Genesis Counseling Services, Ltd.
One South Main St * PO Box 8010 * Janesville, WI 53547-8010 * 608-757-0404 * Fax 608-757-2319
www.genesiscounselingservices.com

ADULT DEMOGRAPHIC QUESTIONAIRE

CLIENT INFORMATION

Patient Name: _____ **Date of Birth:** ____/____/____
(First, Middle, Last)

Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widow/er ☐ Divorced ☐ Separated **Age:** _____

Name of Spouse/Partner: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other: _____ **Ethnicity:** ☐ Hispanic ☐ non-Hispanic

Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

Phone Contact(s): ☐ Home: _____ ☐ Cell Phone _____ ☐ Work Phone: _____

Email Address: _____ ☐ Decline to provide

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student
Name of Employer: _____ Length of Employment: _____
Name of School: _____

Name and ages of Children: ☐ Not Applicable _____

_____

How were you referred to our office? ☐ Google ☐ Word of Mouth ☐ Lawyer ☐ Doctor ☐ Friend/Relative
Other: _____

INSURANCE INFORMATION *(Please present card to the front desk)* ☐ Check if Self-Pay

The client is my: ☐ Self ☐ Spouse ☐ Child ☐ Other Relationship: _____
Primary Insurance Company: _____
Member ID #: _____ **Group #:** _____
Policy Holder Name: _____ **Date of Birth:** ____/____/____ **Sex:** ☐ M ☐ F
Address: _____ **Phone #:** _____
Employer: _____

Secondary Insurance Company: _____
Member ID #: _____ Group #: _____
Policy Holder Name: _____ Date of Birth: ____/____/____ Sex: ☐ M ☐ F
Address: _____ Phone #: _____
Employer: _____

GUARANTOR/RESPONSIBLE PARTY ☐ Check if Self

Name: _____ **Date of Birth:** ____/____/____ **Sex:** ☐ M ☐ F
Address: _____ **Phone #:** _____
Relationship to client: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____

EMERGENCY CONTACT

Name: _____ **Phone Number:** _____
Relationship: _____
Address: _____

Turn over to continue

Primary Physician? ☐ Yes ☐ No
Please provide name, clinic & phone: _____

Has client received mental health treatment in the past 12 months? ☐ Yes ☐ No
If **yes**, Date last seen: _____ Location/Provider: _____

Is client currently taking medications? ☐ Yes ☐ No If **yes**, who Prescribed/s: _____
Please list name and dosage:

_____

Has the client taken any medications in the past 12months? ☐ Yes ☐ No If **yes**, who Prescribed/s: _____
Please list name, dosage and last taken:

_____

Is client their own Legal Representative/Guardian? ☐ Yes ☐ No If **no**, Please complete:
Name: _____ *Must sign intake paperwork
Address: _____
_____ Phone Number: _____

Does client have a Foster Parent/Caretaker? ☐ Yes ☐ No If **yes**, Please complete:
Name: _____ *Will receive reminder phone calls
Address: _____
_____ Phone Number: _____

Does client have a Payee? ☐ Yes ☐ No If **yes**, Please complete:
Name: _____ *Will receive monthly statements
Address: _____
_____ Phone Number: _____

Does client have a Social Worker? ☐ Yes ☐ No If **yes**, Please complete:
Name: _____
Agency: _____ Phone Number: _____

_____ _____

Client/Representative Signature / Date **Office Staff Signature / Date**

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Fee for Service Contract

Financial Policy:
The client/legal representative is responsible for payment of all fees for services provided according to the following fee structure:

	1 Hour	½ Hour	¼ Hour
Psychiatrist / Nurse Prescriber:	$450.00	$325.00	$200.00

	53 to 67 min.	38 to 52 min.	16 to 37 min
Psychologist:	$200.00	$180.00	$100.00
Masters Level Therapist:	$180.00	$160.00	$90.00
Groups:	$60.00		

Clients are billed according to the above stated fee structure. **Uninsured, under-insured, high-deductible and HMO-restricted clients are eligible for discounted fees.** If you meet one of these criteria, please tell our office staff previous to or at the time of your first appointment, and you will be provided a private pay contract. Private payments are expected at the time the client checks in for their appointment.

Insurance:
As a service to our clients, claims will be filed with your insurance company at no charge. It is your responsibility to contact your insurance company to determine if your insurance will cover outpatient mental health and if you have deductible, copayments and if prior authorization is required for payment. If you have a deductible or if your insurance pays only a portion of the total fee, you are responsible for the balance. Genesis cannot accept responsibility for collecting from your insurance or for negotiating a settlement on a disputed claim. Payment on the balance will be expected within 30 days, or arrangements must be made for monthly payment toward the balance. It is up to the client or legal representative to make such arrangements.

Payment of Fees:
Co-payment fees are due at the time of service. Other charges are to be paid upon receipt of your bill. If payments are not made in a timely fashion, Genesis reserves the right to seek legal means to secure reimbursement. For your convenience, we will send you a monthly statement regarding charges for services rendered by Genesis. If you note any discrepancies on that statement, please immediately contact our business office at 608-757-0404. A $50.00 service charge plus bank fees will apply for any returned checks.

Minor Children:
The parent or legal representative, who brings a minor child to Genesis and signs at the bottom of this form, will be held responsible for any part of the bill not paid by insurance. As a service to you, we will file a claim with any insurance company on which the minor is covered.

Cancellations/No-Shows:
If you need to cancel your appointment, you must do so at least 24 hours in advance. This will allow us to fill that appointment time. If we are not notified 24 hours prior to your appointment, you may be charged a $100.00 fee for that hour. We know that there are emergencies due to circumstances beyond your control. If this happens, please notify us as soon as possible. Note that TWO no-shows may be cause for termination of treatment at Genesis Counseling Services. If that occurs, you will not be able to schedule for a period of 120 days. As a courtesy, Genesis attempts to make reminder calls regarding current appointments; however, there are times when this may not occur. Ultimately, it is your responsibility to keep your appointments.

I understand and agree to pay for services provided according to the above fee structure. I authorize payment of medical benefits, as described on the insurance form, directly to Genesis Counseling Services. I understand that this will include a diagnosis.

_____ _____

Client/Representative Signature / Date **Office Staff Signature / Date**

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Client Name: _____ DOB: _____

ASSIGNMENT OF BENEFITS

I _____The undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my designated authorized representative, **Genesis Counseling Services, ltd** (the "Provider"), and its billing agent, lawyers and/or designated business associates, the right to pursue payment for all benefits entitled under my plan or policy.

This authorization includes, taking any and all necessary steps, including pursuing administrative appeals, requesting disclosures and remedies, filing suit and all causes of action and all other protected rights wholly in my stand, for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of the Provider's managed care network participation status. The Patient hereby appoints the Provider, its billing agent, and/or the Provider's appointed business associates, the Patient's rights, title, interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder.

- ✓ I certify that the health insurance information that I provided is accurate, and that I am responsible for keeping it updated with the Provider. I will inform the Provider upon notice of any changes to my plan or benefits.
- ✓ I certify that I agree and understand, I am obligated to pay, as charged and billed for global service charges, regardless, if the above services are covered under my health insurance or plan
- ✓ I agree to assist as needed, in obtaining all benefits entitled and due to me for all healthcare services rendered.

I hereby authorize, instruct and/or assign

- ✓ the Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) to be paid in full compliance of governing laws.
- ✓ my plan, its fiduciaries, and/or its third-party administrators to release to my health care provider, its billing agent, and/or the Provider's appointed business associates, all EDI and other information necessary for my healthcare provider to claim such benefits.
- ✓ my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the Provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider.
- ✓ billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment.

I understand:

- ✓ There are state and federal consumer protections that support, even for out of network providers that may be associated with my care, that I am responsible for co-payments, co-insurance, and deductibles at no more than my in-network cost share rate.
- ✓ That "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: "*The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,*" and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible.
- ✓ Payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws.
- ✓ That I will be held financially responsible for all fees accumulated for collection agency fees, administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law.
- ✓ I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's proactive reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need.

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I hereby designate and appoint the Provider, its attorneys or other designated business associate and authorize them to:

(1) Release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments;
(2) process insurance claims generated in the course of examination or treatment;
(3) file and participate in any administrative or judicial review process;
(4) give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a).
(5) pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead;
(6) pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and
(7) allow a photocopy of my signature to be used to process insurance claims.

I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due, to;

(1) obtain information or submit evidence regarding the claim to the same extent as me;
(2) make statements about facts or law;
(3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process.

- This authorization will remain in effect until all benefits are paid, in full compliance of applicable federal and state laws.
- I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein.
- I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associates, any and all relevant Plan and claim related documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits due and owed to me under my plan or policy.
- This order will remain in effect until revoked by me, in writing.
- I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due to me under my governing plan or policy and to the fullest extent permitted by law.
- A photocopy of this assignment is to be considered valid, the same as if it was the original.

I understand that, by signing this form, I am confirming:

(1) my appointment of my designated authorized representative(s),
(2) the scope of my authorized representative's authority,
(3) and I have the option of revoking of this appointment.

In signing this document, I attest that:
I HAVE READ, BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND FULLY UNDERSTAND THIS AGREEMENT.

_____ N/A ☐ (check box if not applicable)
Employer Group Name Covering Benefits

_____ _____
Patient/Guardian/Insured Signature Date

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CLIENT RIGHTS, RESPONSIBILITIES, AND INFORMED CONSENT

Welcome to *Genesis Counseling Service,*

MISSION STATEMENT
Genesis Counseling Services, in partnership with its clients, seeks to provide comprehensive services to promote change, accountability, and empowerment for individuals, families, and communities.

CORE VALUES
We believe that all persons are valuable and unique. We are passionate about helping each client reach their full potential. We are committed to continued personal and professional development. We believe that proactivity is the best approach, whenever possible. We operate as a team - whether we are together or apart. We are sensitive to the needs, opinions, and concerns of others. We apply the highest standards of professional and personal ethics, while recognizing cultural differences. We are proud of what we do together and individually. We believe that everyone is capable of change and growth. We believe that small changes lead to big changes. We believe in imperfection. We trust ourselves and each other.

DESCRIPTION
Genesis Counseling Services is licensed to provide outpatient mental health and substance abuse treatment. Providers are under the supervision of a licensed psychologist or psychiatrist. During the first session, the therapist will review:

- The services, treatment alternatives and recommendations;
- Possible outcomes, including benefits and side effects;
- Approximate duration and desired outcome;
- The means by which a consumer may obtain emergency mental health services;
- The clinic's discharge policy, including circumstances that may result in involuntary discharge.

Client Rights and Responsibilities

- At *Genesis Counseling Services,* we respect the personal and unique needs and values of each client.
- We consider our clients to be partners in their mental health care.
- Our expectation is that the observance of Client's Rights will support mutual cooperation and greater satisfaction for clients and staff.

As a Client you have the right:

1. To know the name, identity, and professional status of all persons providing services to you and to know the staff member who is primarily responsible for your family's services.
2. To receive complete and current information concerning your assessment and/or treatment service plan in terms that you can understand.
3. To accept or refuse any service offered or treatment, and to be informed of the consequences of any such refusal. If there is conflict between you and your parent/guardian regarding your exercise of this right, you and parent/guardian may need to participate in conflict resolution procedures. If there is a conflict between you and your referring agency (DFCS, DJJ, probation), the referring agency will advise you of such consequences of lack of cooperation.
4. To receive and review the Notice of Policies and Practices to Protect the Privacy of your Health Information.
5. To supportive care including appropriate management and support of your psychological and spiritual needs without regard to sex, race, sexual orientation, age, pregnancy, religious beliefs, national origin, and physical disability.
6. To assistance in obtaining consultation with another therapist regarding your care when needed. This consultation may result in additional cost to you or your family.
7. To know if your care involves research or experimental methods of treatment. You have the right to consent or refuse to participate.
8. To voice complaints regarding your care, to have those complaints reviewed and, when possible, resolved without fear of any harm or penalty to yourself. You have the right to be informed of the response to your complaint.
9. To expect reasonable continuity of care. You have the right to participate in the discharge planning process.
10. To be informed of any policies, procedures, rules or regulations applicable to you.
11. Freedom from financial or other exploitation.
12. Freedom from retaliation, humiliation, and neglect and/or abuse.

Complaints and Appeals
Clients have the right to a fair and efficient process for resolving disputes and differences with provider. Clients have the right to communicate freely with the Therapist, Paraprofessional, supervisor and Clinical Director. All clients should be given a complaint form by their Therapist of Paraprofessional or referred to Maria Hansen, the agency Client Right Specialist, at 608-446-8957.

As a client it is your responsibility:
It is reasonable to expect and encourage clients to assume reasonable responsibilities. Greater individual involvement by clients in their care increase the likelihood of achieving the best outcomes. Those responsibilities include:

1. To provide all personal and family health information needed to provide you with the appropriate services. This includes open and honest disclosure of family/individual social and mental health history and reporting any feelings of harming yourself or others.
2. To participate to the best of your ability in making decisions about your mental health treatment, and to comply with the agreed upon plan of service.
3. To ask questions when you do not understand any information or instructions.
4. To be considerate of others receiving and providing services.

5. To observe facility policies and procedures, including those regarding smoking.
6. To participate in the formulation of your Treatment Plan in discussion with the clinical staff.
7. To follow the Treatment Plan and take any prescribed medication in order to advance in treatment.
8. To provide the administrative staff with all required information to maintain proper and correct records.
9. To keep your appointments and be on time.
10. To treat your Therapist or Paraprofessional with dignity and respect.
11. To inform the administrative staff of any changes in insurance plans, eligibility, or employment status.
12. To pay for services as necessary, including co-pays and deductible, and to provide necessary information for the administrative staff to successfully seek reimbursement of insured services.

Additional Disclosures:

1. Due to ethical and legal guidelines, all staff members are mandated to report any indications, belief, or suspicion of harm to oneself, harm to others, or intent to harm self or others. This includes suspicions of child abuse or neglect and elder abuse or neglect.
2. If you have been referred by another agency, *Genesis Counseling Services* may obtain a release of information to share treatment progress, treatment plan, and participation in services with the referring agency. Case updates, client contact summaries, and assessment and intake information may be provided to the referring agency. The referring agency may be made aware of case plan recommendations and treatment progress throughout the course of treatment with *Genesis Counseling Services.*
3. Counseling and psychiatric services are often sought by individuals and families to alleviate difficulties that are occurring. As counseling services progress, clients may find themselves feeling worse rather than better. Understand that this is a common problem experienced by many. As problems that have never been discussed before are now being talked about during counseling, it can stir up difficult emotions. If you experience this, it is important to talk about this openly with your counselor. Your counselor will help you manage these feelings in a supportive manner. Often times, thing get worse before they get better. Know that the entire treatment team is here to support you, should you feel worse before feeling better.

Financial Disclosure:

You hereby give permission to *Genesis Counseling Services* to file any insurance claims with third party payer sources and provide/receive information necessary to complete these transactions, including the ability to appeal any denial of claims for services rendered and to actively seek compensation for services as necessary. Additionally, you understand that while *Genesis Counseling Services* will seek reimbursement through insurance or other payer sources, you (or parent/guardian) are ultimately responsible for payment for these services or may be responsible for a co-pay as designated by the payer source. You agree that it is your responsibility to provide accurate and updated information regarding alternate payer sources (such as insurance) to *Genesis Counseling Services* and assist the agency with recouping filed claims as necessary. In the event that a claim is denied, you understand that you will be responsible for the payment for service.

You agree to make timely payments for any amounts owed on your account. Failure to pay any amounts you are deemed responsible for may be sent to a collection agency for recoupment of these funds. You understand and agree that should this become necessary, you will be charged for any of the applicable fees associated with this process. Please note that the collection agency charges a 40% fee that you will be responsible for paying if or when any unpaid debts are collected by them.

Termination

1. At any time, *Genesis Counseling Services* or you may terminate services.
2. Services will automatically be terminated after a 90-day lapse in treatment (30 days for substance abuse).
3. Two no-shows within a 12-month period may be cause for termination of treatment.
4. Excessive unpaid fees, or your account being sent to collections

Right to have access to self-help and advocacy support services

Client can receive advocacy support services through the Department of Human Resources - Client Advocacy Department that can be reached at 770-720-3610.

Choice of Providers

Clients have the right to choice of provider (when available) in order to ensure access to appropriate high-quality care. By signing this document, you acknowledge that you have chosen *Genesis Counseling Services* as your provider.

Access to Emergency Services

Clients have the right to access services 24 hours/day, 7 days/week in case of an emergency. A therapist is available on call between 8:30 AM and 7:30 PM Monday through Thursday and 8:30 AM and 4:00 PM Friday during business hours. After hours, should an emergency arise, please call 911 for imminent issues. For all other crises or emergency calls, you may contact the main office at 608-757-0404 in order to obtain the after-hours number listed on the voice mail.

Respect and Nondiscrimination

Clients must not be discriminated against in the delivery of services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Clients and their families have the right to be treated with courtesy, respect and dignity at all times. Limitation to access to service does not infer or result in discrimination. These limitations (i.e. inability to effectively treat psychotic participants with active hallucinations, delusions, patients under the influence of drugs during the majority face-to-face contacts, families without stable housing, autistic patients and children and adolescents without parent/guardian, sexual offenders who are predatory) are discussed with referring agencies and clients/families.

Disclosure Regarding Third-Party Access to Communications

Please know that with the use of electronic communication methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others.

Of special consideration are work email addresses. If you use your work email to communicate with your therapist, your employer may have access to these email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages exchanged.

Social Media Policy
Please refrain from making contact with any employee of *Genesis Counseling Services* using social media messaging systems such as Facebook Messenger Snap Chat or "X' (formerly Twitter). These methods have very poor security, and we are not prepared to watch them closely for important messages from clients.

Genesis Counseling Services staff members, including all clinical and administrative staff, are prohibited from initiating or accepting friend or other connection requests from current or former clients on any social media networking site (Facebook, LinkedIn, etc.). Adding clients as friends or contacts on these sites can compromise client/patient confidentiality. It may also blur the boundaries of the therapeutic relationship.

Genesis Counseling Services Social Media Pages
Genesis Counseling Services maintains a social media page to share information about our practice and health issues that may be of interest to the general public. Page administrators or staff are also prohibited from interacting with current or former clients on any social media platform. While we welcome associates and clients alike to view the social media sites, read and share articles posted there, etc., *Genesis Counseling Services* has no control over the privacy of any of the social media sites. The privacy terms and policies of the various social media sites do apply, and we encourage associates and clients to review those policies and understand that their name may become visible and identifiable. *Genesis Counseling Services* has no control over and accepts no responsibility for privacy on any social media site.

NOTE: Though clients and/or former clients may follow/like/etc. the *Genesis Counseling Services* page, *Genesis Counseling Services* and its associates are prohibited from following current or former clients' social media pages, blogs, websites, etc. *Genesis Counseling Services* only follows/likes/etc. other health professionals and/or groups. Neither *Genesis Counseling Services* nor its associates will solicit likes, follows, testimonials, etc. from current or former clients.

I give permission to *Genesis Counseling Services* to file any insurance claim with third party payer sources and provide/receive information necessary to complete these transactions. *Genesis Counseling Services* has the ability to appeal any denial of claims for services rendered on my behalf. I assign all payment to *Genesis Counseling Services* for services rendered and claims filed.

I understand that while *Genesis Counseling Services* will seek reimbursement through insurance or other payer sources, I (or parent/guardian) am ultimately responsible for payment for these services or may be responsible for a co-pay as designated by the payer source. I agree that it is my responsibility to provide accurate and updated information regarding alternative payer sources (such as primary insurance) or changes in payer sources to *Genesis Counseling Services* in order to assist with filing claims for services rendered and appealing these claims, as necessary. In the event that a claim is denied, I understand that I may be responsible for the full payment for the services rendered.

I understand that *Genesis Counseling Services* makes every attempt to coordinate my mental health/substance abuse treatment and care with my primary care physician. I understand that *Genesis Counseling Services* will notify my primary care physician that I am receiving services at *Genesis Counseling Services* only upon my expressed, written permission. Additional treatment information, such as treatment plan, updates, progress, medical records, recommendations, and medications will only be released upon my expressed, written permission to *Genesis Counseling Services.*

I acknowledge that I have read the above *Genesis Counseling Services* Client Rights and information sheet, the privacy notice, and have had the opportunity to receive a copy of the same.

By signing this document, I acknowledge that I understand the information contained herein and that I give consent for interns to participate in, and provide services related to, my or my child's treatment, under appropriate supervision as described.

By signing this form, I consent to the care and treatment as is prescribed by *Genesis Counseling Services* for myself; if I am the parent/guardian of a minor child under the age of 18, by signing this form, I consent to the care and treatment as is prescribed by *Genesis Counseling Services.* I understand that the purpose of treatment practices will be explained to me and is subject to my agreement.

_____
Printed Client Name

_____
Client (Parent or Guardian) Signature Date

_____
Office Staff Signature Date

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HIPAA Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPM), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and professional certifications.

✓ I understand that this office has the has the right to change its HIPAA Notice of Privacy Practices from time to time as necessitated by changes in HIPAA.

✓ I have the right, at any time, to contact this office at the address above to obtain a current copy of their HIPAA Notice of Privacy Practices.

✓ I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

By signing this form, I am acknowledging that I have received, read, and understand the HIPAA Notice of Privacy Practices containing a more complete and detailed description of the uses and disclosures of my health information.

_____ _____
Printed Client Name Relationship to Client

_____
Client (Parent or Representative) Signature Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of receipt of the HIPAA Notice of Privacy Practices, but was unable to do so as documented below:

☐ The patient (parent or representative) refused or declined to sign.
☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.
☐ We weren't able to communicate with the patient or their parent/representative.
☐ Other (Please provide specific details):

_____
_____
_____
_____

_____
Office Staff Signature Date

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ELECTRONIC DELIVERY OF BILLING NOTICES

Client Name: _____ DOB: _____

☐ Declined: Please send ONLY paper statements.

I, _____ am authorized and hereby give consent for *Genesis Counseling Services* to electronically deliver billing statements and/or balance notification, for the above stated client via:
*Please select one or both

SMS/Text to phone number: _____

-OR-

Email address: _____

I understand that my decision to opt in for electronic notices means I will no longer receive a paper copy in the mail. I understand that billing statements/balance notifications may include the following information:

- Detailed list of services rendered
- Dates of service
- Unit costs
- Total amount due
- Payment due date
- Any applicable fees or charges

I further acknowledge that at any time:

- I may request a paper copy of my billing statement by contacting Genesis Counseling Services
- I can receive paper delivery of billing statements without charge by notifying office staff
- Paper delivery by U.S. Mail will occur within a reasonable time (not to exceed 30 days) after you request it
- I am responsible for reviewing my billing statements for accuracy and notifying the Office Manager, Kelly Clauer, of any discrepancies within 15 days of the billing date.
- I may withdraw my consent to electronic delivery at any time by notifying office staff in writing.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Legal Representative Signature Relationship Date

_____ _____
Witness Signature Date

Genesis Counseling Services, Ltd.
One South Main St * PO Box 8010 * Janesville, WI 53547-8010 * 608-757-0404 * Fax 608-757-2319
www.genesiscounselingservices.com

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY ELECTRONIC, NON-SECURE MEANS

Client Name: _____ Birth Date: _____

Non-secure electronic methods, in their typical form, are not confidential means of communication. If you use any of these methods to communicate with your provider, there is a reasonable chance that a third party may be able to intercept or view those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Third parties on the Internet such as server administrators and others who monitor Internet traffic and may have access to the content of those communications
- Your employer or Human Resources Department. If you use your work email to communicate, your employer may have access to email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with.

Please take a moment to contemplate the risks involved if any of these persons were to access the messages exchanged with the provider.

I, _____ consent to allow _____
(Print Name) (Provider's Name)
at Genesis Counseling Services, Ltd. to use *unsecured* email to transmit and/or communicate with:

O Myself only
O Those directly involved with treatment, please list: _____
O Other service providers, please list: _____
O Others, Please list: _____

The following protected health information is allowed to be addressed:

O Any and all information
O Information related to the scheduling of appointments or other meetings
O Information related to billing and payment, including balance notices or e-statements
O Completed forms, including forms that may contain sensitive, confidential information
O Information of a therapeutic or clinical nature, including personal material relevant to my treatment
O My health record, in part, in whole, or summaries of material from my health record
O Other information. Describe: _____

This authorization will terminate:

O Upon discharge
O When the following event occurs: _____
O Other, Explain: _____

- I understand the risks including, but not limited to, confidentiality in treatment of transmitting my protected health information by unsecured means.
- I understand that I am not required to sign this agreement in order to receive treatment.
- I also understand that I may terminate this authorization at any time.

_____ _____
Email Address SMS/Text Phone Number

_____ _____
Client Signature Date

_____ _____ _____
Parent/Guardian/Legal Representative Signature Relationship Date

_____ _____
Witness Signature Date

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AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE AND REQUEST GENESIS STAFF: ☐ To Release To ☐ To Obtain From ☐ Have Telephone Contact Only

Client Name	DOB	Agency/Facility/Individual	Relationship
Street Address		Street Address	
City, State, ZIP		City, State, ZIP	
Phone Number	Alternate Number	Phone Number	Fax Number

** In compliance with Wisconsin Statutes, which require special permission to release otherwise privileged information (as indicated by *patient's initials*), please release information pertaining to:

_____MENTAL HEALTH _____SUBSTANCE ABUSE _____HIV STATUS

Specific Information Requested: (please check all that apply)

☐ Psycho-Social Assessment	☐ Substance Use Assessment	☐ Treatment Progress Notes
☐ Psychological Assessment/Evaluation	☐ Treatment Plan(s) and Reviews	☐ Appointment Confirmation
☐ Psychiatric Assessment/Evaluation	☐ Legal Status/Court Records	☐ Medical History
☐ Medication(s) and Med Profile	☐ Lab Data/Test Results	☐ School Records
☐ Discharge Summary	☐ Other: (Specify)_____	

Dates of service to be released From:_____ To: _____
**If no Dates listed, please provide information for the past 2 years

Purpose for disclosure: (please check all that apply)

☐ Further Care	☐ To Coordinate Care/Service	☐ Litigation
☐ Insurance Eligibility/Benefits	☐ Claims Resolution	☐ Disability Determination
☐ Verify Treatment Compliance	☐ Medication Verification	☐ Personal Reasons
☐ Obtain Collateral Information	☐ Other: (Specify)_____	

- I understand that I have the right to a copy of this form and inspect the information which is to be released and that I may be charged a fee for record copies.
- I further understand that the records contain information regarding medical conditions and treatment, which possibly could include information pertaining to substance use or abuse and/or mental health status and/or AIDS or HIV related illness.
- It is further understood that I have the right to withdraw this authorization at any time by providing written notice to Genesis. Withdrawal commences upon receipt of the written notice, excluding any prior action that has been taken and/or others have already relied on it.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal confidentiality rules.
- I understand that authorizing the disclosure of this information is voluntary,
  - I can refuse to sign this authorization.
  - I need not sign this form in order to assure treatment.
  - I may experience consequences for not signing this authorization if referred from a mandated agency.
- Unless otherwise withdrawn, this authorization will expire:
  - On the following date _____
  - Upon Discharge
  - Other: _____
- If I fail to specify expiration date, this authorization will expire in *one year* from the date signed.
- Photocopy/facsimile copy is as valid as the original document.

Signature of Patient (includes minors 14 years of age and over)	Date Signed
Signature of Parent/Guardian/Personal Representative** (Relationship)	Date Signed
Signature of Witness	Date Signed

**If signed by a Legal Representative, complete the following: (Please provide appropriate documentation if applicable)

1. Individual is: ☐ A minor ☐ Legally incompetent or incapacitated ☐ Deceased
2. Legal authority: ☐ Parent ☐ Legal guardian ☐ Next of kin/executor of deceased ☐ Activated POA for Health Care

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Primary Care Provider Contact

Date: _____

Patient Name: _____

Date of Birth: _____

To: _____

Clinic: _____

Address: _____

_____

I assessed your patient today at Genesis Counseling Services. Based on this assessment I am recommending the following:

_____ Psychiatric Evaluation

_____ Psychotherapy

_____ Inpatient Psychiatric Care

_____ Psychiatric Day Hospital

_____ Routine Physical

_____ Psychotropic Medication Therapy

_____ Substance Abuse Assessment

_____ Detox Admission

_____ Inpatient Substance Abuse Rehab

_____ Substance Abuse Day Treatment

_____ Outpatient Substance Abuse Treatment

Medical Recommendation: _____

_____

_____

Additional Information: _____

_____

_____

_____

_____

Patient has signed a valid Release of Information. This release will remain effective until your patient is discharged from this clinic. Upon your request, we will provide you with feedback as to your patient's progress. If you have any questions or comments, feel free to call me at the number provided above. Thank you for your continued concern and patient support.

Sincerely,

_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** ____ **Sex:** ❑ Male ❑ Female **Date:**_____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Instructions to Clinicians

The DSM-5 Level 1 Cross-Cutting Symptom Measure is a self- or informant-rated measure that assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the individual's treatment and prognosis. In addition, the measure may be used to track changes in the individual's symptom presentation over time.

This adult version of the measure consists of 23 questions that assess 13 psychiatric domains, including depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance use. Each item inquires about how much (or how often) the individual has been bothered by the specific symptom during the past 2 weeks. If the individual is of impaired capacity and unable to complete the form (e.g., an individual with dementia), a knowledgeable adult informant may complete the measure. The measure was found to be clinically useful and to have good test-retest reliability in the DSM-5 Field Trials that were conducted in adult clinical samples across the United States and in Canada.

Scoring and Interpretation

Each item on the measure is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day). The score on each item within a domain should be reviewed. Because additional inquiry is based on the highest score on any item within a domain, the clinician is asked to indicate that score in the "Highest Domain Score" column. A rating of mild (i.e., 2) or greater on any item within a domain (except for substance use, suicidal ideation, and psychosis) may serve as a guide for additional inquiry and follow up to determine if a more detailed assessment for that domain is necessary. For substance use, suicidal ideation, and psychosis, a rating of slight (i.e., 1) or greater on any item within the domain may serve as a guide for additional inquiry and follow-up to determine if a more detailed assessment is needed. The DSM-5 Level 2 Cross-Cutting Symptom Measures may be used to provide more detailed information on the symptoms associated with some of the Level 1 domains (see Table 1 below).

Frequency of Use

To track change in the individual's symptom presentation over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the individual's symptoms and treatment status. For individuals with impaired capacity, it is preferable that the same knowledgeable informant completes the measures at follow-up appointments. Consistently high scores on a particular domain may indicate significant and problematic symptoms for the individual that might warrant further assessment, treatment, and follow-up. Clinical judgment should guide decision making.

Table 1: Adult DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure: domains, thresholds for further inquiry, and associated Level 2 measures for adults ages 18 and over

Domain	Domain Name	Threshold to guide further inquiry	DSM-5 Level 2 Cross-Cutting Symptom Measure available online
I.	Depression	Mild or greater	LEVEL 2—Depression—Adult (PROMIS Emotional Distress—Depression—Short Form)[1]
II.	Anger	Mild or greater	LEVEL 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)[1]
III.	Mania	Mild or greater	LEVEL 2—Mania—Adult (Altman Self-Rating Mania Scale)
IV.	Anxiety	Mild or greater	LEVEL 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)[1]
V.	Somatic Symptoms	Mild or greater	LEVEL 2—Somatic Symptom—Adult (Patient Health Questionnaire 15 Somatic Symptom Severity [PHQ-15])
VI.	Suicidal Ideation	Slight or greater	None
VII.	Psychosis	Slight or greater	None
VIII.	Sleep Problems	Mild or greater	LEVEL 2—Sleep Disturbance - Adult (PROMIS—Sleep Disturbance—Short Form)[1]
IX.	Memory	Mild or greater	None
X.	Repetitive Thoughts and Behaviors	Mild or greater	LEVEL 2—Repetitive Thoughts and Behaviors—Adult (adapted from the Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale [Part B])
XI.	Dissociation	Mild or greater	None
XII.	Personality Functioning	Mild or greater	None
XIII.	Substance Use	Slight or greater	LEVEL 2—Substance Abuse—Adult (adapted from the NIDA-modified ASSIST)

[1]The PROMIS Short Forms have not been validated as an informant report scale by the PROMIS group.