Michael Noll Counseling, LLC

1477 Kenwood Dr, Suite 200
Menasha, WI 54952
https://michaelnollcounseling.com

(920) 215-1553 Phone/Text
(920) 821-1432 Fax

CLIENT INFORMATION

Date of Appointment _____

Client _____ Preferred Name _____
(First Name) (Middle Initial) (Last Name)

Sex Assigned at Birth ____ (M/F) Gender Identity _____ Date of Birth _____

H (_____)_____ C (_____)_____ W (_____)_____ Married __ Single __ Separated __ Divorced __ Widow(er) __

Address _____ City _____ State ____ Zip _____

Spouse's Name _____ Mother's Name _____
(Father, if minor) (If minor)

Guardian _____ Phone (_____)_____ Client's Employer _____

Primary Care Physician _____ Hospital _____

Whom may we thank for referring you to us? _____

Send bill to _____ Phone (_____)_____

Address _____

Primary Insurance _____ Insured's Employer _____

Primary Insured's Name _____ DOB _____

Insurance Phone # (____)_____ Member Id # _____ Group # _____

Plan Name _____

Secondary Insurance _____ Insured's Employer _____

Insured's Name _____ DOB _____

Insurance Phone # (____)_____ Member Id # _____ Group # _____

Plan Name _____

INSURANCE REPORT AUTHORIZATION

I hereby authorize __ Michael Noll Counseling, LLC**__ to release medical information to the above-named insurance company and/or HEALTH CARE FINANCING ADMINSTRATION AND ITS AGENTS, any information needed to determine insurance benefits or the benefits payable for related services. I authorize payment directly to the provider and request that payment of authorized MEDICARE benefits be made either to me, or on my behalf, to the provider. I understand and agree that I am responsible for any balance not paid by the insurance company. I have reviewed all of the above information and certify that this information is true and correct to the best of my knowledge. This authorization is in effect until I choose to revoke it.**

Client Signature _____ Date Signed _____

Parent/Guardian Signature _____ Date Signed _____

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Client Rights

As a client of Michael Noll Counseling, LLC, you have the right:

1. To be treated with dignity and respect, free from abuse.
2. Receive prompt and adequate treatment.
3. To participate in the planning of your treatment.
4. To have access to your treatment records after discharge/termination (or during treatment with the approval of your treating provider).
5. To refuse treatment.
6. To file a grievance.

Patient Privacy Consent of Personal Health Information (PHI)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that PHI is protected for privacy. The Privacy Rules was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about a patient to carry out treatment, payment or health care operations (PTO).

As our patient, we want you to know that we respect the privacy of your personal medical records, and will do all we can to secure and protect privacy. We strive to always take reasonable precautions to protect your privacy. When it is necessary, we provide the least amount of information possible to those entities that require us to do so. This information may include your treatment, payment or health care operations and will always be in your best interest. As a matter of clinic property, PHI will not be released without obtaining written client consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose not to allow disclosure of your PHI. If you choose to give consent by signing this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have objections to this form, please ask to speak to our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Grievance

If you have a concern about the services you are receiving, please discuss it with your provider. You will not be penalized or threatened in any way for presenting your concerns.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

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Consent for Treatment form Mental Health Evaluation and/or Treatment

1. **Consent to Evaluate/Treat:** I am voluntarily consenting to a mental health evaluation and/or treatment by Michael Noll Counseling, LLC. Evaluation and/or treatment may be administered via interview, psychological assessment or testing, psychotherapy or medication management. The length and frequency of treatment will vary according to my individual needs. I understand that following the evaluation, I will receive complete and accurate information regarding:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment, and/or the risks of side effects from medications (when applicable)
    e. Probable consequences of not receiving treatment

    Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Social Work, Professional Counseling, or Marriage and Family Therapy.

2. **Benefits to Evaluation/Treatment:** Possible benefits to treatment include improved cognitive and/or academic/job performance, health status, quality of life, and awareness of strengths and limitations. Risks associated with psychotherapy may include:
    a. Disruptions to your daily life that occur because of therapeutic changes
    b. Emotional pain due to recalling and exploring past personal issues and family history
    c. Emotional pain due to discussing and exploring current relational issues
    d. Although one anticipates improvement of symptoms through therapy, we cannot guarantee positive results.

3. **Charges:** Fees are based on the length or type of evaluation and/or treatment which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fee schedules are available to me upon request.

4. **Confidentiality, Harm and Inquiry:** Information from my evaluation and/or treatment is contained in confidential records at the office. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or other; 2) if concerns about possible abuse or neglect arise or domestic violence; 3) if a court order is issued to obtain my records; 4) there is reportable child abuse.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will expire 18 months from the date of signature, unless otherwise specifies.

I have read and understand the above, and I consent to the evaluation and treatment. I understand that I have the right to discuss this information with my provider at any time.

Client Name (print)	Date of Birth
Patient Signature	Date
Parent/Guardian Signature	Date

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Credit Policy

1. **A 24-hour notice is required for cancellation of any appointment, including your initial visit.** You will be charged for 'no-shows' and cancellations with less than a 24-hour notice. After **two** missed/late cancelled appointments services may be discontinued.

2. Prior to your appointment, **call your insurance company** and check your mental health benefits including deductible, co-payments, maximum benefits and any pre-certification requirements. Bring yourinsurance card(s) to each appointment.

3. Insurance benefits: You agree to provide us with all insurance carriers including (Wisconsin ForwardHealth, BadgerCare, Medical Assistance and HIRSP). If accurate insurance information was not provided to us during your initial phone call, services may be declined due to the inability to accommodate certain insurances.

4. Please bring your credit card and/or flex card number at the time of your appointment. We will not charge against your card until your insurance company notifies us of your responsibility or if there is a no-show fee. We will assume you want to make payment by credit or flex card unless you make alternative arrangements. All credit card information will be kept in a secure and confidential location. You retain the right to dispute any charges or payments with which you question or disagree.

5. Payment of your co-pays and deductibles are expected at the time of service. Payments may be made with cash, check, or VISA/Mastercard. If you cannot pay in full at the time of service, you must speak with our Billing Manager and set up a reasonable payment plan on your initial date of service.

   *** Non-payment for services and/or refusal to set up and follow through with a payment plan may result in immediate disruption of service.*

6. A Finance Charge of 1.5% PER MONTH (equivalent to 18% per annum computed monthly) may be charged on account balances that are more than 30 days old.

7. As a courtesy to you, we will submit a claim to your insurance carrier for each charged visit. If it is necessary to re-submit a claim for any charge, we will do so one additional time only. Any balance not paid by insurance is your responsibility. If your insurance is unresponsive, interest will begin to accrue on unpaid balances 60 days from the initial date of service. At this point, we recommend you contact your insurance company and set up a payment plan with our Billing Manager 920-215-1553.

8. There may be a charge for telephone calls (at the provider's discretion). Most insurance companies do not pay for this service.

9. **Divorce cases –** In cases of divorce, the individual who receives care is responsible for payment of co-pays, coinsurance and nonparticipating insurance balances at the time of service. We are not required to follow divorce decrees.

10. **Child custody cases –** In the case where one parent has sole legal custody, we will only bill that parent. In the case where there is joint custody, the parent who brings the minor child in for services will be billed. The clinic does not get involved with divorce specifics, (e.g. one parent pays 80%, the other pays 20%). It is the parents'/guardian's obligation to work out a satisfactory agreement between themselves or through the court system.

_____ _____

I have reviewed the above terms and agree to comply with them Date

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Informed Consent for Technology Assisted Counseling/Online Counseling

Process:
Possible misunderstandings: The client should be aware that misunderstandings are possible with telephone, text-based modalities such as email, and real-time internet chat, since nonverbal cues are relatively lacking. Even with video chat software, misunderstandings may occur, since bandwidth is always limited and images lack detail. Counselors are observers of human behavior and gather much information from body language, vocal inflection, eye contact, and other non-verbal cues. If you have never engaged in online counseling before, have patience with the process and clarify information if you think your counselor has not understood you well. Be patient if your counselor asks periodically for clarification as well.
Turnaround time: Using asynchronous (not in "real time") communication such as email entails a "lag" of response. Michael Noll Counseling, LLC (MNC) will make every effort to respond to email requests within a 12 to 24 hour period.
Privacy of Michael Noll Counseling, LLC: Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in person. The client is responsible for securing their own computer hardware, internet access points, chat software, email and passwords.

MNC has a right to their privacy and may wish to restrict the use of any copies or recordings the client makes of their communications. Clients must seek written permission of MNC before recording any portion of the session and/or posting any portion of said sessions on internet websites such as Facebook, YouTube, TikTok, etc.

Potential benefits:
The potential benefits of receiving mental health services online include both the circumstances in which Michael Noll Counseling considers online mental health services appropriate and the possible advantages of providing those services online. For example, the potential benefits of email may include: (1) being able to send and receive messages at any time of day or night; (2) never having to leave messages with intermediaries; (3) avoiding not only intermediaries, but also voice mail and "telephone tag"; (4) being able to take as long as one wants to compose, and having the opportunity to reflect upon, one's messages; (5) automatically having a record of communications to refer to later; and (6) feeling less inhibited than in person.
Text-based chat has many of the same advantages of convenience, feeling reduced scrutiny from MNC, having time to compose a response and being able to refer back to the chat log for reference.
Video chat is also convenient, allowing clients to potentially be counseled from anywhere, within Wisconsin, once they can gain an internet signal and operate the necessary hardware.

Potential risks:
There are various risks related to electronic provision of counseling services related to the technology used, the distance between counselor and client, and issues related to timeliness. For example, the potential risks of email based counseling may include (1) messages not being received and (2) confidentiality being breached through unencrypted email, lack of password protection or leaving information on a public access computer in a library or internet café. Messages could fail to be received if they are sent to the wrong address (which might also be a breach of confidentiality) or if they just are not noticed by Michael Noll Counseling. Confidentiality could be breached in transit by hackers or Internet service providers or at either end by others with access to the client's account or computer.
People accessing the internet from public locations such as a library, computer lab or café should consider the visibility of their screen to people around them. Position yourself to avoid peeping by those around you. Using cell phones can be risky in that signals are scrambled but rarely encrypted.

Safeguards:
MNC has selected an email account with a private internet website host and an account with iPlum for chat based communications to allow for the highest possible security and confidentiality of the content of your sessions. Your personal information is encrypted and stored on a secure server. Clients are responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer, keeping their email and chat IDs and Passwords secret, and maintaining security of their wireless internet access points (where applicable). Please discuss any such concerns with your counselor early in your first session so as to develop strategies to limit risk.

Alternatives:
Online counseling may not be appropriate for many types of clients including those who have numerous concerns over the risks of internet counseling, clients with active suicidal/homicidal thoughts, and clients who are experiencing active manic/psychotic symptoms.
An alternative to receiving mental health services online would be receiving mental health services in person. The online counselor can and will assist clients who would like to explore face-to-face options in their area. Many state and local agencies will treat low-income clients on a low or no-fee basis. Please feel free to request a referral any time you think a different counseling relationship would be more practical or beneficial for you.

Proxies:
MNC only treats clients who are legally in a position to consent for themselves to receive mental health services. Clients who are not in such a position include children under the age of consent or clients who have a legally appointed guardian.

Confidentiality, Harm and Inquiry:
Information from my evaluation and/or treatment is contained in confidential records at the office. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or other; 2) if concerns about possible abuse or neglect arise or domestic violence; 3) if a court order is issued to obtain my records; 4) there is reportable child abuse.

Records:
MNC will maintain records of online counseling services. These records can include reference notes, copies of transcripts of chat and internet communication and session summaries. These records are confidential and will be maintained for seven years as required by applicable legal and ethical standards according to the American Counseling Association. The client will be asked in advance for permission before any audio or video recording will occur on MNC's end.

Procedures:
MNC might not immediately receive an online communication or might experience a local backup. If the client is in a state of crisis or emergency, we recommend contacting a crisis line or an agency local to the client. Clients may utilize the following crisis hotlines:

National	800-SUICIDE
	800-273-TALK
	For the Deaf: 800-799-4TTY
Winnebago County	(920) 722-7707 - 24 hr Crisis Line - Neenah/Menasha
	(920) 722-7707 - 24 hr Crisis Line – Oshkosh
Outagamie County	(920) 832-4646
Calumet County	(920) 849-9317 - 24 hr Crisis Line –Chilton
	(920) 832-4646 - 24 hr Crisis Line – Appleton

Work with your counselor to identify local resources if you have concerns about the timeliness of responses.

Charges:
Fees are based on the length or type of evaluation and/or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fee schedules are available to me upon request.

Disconnection of Services
If there is ever a disruption of services on the internet then the client will need to call 920-215-1553.

Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

Expiration of Consent: This consent to treat will expire 18 months from the date of signature, unless otherwise specifies.

Client Name (print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Sliding Scale Fees (Cash Rate)

Annual Household Income	Cost per session (45-60 minutes)
< $60,000	$80
$60,001 - $150,000	$125
> $150,000	$150

** Fees are as of April 26, 2023, and are adjusted periodically*

* Fees agreed upon under previous sliding fee scale charts will remain in effect and be honored for the duration of client's time with **Michael Noll Counseling, LLC**
* Extenuating circumstances regarding ability to pay (ex. High medical bills, job loss, etc.) can be documented below and taken into account when agreeing upon a fee
* Sliding scale is based on honor of client. IF any changes arise in income, please notify **Michael Noll Counseling, LLC**, so adjustments may be made to fees
* Fees are based on a regular *45-60 minute session* and will be adjusted and documented below if *25-30 minutes*, *75-90 minute* sessions.
* Sliding fee clients pay the same rate for an intake session as a regular session

FINANCIAL AGREEMENT

By signing below I agree to the above fee schedule and understand payment (cash, check, Visa, MasterCard, etc) is due in full at the time of the session.

* I also agree to pay a fee of **$50** plus the amount for the check for any returned checks (NSF)

* I understand I am **opting out** of using insurance, whether Michael Noll Counseling, LLC, is an approved provider with them or not

___ (initial) Pay the appropriate amount based on my stated annual household income above.

The agreed upon fee per 45-60 minute session is _____. (100%)

The agreed upon fee per 75-90 minute session is _____. (150% of 45-60 minute)

The agreed upon fee per 30 minutes or less is _____. (75% of 45-60 minute)

Comments or notes about fees or fee arrangements. _____

_____

_____

_____ _____
Client Full Name Date

_____ _____
Signature Parent/Guardian (for minors)

_____ _____
Therapist Date

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○