Ascent Counseling Services
PATIENT REGISTRATION FORM

New _____ Change _____
Diagnosis _____
Therapist name _____
Physician name _____

PATIENT INFORMATION

PATIENT NAME *First* *Middle* *Last*

Street Address

City, State, Zip Code

Phone Number

Date of Birth

Cell Phone Number

Check Gender
☐ *Male*
☐ *Female*

Social Security Number

Email Address

Patient Employer

Employer Address

Check Marital Status
☐ *Single*
☐ *Married*
☐ *Divorced*
☐ *Widowed*

Employer Phone

Name of Spouse

BILLING INFORMATION *(If same as patient, omit)*

RESPONSIBLE PARTY FOR BILL

Street Address

City, State, Zip Code

Email Address

Responsible Party's Employer

Responsible Party's Employer Address and Phone

Nearest Friend or Relative *(Not at same address)*

Relationship

Address and Phone Number of Above

Ascent Counseling Services will bill the insurance company as a courtesy to the client.The client is ultimately responsible for the payment of all services. Appointments cancelled with less than 24 hours notice will be billed to the client. Insurance companies and EAPs do not pay for missed appointment charges.
FEE: Your fee will be _____ per 50-60 min. session.

PRIMARY INSURANCE

Policyholder Name Date of Birth

Insurance Company Name

Insurance Street Address

City, State, Zip Code

Insurance ID Number Group #

SECONDARY INSURANCE

Policyholder Name Date of Birth

Insurance Company Name

Insurance Street Address

City, State, Zip Code

Insurance ID Number Group #

Authorization/Assignment of Benefits: Please sign by the 'X' for release of your records to your insurance for medical information necessary to process insurance and for payment to Ascent Counseling Services by your insurace. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original copy. I understand that partial payments made by insurance carriers are not accepted as full payment for the services rendered and I will be responsible for any charges not covered by insurance. I agree to the stated fees and I understand that I am financially responsible for all charges, including interest accrued on unpaid balances. I hereby authorize said assignee, Ascent Counseling Services, to release all information to secure payment on my behalf.

X _____ Date _____

Ascent Counseling Services

NOTICE OF PRIVACY PRACTICES

Effective Date:
May 1, 2004

This notice explains how your medical information may be used and disclosed and how you can get access to this information. Please review carefully.

Our Duty to Safeguard Your Protected Health Information Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" (PHI). We are required to extend certain protections to your PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure. We are required to follow the privacy practices described in this Notice.

How We May Use and Disclose Your Protected Health Information We use and disclose PHI for a variety of reasons. We have a limited right to use and/or disclose your PHI for purposes of treatment, payment, or our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization. If we disclose your PHI to an outside entity in order for that entity that it will extend the same degree of privacy protection to your information that we must apply to your PHI. However, the law provides that we are permitted to make some uses/disclosures without your consent or authorization. The following offers more description and some examples of our potential uses/disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Generally, we may use or disclose your PHI as follows:
For treatment: We may wish to disclose your PHI to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition. We will do so only if you have signed a Release of Authorization for us to provide such information.
To obtain payment: We may disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions to your PHI to the Medicaid/Medicare program and/or an insurance insurer, and HMO, or PPO to get paid for services that we delivered to you.
For health care operations: We may disclose your PHI in the course of operationg our program. For example, we may use your PHI in evaluating the quality of services provided, or disclose to our accountant or attorney for audit purposes.
Appointment reminders: Unless you provide us with alternative instructions, we may call you with appointment reminders and occasionally send materials that may be of interest to you to your home.

Uses and Disclosures Requiring Authorization: For uses and disclosures beyond treatment, payment and operations purposes we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action.

Uses and Disclosures NOT Requiring Consent or Authorization: The law provides that we may disclose your PHI from mental health records without consent or authorization in the following circumstances:
When required by law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or violence, or relating to planned criminal activitiy, or in response to a court requirements.
For health oversight activities: We may disclose PHI to the agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.
Relating to decedents: We may disclose PHI relating to a death to state medical examiners.
To advert threat to health and safety: In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

Your Rights Regarding Your Protected Health Information:

To request restrictions on uses/disclosures. You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To choose how you're contacted. You may ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and request a copy of your PHI. Unless your access to your records is restricted for clear and documented treatment reasons, you have a right to see your protected health information upon your written request. We will respond within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, depending on your circumstances. You have the right to choose what portions of your information you want copied and to have prior information on the cost of copying.

To request amendment of your PHI. If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made. You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure: for treatment, payment, and operations; or pursuant to your written authorization. We will respond to your written request within 60 days of receiving it. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

To receive this notice. You have the right to receive a paper copy of this Notice and/or electronic copy by email upon request.

To complain about our Privacy Practices. If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. We will take no retaliatory action against you if you make such complaint.

To contact us for information, or to submit a complaint: If you have questions about this Notice or any complains about our privacy practices, please contact Ascent Counseling Center's director, Joseph Weidenbenner at Ascent Counseling Services, 717 South Boulevard, Suite 9, Baraboo, WI 53913.

Print Client Name	*Signature*	*Date*
Print Guardian Name	*Signature*	*Date*
Print Therapist Name	*Signature*	*Date*

Ascent Counseling Services
CONSENT TO TREATMENT

Ascent Counseling Services wants you to be aware of your rights and responsibilities as a patient/client of our clinic. We ask for your **INFORMED CONSENT** to receive treatment. A copy of the *Client Rights and Grievance Procedure* appears in our waiting room and you have given a copy of the *Client Rights and Grievance Procedure* to take with you. Please read this. In addition, please read the following general information about the psychotherapy process:

CONSENT TO TREATMENT:

1. The benefits of psychotherapy are to help alleviate the problems and symptoms that you present. As a client you will be involved in the formulation and evaluation of your treatment plan throughout the therapy process.

2. Psychotherapy is conducted in a professional and appropriate manner between psychotherapist and patient/client talking about the presenting problem.

3. If there is any expected side effects from psychotherapy (or medication when that is a consideration) they will be discussed with you.

4. The psychotherapist will suggest alternative treatment methods and will make referrals to other psychotherapists when appropriate or necessary.

5. The possible consequences of not receiving psychotherapy may be discussed.

6. What you say to your therapist, as well as any case notes or other records are confidential and generally will not be shared with others unless you provide written consent. However, there are exceptions to this.

   a) Sound ethical treatment as well as state mental health policy requires periodic review of psychotherapy performed by your therapist. The review will be done by other mental health professionals in consultation with Ascent Counseling Services.

   b) If your therapist has reason to believe you or someone else may be in danger of physical harm, state law and professional ethics require your therapist to take steps to protect you and/or other persons involved. This may include notification of appropriate social service and legal agencies.

   Examples of such instances include:
   - Danger of suicide or other self-injurious behavior
   - Danger of causing physical harm to another
   - Occurrence of suspicion of child abuse or neglect

CLIENT RESPONSIBILITIES

1. The client will devote time and energy to therapy. The client will follow through with treatment recommendations. This commitment strengthens your chances of reaching the goals of treatment that you and your therapist develop.
2. Refrain from physical or other types of abusive behavior to yourself, to others or to any property.
3. Be honest regarding your thoughts and feelings about your treatment.
4. Keep appointments made. Cancellations with less than 24 hour notice will be charged to your account.
5. Stay current with your bill. Full payment is expected at time of service.

INFORMED CONSENT I have read the above statements regarding my rights and responsibilities. I hereby give my consent to be assessed and treated by this clinic. I have discussed any concerns I might have about the above statements. I understand that this statement of consent is in effect for twelve months from the date below unless I wish to revoke it earlier.

Patient/Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

Ascent Counseling Services
SOCIAL MEDIA POLICY

Ascent Counseling Services staff conduct themselves on the Internet as mental health professionals. Confidentiality means we cannot tell others that you are our client.

FRIENDING

We don't accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.) This would compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

LOCATION-BASED SERVICES

Be aware of privacy issues using GPS tracking enabled on your device. Sites such as Foursquare, Gowalla, Loopt, etc. may passively "check in" to our office, from which others may draw conclusions if this occurs regularly.

INTERACTING

Please do not contact us by using SMS or messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn. These sites are not secure. We may not read these messages in a timely fashion. Do not use wall postings, @replies, or other ways of engaging me in public online if we have had an established client/therapist relationship. This can compromise your confidentiality.

If you need to contact us between sessions, the best way to do so is by phone. Direct email at joe@ascent-counseling.com is second best for quick, administrative issues such as changing appointment times.

USE OF SEARCH ENGINES

We do not search for clients on Google or Facebook or other search engines. Exceptions may be made during times of crisis. If we suspect that you are in danger, and you have not been in touch via our usual means, there might be an instance to use a search engine (to find you, or to check on your recent status updates.) We fully document it all and would discuss it with you when we next meet.

BUSINESS REVIEW SITES

If you should find Ascent Counseling Services on rated business lists (Yelp, Healthgrades, Yahoo Local, Bing), this is not a request for a testimonial, rating, or endorsement as our client. Of course, you have a right to express yourself on any site. Due to confidentiality, we can not respond to any review. If you use these sites to communicate indirectly with us, there is a good possibility that we may never see it.

Our ethics code prohibits us from soliciting testimonials. Keep in mind that what you share on the Internet is personally revealing in a public forum. Create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

EMAIL

Do not email content related to your therapy sessions, since email is not completely secure or confidential. If you choose to communicate by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are available to be read by the system administrator(s) of the Internet provider. Emails received or sent become a part of the legal record.

If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, bring them to our attention so that we can discuss them.

Patient/Client Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

717 South Boulevard, Suite 9
Baraboo, WI 53913
608-501-2497
joe@ascent-counseling.com
ascent-counseling.com

ONLINE TELEHEALTH SERVICES INFORMED CONSENT

I hereby consent to engage in telemental health (internet based therapy) with Ascent Counseling Services, LLC, for my psychotherapy treatment. I understand that telemental health includes the practice of health care delivery, including diagnosis, consultation, treatment, and education using interactive audio, video, and/or data communication. All protections and limitations of HIPAA are the same for online therapy as they are in person, as outlined in the Privacy Policies you have already received from our clinic.

In addition, I agree that I understand that I will need to download an application to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. The secure, HIPAA compliant server to be used is Ascent Counseling Services, LLC from a computer or the free Zoom, Inc. from a phone/tablet.

Initials _____

SESSION STRUCTURE

It is important to maintain a setting similar to being in an office together. **In order to have effective online therapy sessions, the following guidelines must be followed**:

- Your device must be placed on a steady surface throughout sessions, and not held in your hand if it can be avoided. You should also be in a set location and not moving about.
- Make sure that you are in a private location where you cannot be overheard by others, and adjust the volume to ensure your privacy. You are required to inform me if there is anyone in the room with you, or who you believe may overhear the session.
- Try to have proper lighting so that I can best communicate with you. You must be fully dressed and sitting in an appropriate setting for our session.
- Minimize background noise. Turn off televisions, music or other sounds. Please close the door to the room you are in.
- Minimize distractions. You should not be playing games on a device, on social media, or working on other things while in therapy. Make sure that pets, children, household members and roommates will not be distractions from treatment.
- You may not invite others into session time without discussing this with me first. If the connection is broken for any reason, I will call you to remedy the situation. Clinician will resume session via phone at 608-370-4169 until internet-based therapy has returned.

Initials _____

CLIENT RIGHTS

Initials _____ I understand that I have the following rights with respect to telemental health: I have the right to withdraw consent at any time without affecting my right to future care or treatment.

Initials _____ The laws that protect the confidentiality of my medical information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (*See also Privacy Policies*)

Initials _____ I understand that there are risks and consequences from telemental health. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of services could be disrupted or distorted by technical failures; misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner; and/or possible confidentiality breaches if someone should walk into the client's room while in a psychotherapy session.

Initials _____ In addition, I understand that telemental health based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service.

Initials _____ I understand that I may benefit from telemental health, but results cannot be guaranteed or assured. The benefits of telemental health may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

Initials _____ In emergencies, call 911 or go to your local emergency room. Your therapist can be contacted during business hours and will return calls within one business day.

Sign Name _____ *Date* _____