LifeStriders

Phone: 262.565.6124
Fax: 866.404.3105
veronica@lifestriders.org

W288S290 Elmhurst Dr.,
Waukesha , WI 53188

Welcome to LifeStriders. We look forward to helping you reach your personal Life Strides. This form requests information about your needs and informs you of the services offered and the policies we adhere to. Please take a few moments to complete these forms. The questions on the following pages are designed to help us best meet your treatment needs. **If the person seeking care is a child, the parent/guardian should complete this form.** If you have any questions, we will be happy to answer them.

Client Information Form

Today's Date:______________________________

Client Name (First, Middle Initial, Last) Date of Birth Sex Marital Status

Address (Street - City -State) Zip Code Home Phone#

My E-mail Address Work Phone Cell Phone#

Employer's Name Your Social Security Number

If minor: Parent's Name His/her Date of Birth His/her Social Security#

Emergency Contact Relationship Phone #

How did you hear about LifeStriders?____

MEDICAL PROFILE

1) Please list **all** current medications you are taking:

Prescribed by:	Medication:	Dosage:	Taken how long?

2) Allergy (Medication): ____

LifeStriders

Phone: 262.565.6124
Fax: 866.404.3105
veronica@lifestriders.org

W288S290 Elmhurst Dr.,
Waukesha , WI 53188

3) Are you currently under a physician's care? ____________________________
Name:____
Date Last Seen: __________________
Problem: ____

4) Medical Doctor:___________________________________ Phone#:_________________________________
Date of Last Physical Exam: __________________________

5) Current medical Conditions: (Please Check)

___Allergies
___Asthma
___Arthritis
___Back Trouble
___Cancer
___Heart Problem
___Chronic Pain
___Diabetes
___Frequent Constipation
___Frequent Headaches
___Hay Fever
___Hearing Problem
___Irritable Bowels
___Stomach Problems
___Skin Problems
___Vision Problems
___High Blood Pressure
___Other

6) Significant past medical problems if not indicated above

____

7) Past Surgery:

____
____

8) Past Accidents:

____

9) How do you rate your current physical health?
_____Excellent _____Good _____Fair _____Poor

10.) Please describe your reasons for seeking treatment at this time. If ther is a particular event which triggered your decision to seek treatment now please list the event(s):

____
____
____

12.) What results do you expect from treatment?

____
____
____

13.) If you received mental health treatment in the past, please list the aspects of treatment that you feel worked the best and what did not work for you.

____
____
____
____
____

LifeStriders

Phone: 262.565.6124
Fax: 866.404.3105
veronica@lifestriders.org

W288S290 Elmhurst Dr.,
Waukesha , WI 53188

14.)How is the issue(s) for which you are seeking treatment affecting the following areas of your life ?

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/Relationship						
Family						
Job/School Performance						
Friendships						
Financial Situation						
Physical Health						
Anxiety Levels/Nerves						
Mood						
Eating Habits						
Sleeping Habits						
Sexual Functioning						
Alcohol/Drug Use						
Ability to Concentrate						
Ability to Control Anger						

TREATMENT PHILOSOPHY

At Lifestriders we believe in providing goal-directed, client-centered therapy in a manner that best meets the individual needs of our clients. This means that treatment goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time efficient manner. If you ever have any questions about the nature of the treatment or anything else about your care, please don't hesitate to ask.

I understand and agree to all the above information.

____

Client (or Parent/Guardian) Name Printed **Date**

Client Signature:______________________________ **Date:** ____________

LifeStriders

Phone: 262.565.6124
Fax: 866.404.3105
veronica@lifestriders.org

W288S290 Elmhurst Dr.,
Waukesha , WI 53188

LIFESTRIDERS, INC. TREATMENT, PRIVACY AND FINANCIAL POLICIES

Thank you for choosing LifeStriders as your mental health care provider. We are committed first and foremost to your health and wellbeing. Please understand that payment of your bill is considered part of your treatment. In this regard, the following is a statement of our Treatment, Privacy and Financial Policies, which we require you to read and sign prior to beginning treatment.

TREATMENT CONSENT AND CLIENT RIGHTS

I consent to treatment as agreed upon with my Counselor. I understand my client rights and that I have received a written copy of these rights upon request. I further authorize and request that my treating provider carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are adviseable. I understand that the purpose of these procedures will be explained to me upon my request and subect to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

CONSENT FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I authorize the release of any medical or other information necessary to design effective treatment plans. This information may include but is not limited to diagnosis, treatment procedure, and/or photocopies of all or part of my records.

CANCELLATION POLICY

Twenty-four (24) hour advance notice is required for cancellation of appointments. I am aware that I will be charged according to the scheduled fee if the cancellation is made with less than a 24 hour notice.

CONFIDENTIALITY AND PRIVACY NOTICE

All information between provider and client is held strictly confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a physical danger to others.
4. Child/elder abuse and neglect are suspected.

In the latter two cases, am required by law to inform potential victims and legal authorities so that protective measures can be taken. Included on the last page of this package is a copy of the Privacy Notice as required by the Federal Health Insurance Portability and Accountability Act related to legal duties with respect to health information.

FINANCIAL AGREEMENT

LifeStriders, Inc. strives to provide you with affordable mental health support services. You will be responsible to pay a fee that may range between $40.00 -$140.00 per therapeutic hour (45-50 minutes) or sliding scale fee depending on eligibility and fund availability. However, if you are not elligible at the time services are rendered you are responsible for full payment. All payments must be payed at the time services are rendered.

ACKNOWLEDGEMENT AND NOTIFICATION

I acknowledge that I was provided with an explanation of cancellation, emergency, financial and privacy policies; the last page of this package (client's copy) – to take with me.

☐ Yes, I agree to receive communication via e-mail from my Counselor regarding appointments.
☐ No, I do not want to receive communication via e-mail from my Counselor regarding appointments.

I have read and agree to the LifeStriders, Inc. policies stated above.

____

Client Signature (or authorized representative) Printed Name Date

Phone: 262.565.6124
Fax: 866.404.3105
veronica@lifestriders.org

W288S290 Elmhurst Dr.,
Waukesha , WI 53188

LifeStriders

TREATMENT, PRIVACY AND FINANCIAL POLICIES-Client's Copy

Confidentiality and Privacy Policy

All information between provider and client is held strictly confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a physical danger to others.
4. Child/elder abuse and neglect are suspected.

In the latter two cases, am required by law to inform potential victims and legal authorities so that protective measures can be taken. Included on the last page of this package is a copy of the Privacy Notice as required by the Federal Health Insurance Portability and Accountability Act related to legal duties with respect to health information.

Financial Policy : LifeStriders is committed first and foremost to your health and well-being. Please understand that payment of your bill is considered part of your treatment. In this regard, the following is a statement of our Treatment and Financial Policies, which we require you to read and sign prior to treatment.

LifeStriders, Inc. strives to provide you with affordable mental health support services. You will be responsible to pay a fee that may range between $40.00 - $140.00 per therapeutic hour (45-50 minutes) or sliding scale fee depending on eligibility and fund availability. However, if you are not elligible at the time services are rendered you are responsible for full payment. All payments are due at the time services are rendered.

Please note that there will be a $20.00 charge for all returned checks.

Cancellation Policy : Twenty-four (24) hours advance notice is required for all cancellations. You will be charged a missed appointment fee as customary. If you need to cancel an appointment, please leave a message in your Counselor's voice mailbox or email 24 hours in advance.

Emergency Procedures : If you are having a medical and /or lifethreatening emergency call 911 or go to the nearest Emergency Room.

Crisis Lines : County Mental Health Division (414) 257-6995. Suicide Intervention/Mental Health Crisis Line (**414**) **257-7222**

If you need to contact a LifeStriders counselor, leave a message according to the instructions on the phone service and your call will be returned. There may be a charge for lengthy telephone consultations.

Phone: 262-309-9297
Email: veronica@lifestriders.org

LifeStriders

Phone: 262.565.6124
Fax: 866.404.3105
veronica@lifestriders.org

W288S290 Elmhurst Dr.,
Waukesha , WI 53188

Client's Copy of Privacy Notice

LifeStriders, Inc. must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information.

Without your-written authorization, we can use your health information for the following purposes:

1) Treatment. A provider may use the information in your medical record to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care. ***2) Payment.*** In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you or cost of care we deliver. ***3) Health Care Operations***. We may need your diagnosis, treatment and outcome information in order to improve the quality of care. In addition, we may want to use your health information for appointment reminders. **4) As *required or permitted by law***. Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. ***5) For public health activities.*** We may be required to report your health information to authorities to help prevent or control disease, injury or disability. ***6) For health oversight activities***. We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs. ***7) For activities related to death.*** We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death. ***8) To avoid a serious threat to health or safety***. As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minim i e a serious and approaching threat to you or the public's health or safety. ***9) For military, national security, or incarceration by law enforcement custody***. If you are involved with-the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law. **10) *For workers' compensation.*** We may disclose your health information to the appropriate persons in order to comply with the law related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

Note: Except for the situations listed above, we **must obtain your specific** written authorization for any other release of your health information. If you sign an authorization form, you may **withdraw your authorization** at anytime, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to the Medical Records Department at LifeStriders, Inc..

Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact your individual provider. Specifically, you have the right to: ***1) Inspect and copy your health information***. With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial. proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information. ***2) Request to correct your health information.*** If you believe your health information is incorrect, you may ask us to correct the information. You may be asked to make such requests -in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request. ***3) Request restrictions on certain uses and disclosures.*** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. You can ask to limit the health information provided to family or friends involved in your care or payment of medical bills. However, we are not required to agree in all circumstances to your requested restriction. ***4) As applicable, receive confidential communication of health information.*** You have the right to ask that we communicate your health information to you in different ways or places. We must accommodate reasonable requests. **5) *Receive a record of disclosures of your health information***. In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. **6) *Obtain a paper copy of this notice***. Upon your request, you may at any #me receive a paper copy of this notice. ***7) Complaints.*** If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services.

Again if you have any questions or concerns regarding your privacy rights or the information in these notices, please contact your individual provider. This notice of Medical Information Privacy is a Federal regulation (HIPPA). Effective 4/14/2003.