.B._____Date_____
Signature(parent/guardian for minor)_____
Check one ___Client ____Parent ___Legal Guardian
Witness(must be 18 or over)_____Date_____

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.

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.

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CLIENT 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 SCHEDULE:

Co-Pay Due On Day of Service

Court Ordered Evaluation (including testifying or report writing)	
Psychiatrist	$250.00 per hour
Licensed Psychologist	$180.00 per hour
Clinical Social Worker	$130.00 per hour
Initial Assessment with a	
Psychiatrist	$240.00 per hour
Licensed Psychologist	$180.00 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	Billed at regular rate (based on time spent)
Telephone calls/consultations	Billed at regular rate (based on time spent)
Copies of Records	$ .30 per page

FEE PAYMENT:

Therapy costs are the responsibility of the client, or in the case of a child, the child's parent or legal guardian. 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 Cambridge Counseling Clinic, Inc. Many clients save insurance reimbursement with your insurance company when you authorize your insurance provider to pay Cambridge Counseling Clinic, Inc. directly. However, Cambridge Counseling Clinic, Inc. is not responsible for collection of claims or the negotiation of a disputed claim. Therefore, any portion of your bill not paid by your insurance 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. Please bring billing concerns to the attention of your therapist.

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HEALTH PROFILE

Name: _____ Birth Date: _____

A. Health History

Please list any hospitalizations (dates and reasons): _____

_____

_____

Have you ever been treated for the following conditions? (Please check those that apply.)

( )	Allergies	( )	Diabetes	( )	Heart Disease
( )	Asthma	( )	Emotional Problems	( )	High Blood Pressure
( )	Arthritis	( )	Epilepsy	( )	Hypoglycemia
( )	Back Trouble	( )	Seizure Disorders	( )	Irritable Bowels
( )	Cancer	( )	Hay Fever	( )	Skin Problems
( )	Constipation	( )	Headaches	( )	Vision Problems
( )	Chronic Pain	( )	Hearing Problems		

Do you have any allergies? ☐ Yes ☐ No If yes, what do you have allergies to?

_____

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

If yes, please list doctor(s) name(s) and the reason for treatment: _____

_____

List all prior mental health services received:

With Whom	Year	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle support groups you have used: AA AO NA ALANON OTHER __

_____

Please list any medications you are presently taking: _____

_____

Are you presently involved in litigation regarding a physical injury through an accident?
☐ Yes ☐ No

If yes, please explain: _____

B. Current Health Status

PHONE: 608-423-4700 FAX: 608-423-7751 EMAIL: CCC4700@CHARTER.NET

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Please check any area where you think you may have a problem:

( )	Anger	( )	Hearing	( )	Skin Condition
( )	Anxiety, Nervousness	( )	Interpersonal Relationships	( )	Speech
( )	Bowel Function	( )	Joint/Muscle Function	( )	Stress
( )	Breathing	( )	Menopause	( )	Urinary Function
( )	Circulation	( )	Menstrual Cycle	( )	Vision
( )	Dental Health	( )	Pain	( )	Other
( )	Depression	( )	Parenting Skills	( )	Identify: _____
( )	Digestion	( )	Reproduction		
( )	Frequent Mood Changes	( )	Self-concept		
( )	Guilt	( )	Sexuality		

C. Health Behaviors

Briefly describe your:

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

_____

2. Sleep/rest patterns (how much, restful or fitful sleep) _____

_____

3. Physical exercise (how much, what type) _____

_____

4. Use of alcohol, un-prescribed drugs (how much, what kind) _____

_____

5. Caffeine (how much, in what) _____

6. Smoking (how much) _____

7. How do you rate your current physical health?
   ( ) Excellent ( ) Good ( ) Fair ( ) Poor

Client: _____ D.O.B. _____ Date: _____
(Please Print)

Signature: _____
Check one: ( ) Client ( ) Parent ( ) Legal Guardian

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Cambridge Counseling Clinic
Treatment Plan

Dear Client or Parent/Guardian,

As part of Cambridge Counseling Clinic's philosophy of full consumer participation in the development of treatment plans please respond (to the best of your ability) to the following questions.

Date_____

Name_____**(Guardian Name if Applicable)**_____
This is my: (circle) Initial Plan Updated Plan
What problems/concerns would you like to see addressed during your treatment? (Examples: trouble sleeping, depression, poor concentration, need to stay feeling well)
_____
_____
_____
What are your short term goals? (Objectives:sleep better, improved mood, stay well)
_____
_____
What are your long term goals? (Desired Outcomes) (Examples: get through school, return to work, get long better in relationships, stay well)
_____
_____
Primary Treatment/Recommendation:
What ideas do you have about the type of therapy that may help you achieve the above goals? (Check those that apply)
_____Individual Counseling _____Medication Therapy
_____Other (Describe) _____Group Counseling
Frequency/Duration:_____
Estimated Length Of Treatment_____

I choose to receive outpatient treatment as described. Potential benefits, risks, and viable alternatives of the proposed treatment have been discussed as well as risks of not getting treatment. All of my questions about the proposed treatment have been discussed to my satisfaction. I understand the information discussed. I also understand that no guarantee is given as to the outcome/effects of treatment. My signature below is my authorization to receive the outpatient treatment presented here. I understand I may terminate treatment at any point.
I have participated in the development of this treatment plan, and I understand it. I agree to work towards the goals described. I understand that this plan may be modified in the future if either the patient or the provider believes that these goals are not being met.

Consumer/Guardian _____Date Signed_____
(Signature required by any client age 14 or older)

(For Clinic Use)
I agree with the above except as follows: (no disagreement if left blank) _____
_____

Provider_____Date Signed_____

PHONE: 608-423-4700 FAX: 608-423-7751 EMAIL: CCC4700@CHARTER.NET