KB
Psychotherapy & EMDR
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INTAKE INFORMATION

Today's Date: _____

Client Information:
Name:_____ Home/Work Phone(circle one): _____
Date of Birth: _____Age: _____ Cell Phone:_____
Address:_____ City: Email Address:_____
_____State:_____ Zip Code:_____

Parent's Names (if client is a minor): Mother _____ Father _____
Are the parents of the client divorced?: Yes _____ No _____
If Yes, and both parents hold legal authority, does each parent/guardian consent to psychological services:
Yes _____ No _____
Childs Primary Residence: _____
Person responsible for payments: _____Relation to Client: _____

Emergency Contact Person: _____Phone Number: _____
We may contact you by (check all that apply): Phone _____Voicemail _____Text _____Email _____
Who referred you or how did you find us?: _____

Education:
Current Student? Y N If yes, School:_____ Last Grade Completed _____
High School Diploma/GED? Y N College? Some__ 2year__ 4year__ Graduate School? Y N
Teachers or primary school contacts if client is a child_____
Concerns at school?_____

Occupation:
Occupation: _____ Employer: _____
Marital Status: _____ Spouse/Partner's Name: _____
Children's Names and Ages: _____

Presenting Problem (Reason you are seeking treatment for yourself or your child):
_____
_____
_____
_____
_____

I am interested in:
Individual Psychotherapy__ Couples Therapy__ Family Therapy__ Parenting __ Substance Abuse Treatment__
EMDR__ Walk/Talk Therapy__

Kathleen Bullard Psychotherapy LLC | 647 West Main Street #900 Lake Geneva Wisconsin 53147 | P: (262) 806-1467 | F: 262.661.7702
Updated 7/12/19

Please check all symptoms that apply:

(Parents please check symptoms you have observed or have been expressed by your child)

__Constant sadness/depressed mood
__Often agitated
__ argumentative
__Decreased need for sleep
__Difficulty falling asleep
__Difficulty staying asleep
__Increased sleep
__Decreased enjoyment in formerly pleasurable activities
__Feelings of guilt
__Low self esteem
__Feelings of helplessness
__Feelings of hopelessness
__Fatigued/low energy
__Unpleasant thoughts
__Reoccurring unpleasant thoughts
__Difficulty controlling anger
__Homicidal thoughts/thoughts of hurting others
__Indecisiveness/slowed thinking
__Increased appetite
__Decreased appetite
__Overeating/binge eating
__Purging food
__Anorexia
__recent weight loss ___lbs.
__recent weight gain ___lbs.
__Crying spells
__Suicidal thoughts
__Attempt to hurt self /cutting self
__Decreased libido
__Increased libido
__Sexual concerns
__Cruelty to animals
__Physically aggressive towards others
__Have been physically abused
__Have been verbally abused
__Tendency to isolate
__Dislike being alone
__Difficulty with relationships (spouse, children, co-workers)
__Trembling/shakiness
__Restlessness
__Irritability
__ Dizziness
__Nausea/abdominal distress
__Headaches
__Feeling detached
__Menstrual problems/changes
__Sexual problems
__Amnesia (memory loss)
__Feeling numb
__Nightmares/bad dreams
__Have been emotionally abused
__Have been sexually abused
__Experienced traumatic event

Please list any other concerns/symptoms you would like to address:

_____
_____
_____
_____
_____

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HEALTH ASSESSMENT

Has you (or your child) seen a psychologist or counselor in the past?: YES_____ NO_____

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

Reason: _____

Have you (or your child) had a (neuro)psychological evaluation in the past?: YES_____ NO_____

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

Findings: _____

Are you (or your child) currently under the care of a psychiatrist? YES _____ NO_____

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

Please list currently prescribed medications and dosages:

_____

_____

Please list any major health problems:

_____

_____

Client's primary care physician or pediatrician: _____

Date of last exam: _____

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INFORMED CONSENT CONFIDENTIALITY AND DENIAL OF RIGHTS

Thank you for choosing to receive services from Kathleen Bullard Psychotherapy LLC. In keeping with the State Statute section 51.61 and HSS 94, we are required to inform you of your rights when seeking psychological services at this clinic. This clinic is designed to provide individual, couples, family, and group therapy for children and adults. These services are beneficial only to the extent that the client(s) are actively participating with the staff in delivery of services. It is our belief that the providers and client(s) together design and implement the treatment program for the therapeutic services rendered.

- The benefits from psychotherapy may include, but are not limited to, being better able to meet your needs, improve communication skills, more satisfying intimate relationships, and better understanding of your personal goals and values. Psychotherapy is conducted in individual, couples, family, and group contexts with a therapist/facilitator for purposes of identifying and resolving problems or concerns.
- Psychotherapy may include the risk of remembering unpleasant events and can arouse intense emotions such as sadness, fear, and anger. Feelings of anxiety, depression, frustration, loneliness, and helplessness may also be aroused.
- The therapist may suggest alternative treatment modes and will make referrals when appropriate or necessary.
- If you forgo psychotherapy, it is possible that your problems may not resolve, or become worse than they are at the present time.
- This informed consent will be in effect until such time that you are discharged from treatment either by mutual agreement with your therapist, your own decision, or your therapist's clinical decision that services with another provider or agency are more appropriate for your treatment needs.
- You have the right to withdraw this informed consent at any time. Your request must be in writing.

Information discussed with a clinician is confidential and will not be discussed without your release of that information. However, Wisconsin Law requires that therapists break this confidentiality under the following conditions: a) when there is a court order to do so; b) there is a serious threat of harm to oneself or another person; or c) if a child or older adult (over the age of 60) is being endangered through abuse or neglect.

As your clinician, there may be times in which it may be necessary to consult with other professional colleagues about your treatment. Should it be useful or necessary for the rendering provider to do so, your personal information will be kept confidential so that no identifying information will be shared without your consent.

Insurers sometimes require the release of certain information before they will authorize payment. In such instances, only the minimal information required for reimbursement will be released.

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

Printed Name of Client: _____

Signature of Client: _____ Date: _____

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

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

Relationship to Client: _____

FINANCIAL POLICY

Please understand that when you come for psychological services, you and your therapist automatically contract with one another. If you are an out of network client and paying out of pocket, you will be given a super bill upon request with the purpose of submitting this bill to your insurance provider for out of network coverage. KB Psychotherapy LLC does not have any contact with your out of network insurance company or knowledge of your out of network benefits. It is your responsibility to know and understand your out of network policy in order to obtain reimbursement for services. This includes deductibles, co- pays, co-insurance, lapses in coverage. Payments are due in full at time of services rendered.

Cost of Treatment:

Initial Diagnostic Interview: .....$200 per 45 –60 minute session
Individual Psychotherapy: ..... $150 per 45 –60 minute session
Family Therapy: .....$175 per 45 –60 minute session
AODA Assessment ……$200

Kathleen Bullard Psychotherapy LLC reserves the right to charge a $50 fee for failure to cancel any appointments 24 hours in advance.

Self-Pay

Payer Full name:_____

Date of Birth _____ Social Security Number_____

Address_____City_____State_____Zip_____

_____ *initial* (1) I will pay the customary Fee by cash check (*there will be a $50 fee for any returned checks- Checks can be made out to KB Psychotherapy LLC*), or credit card.

Please fill out the following information to pay by credit or debit card:

(circle) Visa MC other_____ Card Number_____

Expiration:_____/_____ Security Code: _____

Insurance Coverage

It is your responsibility to understand your insurance policy and coverage terms including co-payments/deductibles that will be do at the time of each visit.

As a courtesy, KB Psychotherapy LLC will submit your claims to your insurance carrier and try to keep you informed of coverage/benefits. If your insurance changes during your treatment, you will need to notify your therapist immediately.

If you have secondary insurance, we will need to notify us at the time you begin treatment or when your policy begins with the second insurance carrier.

You will be financially responsible for any lapse in coverage or any change in insurance that you did not report to KB Psychotherapy LLC.

Primary Insurance: _____

ID Number _____ Group Number _____

Who's Insurance is this?

Name:_____ Birth Date: _____

Address: _____City_____State_____Zip_____

Phone: _____ Cell Home Work (Please circle one)

Client's Relationship to insured: ___ Child ___ Spouse ___ Employee ___ Life Partner ___ Self ___ Other

___ Private Commercial Insurance

___ Employer Provided Insurance (please provide employer name):_____

___ Market Place Insurance (please provide employer name):_____

Secondary Insurance: _____

ID Number _____ Group Number _____

Who's Insurance is this?

Name:_____ Birth Date: _____

Address: _____City_____State_____Zip_____

Phone: _____ Cell Home Work (<Please circle one) Male___ Female ___ Other ___

Client's Relationship to insured: ___ Child ___ Spouse ___ Employee ___ Life Partner ___ Self ___ Other

___ Private Commercial Insurance

___ Employer Provided Insurance (please provide employer name):_____

___ Market Place Insurance (please provide employer name):_____

In order to accept you as a client, you will need to initial the following points indicating your understanding of the financial agreement.

____ *initial* (1) I will submit my bill to insurance carrier and collect from my insurance if I want out of network benefits.

____ *initial* (2) I will pay the usual and customary fee (or negotiated rate) at each session including co-pay or deductible. if my insurance lapses or does not provide coverage for services rendered, I will pay the usual and customary fees provided above.

____ *Initial* (3) I have read and understand the missed appointment fee of $50 if I cancel later then the requested 24 hour notice or if I do not show for a scheduled appointment.

____ *Initial* (4) I understand that payments for services rendered are non-refundable.

____ *Initial* (5) I will pay the customary Fee by cash, check (*there will be a $50 fee for any returned checks- Checks can be made out to KB Psychotherapy LLC*), or credit card.

FINANCIAL POLICY (Continued)

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

Printed Name of Client: _____

Signature of Client: _____ Date: _____

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

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

Relationship to Client: _____

Printed Name of Payer
(if different from client and the client is over the age of 18):_____

Signature of Payer:_____Date:_____

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RELEASE OF INFORMATION

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

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

Name and Relationship to Client: _____
Address: _____
Phone/Fax Number: _____
Email Address: _____
Name and Relationship to Client: _____
Address: _____
Phone/Fax Number: _____
Email Address: _____
For the following information:

Obtain/disclose

- ☐ Dates of services
- ☐ Treatment Progress
- ☐ Recommendations
- ☐ Discharge/Treatment Summary
- ☐ Medications
- ☐ Other, please specify
  _____

For the purposes of:

- ☐ Continuity of care
- ☐ Other, please specify
  _____

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

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

Printed Name of Client: _____

Signature of Client: _____ Date: _____

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

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

Relationship to Client: _____ Date: _____

Witness Signature_____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

Uses and Disclosures of Protected Health Information

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

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

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

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

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

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

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

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

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

Your Rights Following is a statement of your rights with respect to your protected health information.

HIPAA NOTICE OF PRIVACY PRACTICES CONTINUED

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask me not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. I am not required to agree to a restriction that you may request. If I believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to choose another Healthcare Professional.

You may have the right to request an amendment of your protected health information. If I deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. I reserve the right to change the terms of this notice and will inform you in person of any change. You then have the right to object or withdraw as provided in this notice.

This notice is effective January 1, 2018. I am required by law to maintain the privacy of, and provide individuals with, this notice.

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

Printed Name of Client: _____

Signature of Client: _____ Date: _____

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

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

Relationship to Client: _____ Date: _____

Witness Signature:_____ Date: _____

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AUTHORIZATION FOR ELECTRONIC COMMUNICATION

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

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

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

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

I understand that in the event I no longer wish to receive electronic communications from Kathleen Bullard Psychotherapy LLC, I may revoke this authorization by providing written notice to Kathleen Bullard Psychotherapy LLC at 647 W Main Street Suite #900 Lake Geneva WI 53147.

I HAVE BEEN PROVIDED NOTICE OF THE RISKS INHERENT IN THE USE OF ELECTRONIC COMMUNICATIONS. I HEREBY AUTHORIZE KATHLEEN BULLARD PSYCHOTHERAPY LLC STAFF TO COMMUNICATE ELECTRONICALLY WITH ME.

Printed Name of Client: _____

Signature of Client: _____ Date: _____

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

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

Relationship to Client: _____ Date: _____

Litigation Process Information

Please be advised that, if you are involved in a court process, law suit, or any other legal action and you would like your therapist to communicate with an attorney or any other professional involved in the case, you will be responsible for payment for these services. Health insurance does not reimburse for services outside the therapeutic hour. These services may include, but are not limited to: telephone calls, conferences, letter writing, faxing of information, copying records, report writing, attendance and/or testifying in court, meeting with other professionals involved in the case, travel time, any subpoena to appear as a witness or to appear to invoke confidentiality, any time spent waiting to appear in court, and out of office meetings or appearances.

Services will be billed at the hourly rate of $200.00. There is a separate fee of $0.25 per page for copying records. The copying charge must be paid before any information is sent. Prior to providing any of these services, your therapist will discuss what services are being requested, and the estimated cost. You will be asked to submit an estimated payment, similar to a legal retainer, for the anticipated services in advance. A consent for release of information must be signed before any information can be released to anyone.

I understand that I am responsible for payment for any services related to a legal/court matter. My health insurance will not be billed for these services. I understand that I will be required to pay the estimated retainer prior to the services being rendered. If, when therapy is ended, there is an unused balance, it will either 1) be applied to a therapy balance or 2) if there is no balance it will be returned to me.

Client/Parent signature	**Date**
Therapist signature	**Date**

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