Welcome,

 We understand that self-exploration through creativity and “art” can be a daunting thought. It is our mission to work with where you are to find alternative forms of communicating your authenticity. Art therapy is not about creating beautiful artwork, but instead using creative materials to “mess make” in attempt to sort out difficult experiences. Like all mental health therapy, art therapy is a way to understand yourself and the way you interact in the world. We welcome all questions about our service and your care.

It is our mission to therapeutically assist in the discovery, renewal and celebration of the unique qualities of individuals through expressive arts therapies. We will accomplish this through ongoing program development by designing purposeful activities, utilizing a variety of expressive modalities, and providing nurturing individual attention. We strive to work with people in every stage of life with an emphasis on different abilities, survivors of trauma, and memory care. It is our mission to facilitate healing from the inside out by encouraging personal expression and creative potential.

Together we can nurture self-respect, heal the struggles of the present, find peace in the moment, and build strength for the future.

In an effort to serve you in the best way possible, we need the following information. Please *complete each section with as much detail as possible* so that we can spend our time together focused on healing. Getting to know you and joining your journey is our most important goal.

****Thank you!

Tami Joe DeLisle, MSAT, LPC-IT

****

**Client’s Information Sheet**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sex: \_\_\_\_\_\_\_\_\_\_

 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best time to reach you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Name and SS# (of primary insurance carrier) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please include copies of all cards (front and back)

Client Information Sheet

Age Today:\_\_\_\_\_ Date of Birth:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Current**

Life Challenge Today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Impact on Life:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past**

History of Challenge:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Given:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**:

Current Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What led you to seek services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What lessens symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What worsens symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Developmental History**:(Developmental Milestones, past concerns, abuse, school, social, mental health, medical health, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strengths**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Likes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hobbies (Past and Present:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family/Household members**:

Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_ Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_ Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_

Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_

Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_ Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_ Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_ Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_ Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_

Member: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_

**History of Therapy**:

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

What was helpful? What was not?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Checklist**

|  |  |  |
| --- | --- | --- |
| * Depressed mood
* Weight gain
* Sleep change
* Too much sleep
* Too little sleep
* Death/suicide ideation
* Sadness
* Talkativeness
* Excessive pleasure
* Sweating
* Nausea
* Dizziness
* Fear of losing control
* Restlessness
* Muscle tension
* Anger
* Cognitive issues
* Substance use
 | * Anxiety
* Weight loss
* Weight gain
* Feeling worthless
* Guilt
* Crying spells
* Hopelessness
* Flight of ideas
* Agitation
* Trembling
* Feeling of choking
* Chills
* Hot flashes
* Numbness
* Easily fatigued
* Dissociation
* Thought disorder
* Phobia
* Medical conditions
 | * Conduct problems
* Appetite change
* Low energy
* Withdrawn
* Grandiosity
* Distractibility
* Palpitations
* Shortness of breath
* Chest pain
* Derealization
* Fear of dying
* Irritability
* Impulse control
* Relationship difficulties
* PTSD
* Inflicting harm on self
* Inflicting harm on others
* Sexual concerns
 |

**Personal Therapy Goals**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Release of Information**

(one for each agency or individual per release)

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

Clients’ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, hereby give consent to UnMasked Expressive Therapies to correspond with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regarding my care and treatment. This allows for verbal and written exchange of information regarding:

\_\_\_ Intake Interview

\_\_\_ Progress notes/ therapist notes

\_\_\_ Treatment planning

\_\_\_ Discharge Summary

\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This release is valid until \_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ or one year.

A photocopy is as valid as original. I, the undersigned, have the right to revoke this permission at any time in writing.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

****

**Waiver of Liability**

As a client (or guardian of a client) of UnMasked Expressive Therapies:

UnMasked Expressive Therapies

PO Box 229

Reeseville, WI 53579

I hereby release the representative, agents, supervisors and board of directors of all liability for damages or injuries sustained by myself or my child while participating in this program.

This release is valid for one year or until I exit the programs with UnMasked Expressive Therapies (which ever happens first).

A photocopy is as valid as original. I, the undersigned, have the right to revoke this permission at any time in writing.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Informed Consent**

**Photography, film and recordings**

As an expressive arts modality, UnMasked Expressive Therapies will, with permission, periodically use digital media to capture and record moments and images as deemed appropriate to therapeutic goals. As change is explored through therapy, it is often helpful to have a digital record of earlier art. Digital recordings include and are not limited to audio, video and photographic representations of client works.

In order to maintain our high level of therapeutic attention and techniques with in our programs, UnMasked Expressive Therapies participates in ongoing research of art therapy practices.

Also, as a means to share in the healing power of art making, a variety of show experiences may be made available for client’s finished work.

I agree to allow UnMasked Expressive Therapies to use and/or display and/or photograph my artwork for the following purpose (s):

* Reproduction, presentation, and/or inclusion within academic journals as a part of research findings.
* Reproduction and/or presentation at professional conferences.
* Publication in art therapy related journals.
* Inclusion in area Art Shows.

UnMasked Expressive Therapies agrees to keep your artwork safe, whether an original or reproduction, to the best of our ability and notify you immediately of any loss or damage while your art is in our possession. Artwork will be returned immediately if you decide to withdraw your consent at any time. Confidentiality will be safeguarded your confidentiality. Names and identifying information will not be included in presentations or displays without your express request.

This release is valid for one year. A photocopy is as valid as original. I, the undersigned, have the right to revoke this permission at any time in writing.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

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Policies and Procedures

Confidentiality

 All agency case material is kept strictly confidential. Periodically it may be helpful to consult with other professionals and agencies for the ongoing management of therapy, and we will request written consent for exchange of information. The only exceptions to the above policy relates to the following obligations under Wisconsin Law:

Psychotherapists, Occupational Therapists, Speech Therapists, and Therapeutic Facilitators are legally responsible to report to authorities when they feel an individual may cause harm to self or others.

Psychotherapists, Occupational Therapists, Speech Therapists, and Therapeutic Facilitators are required by law to report any evidence of child abuse.

 I have read and understand the policy and procedures and I have received a copy of the HIPPA notice of privacy practices.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

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Policies and Procedures

Cancellations

 Late-cancelled appointments prohibit the ability of UnMasked Therapists to provide appropriate and quality care to the needs of all clients.

 If you must reschedule an appointment, please let us know 24 hours prior to your scheduled session. If you arrive 15 min or more late, you will be asked to reschedule. Both of these events will be considered a “late cancel” and all clients will be charged a $25 fee for “late cancel”.

 This fee is not paid by insurance, community partnerships or any other funding source. The client/family is responsible for this fee.

 Each Client will be given two exceptions per calendar year. We adhere strictly to this cancellation policy.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

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Policies and Procedures

Emergency On-Call

**What is an Emergency?**

 A mental health emergency is and emotional or behavioral crisis that warrants same day attention by a mental health professional. This may include, but is not limited to, significant changes in behavior that are not characteristic of a person, the presence of disruptive symptoms that interfere with the responsibilities of daily living, direct or indirect expressions of the intent to harm self or others, or the experience of trauma.

**Daytime emergency services.**

 UnMasked Expressive Therapies provides emergency services from 8am to 6pm. Clients may call and request an emergency appointment or request to speak with a clinician. If the clinician is not available, s/he will typically return a call within the hour. Each client is expected to have an emergency safety plan in place and support persons who are willing to be called on.

After-hours emergency services

 Clients in crisis after 6 pm who are experiencing a mental health emergency should call 911 for medical and mental health support.

 Additionally, clients in crisis may desire to contact the National Suicide Prevention Hotline at 1-800-273-8255.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

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**CLIENT RIGHTS AND RESPONSIBILITIES**

**When you receive any type of service for mental illness, alcoholism, drug abuse, or a**

**developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:**

PERSONAL RIGHTS

• You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.

• You have the right to have staff make fair and reasonable decisions about your treatment and care.

• You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.

• You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.

• You may make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18, and have not been found legally incompetent.

• You may use your own money as you choose.

• You may not be filmed, taped or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

• You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for you.

• You must be allowed to participate in the planning of your treatment and care.

• You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.

• No treatment or medication may be given to you without your written, informed consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders it. [If you have a guardian, however, your guardian may consent to treatment and medications

on your behalf.]

• You may not be given unnecessary or excessive medication.

• You may not be subject to electroconvulsive therapy or any drastic treatment measures such as

psychosurgery or experimental research without your written informed consent.

• You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.

• You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

• Your treatment information must be kept private (confidential), unless the law permits disclosure.

• Your records may not be released without your consent, unless the law specifically allows for it.

• You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while

you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.

• After discharge, you may see your entire treatment record if you ask to do so.

• If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.

• A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

• Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program’s Grievance Procedure is available upon request.

• If you feel your rights have been violated, you may file a grievance.

• You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.

• You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your

rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

• If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day

time limit.

• The program’s Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.

• Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.

• If you and the program manager agree with the CRS’s report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.

• You may file as many grievances as you want. However, the CRS will usually only work on one at a time.

The CRS may ask you to rank them in order of importance.

Program Manager’s Decision

If the grievance is not resolved by the CRS’s report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS’s report. You will be given a copy of the decision.

County Level Review

• If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager’s decision to the County

Agency Director. You must make this appeal within 14 days of the day you receive the program manager’s decision. You may ask the program manager to forward your grievance or you may send it yourself.

• The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

• If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.

• If you are paying for your services from a private agency, you may appeal the program manager’s decision directly to the State Grievance Examiner.

• You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to

the State Grievance Examiner or you may send it yourself. The address is:

State Grievance Examiner, Division of

Mental Health and Substance Abuse

Services (DMHSAS), PO Box 7851,

Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Mental Health and Substance Abuse Services or designee. Send your request to the

DMHSAS Administrator, P.O. Box

7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is: Tami Joe DeLisle, MSAT,LPC-IT

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential

treatment facilities. A copy of sec. 51.61, Wis. Stats. And/or DHS 94, Wisconsin Administrative Code is available upon request.

**As a Client of UnMasked Expressive Therapies you have the responsibility to:**

* Respect yourself
	+ Be involved in writing your service plan.
	+ Tell your provider if you do not understand or do not agree with the plan.
	+ Give your treatment team all of the information they need so that all of you can make the best decisions about your care.
	+ If you cannot make an appointment, call ahead of time and set up another appointment.
* Respect others
	+ Arrive on time for appointments.
	+ Treat staff and other consumers with the same courtesy you expect.
	+ Speak of other clients with gentleness and courtesy.
* Respect the art: We believe that once it is created the artwork has an entity of its own and must be respected by the creator and the viewer.
	+ No artwork will be destroyed unless it is agreed that it is therapeutically beneficial.
	+ All art has a message, listen to it without judgement.
* Respect the space and materials: Without creative space and materials, our voices are silenced. It is essential that the space and materials are treated with respect.
	+ Clean up the space efficiently and properly
	+ Take only what you need, you may always get more, but it is difficult to squeeze paint back into a tube.
* Sign and Date your art work: it is essential to take ownership of that which is created.
	+ A signature helps us know who
	+ A date helps us know when in your treatment
	+ A title reminds us of the message.

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**CLIENT RIGHTS AND RESPONSIBILITIES**

**Acknowledgement of receipt**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge receipt of the client’s rights and responsibilities as a client and member of the UnMasked creative community.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

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**NOTICE OF PRIVACY PRACTICES**

Protected Health Information as it relates to

Mental Health & Alcohol and Other Drug Abuse Services

provided by

**UnMasked Expressive Therapies**

Effective July 15, 2016

**This notice describes how health information about you may be used and disclosed and**

**how you can get access to this information. Please review it carefully.**

UnMasked Expressive Therapies (UET) is committed to protecting the privacy of health information about you and the services you receive at JMHC. Your privacy rights and our responsibilities are governed under provisions of State and Federal Law, including but not limited to:

Sec. 51.30, Wisconsin Statutes

HFS 92, Wisconsin Administrative Code

42 Code of Federal Regulations, Part 2, Confidentiality of Alcohol & Drug Abuse Patient Records

45 Code of Federal Regulations, pts 160 & 164, Health Insurance Portability/Accountability Act of 1996 (HIPAA)

UET is required by law to:

Maintain the privacy of your health information

Provide you with this notice of our duties and practices with respect to your health

information; and

Abide by the terms of this notice.

In general, UET must obtain your written consent before giving anyone outside UET

information which identifies you as someone who has applied for or received services at UET

or before disclosing any personally identifiable information from your treatment record. You may

revoke any such authorization at any time, except to the extent that information has already

been shared. This can be done by giving written notice to your JMHC service provider(s) or to UETʼs Records Department.

The following page lists exceptions in which information about you may be disclosed without

your consent. In all cases—with or without consent—information given will be limited to that

information needed to meet the purpose for the disclosure and/or to the extent provided for by

law.

**USES AND DISCLOSURES REQUIRED OR PERMITTED**

**WITHOUT YOUR CONSENT**

**Within UnMasked Expressive Therapies, Inc. — Without Consent**

UETis made up of a number of programs staffed by employees, students and volunteers. Your health information may be shared across these programs, for purposes of treatment, payment and health care operations, but this is done only where there is a need to know the information. For example, mental health staff at UET may need to consult with supervisors for purposes of evaluating services or the performance of your health care provider, etc.

**Outside UnMasked Expressive Therapies, Inc. — Without Consent**

**To Avert a Serious Threat to Health or Safety:** As required or permitted 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 minimize a serious and

approaching threat to your health or safety or to the health or safety of the public. Examples

might include reporting of child abuse, a threat made to harm a specific individual, sharing of

information with physicians in a hospital emergency room, etc.

**For Payment:** UET may need to submit a bill identifying you, your diagnosis and treatment

provided to an insurer or other agency paying for your mental health services (for example,

Medicare or Medicaid, grant funders, private insurance, etc.). If you are receiving alcohol or

other drug abuse treatment, however, your signed release is required to release information for

payment purposes.

**Health System Oversight Activities:** Certain information may be shared with government

agencies who provide funding to or oversight of UETʼs services. Examples of such agencies

include the Wisconsin Department of Health and Family Services and the Dodge County

Department of Human Services. Purposes for disclosing the information might include service

coordination, financial or program audits, program certification, death investigation, etc.

**Research:** UET may use or disclose information about you for research purposes under

conditions that meet the stringent requirements of both State and Federal law and UETʼs

Research Committee. In most cases, however, UET will first remove information that

personally identifies you or seek your approval to participate in a research study before sharing

the information.

**Judicial Proceedings:** UET may disclose information in response to a specific legal

proceeding, court order or other legal process, as stipulated by law. For example, law

enforcement officers often consult with UETʼs Emergency Services staff in the process of an

emergency detention.

**Crime on Premises or Against Program Personnel:** In certain circumstances, UET may

disclose limited information to law enforcement officers when a consumer commits or threatens

to commit a crime at any UET facility or against UET staff.

**Family Members:** Limited information may be shared with your spouse, parent, adult child or

sibling, but only if UET treatment staff have verified that the family member is directly involved

in providing or monitoring your treatment.

**YOUR HEALTH INFORMATION RIGHTS**

**You have the right to:**

**Receive Confidential Communications:** You have the right to request that we communicate

with you by alternative means or at an alternative location. For example, you may ask that we

phone you at work rather than at home. We will try to accommodate reasonable requests.

**Access your Treatment Record:** You have the right to inspect (within one working day) and

obtain (within five working days) a copy of your treatment record, except for specific documents

where access is prohibited by law. This information will be provided at no cost to you for the first

copy. Requests for additional copies may result in a customary fee to cover the cost of

duplication.

**Amend your Treatment Record:** You have the right to request an amendment to your

treatment record if you believe information in the record is incorrect or incomplete. If the staff

person working with you disagrees with the requested amendment, you may submit a written

request to UETʼs Executive Director specifying the information you would like to have changed

and the reason for the change. Your request will be reviewed by the clinical team and granted or denied by the Executive Director within 30 days. You will receive either a copy of the information as amended in your record or a written explanation of why the request was denied. If the request is denied, you have the right to insert a statement in the record disputing the accuracy or completeness of the information which was not changed. This statement will become part of your treatment record.

**Request Restrictions:** You have the right to request restrictions on certain uses and

disclosures of your health information for payment of services or UETʼs service related

operations. UET is not obligated to agree to your request but will give every reasonable

request careful consideration. For example, if your neighbor works at JMHC as a

transcriptionist, we may be able to have someone else type any information dictated by a

clinician for your treatment record.

**Obtain an Accounting of Disclosures:** You have the right to an accounting of disclosures of

your health information made by UET. This accounting will list the date of each disclosure, a

brief description of information disclosed and the reason for disclosure. The first accounting in

any 12-month period is free; you may be charged a reasonable fee for any additional accounting

requested by you within the same 12-month period.

**Request a Paper Copy of this Notice:** If you received this “Notice of Privacy Practices”

electronically, you may request that UET provide you with a paper copy.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint by contacting

UETʼs Client Rights Specialist at (920) 382-0445. You may also file a complaint with the

Secretary of the U.S. Department of Health and Human Services in Washington, D.C., in writing, within 180 days of the violation. There will be no retaliation against you for filing a complaint.

**FOR FURTHER INFORMATION ABOUT THIS NOTICE**

Contact;

Tami Joe DeLisle, Exectutive Director

UnMasked Expressive Therapies, Inc.

PO Box 229, Reeseville, WI 53579

(Phone) 920-382-0445

UET must comply with the provisions of this notice, although we reserve the right to change

our privacy practices and the terms of the notice and to make the revised notice effective for all

protected health information maintained by UET.

UET will promptly revise and distribute its notice, during a consumer contact with UET or by

mail, whenever a substantial change in any of its privacy practices is made.

Revised 07/27/2016

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge receipt of the notice of Privacy Practices of UnMasked Expressive Therapies.

Signature of Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

Signature of Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_