ICF Consultants, Inc.

1524 North Farwell Avenue
Milwaukee, WI 53202

16535 Bluemound Rd, Suite 300
Squires I Building
Brookfield, WI 53005

INTAKE INFORMATION

Date: _____ ID # (for office use) _____

Client's Name: _____ Date of Birth: _____

Address: _____ City/State _____ Zip _____

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

Sex: Male _Female_ Occupation: _____ SS# _____

Referral Source _____ Diagnosis: (for office use) _____

1. FAMILY __ None

Name (Spouse/Partner)	Sex	Birth Date	Living in your home?	Occupation/Grade
_____	M_ F_	_____	Yes_ No_	_____
Name (Children)				
_____	M_ F_	_____	Yes_ No_	_____
_____	M_ F_	_____	Yes_ No_	_____
_____	M_ F_	_____	Yes_ No_	_____

2. PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____

Phone #: Home _____ Work _____ Cell _____

3. CONTACT RESTRICTIONS

Please do not contact me at home ___ at the office___ by e-mail___ by cell or text___

Name: _____ ID# (for office use) _____

4. REASON FOR SEEKING TREATMENT

(Please check up to three of the most important ones)

_ Depression or anxiety
_ Worry about drinking or drug use
_ Experience communication problems
_ Desire to improve sexual relations
_ Experience parent/child conflict
_ Struggle with sexual orientation questions
_ Am dealing with my own or others' anger
_ Am socially isolated or have other social challenges
_ Have trouble controlling impulses
_ Suffer Abuse (physical/sexual/emotional/verbal)
_ Experienced trauma other than abuse
(Natural disaster, accident, crime witness
or subject, other: _____

_ Am thinking of harming myself or others
_ Have learning/memory problems
_ Experience difficulty with loss or death
_ Want my relationship to be better
_ Want divorce counseling
_ Want individual counseling
_ Want Pre-marital counseling
_ Want Family counseling
_ Want Couple counseling
_ Partner/other wanted me to come

With regard to the 3 reasons above, please check off the following:

Reason 1: How often:
__ Sometimes
__ very often
__ always

Reason 1: Since when?
__ past week
__ past month
__ past year/longer

Reason 2: How often?
__ sometimes
__ very often
__ always

Reason 2: Since when?
__ past week
__ past month
__ past year/longer

Reason 3: How often?
__ sometimes
__ very often
__ always

Reason 3: Since when?
__ past week
__ past month
__ past year/longerp

What effect does the above have on your functioning?

__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I want and need to do
__ I am unable to work or care for myself

How do you hope treatment will help? _____

_____

Is there anything else you want the therapist or counselor to know?

_____

Date of Initial Appointment_____ Therapist_____

ICF CONSULTANTS, INC.
Medical History Checklist

Client:_____ ID No:_____ Therapist:_____

GENERAL

Yes	No	Do you have or have you had:
—	—	Excessive thirst
—	—	Seizures or convulsions
—	—	Weight loss
—	—	Weight gain
—	—	Bruise easily
—	—	Skin problems (Explain)

HEAD-EYES-EARS-NOSE-THROAT

Yes	No	Do you have or have you had:
—	—	Frequent headaches
—	—	Frequent sore throats
—	—	Difficulty swallowing
—	—	Ringing in ears
—	—	Discharge from ears
—	—	Recurring ear aches
—	—	Visual disturbances (Explain)
—	—	Frequent nose bleeds
—	—	Dizziness
—	—	Neck swelling
—	—	Continuous nasal discharge
—	—	Fainting spells

CARDIOVASCULAR-RESPIRATORY

Yes	No	Do you have or have you had:
—	—	Chest pain
—	—	Shortness of breath
—	—	Difficulty breathing
—	—	Chronic cough
—	—	Pounding in chest
—	—	Night sweats
—	—	Coughing up blood

MUSCULAR-SKELETAL

Yes	No	Do you have or have you had:
—	—	Stiff or painful joints
—	—	Weakness
—	—	Difficulty walking
—	—	Poor balance

(Over)

GASTRO-INTESTINAL

Yes	No	Do you have or have you had:
—	—	Poor appetite
—	—	Spitting up blood
—	—	Vomiting of blood
—	—	Heartburn
—	—	Stomach pain before eating
—	—	Stomach pain after eating
—	—	Abnormal stools (black, bloody, gray)
—	—	Rectal bleeding

GENITO-URINARY

Yes	No	Do you have or have you had:
—	—	Blood in urine
—	—	Painful urination
—	—	Inability to control urination
—	—	Frequent urination
—	—	Difficulty in urination
—	—	Urinating during the night
		<u>Female</u>
—	—	Painful intercourse
—	—	Difficulty with menstrual cycle (Explain)
—	—	Breast lumps
		<u>Male</u>
—	—	Swelling, lumps or painful testicles
—	—	Burning or discharge from penis
—	—	Breast lumps

MISCELLANEOUS

Alcohol frequency__ daily __weekly__ other__ # of drinks per sitting__
Caffeine __ if so, # of cups per day __
Tobacco __ if so, # of cigarettes per day __
Do you have any allergies? _____
_____
Are you taking any prescription drugs? If so, please list drug(s) & dosage(s).
_____Are you using any other drugs or substances?
_____

Name of primary care physician_____

Previous psychotherapy? ___ Dates from ____ to ____
& Name of provider_____

Previous psychiatric hospitalizations? __ Dates from ____ to ____
& Name of facility_____

SIGNATURE _____ DATE _____

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CONSENT FOR ADMISSION
For
MENTAL HEALTH/SUBSTANCE ABUSE EVALUATION AND/OR TREATMENT

New Client: Welcome!

Thank you for choosing our agency. ICF therapists aim to collaborate with you to identify and help you achieve your goals. Our mission is respectful understanding and expedient help. Below we will provide you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies. All treatment will be conducted within the boundaries of Wisconsin Law for Psychology, Nursing, Social Work, Professional Counseling or Marriage and Family Therapy.

Benefits and Risks of Therapy

The majority of individuals and families benefit from therapy, but there are no guarantees. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and to assess your progress. You may be asked to fill out questionnaires or do homework. Your open, honest and accurate participation in these activities is vital. Throughout the course of treatment some people experience increased unwanted feelings. These feelings may be difficult, but are a natural part of the psychotherapeutic process and often provide the basis for change.

Your Personal Rights

Under Wisconsin Law (DHS 35) you must be treated with dignity and respect. You must be allowed to participate in the planning of your treatment and care. You are entitled to inspect and make a written request for a copy of your records. You also have the right to ask to amend the medical record.

You have the right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist, or any office policy please inform your therapist or the Director of ICF Consultants, Marilyn J. Bonjean, Ed.D. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

Appointments:

Our office hours are Monday – Friday 9:00 am – 8:00 pm
Saturday by appointment

Appointments are usually scheduled for 50 minutes. Patients are generally seen weekly or more or less frequently depending on what you and your therapist agree on. You may discontinue treatment at any time, but please discuss any decisions with your therapist first. In the event of an emergency, you can call (414) 273-2220 to learn how you can get in touch with your therapist or a therapist on call. In the event of a life threatening emergency call 911 or go to the nearest hospital Emergency Room.

Fees

Our fee schedule is as follows:

Initial visit (Assessment)		$170.00 per 50 min
Subsequent sessions:	Individual	$150.00 per 50 min
	Couple or Family	$165.00 per 50 min

Payment

All payments are due at the time of the session unless other arrangements have been made. If you have insurance coverage, payment is contingent on accurate and current insurance information provided by you. If there is any change in insurance coverage or benefits it is your responsibility to notify ICF Consultants. ICF Consultants will file your insurance claim, but you are responsible for deductibles
and co-payments. I understand that failure to provide current insurance information in a timely manner may result in loss of insurance coverage for services rendered. In the event that you do not respond to our reminders about payments due within ninety days we reserve the right to send your bill to a Collection Agency.
I give permission for ICF Consultants to bill my insurance company.

PLEASE INITIAL: _____

For Self-pay clients: I request that ICF Consultants, Inc. does <u>not</u> inform my health plan that I am receiving treatment.

PLEASE INITIAL: _____

Cancellations and Missed Appointments

You will be billed for a session that you cancel with less than 24 hours notice. You may leave messages 24 hours a day. You will be billed the amount your insurance company pays us plus the co-payment. Insurance companies generally do not reimburse for failed appointment.

Discharge Policy

A client may be involuntarily discharged from treatment because of his or her behavior that is reasonably a result of mental health symptoms that cannot be met by the clinic or that endanger the safety of staff or other clients. The client must be notified in writing of the reasons for the discharge, given sources for further treatment, and has the right to grieve the discharge.

Limits of Confidentiality Statement

We are required by State and Federal law to maintain the privacy of your personal health information. We can not release your medical information for reasons other than those necessary for treatment (e.g. consulting with a supervisor), payment (e.g. billing your insurance company) or business operations (e.g. a billing service). Any associates used for business operations have a contract with us that require them to safeguard the privacy of your personal information.

ICF is legally mandated to release your personal health information only under the following circumstances:

1. prevention or control of disease, injury or disability;
2. threat of injury to yourself or others;
3. to report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse;
4. in response to a valid court order.

All other release of personal information requires a written authorization by you specifying who the information is to be released to, how much of it, and for what period of time. You have the right to revoke this authorization any time.

You have the right to request how you want written, telephone or e-mail reminders of appointments or any other notifications to be handled by ICF Consultants in order to protect your privacy.

If you believe your privacy rights have been violated you may file a complaint with your insurance carrier, or with the Secy. of the Department of Health and Human Services. To file a complaint with ICF Consultants contact the Privacy Officer, Ronald Bonjean, Ph.D. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

Consent for Treatment

I accept, understand and agree to abide by the contents and terms of this agreement. I have been given a summary of my rights and a notice of ICF Consultants, Inc.'s Privacy Practices. I consent to participate in evaluation and/or treatment, and I understand that I can withdraw this consent at any time.

Name of patient (please print) _____ ID# _____

Signature: _____ Date: _____

General Consent for Child or Dependent Treatment

I am legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Patient's Name_____ ID#_____

Name of Legal Guardian/Rep._ (please print) _____

Signature of Legal Guardian/Rep._____

Relationship to Patient_____ Date: _____

ICF Consultants, Inc.
Notice of Privacy Practices
Receipt and Acknowledgment of Notice

ID# (for office use) _____

Patient/Client Name_____DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of ICF Consultants, Inc. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ronald Bonjean, Ph.D. at ICF Consultants, Inc., 1524 N. Farwell Avenue, Milwaukee, WI 53202, or by calling 414-273-2220.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

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CLIENT CONSENT FOR E-MAIL, CELL PHONE & TEXT COMMUNICATION

Name: _____ ID# (for office use only) _____

I hereby request that my therapist and/or the staff of ICF Consultants, Inc. communicate with me via cell phone, e-mail or text messaging in addition to US Mail and land-lines, and I therefore acknowledge and accept the conditions listed below:

Check one or more options: __cell phone __e-mail __text messaging

1. The privacy and security of e-mail, cell phones or text communications using a non-secure Web messaging system cannot be guaranteed.

2. ICF Consultants, Inc. is not liable for breaches of confidentiality caused by a client or third party. I am responsible for protecting my password, or other means of access to my e-mail, cell phone or text messaging.

3. E-mail to, and from me, may be printed in full and made part of my medical record. Office staff and billing personnel will have access to records.

4. ICF Consultants, Inc. cannot guarantee a response to your e-mail, cell phone or text message although your therapist and the ICF Consultant staff will endeavor to read and respond as promptly as possible.

5. If your e-mail or text has not been responded to within a reasonable time period it is your responsibility to follow up to determine whether the e-mail or text was received, and to inquire when you can expect a response.

6. E-mail, cell phone and text messages are not to be used for communication of sensitive medical and mental health information, or for emergency situations. In an emergency please contact your therapist or the on-call emergency therapist to whom you will be directed by the telephone message when you call the office at 414-273-2220. You can also call 911 or go to the nearest hospital Emergency Room.

7. ICF Consultants is not responsible for information loss due to technical failure.

I have read and I understand the information above, and any questions I had were answered to my satisfaction. I know that I can withdraw this consent in writing at any time.

_____ _____ _____

(Signature) (E-mail address) (Cell phone number)

Relationship to client if other _____ Date_____