

Patient Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE LAST

Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Age\_\_\_\_

Relationship status: ❑Married ❑Single ❑Divorced ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

*Only list numbers and email addresses that you approve us to call, text, or email, identifying our self to whomever receives this communication as “Men’s Therapy”.*

Cell Phone (\_\_\_\_) \_\_\_\_\_\_- \_\_\_\_\_\_\_\_ Secondary Phone (\_\_\_\_) \_\_\_\_\_\_- \_\_\_\_\_\_\_\_

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

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ *Signed Release*

Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ *Signed Release*

**Referred by / How did you hear about us? (please be specific):**

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



**Disclosure and Consent**  
I am pleased that you have selected me to be your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

INITIAL **each paragraph to indicate you have been fully informed, understand, and agree:**

**\_\_\_ FINANCIAL/INSURANCE ISSUES:** I understand & acknowledge that I am responsible for all charges for services and materials, including those not covered by insurance. I give Men’s Therapy, LLC the right to keep my credit/debit card on file and to charge it for any unpaid fees. I understand that all known fees are due before each session. If, after 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held liable for any collection fee charged to our office to collect the debt owed. If at any time you have any questions regarding insurance, fees, balances or payments, do not hesitate to ask.

**\_\_\_ 24-HOUR CANCELLATION AGREEMENT:** I understand that counseling appointments are limited and another client may be on a waiting list for a session to open. I understand that if I do not cancel more than 24-hours before my appointment I will be charged and pay half the session fee.

**\_\_\_ CONFIDENTIALITY**: I understand my verbal communication and clinical records are strictly confidential except for: a) information you and your child or children report about physical or sexual abuse; then, by Wisconsin State Law, this office is required to report this information to the Wisconsin Department of Children and Family Services, b) information shared with your insurance company to process your claims, c) where you sign a release to have specific information shared, d) if you provide information that informs your therapist that you are in danger of harming yourself or others, d) meeting with a Professional Clinical Counselor licensed by the State of Wisconsin for reasons of consultation, e) on the rare occasion that a court subpoenas records. If during the course of treatment you have any questions about the goals, procedures, or nature of your treatment, or about office procedures or fees, please feel free to ask.  
**\_\_\_ COMMUNICATION**: By signing below I give my permission to receive phone calls, text messages, or emails to confirm appointments and communicate with staff from HIPAA-Compliant sources. By signing this agreement the client acknowledges that they understand and are aware of the level of risk inherent to client confidentiality when using or requesting any form of electronic data transmission (email, fax, voicemail, and/or text messages), as these forms of communication cannot be guaranteed to be secure and may be intercepted by a third party. The client agrees by signing this document to receive electronic data transmissions as listed above from Men’s Therapy, LLC. and/or its software provider: Office Ally.

**\_\_\_ NEWSLETTER:** I consent to receive Men’s Therapy, LLC newsletter, containing news, mental health information, links to our site, links to external sites, and promotions by email or standard mail. You may unsubscribe at any time.  
\_\_\_ **SESSIONS**: I accept clients into my practice who I believe have the capacity to resolve their issues with my assistance. Some clients only need a few sessions to make the changes they desire and others may require longer term therapy which could last months and in some cases years. You have the right to end treatment at any time; however, it is recommended that we discuss this decision to make sure you have considered all the options and potential results of ending treatment. If counseling is successful, you should feel better able to face life’s challenges without my continued support and intervention. It may be common for patients to lessen session frequency over time, eventually using sessions for maintenance only.

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you. If you have any questions, please feel free to ask.

\_\_\_ **THERAPIST/PATIENT RELATIONSHIP**: Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Thank you for not inviting me to social gatherings, offering gifts, or asking me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. You will learn a great deal about me as we work together during your counseling, however, you must realize that you are only experiencing me in my professional role.

**\_\_\_** By signing this agreement you are authorizing the clinician to see the client at either the main office any of the satellite locations held by Mens Therapy, LLC.

**\_\_\_ EMERGENCY SITUATIONS:** If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian agrees that they will contact the emergency services in the community for emergency services (i.e. dial 911). I release Carl Mothes, LPC and Men’s Therapy, LLC of any liability for emergencies outside of my counseling session. I understand that Carl Mothes, LPC and Men’s Therapy, LLC does **not** take emergency or after-hours calls. Carl Mothes, LPC and Men's Therapy, LLC will follow any emergency services with standard counseling and support to the client or the client’s family in a timely manner.  **NWC Crisis Line 888-552-6642**

**I understand, attest, and agree to the above. I understand that payment for services is due before each session:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_

PATIENT SIGNATURE DATE



**Financial Policy**

**We will always work with patients to keep their out-of-pocket expenses as affordable as possible.**

**Fees:** Counseling sessions are typically approximately 50 minutes long. The fee for a session is $125. **Payment is collected before your session**. We can automatically bill your credit/debit card at each session at your request.

**Insurance Patients:** For reasons of maintaining the highest level of confidentiality *Men's Therapy, LLC* does not contract with insurance companies. We will be glad to provide you with a “Superbill” which you can submit to your insurance company. If you choose to do this, please verify your benefits for “out-of-network” providers to avoid surprises.

**Self-Pay Patients:** Patients are responsible for the total cost of their care. Payment in full is due before each session.

**Advanced Payment Discount:** You may be eligible for an Advanced Payment Discount if you self-pay. You may pay up to 20 sessions (10 sessions minimum) in advance and receive a 20% discount. Payment must be made before the prepaid visits. Let the receptionist or your therapist know you are interested in this discount.

**Methods of Payment:** *Men's Therapy, LLC* accepts cash, check, debit cards, and major credit cards.

**Missed Appointment Policy:** 24-hour notice is required for cancellation of an appointment. Appointments not rescheduled or cancelled with less than 24-hours notice will be charged at half your full session fee. Your charge will be applied to your debit/credit card on file or to your prepaid balance.

**Credit / Debit Card Guarantee**

*We require a Credit/Debit card for each of our patients to guarantee their account, unless cash payments are made before each session.* ****

**Patient Balances**

Any balance not paid by the end of the week will be automatically charged to your designated card below. This procedure will enable you to spread out your payments while keeping your account current. A partial payment plan may be arranged as well (*sign Payment Plan Agreement*). Please contact us for details.

*I agree to the above terms and authorize you to charge payment to my credit/debit card on file.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_

PATIENT SIGNATURE DATE

Cardholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Exp Date: \_\_\_\_ /\_\_\_\_\_ 3-digit CID #: \_\_\_\_\_\_



**Consent for Coordination Of Care**

**With Primacy Care Physician**

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

**Name of Patient Making Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician Location/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I acknowledge that this mental healthcare facility, in accordance with their Notice of Privacy Practices (NOPP) and the Omnibus HIPAA law, will release Patient Health Information derived from my treatment records to the physician listed above. I have reviewed the NOPP of this mental healthcare facility and have been given an opportunity to ask questions about it, understand it, and agree to its terms. A copy of this signed, dated consent shall be effective as the original.

I release, hold harmless, and agree to indemnify this mental healthcare facility, its employees, and its agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

I specifically authorize this mental healthcare facility to use and disclose verbally, by mail, fax, or encrypted email the following type of super-confidential information as stated in the NOPP:

\_\_\_\_\_\_ Psychotherapy Records

*(Initial)*

I also understand that I may withdraw my consent at any time by informing this office in writing.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

-OR-

Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Representative Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Regarding Testimony**

Men’s Therapy, LLC has a policy against therapists testifying as a non-party witness in legal proceedingsabout therapy sessions with you, your partner, and/or your child. This is true even when you are the one requesting us to testify.

If you are currently involved in (or think you will become involved in) litigation of any kind, including a divorce or a child custody case, please let your therapist know immediately.

Below are some of our reasons for choosing not to provide testimony.

1. **Confidentiality is essential to therapy**. As a psychotherapist, our job is to develop a trusting relationship with you so you can share personal information without fear of judgment. Without your trust, treatment is much less successful. Our policy allows our clients to trust that we will not reveal their confidences unless legally required to do so.
2. **Testimony may be harmful to your progress in therapy.** In therapy, we use an approach called “unconditional positive regard” to support you as you make important changes. When testifying, we have a duty to answer questions from a more objective viewpoint. This creates a conflict of interest. Hearing unexpected or unfavorable testimony can damage clients’ trust in us and undo our work.
3. **We are biased witnesses not likely to help the court.** As a treating psychotherapist, our clinical role is to develop a strong alliance with and bias in favor of our clients. As a result, we are not able to be a neutral, expert witness regarding your case. Our usefulness as a fact witness is also limited for this reason.
4. **Testifying is very disruptive to our practice**. Psychotherapy clients are often in distress. Having to cancel appointments can be harmful to our other clients. Also, it can be difficult to meet financial obligations when we do not see clients as scheduled.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_

PATIENT SIGNATURE DATE

**Agreement Not To Seek Testimony**

I hereby acknowledge that Men's Therapy, LLC (“MT”) and Carl Mothes (“Therapist”) have informed me how involving a treating psychotherapist as a non-party witness in legal proceedings can create conflicts of interest and negatively impact therapy, reducing the possibility of a successful treatment outcome.

I also acknowledge that involving MT and/or Therapist as a non-party witness in legal proceedings would be disruptive to his/her practice and unfairly impose upon him/her.

It is with this understanding that I hereby agree,as a condition upon which MT and Therapist has consented to provide therapy,thatI (or my legal representative) will not call, subpoena, or otherwise seek to compel MT or Therapist to provide oral or written testimony as a non-party witness in a legal proceeding with respect to his/her assessment, evaluation, or treatment of me, my partner, or my child.

I agree that such attempts to seek MT or Therapist’s testimony as a non-party witness shall constitute a basis upon which a court should quash any subpoena or issue a protective order, and I agree to be responsible for and to pay for any attorney fees and costs incurred by MT or Therapistin attempting to secure enforcement of, and compliance with, this agreement.

I also agree that Therapist, whether in the role of fact or expert witness, is entitled to recover from me his/her current professional rate of $500 per hourfor any time he/she spends providing, preparing to provide, or traveling to provide oral or written testimony as a non-party witness in a legal proceeding in which I or my representative seek his/her testimony. This includes testimony compelled by a court order.

Finally, I agree to deliver to MT or Therapist a retainer of $2,000 before he/she provides any oral or written testimony as a non-party witness in any legal proceeding in which I or my representative seek his/her testimony.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_

PATIENT SIGNATURE DATE

**Acknowledgement of Receipt of Notice of Privacy Practices**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

**I acknowledge that I have received a copy of this office’s Notice of Privacy Practices.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Please print your name here

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

□ The patient refused to sign.

□ Due to an emergency situation, it was not possible to obtain an acknowledgment.

□ We we not able to communicate with the patient.

□ Other (please provide specific details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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