



Into the Woods
WELLNESS

Welcome to Into the Woods Wellness, LLC—we are so glad you're here. We value a collaborative partnership with our clients and this document contains important information so you are an informed client throughout this therapeutic journey. This document contains important information about my professional services as well as counseling policies to ensure that you are knowledgeable about your therapeutic journey. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, and health care operations.

Signing this document represents an agreement between you and Into the Woods Wellness, LLC. We can discuss any questions you have when you sign or at any point in the future. Please read them carefully and let us know what questions you have.

Initial and Date: _____

Complimentary Wellness Services Provided by a Supervised Intern

As part of our commitment to community healing and accessible wellness, Into the Woods Wellness, LLC is proud to offer free services provided by a qualified intern who is actively completing their clinical or professional training.

These services are:

- Completely free of charge
- Offered in person or virtually, depending on availability
- Delivered by an intern who is receiving close supervision and mentorship from Kaitlyn Kenealy, MA, LPC, CEO of Into the Woods Wellness

Please Note:

While your sessions are with a student-intern, they are thoughtfully designed to provide support, guidance, and care within the scope of their training. All services are reviewed and overseen by Kaitlyn Kenealy, MA, LPC, to ensure safety, quality, and ethical standards.

We believe in empowering future wellness professionals through hands-on learning while also increasing access to holistic care for our community.

If you have any questions about the internship program or your services, please don't hesitate to reach out to our team.

UNDERSTANDING COUNSELING: WHAT TO EXPECT

We're so glad you're here and we are looking forward to supporting your needs through the counseling process. Engaging in counseling can bring about a range of emotions, including sadness, anxiety, or frustration. This is because therapy often involves discussing challenging aspects of your life. While these feelings may arise, many individuals find that counseling leads to positive changes, such as:

- Reduced distress and emotional pain
- Improved relationships
- Greater self-awareness
- Enhanced stress management skills
- Solutions to specific problems

- Emotional healing

Although many people experience positive outcomes, it's important to note that outcomes can vary, and there are no guarantees in the therapeutic process.

YOUR ROLE IN THE COUNSELING PROCESS

For therapy to be effective, your active participation is essential. This means engaging in sessions, reflecting on discussions, and practicing new skills or perspectives outside of our sessions.

BEGINNING OUR WORK TOGETHER

In our initial sessions, we'll conduct a thorough assessment to understand your needs. By the end of this evaluation, I'll share my initial thoughts on how we can work together. We'll then discuss your goals and develop a plan tailored to you.

It's important that you feel comfortable with our approach. If you have any questions or concerns, please bring them up. If you're uncertain about proceeding, I'm here to help you explore other options or refer you to another professional for a second opinion.

YOUR RIGHTS AND CHOICES

- Voluntary Participation: You have the right to begin or discontinue counseling at any time.
- Confidentiality: What you share in sessions is private, with certain legal exceptions.
- Informed Decisions: You should feel fully informed about your treatment and comfortable with the process.

By signing this agreement, you authorize and request that Into the Woods Wellness, LLC provide counseling services, including any assessments or procedures that may be necessary during your treatment. If you have any questions or need further clarification, please don't hesitate to ask. Your understanding and comfort are my top priorities.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each party. As a client in psychotherapy, you have certain rights and responsibilities. There are also legal limitations to those rights you should be aware of. As your therapist, I have responsibilities to you, as well. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems, however there are no guarantees regarding the outcome of therapy. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. By signing this agreement, you are authorizing and requesting that Into the Woods Wellness, LLC carry out counseling treatment and/or diagnostic procedures now or during the course of your treatment.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion or assist with the referral process.

Initial and Date: _____

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices that we went through during the intake and upon request you can have another copy provided to you. Please remember that you may reopen the conversation at any time during our work together.

At Into the Woods Wellness, LLC we abide by HIPPA and state guidelines when it comes to your confidentiality. We store your information on a private HIPPA compliant platform. Per Wisconsin guidelines, your confidentiality is protected unless: 1) there is a reasonable suspicion of child, dependent or elder abuse or neglect 2) the client presents a danger to themselves, to other(s), to property 3) court ordered issues.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Protected health information (PHI) is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, and the provision of health care services.

Use and Disclosure of Protected Health Information

At Into the Woods Wellness, LLC we understand that health information about you and your health care is personal and confidential. We are committed to protecting health information about you. We use and disclose the minimum necessary health information about you for treatment, and for Into the Woods Wellness, LLC's mental health care operations. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

The following categories describe the different ways that Into the Woods Wellness, LLC may disclose health information:

- For Treatment: At Into the Woods Wellness, LLC we can internally disclose health information for treatment within the organization. For example: If you are referred to another provider within the organization or if you sign a ROI (Release of Information) for us to discuss your treatment with another provider or agency.
- Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the client/client to use or disclose the client/client's

personal health information without the client's written authorization, to carry out the health care provider's own treatment, or health care operations. We may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

- **Lawsuits and Disputes:** If you are involved in a lawsuit, Into the Woods Wellness, LLC may disclose health information in response to a court or administrative order. We may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Certain Uses and Disclosures Require Your Authorization:

1. **Psychotherapy Notes.** At Into the Woods Wellness, LLC we keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

- For use in treating you.
- For use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
- For use in defending myself and Into the Woods Wellness, LLC in legal proceedings instituted by you.
- For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- Required by law and the use or disclosure is limited to the requirements of such law.
- Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- Required by a coroner who is performing duties authorized by law.
- Required to help avert a serious threat to the health and safety of others.
- **Marketing Purposes.** As a psychotherapist, we will not use or disclose your PHI for marketing purposes.
- **Sale of PHI.** As a psychotherapist, we will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization:

Subject to certain limitations in the law, Into the Woods Wellness, LLC can disclose your PHI without your Authorization for the following reasons:

- When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
- For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
- For health oversight activities, including audits and investigations.
- For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
- For law enforcement purposes, including reporting crimes occurring on my premises.
- To coroners or medical examiners when such individuals are performing duties authorized by law.
- For research purposes, including studying and comparing the mental health of clients who received one form of therapy versus those who received another form of therapy for the same condition.

- Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
- For workers' compensation purposes. Although my preference is to obtain an
- Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
- Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with me. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

Certain Uses and Disclosure Require You To Have the Opportunity to Object:

Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations as deemed by Into the Woods Wellness, LLC.

You Have the Following Rights with Respect to Your PHI:

- The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment or health care operations purposes. Into the Woods Wellness, LLC is not required to agree to your request, and we may say “no” if we believe it would affect your health care.
- The Right to Choose How Into the Woods Wellness, LLC will send PHI to you. You have the right to ask Into the Woods Wellness, LLC to contact you in a specific way

Initial and Date: _____

APPOINTMENTS & CANCELLATIONS

Appointments will ordinarily be 45- 60 minutes in duration and initial intakes around 60-90 minutes in duration. Other appointments can be scheduled with the provider, please work with your provider to meet your needs. Typically, clients will start weekly or bi-weekly, however this is based upon clinical judgement and client needs. Scheduling, appointments, and modality of treatment will happen with the provider and be agreed upon between the client and provider.

****Please Note:**

*****Session times may vary based on individual needs, school schedules, and availability through the Shepherd of the Hill Catholic Schools. While we strive for consistency, flexibility is sometimes required to meet students where they are and accommodate the school environment*****

*****Telehealth appointments may vary; therefore, look over telehealth consent forms*****

At Into the Woods Wellness, LLC we encourage clients to arrive on time. Additionally, please connect with your provider as soon as possible if a conflict arises with the appointment. Per our policy, a 24-hour notice is required in advance for any missed or cancelled appointments.

If the provider is unable to report to the assigned/scheduled school site for the day to provide therapy support for any reason, the provider will inform the Shepherd of the Hill Catholic School, the school site secretary at the elementary schools and/or the attendance secretary at the middle and high school level. The provider will call each family to inform them the appointment was canceled.

The provider will inform the parents/guardians if the student is missing or refusing to attend sessions. The provider will contact the Shepherd of the Hill Catholic Schools if a student is continually missing sessions.

Initial and Date: _____

Contact Information

If you need to contact me between sessions, please call Into the Woods Wellness, LLC at 920-904-8128. If I am not available, please leave a message and I will return your call within 24 to 72 business hours. Please note that I am often not immediately available. If you feel comfortable leaving a message, be brief and leave your contact information. I can also be reached at my work email: landri@intothewoodsjourney.com and I will return your email within 24 to 72 business hours. All forms of communication through electronic media cannot be guaranteed confidentiality.

****If it is an emergency, please contact 911, Fond du Lac County Crisis line (920-929-3535), and/or follow the safety plan, if applicable****

Initial and Date: _____

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

Initial and Date: _____

MINORS

If you are a minor, your parents/guardians may be legally entitled to some information about your therapy. At Into the Woods Wellness, LLC we will discuss with you and your parents/guardians what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Initial and Date: _____

TERMINATION AND DISCHARGE

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Into the Woods Wellness, LLC may terminate treatment after appropriate discussion with you and a termination process if we determine that the psychotherapy is not being effectively used. Into the Woods Wellness, LLC will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason, or you request another therapist, I will provide a list of qualified psychotherapists to provide services to you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for 30 consecutive days, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued. Repeated cancellations or missed appointments are also grounds for termination. At Into the Woods Wellness, LLC your discharge could be voluntary or an involuntary discharge. A letter will be sent to you acknowledging termination.

Initial and Date: _____

CLIENT BILL OF RIGHTS

- To receive prompt and adequate treatment.
- To refuse treatment or medication at any time.
- To request restrictions on uses and disclosures of mental health information.
- To refuse to take part in experimental research.
- The right to refuse to be filmed or taped.
- To request how you are contacted.
- If you feel your rights have been violated, you have a right to use a grievance procedure. • To have your conversation with staff and all medical and health care records kept confidential in accordance with Wisconsin Law.
- To see your health care record after termination of treatment according to Agency policy.
- To see parts of your health care record during treatment if your physician or case manager agrees. Some of the above rights may be restricted because of your treatment or security needs.

I acknowledge that I fully understand the information listed above. If I have any questions and/or concerns, I will contact my provider immediately to discuss and clarify any questions and/or concerns.

Signature: _____

Date: _____

Client Information

Please fill out completely:

Last Name _____ First Name _____ Middle Initial _____

Nickname _____ Date of Birth ____ / ____ / ____

Age _____ Gender Identified as: _____ Race _____ Ethnicity _____

Address:

(Street and Number)

(City) (State) (Zip)

Home Phone: () _____ May we leave a message? Yes No

Cell/Other Phone: () _____ May we leave a message? Yes No

E-mail: _____

May we email you? Yes No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Current Marital Status: Single __ Engaged __ Married __ Separated __ Divorced __ Widowed __

Spouse's Name: _____ Age _____ Years Married _____

Names of Children and/or Step Children with Ages:

If the patient is a minor, please list responsible party information:

Client's Name:

Parent/Guardian Name:

Address:

(Street and Number)

(City) (State) (Zip)

Home Phone: () May we leave a message? Yes No

Cell/Other Phone: () May we leave a message? Yes No

Presently living with: Parents _____ Spouse _____ Roommate _____ Alone _____ Other: _____

Name of child's school: _____

Grade/year: _____ Typical grades: _____

Who referred you to Into the Woods Wellness, LLC or how did you hear about us?

Emergency Contact:

Name: _____ Relationship: _____ Phone

number: _____ Occupation:

_____ Place of

Employment: _____ Work

number: _____ Occupation: _____

Highest level of Education: _____

BIOPSYCHOSOCIAL HISTORY

Presenting Problem: Please describe in detail the present concerns you have

regarding your child.

When did the presenting problem first start? Please explain below:

Please check any of the concerns or symptoms listed below that you currently are experiencing:

Mood & Emotions	Thoughts
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<ul style="list-style-type: none"> ● Depressed, sadness, or low mood ● Anxiety, nervousness, or excessive worry ● Irritability ● Anger ● Mood swings ● Feeling numb or disconnected ● Becomes easily overwhelmed by stress or frustration ● Shy, uneasy around others 	<ul style="list-style-type: none"> ● Racing thoughts ● Difficulty concentrating ● Negative or self-critical thoughts ● Overthinking or rumination ● Feeling hopeless or helpless ● All or nothing thinking ● Thoughts of hopelessness ● Self-doubt/indecisiveness ● Always expecting the worst outcome ● Excessive fears
<p style="text-align: center;">Body & Behavior</p> <ul style="list-style-type: none"> ● Trouble sleeping (too much or too little) ● Changes in appetite or eating habits ● Serious physical illness-self or family member ● Fatigue or low energy ● Restlessness or difficulty relaxing ● Physical tension (headaches, stomachaches, muscle tightness) ● Sensory (temperature, textures, noise, lights) ● Aggressive behaviors (hitting, kicking, punching, throwing, etc.) 	<p style="text-align: center;">Daily Life & Relationships</p> <ul style="list-style-type: none"> ● Stress at work or school ● Difficulties making friends ● Difficulties keeping friends ● Feeling isolated or withdrawn ● Difficulty managing responsibilities ● Loss of interest in activities once enjoyed ● Family Changes (separation, divorce, recent move, etc.) ● Difficulties with family ● Step-family concerns ● Death of family member or friend
<p style="text-align: center;">Safety</p> <ul style="list-style-type: none"> ● Using substances to cope (alcohol, drugs, etc.) ● Abuse (emotional, sexual, and/or physical) ● Thinking about death or dying ● Self-harm urges ● Self-harm behaviors ● Suicidal Ideation 	<p style="text-align: center;">Executive Functioning</p> <ul style="list-style-type: none"> ● Interrupts others or talks over people ● Acts without thinking about consequences ● Difficulties waiting their turn ● Struggles to adapt to new or unexpected situations ● Difficulties with organization ● Trouble with memory or concentration

Are you experiencing suicide ideation? ___ Yes ___ No
If yes, do you have a current safety plan? ___ Yes ___ No

Please rate and describe the overall level of stress that you feel:

Please describe how your concerns / symptoms are interfering with your life

Through the therapeutic process, what specific results or changes do you wish to see:

Previous Mental Health Treatment:

Have you previously been in Counseling: ___ Yes ___ No

Briefly describe your prior counseling experience:

Prior Mental Health History

Prior Therapist: Date(s): Reason:

- 1.
- 2.
- 3.

Medication History (Please list current medications and past medications that are applicable):

Medication Dose Prescriber Date/Year Began

1.

2.

3.

CHILD/ADOLESCENT INTAKE FORM (PARENT SECTION)

CHILD'S DEVELOPMENT: Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:

Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ___ No ___ Not sure _____ If yes, describe:

Did your child have any unusual behaviors or problems prior to age 3?

Yes ___ No ___ Not sure _____ If yes, describe:

Has your child experienced emotional, physical, or sexual abuse?

Yes ___ No ___ Not sure _____ If yes, describe:

CHEMICAL USE: Do you have any concerns with your son or daughter using alcohol or drugs?

Yes ___ No ___ If yes, please explain your concern:

ELECTRONIC COMMUNICATIONS USAGE: Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? Yes ___ No ___ If yes, please explain your concern:

LEGAL ISSUES: Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

FAMILY HISTORY: (Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Father's Name: _____ **Birth Date:** _____ **Age:** _____

Ethnic Origin: _____ **Total years of education completed:** _____

Occupation: _____ **Place of Employment:** _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship if applicable: Poor ____ Fair ____ Good ____

Mother's Name: _____ Birth Date: _____ Age: _____

Ethnic Origin: _____ Total years of education completed: _____

Occupation: _____ Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship if applicable: Poor ____ Fair ____ Good ____

PARENT'S MARITAL STATUS:

<ul style="list-style-type: none">● Single● Married (legally)● Divorced● Widowed	<ul style="list-style-type: none">● Cohabiting● Divorce in process● Separated● Other: _____
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Length of marriage/relationship: _____

If divorced, how old was your child at the time of divorce? _____

If divorced, how much time does your child spend with each parent? Mother __%, Father __%

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

<ul style="list-style-type: none">● Fighting/Arguing● Disagreeing about relatives● Divorce/separation● Feeling distant● Death of family member or close family friend● Alcohol and/or Drug Use● Trauma	<ul style="list-style-type: none">● Education problems● Financial problems● Disagreeing about friends● Issues regarding remarriage● Loss of fun● Birth of child● Lack of honesty● Inadequate health insurance/care
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- Job change or job dissatisfaction
- Inadequate housing/feeling unsafe
- Other: _____

- Medical concerns
- Infidelity (couple)

Have you, or anyone in your family, experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable:

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

YOUR CHILD'S/ADOLESCENT'S STRENGTHS:

What activities do you feel your son or daughter is successful when they try?

What personal qualities would you say your son or daughter has?

Who are some of the influential and supportive people, activities (e.g., walking) or beliefs (e.g., religion) in your son or daughter's life? Please describe:

Signature of Client: _____ **Date:** _____

Signature of Parent/legal guardian/Foster Parent/Conservator/Other (Required if client is minor, under the age of 18):

_____ **Date:** _____