





## INFORMED CONSENT FOR MENTAL HEALTH & ASSESSMENT SERVICES

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

Cathedral Home offers a range of services to include individual, family, and group therapies, substance use and mental health evaluations, and case management services. The purpose of treatment is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be ready to talk to a counselor or therapist about these problems. Or you may be here because someone in your life had concerns about you. When you meet with your counselor and/or treatment team, you will discuss these problems. They will ask questions, listen to you, and suggest a plan for improving these problems. It is important that you feel comfortable talking about the issues that are bothering you. Sometimes these issues will include things you don't want your family members to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor and treatment team.

Under the Health Insurance Portability and Accountability Act (HIPAA), Cathedral Home is required by law to maintain the privacy of protected health information (PHI). Most of the information you share with the staff of Cathedral Home is confidential and no information will be released outside the agency without written consent from you (or your parent/guardian if under 18). There are, however, important exceptions to this rule that are important for you to understand before you share personal information in counseling. Confidentiality cannot be maintained when:

- You tell someone you plan to cause severe harm or death to yourself. If you are under 18 years of age, steps must be taken to inform a parent or guardian of what you have disclosed and how serious the threat is believed to be.
- You tell someone you plan to cause severe harm or death to someone else who can be identified. We must inform the person whom you intend to harm. If you are under 18 years of age, steps must be taken to inform a parent or guardian of what you have disclosed.
- You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, we will need to use professional judgment to decide who should be informed.
- If you are under 18 years of age and you tell someone you are being abused - physically, sexually, or emotionally - or that you have been abused in the past. In this situation, we are required by law to report the abuse to the Wyoming Department of Family Services.
- You are involved in a court case and a request is made for information about your therapy. If this happens, we will not disclose information without your written agreement unless a court requires us to do so. If we are required by the court to disclose information, our attorney will review the validity of this request.
- Permitted uses listed in Cathedral Home's Notice of Privacy Practice Act

If you are under 18 years of age, there may be times when your counselor and/or treatment team feel that it would be important for your parents to know what is going on in your life. In these situations, we will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, we may sometimes describe problems in general terms, without using specifics, to help them know how to be more helpful to you.

## SERVICES

The mental health services we provide include individual, family, and group therapy, and any testing that is pertinent to treatment and/or substance use and mental health evaluations. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. For therapy to be most successful, you will have to work on things we talk about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

Your counselor and treatment team will offer you some sense of what therapy will entail and how they will work with you to address your concerns. If you have questions about your program, you should discuss them with your counselor whenever they arise. You have the right to ask for the rationale for any aspect of your treatment or to decline any part of your treatment.

When you participate in testing, you have the right to an explanation of what the test or tests being administered are for and how they contribute to your treatment program and/or evaluation, and you may decline participation at any time. You also have the right to a summary (which may be either verbal or written) of any test results. This testing gives us the basis for knowing you and how to get you through your treatment program as quickly as possible.

Individual counseling appointments are generally for 50 minutes and are typically scheduled once per week. Therapy groups usually meet once a week for approximately 60 minutes.

A range of mental health professionals, some of whom are provisionally licensed (in training), provide services at Cathedral Home. All professionals-in-training are supervised by licensed staff, as required by Wyoming Medicaid and Mental Health Licensing Board Standards.

While psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories.

There are risks inherent in these activities, and while every precaution is taken to minimize these risks, the potential exists for unintended outcomes.



## TELEHEALTH

Telehealth is a way for you to virtually meet with your counselor via video or phone. At Cathedral Home, we administer Telehealth through two HIPAA secure platforms – Microsoft Teams and BestNotes.

It is important to understand that utilizing Telehealth may feel different than an in-person visit and that technical problems may interrupt or stop your session.

Sessions are not recorded and will be conducted in a private and confidential manner. It is important that if you use Telehealth, you too are in a private, comfortable place that minimizes interferences and distractions.

You can choose to stop or start Telehealth as your preferred method at any point.

## PROFESSIONAL RECORDS

The laws and standards of our profession, and the HIPAA Privacy Rules require that we keep Protected Health Information (PHI) about you in your clinical record. Your clinical record may include some or all of the following: information about your reasons for treatment, a description of the ways in which your problem affects your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests, any past treatment records that we receive from other providers, reports of any professional consultations, and copies of any reports that have been sent to anyone.

Your clinical record serves as a:

- basis for planning your care and treatment
- means of communication among the health professionals who may contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Cathedral Home. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI. We encourage you to read it in full – it can be found at [www.cathedralhome.org/privacy](http://www.cathedralhome.org/privacy)

## MINORS

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. Before giving parents any information, we will discuss this with you, if possible, and do our best to handle any objections you may have with what is shared.

## ACKNOWLEDGEMENT

Your signature indicates you have read this information and agree to its terms during your utilization of services with Cathedral Home.

Client Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_



## OUTPATIENT COUNSELING - CLIENT INFORMATION

### PERSONAL INFORMATION

Client Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_ Pronouns: circle all that apply: they them she her he him other \_\_\_\_\_

SSN: \_\_\_\_\_ Parent/Guardian Name(s) for clients under 18: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_ Email: \_\_\_\_\_

is it OK to leave voicemails at this number? \_\_\_\_\_ Receive text messages? \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Referred By (if any): \_\_\_\_\_

Student  Unemployed  Employed  Occupation: \_\_\_\_\_

Have you sent a picture (front + back) of your insurance card to [outpatientservices@cathedralhome.org](mailto:outpatientservices@cathedralhome.org)?

yes  not yet  I need help with this

### FAMILY & RELATIONSHIPS

Who resides in your household with you? \_\_\_\_\_

Do you feel safe in your current home? \_\_\_\_\_

Describe your relationship with those you live with: \_\_\_\_\_

Do you have a significant other/partner/are you in a committed relationship? \_\_\_\_\_

Has any member of your family ever experienced any emotional, mental, or drug/alcohol-related issues?

yes  no

If yes, please describe: \_\_\_\_\_



## COUNSELING NEEDS

What do you consider to be some of your needs? \_\_\_\_\_

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What significant life changes or stressful events have you experienced recently, if any? \_\_\_\_\_

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What do you hope to achieve during your time in counseling? \_\_\_\_\_

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What do you consider to be some of your strengths? \_\_\_\_\_

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What should we know about your culture, values, and religious beliefs? \_\_\_\_\_

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Are you interested in working with our horses for therapy (Equine Assisted Psychotherapy, EAP)?

yes     no     tell me more

Have you ever been assessed for/diagnosed with a learning disability?  yes  no

If yes, please describe: \_\_\_\_\_

Are you a student?  yes  no                      Currently Employed?  yes  no

How do you feel about your current school/work situation? \_\_\_\_\_

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What else would you like your therapist to know about you? \_\_\_\_\_

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## TREATMENT HISTORY

Have you ever been given a psychiatric diagnosis?  yes  no

If yes, please describe: \_\_\_\_\_ When? \_\_\_\_\_

Have you ever been treated for a substance use issue?

If yes, where: \_\_\_\_\_ When? \_\_\_\_\_  inpatient  outpatient

Duration of treatment: \_\_\_\_\_

Have you received mental health services before or are you currently?  yes  no

If yes, where: \_\_\_\_\_ When? \_\_\_\_\_  inpatient  outpatient

Duration of treatment: \_\_\_\_\_ Diagnosis/Purpose: \_\_\_\_\_

Have you ever had psychological testing?  yes  no

If yes, please describe and include dates + reason: \_\_\_\_\_

List any support groups you have attended: \_\_\_\_\_

Was support group attendance helpful?  yes  no  n/a

Have you ever been involved with the legal system?  yes  no

If yes, please describe: \_\_\_\_\_

If you have participated in therapy/counseling in the past or received treatment, how would you describe the experience and outcomes? \_\_\_\_\_

## PHYSICAL HISTORY

What medications are you currently taking? include over-the-counter, prescriptions, other drugs

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List any vitamins or supplements you take: \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Do you carry an inhaler or epinephrine pen?  yes  no If yes, name/type: \_\_\_\_\_

Are you under the care of a physician for any ongoing medical needs?  yes  no

Please describe: \_\_\_\_\_

Please list any surgeries, serious illnesses, hospitalizations: \_\_\_\_\_

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When was your last physical exam/checkup with a doctor: \_\_\_\_\_

Are you involved in any sports or activities? Please describe: \_\_\_\_\_

What things do you enjoy/hobbies do you practice? \_\_\_\_\_

Have you experienced a weight change recently?  loss  gain Approximate Number: \_\_\_\_\_

Have you noticed any recent changes in:

appetite  mood  sleep  energy \_\_\_\_\_

Do you use alcohol?  yes  no Frequency:  daily  weekly  monthly

Do you use tobacco?  yes  no Frequency:  daily  weekly  monthly

Do you use caffeine?  yes  no Frequency:  daily  weekly  monthly

Is there anything your therapist should know about your mobility and comfort during sessions?

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## AREAS OF NEED

Below is a list of issues and areas of functioning in which some people experience difficulties. Using the scale below, write in the rating column the number that best describes the degree of difficulty you have been experiencing in each area.

- 1 - NO DIFFICULTY
- 2 - A LITTLE
- 3 - MODERATE
- 4 - QUITE A BIT
- 5 - EXTREME

Please respond to each item. If there is an area you find to be inapplicable, indicate that with a 0.

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:	RATING	FOR HOW LONG?
managing day-to-day life (personal care + hygiene, getting places on time, handling money, making everyday decisions)		
household responsibilities (shopping, cooking, laundry, cleaning)		
school (academic performance, completing assignments, attendance)		
work (completing tasks, performance level, finding/keeping a job)		
adjusting to stress (relationship difficulties, moving, new job, death in the family)		
family relationships		
peer and friend relationships		
isolation, feelings of loneliness		
lack of confidence, feeling bad about yourself		
lack of interest in things, apathy		
depression, hopelessness		
suicidal feelings or behavior		
physical symptoms (headaches, aches and pains, sleep disturbance, digestive issues, dizziness)		
fear, anxiety, panic, or worry		
confusion, concentration, memory		
mood swings, unstable mood		
uncontrollable behavior or compulsions (eating, hand-washing, hurting yourself)		
controlling temper, outbursts of anger, violence		
impulsive, reckless, or illegal behavior		
addictive patterns (gaming, gambling, pornography, substances)		



please contact me about financial assistance

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

## FEE AGREEMENT & FINANCIAL POLICY FOR MENTAL HEALTH & ASSESSMENT SERVICES

Cathedral Home strives to ensure that every client receives quality care regardless of ability to pay. Cathedral Home can offer financial assistance to help you pay for the services you receive. In order to determine if you qualify for assistance, please ensure that you select "please contact me about financial assistance" above. The various financial assistance options can be discussed with our Client Services Advocate.

please bill my health insurance       I will self-pay

### INSURANCE/MEDICAID

Your health insurance is a contract between you and your insurance company and should be viewed as a method to help pay for care. As a service to you, we will contact your insurance company prior to your first appointment in an attempt to verify your insurance benefits (if you provide us with the information before you come in). Please keep in mind that insurance companies DO NOT guarantee payment for services, and you are ultimately responsible for any expense incurred if your insurance does not pay what you expected they would. It is in your best interest to be aware of your outpatient mental health benefits (in-network and out of network) before you come to your first appointment. We will submit claims to your insurance company if you provide us with current insurance information. Depending on the insurance company our fees may or may not be considered usual and customary. Insurance companies use many different equations to form a fee schedule.

Cathedral Home accepts and processes insurance payments through a variety of insurance providers. If you are using insurance to pay for our services, then we will:

1. File your claim with your insurance provider
2. Receive payment from your insurance provider
3. Expect that you will pay your portion due of co-insurance, deductible, or fee-difference upon receipt of invoice.

Cathedral Home bills insurance as a courtesy, and you (not your insurance company) are ultimately responsible for your bill balance due. If your insurance company denies a claim filed on your behalf, then you are responsible for paying Cathedral Home for services rendered.

By signing below, I agree to:

1. Allow Cathedral Home to bill my insurance for services provided
2. Give permission for Cathedral Home to release information to my insurance company that is required to process payment and act as my authorized representative to obtain payment
3. Assign my rights to claims and payment by my insurance to Cathedral Home
4. Assist with the claims process as requested by Cathedral Home or my insurance provider

I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in counseling are reimbursed by insurance companies.

Printed Client Name \_\_\_\_\_ Date \_\_\_\_\_

Client/Guardian Signature \_\_\_\_\_



## SELF-PAYMENT

If you choose to self-pay (not through an insurance company), our policy requires payment upon receipt of invoice.

### Self-Payment for Services

I will self-pay for outpatient services at Cathedral Home. I agree to the fee schedule outlined in this document. I understand that payment for services is due when I receive an invoice.

Printed Client Name \_\_\_\_\_ Date \_\_\_\_\_

Client/Guardian Signature \_\_\_\_\_

## ACKNOWLEDGEMENTS

### CANCELATIONS AND MISSED APPOINTMENTS

<p>Insurance carriers will not pay for late cancelations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancelations should be made at least 24 hours in advance. Although 24 hours is preferred, if you need to cancel or reschedule, please give as much notice as possible. You may notify our office of cancelation by phone or email to your counselor. Late cancelations (Fewer than 24 hours before the appointment) will incur a fee of \$35.00.</p>	<p>_____ Initial to acknowledge</p>
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### PAST-DUE ACCOUNTS

<p>Amounts past-due by more than 30 days will incur a late fee each month of \$25.00. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, Cathedral Home may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney, or going through small claims court. If such legal action is necessary, you will be responsible for those costs.</p>	<p>_____ Initial to acknowledge</p>
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## SERVICE RATES

- Individual Therapy (60 min) \$175
- Brief Individual Therapy (45 min) \$130
- Brief Individual Therapy (30 min) \$100
- Family Therapy (60 min) \$200

\*this list reflects most commonly used service but is not all-encompassing of available services

### ADDITIONAL FEES

- Late cancelations/missed appointments w/ failure to notify: \$35.00
- Non-sufficient funds or bounced check: \$25.00
- Past-due accounts – over 30 days: \$25.00 per month



## SIGNED AGREEMENTS

I have read the agreement and policy above and have been offered a copy for my records. I understand the policy and by my signature below, agree to its terms in association with outpatient counseling services provided by Cathedral Home.

Printed Client Name \_\_\_\_\_ Date \_\_\_\_\_

Client/Guardian Signature \_\_\_\_\_

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## CARD ON FILE

If you would like to keep credit card information on file to be used as a form of payment for fees incurred, please complete the following.

A receipt will be emailed to you at the address you specify below.

Card # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration \_\_\_\_/\_\_\_\_ Security Code \_\_\_\_\_ Billing zip code \_\_\_\_\_

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

Email \_\_\_\_\_

I authorize Cathedral Home to charge this card as needed according to the terms specified in this agreement and policy.

Printed Client Name \_\_\_\_\_ Date \_\_\_\_\_

Client/Guardian Signature \_\_\_\_\_

## CONCERNS & GRIEVANCES PROCEDURES

As a client of Cathedral Home you have the right to receive high-quality services. If you believe the services you receive have not been satisfactory, we would like the opportunity to discuss your concerns with you. As we promote open communication between our clients and staff, we encourage you to communicate with the counselor you are working with to resolve the issue. If this is not possible for some reason, or your attempt to resolve the conflict with the counselor is unsuccessful, you have the right to contact:

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<p><b>Stacey Scholl, MAE, LPC</b> Clinical Director 4989 N Third St, Laramie, WY 82072 (307) 745-8997 sscholl@cathedralhome.org</p>	<p><b>Nicole Hauser, MSW, LCSW</b> Executive Director 4989 N 3rd Street, Laramie, WY 82072 (307) 745-8997 nhauser@cathedralhome.org</p>
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If you have a safety or quality of care concern that is not resolved by our administration, we encourage you to contact the Joint Commission via:

**The Office of Quality & Patient Safety**  
**The Joint Commission**  
1 Renaissance Blvd.  
Oakbrook Terrace, IL 60181  
www.jointcommission.org  
1 (800) 994-6610



## ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES PROTECTED HEALTH INFORMATION (PHI)

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Cathedral Home. Our Notice of Privacy Practices provides information about how we may use and disclose clients' Protected Health Information (PHI). We encourage you to read it in full at [cathedralhome.org/privacy](http://cathedralhome.org/privacy).

Our Notice of Privacy Practices is subject to change and we have reserved the right to do so if necessary. If we change our notice, you may obtain a copy by contacting Cathedral Home.

Please find a complete version of Cathedral Home's Privacy Policy: [cathedralhome.org/privacy](http://cathedralhome.org/privacy)

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Client, over 18 years old: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

Cathedral Home attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices, but Acknowledgement was unable to be obtained due to:

Reason: \_\_\_\_\_

\_\_\_\_\_

Signature of Cathedral Home Representative: \_\_\_\_\_ Date: \_\_\_\_\_