



PEACE COUNSELING &
SUPPORT SERVICES
..... MARINETTE

Today's Date _____

CLIENT FIRST NAME _____ LAST NAME _____ MI _____

Address _____ City _____ State _____ Zip _____

Birthdate ____/____/____ Age _____ Gender _____

Phone Number _____ This is a () cell phone () home/landline

Is it okay to call and/or text you at this number? Call () yes () no Text () yes () no

Email (used to connect to client portal): _____

Counseling Support Needs _____

For Minors Only

Parent/Guardian _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Is there another person responsible for payment? _____

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION - ONLY IF ANOTHER FAMILY MEMBER CARRIES COVERAGE

A copy of insurance card(s) is also required to start services.

Primary Insurance _____

Subscriber Name (policy holder) _____ () Spouse () Child () Other

Subscriber Date of Birth ____/____/____ **Employer** _____

NOTICE OF PRIVACY PRACTICES:

Notice of Privacy Practices will be electronically signed. I have been given the opportunity to read Peace Counseling & Support Service's Privacy Practices Pamphlet.

Initial _____ I took a printed copy of Peace Counseling & Support Service's Privacy Practices Pamphlet

Initial _____ I DECLINE to take a printed copy of Peace Counseling & Support Service's Privacy Practices Pamphlet.



INFORMED CONSENT:

I consent to have treatment provided by a social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with this treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Agency encourages that this decision be discussed with the treating professional to help facilitate a more appropriate plan for discharge. Outpatient mental health treatment is designed to assess, diagnose, and treat emotional, behavioral, psychiatric, and relationship concerns through counseling, psychotherapy, assessment, and related behavioral health services. The client may be financially responsible for services not covered by insurance. Clinical records will be maintained as required by Wisconsin law. I consent to participate in a mental health assessment to determine diagnosis, medical necessity, treatment recommendations, and ongoing services. Peace Counseling & Support Services provides psychotherapy and behavioral health services. Medication evaluation or management may require referral to another provider.

I, the undersigned, hereby certify that I have read this informed consent, that I have had the opportunity to ask questions, that my questions have been answered to my satisfaction, and that I understand the benefits, risks, alternatives, costs, confidentiality limits, and my rights as a client. I voluntarily consent to receive outpatient mental health services or give my consent for the minor person under my legal guardianship mentioned above, at Peace Counseling & Support Services (referred to as the Agency). This consent remains in effect until revoked in writing or until treatment is terminated.

Signature of Client _____ Date _____

Signature of Legal Representative _____ Date _____

RECIPIENT RIGHTS:

When you receive any type of service for behavioral care, substance use, or a developmental disability, you have the following rights under Wisconsin DHS 94 Administrative Code or Chapter 330 of the Michigan Mental Health Code.

GENERAL RIGHTS:

No treatment will be provided to you without your written, informed consent. If you have a guardian, your guardian can consent to treatment on your behalf. You may refuse treatment at any time, for any reason.

You have the right to be treated with dignity and respect, with freedom from any verbal, physical, emotional, sexual abuse or harassment. You shall not be treated differently because of your race, national origin, sex, age, religion, disability, identified gender, or sexual orientation.

You have the right to be informed of any costs associated with your care and treatment, which you may be financially responsible for, and you have the right to examine your bill and receive an explanation of the bill, regardless of payment source.

TREATMENT AND RELATED RIGHTS:

You have the right to prompt and adequate treatment, within the limits of the Agency.

You have the right to copies of applicable licensing and certification guidelines.



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The Mental Health Code requires a person-centered approach to planning, selection, and delivery of supports, services, and/or treatment you receive.

You will be informed of your treatment and care and are encouraged to participate in the planning of your treatment and care. If you disagree with your treatment plan, a second consultation will be provided to you.

You will not be recorded, photographed, or filmed for any purpose without your written consent.

You have the right to a clean, safe environment at the Agency.

Participation is voluntary. You may refuse any recommended treatment or withdraw consent at any time.

You have the right to participate in developing your treatment goals, interventions, and discharge planning.

EXCEPTED RISKS AND BENEFITS:

The Agency wants the client to be aware that there are risks associated with treatment. Some risks might include: discussing painful experiences may temporarily increase distress, symptoms may worsen before improving, relationships may change, and treatment cannot guarantee specific outcomes.

The Agency will support the client's treatment with the following expected benefits: reduction in symptoms, improved coping skills, improved relationships, increased emotional functioning, and improved quality of life.

TELEHEALTH SERVICES

I understand that some services may be provided through secure telehealth technology when clinically appropriate. I acknowledge that I have received and signed the Peace Counseling & Support Services Telehealth Informed Consent.

Initial _____

EMERGENCY AND CRISIS LIMITATIONS

Peace Counseling & Support Services is not a 24-hour crisis service.

Please call 988, call 911, or go to the nearest emergency room if you are experiencing a psychiatric emergency.

CONFIDENTIALITY AND RECORD PRIVACY RIGHTS:

The Agency will maintain a client treatment record for each client. All treatment records are confidential.

You have a right to inspect, copy, or challenge your records.

Your records will not be released without your written consent, except as required or allowed by law.

Examples of when confidential information may be released by law: Client consent, court order, reimbursement for costs of treatment (billing and collections), research or statistical purposes (with safeguards regarding your identity), in the event of your death to a surviving spouse or family member.

If you tell your mental health professional that you are going to harm yourself or another person, he/she may have to notify the police or the person who you threaten harm to.

RIGHT TO GRIEVANCE & APPEAL:

You will be informed of your rights and how to use the grievance process.



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

You will not be threatened or penalized in any way for filing a grievance.

If you have a grievance, you may contact Ivy Sutek, Owner/Director, at ivy@peace-counseling.org to discuss your concern.

You may also communicate your concerns directly to:

Wisconsin Division of Quality Assurance: 608-266-8481

Michigan Office of Recipient Rights MDHHS-ORR Hotline: 800-854-9090

By signing below, I acknowledge that I have read and understand my rights and responsibilities as a client of Peace Counseling & Support Services.

Signature of Client _____ Date _____

Signature of Legal Representative _____ Date _____

NOTICE OF POLICIES:

CLIENT RESPONSIBILITIES:

You are responsible for knowing your insurance policies for mental health coverage. Clients are responsible for communications with their insurance company to determine eligibility, benefits, and any co-pays, co-insurance or deductible. In some cases, insurance companies may not cover certain services. In such cases, the person responsible for payment of the account is responsible for the service fees.

You are responsible for your financial obligations to the Agency as outlined in the Payment Contract for Services. When all efforts to collect outstanding balances have been exhausted, you will not be able to schedule appointments with your counselor/therapist.

CLIENT PROTECTIONS:

As a recipient of services at **Peace Counseling & Support Services**, you have rights that are protected under Wisconsin law, including Wisconsin Administrative Code Chapters DHS 35 and DHS 94. These rights include the right to be treated with dignity, courtesy, and respect; to receive services free from abuse, neglect, exploitation, discrimination, retaliation, or unnecessary restraint; to participate in the development of your treatment plan; to give informed consent or refuse treatment as permitted by law; to receive services in the least restrictive and most appropriate setting; to have your privacy and confidentiality protected; to access your clinical records as permitted by law; and to voice concerns or file a grievance without fear of retaliation. You also have the right to receive information about the services available to you, the qualifications of your providers, the costs of treatment, and your responsibilities as a client.

Peace Counseling & Support Services will provide you with information regarding your Recipient Rights, including how to contact the Client Rights Specialist or other appropriate agencies if you believe your rights have been violated. Staff are available to answer any questions regarding your rights at any time during treatment.



NOTICE OF TRAINING FACILITY:

Peace Counseling & Support Services has made it part of our mission to provide culturally competent, holistic, and wellness-focused services that promote social-emotional development, prevent the development of mental health challenges, and address social-emotional problems that currently exist. We strive to be a training facility for future counselors, and your provider may be under the supervision of Christine Nicklaus, MS, MS-Ed, NCC, LPC (WI & MI). This supervision measure is to ensure proper training and the ability to consult to provide the highest quality of care.

NO SHOW AND CANCELLATION POLICY:

It is the policy of this practice to monitor and manage appointment no-shows and late cancellations. If it is necessary to cancel an appointment, clients are required to call, text, or leave a message at least 24 hours before their appointment time.

If this does not occur, it will result in a **\$55.00 missed appointment fee**. This must be paid prior to rescheduling any appointments. The fee also applies if a client arrives 15 minutes or more after their scheduled appointment time.

DISCHARGE:

You may voluntarily discharge from the Agency at any time, for any reason. Please let us know if you would like to close your file.

Non-voluntary discharge may be necessary if:

1. The client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Agency.
2. The client refuses to comply with treatment recommendations, misses two appointments or more without notice, or does not make payment arrangements in a timely manner;
The client will Not be rescheduled and will be discharged. The client may appeal the decision with the Agency Director or request to reapply for services at a later date.

PAYMENT CONTRACT FOR SERVICES:

As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all clients. The financial policy is designed to clarify the payment policies as determined by the Agency.

The person responsible for payment of the account is required to sign a Payment Contract for Services.

Your insurance policy is a contract between you and the insurance company, we cannot guarantee coverage.

As a service to you, the Agency will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered, nor are we responsible for the collection of payments from the insurance company.

In some cases, insurance companies or other third-party payers may not cover certain services, or deem them as not reasonable or necessary. In such cases the person responsible for payment of the account is responsible for these service fees.

We charge our clients the usual and customary rates for the area, and the client or person responsible for payment on the account is responsible regardless of the insurance company's arbitrary determination of usual and custom rates.



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FEES FOR SERVICES:

Initial Assessment- \$225.00

Individual Counseling Session (60 minutes)- \$225.00

Interactive Complexity Fee- \$25.00

Missed Appointment Fee- \$55.00

A discount is available for clients with no insurance or those who opt to pay out of pocket without insurance claims.

Self-pay fees are due at the time of service.

SELF PAY FEES FOR SERVICES:

Initial Assessment- \$140.00

Individual Counseling Session (50 minutes)- \$90.00

Missed Appointment Fee- \$55.00

Insurance co-pays are due at the time of service.

For minors, the adult accompanying the minor is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency services unless charges have been preauthorized to an approved credit plan, charge card, or payment at time of service.

All co-insurance and/or deductible payments are due upon payment of your visit by your insurance plan.

The amount will be collected by the Agency until deductible accumulations can be verified as met by the insurance company or third-party provider.

Payment methods include check, cash, charge card, and health savings/flex spending (HSA/FSA) accounts.

I have read, understand, and agree with the provisions of the Financial Policy.

Signature of person responsible for account: _____ Date _____

Signature of co-responsible party: _____ Date _____

OPTIONAL- DISCOUNT RATE - WAIVER OF INSURANCE BILLING

If you have insurance coverage, but would like to take advantage of the self-pay discount rate, the agency will not bill your insurance. This may be beneficial if you have a high deductible or if counseling sessions are not a benefit covered by your plan. Waiver of insurance billing is NOT available if you have Medicaid.

If this applies to you, please acknowledge the following waiver:

I waive my right to have an insurance claim filed for these services. I chose to pay out of pocket and acknowledge that claims will not be submitted to my insurance by Peace Counseling & Support Services or myself.

I understand that I can cancel this waiver in the future if I chose to have my insurance billed, however claims cannot be backdated.

Signature of Client _____ Date _____



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RECURRING PAYMENT AUTHORIZATION FORM:

For recurring payments (co-ins/co-pays/deductibles) Peace Counseling & Support Services will automatically charge your Visa, MasterCard, American Express, or Discover Card (including Flex Spending or HAS cards).

Here is how recurring payments work at Peace Counseling & Support Services

You authorize regularly scheduled charges to be withdrawn from your debit or credit card. You will be charged your insurance statement amount (or dollar amount agreed upon at appt scheduling) for each billing period or session on or after the day of your session. A receipt for each payment will be provided to you, upon request. The charge will appear on your statement as an "ACH Debit". **You agree that no prior-notification will be provided, but agree to quoted or processed insurance benefits &/or office contracted out-of-pocket.**

☐ Visa	☐ MasterCard
☐ American Express	☐ Discover
Cardholder Name: _____	
Account Number: _____	
Exp Date: _____	
CVV: _____	
Email Address: _____	

Zip Code: _____

I _____ authorize Peace Counseling & Support Services to charge my credit card for each counseling session. I understand the quoted out-of-pocket expense may change, as insurance estimates are only quoted and not guaranteed. Peace Counseling & Support Services will follow through with charging the statement balance after insurance processes your claim. If a session is not cancelled with a minimum of 24-hour notice, as stated in the intake agreement, my card may also be charged a \$55.00 no show/late cancellation fee.

I understand this authorization will remain in effect until I cancel it in writing and I agree to notify Peace Counseling & Support Services in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I acknowledge that if the payment date falls on a holiday or weekend, and is also subject to office work hours, the payment may be executed the next business day or after. I acknowledge the origination of ACH transactions to my account must comply with provisions of U.S. law. I certify that I am an authorized user of this debit/credit account and will not dispute these scheduled transactions with my bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form.

Signature _____ **Date** _____



TELEHEALTH INFORMED CONSENT

Peace Counseling & Support Services offers telehealth services as an alternative to in-person appointments when clinically appropriate. Telehealth allows behavioral health services to be provided using secure audio and/or video technology.

By signing this form, you acknowledge that you have read, understand, and agree to the following:

Nature of Telehealth Services

Telehealth is the delivery of mental health counseling services using secure electronic communication technology. Services provided through telehealth are intended to be comparable to in-person counseling and may include:

- Mental health assessment and evaluation
- Individual psychotherapy
- Family or couples counseling (when clinically appropriate)
- Treatment planning and review
- Psychoeducation and skill development
- Care coordination and consultation

Benefits of Telehealth

Potential benefits include:

- Increased access to mental health services
- Reduced travel time and expenses
- Greater scheduling flexibility
- Continuity of care when travel, illness, weather, or other circumstances make in-person appointments difficult

Potential Risks and Limitations

While telehealth provides many benefits, there are also potential risks, including:

- Technology failures, poor internet connectivity, or interruptions
- Reduced ability to observe nonverbal communication compared to in-person sessions
- Possible unauthorized access if you do not use a private, secure location
- Technical difficulties that may require rescheduling or completing the session by telephone when clinically appropriate

No guarantees can be made regarding the outcome of treatment provided through telehealth.

Confidentiality

Peace Counseling & Support Services uses HIPAA-compliant technology to protect the privacy and confidentiality of your health information whenever possible.

Although reasonable safeguards are used, no electronic communication system can guarantee absolute security.

You are responsible for participating in telehealth sessions from a private location where conversations cannot be overheard by others unless you have invited another person to participate in the session.

The same confidentiality protections and legal limitations that apply to in-person counseling also apply to telehealth services, including mandatory reporting requirements and situations involving imminent risk of harm to yourself or others.



Emergencies

Telehealth is not intended for emergency or crisis situations.

If you are experiencing a mental health emergency, thoughts of harming yourself or someone else, or another life-threatening emergency, immediately:

- Call 911; call or text the Suicide & Crisis Lifeline at **988**; or go to the nearest emergency department.

Because your therapist may not be physically located near you during telehealth services, you agree to provide your physical location at the beginning of each telehealth session and to provide an emergency contact when requested.

Technical Difficulties

If a telehealth session is interrupted due to a technology failure:

1. Your therapist will attempt to reconnect using the telehealth platform.
2. If reconnection is unsuccessful, your therapist may contact you by telephone using the number you have provided.
3. If the session cannot be completed, it may be rescheduled.

Client Responsibilities

By participating in telehealth services, you agree to:

- Participate from a safe, private location.
- Use a secure internet connection whenever possible.
- Minimize distractions during the session.
- Avoid recording sessions unless both you and your therapist provide prior written consent.
- Notify your therapist if anyone else is present during the session.

Right to Withdraw Consent

Participation in telehealth services is voluntary.

You have the right to withdraw your consent for telehealth services at any time without affecting your right to receive in-person services, when available and clinically appropriate.

Your therapist may also determine that telehealth is no longer clinically appropriate and recommend transitioning to in-person services or another level of care.

Consent

I certify that:

- I have read and understand this Telehealth Informed Consent.
- I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.
- I understand the benefits, risks, and limitations of telehealth services.
- I understand that confidentiality protections and legal exceptions apply equally to telehealth.
- I understand that telehealth is not appropriate for emergencies.
- I voluntarily consent to receive behavioral health services through telehealth at Peace Counseling & Support Services.

Client Name: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian (if applicable): _____ Date: _____

Therapist/Counselor Signature: _____ Date: _____



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CONSENT FOR TREATMENT OF A MINOR

I certify that I am the parent or legal guardian of the minor identified in this intake packet, or that I otherwise have the legal authority to consent to behavioral health treatment on the minor's behalf. I voluntarily authorize **Peace Counseling & Support Services** to provide outpatient mental health assessment, counseling, psychotherapy, treatment planning, and other clinically appropriate behavioral health services to the minor.

I understand that effective counseling requires a relationship built on trust and open communication. While I have legal rights regarding my child's treatment and access to information as permitted by Wisconsin and federal law, I understand that the therapist may maintain appropriate confidentiality regarding information shared by the minor during counseling when doing so is clinically appropriate and in the minor's best interest. The therapist will encourage open communication between the minor and parent(s)/guardian(s) and will share information necessary to support treatment, ensure safety, and comply with applicable laws and professional ethical standards.

I understand that confidentiality may be limited in circumstances including, but not limited to, suspected abuse or neglect of a child or vulnerable adult, court orders, medical emergencies, or when the therapist believes the minor presents a serious risk of harm to themselves or others. In these situations, Peace Counseling & Support Services may disclose information as required or permitted by law.

I understand that I have the right to ask questions regarding my child's treatment, to participate in treatment planning when appropriate, and to withdraw my consent for treatment at any time, unless otherwise prohibited by law or court order. I acknowledge that I have received information regarding my rights and responsibilities, have had the opportunity to ask questions, and voluntarily consent to treatment for the minor.

Name of Minor: _____

Parent/Legal Guardian Name: _____

Relationship to Minor: _____

Parent/Legal Guardian Signature: _____ **Date:** _____