

AMERICAN FOUNDATION OF COUNSELING SERVICES, INC.

130 EAST WALNUT STREET



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**INSTRUCTIONS FOR COMPLETING INTAKE PAPERWORK**

*Welcome to the American Foundation of Counseling Services. Please take a few moments to complete the following paperwork in this packet and bring it with you to your first appointment. Remember to arrive for your first appointment 10-15 minutes before the scheduled time. If you would like us to bill your insurance, please present your insurance card at the time of your first appointment. We look forward to meeting you.*

*Included in this packet:*

**Client Information Form/Client Health History** – Fill out all sections as completely as possible to the best of your ability. If you are filling this out on behalf of your child or someone you have guardianship over, please use his or her information in *Section 1* of the Client Information Form and your information in *Section 2*. Answer subsequent questions as they would pertain to the client.

**Patient Rights and Informed Consent** – Please review the information provided in this form as it outlines your rights as a patient and the process of treatment at the American Foundation of Counseling Services and sign and date.

**Responsible Party** – Please designate who is responsible for payment on this account. Signature of the responsible party is required on this form.

You will also be asked to sign a Financial Agreement and Notice of Privacy Practices when you arrive for your appointment.

When billing your insurance carrier, if you have questions about what you will be responsible for after insurance has paid its portion, please call your insurance company at the phone number listed on your insurance card or visit their website.

If you have additional questions, please call our office at (920)437-8256.

Thank you,

The American Foundation of Counseling Services



# CLIENT INFORMATION FORM



Date: \_\_\_\_\_

Therapist: \_\_\_\_\_

**Section 1. Client Information:**

\_\_\_\_\_  
 Last Name First Name Middle Initial

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F SS#: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Religion: \_\_\_\_\_

Client Address: \_\_\_\_\_  
Street Address City State Zip

County: \_\_\_\_\_

Phone Number(s): Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Other ( ) \_\_\_\_\_

**Section 2. Spouse/Parent(s)/Legal Guardian (if client under 18) Information:**

a. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address (if different from client): \_\_\_\_\_

\_\_\_\_\_  
Street Address City State Zip  
 SS#: \_\_\_\_\_

b. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address (if different from client): \_\_\_\_\_

\_\_\_\_\_  
Street Address City State Zip  
 SS#: \_\_\_\_\_

**Section 3. Your Occupation – (or of parent(s)/legal guardian if client is under 18):**

a. Employer: \_\_\_\_\_ b. Employer: \_\_\_\_\_

Gross Family Income: \_\_\_\_\_

**Section 4. Children/Siblings:**

Name	Age	DOB	M/F	Live w/: Mom/Dad/both/other

Referral Source: \_\_\_\_\_

Any Previous Therapy: \_\_\_\_\_



**Patient's Name** \_\_\_\_\_

**Responsible Party Information**

It is our goal to make financial arrangements as convenient as possible for all concerned. So that your account may be created in the correct fashion, please complete the following for us:

<p><b>Person responsible for paying this account:</b></p> <p>_____</p> <p><i>(The account will be set up in this name)</i></p> <p>Address _____</p> <p><i>(Only if different from patient)</i></p> <p>City _____ State _____ Zip _____</p> <p><i>( Only if different from patient)</i></p>
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**If the person(s) responsible for payment will not be present for the initial appointment, the lower portion of this form must be completed:**

In many instances involving divorce, separation or shared custody situations, the individual responsible for payment of an account is different from that person accompanying the patient to the office for care. *In these situations, the signature of the person listed above must be provided below.*

I (we) the undersigned, accept responsibility for  
Payment of all costs incurred on the behalf of \_\_\_\_\_

*(Patient's name)*

\_\_\_\_\_  
*(Signature of responsible party)* \_\_\_\_\_  
*(Date)*

**If no signature of responsibility is provided, Wisconsin Law states that the person accompanying a minor patient for care is responsible for all financial obligations regardless of court decrees or other legal or personal arrangements.**



## CLIENT HEALTH HISTORY

Family or personal physician: \_\_\_\_\_

Health: (note any health conditions/surgeries as necessary)

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Medications: (including over the counter medications, frequency and dosage)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

.....

Note average *daily*, *weekly* or *monthly* intake:

Caffeine: \_\_\_\_\_ Nicotine: \_\_\_\_\_ Alcohol: \_\_\_\_\_ Other Drugs: \_\_\_\_\_

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Any concerns you would like the therapist to note: \_\_\_\_\_

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# AMERICAN FOUNDATION OF COUNSELING SERVICES, INC

## YOUR RIGHTS AS A PATIENT (HSS 94.04)

Under Wisconsin State Mental Health Act, each individual in treatment has rights. The rights are pertinent to outpatient mental health clinics. Should you need in-patient treatment at another facility, please note that there are additional rights.

### TREATMENT RIGHTS:

1. To receive prompt and adequate treatment.
2. As a voluntary patient, to refuse treatment or medication at any time.
3. To be free from unnecessary or excessive medication or drastic treatment.

### COMMUNICATION/PRIVACY RIGHTS:

1. To refuse to be filmed or taped without your consent.
2. To have your treatment records and conversations about your treatment kept confidential.
3. To have access to your treatment record after discharge (or during treatment, if the program director approves it).

### CIVIL RIGHTS:

1. No client is to be refused services on the basis of race, creed, color, religion, age, sex, or national origin (HSS 61.10-61.13).

### RIGHT TO COMPLAIN:

1. If you feel your rights have been violated, you have a right to use a grievance procedure.
2. A complaint investigator will honor your complaint and explain the grievance procedure stages and give you a written outline of the procedure.
3. You have a right to legal action.

## INFORMED CONSENT (HSS 94.03)

### THE PROCESS OF TREATMENT:

The benefit of therapy is to help the client meet his/her goals for treatment. These goals will be developed together with the therapist.

1. *Administration of treatment:* The client and the therapist will together determine how best to meet the goals of treatment. If the client does not think that his/her goals are being met, this should be discussed with the therapist for evaluation, recontracting, or referral to a therapist who may better meet the needs and goals of the client.
2. *Side effects of treatment:* Therapy helps the client work on his/her goals. In some cases this means that uncomfortable feelings may increase before things start to get better.
3. *Probable benefits of receiving proper treatment:* People who choose counseling to overcome their problems in living have a better advantage at making more appropriate life choices and decisions.
4. *Effective time period of consent to treatment:* The client's consent to treatment will last until the goals of treatment have been satisfactorily reached and the case is closed, the client withdraws consent and terminates treatment, or a year has passed and a resigning of the Informed Consent has taken place.

### IF APPLICABLE:

I give permission for my child to receive evaluation and treatment by a therapist at the American Foundation of Counseling Services.

The types of services I am requesting from the American Foundation of Counseling Services have been explained to me. I voluntarily consent to become *actively involved* in the treatment process program. ***I HAVE READ AND UNDERSTAND THE RIGHTS OF A PATIENT AND INFORMED CONSENT:***

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client (or legal guardian) Signature

\_\_\_\_\_  
Therapist Signature

A COPY OF THIS INFORMED CONSENT MAY BE GIVEN TO THE CLIENT UPON REQUEST.