



## Welcome

Affiliated Clinical Services (ACS) has partnered with GPS Education Partners (GPS Ed) to provide programming designed to help students succeed in their GPS Ed program. This partnership is designed to help students' success in the GPS program. We know that everyone has struggles from time to time with school, work, family, and life. That is where this partnership comes into existence.

ACS will be supporting the GPS Ed students with on-site graduate-level interns who are completing their educational training in the mental health field. Interns will be program success coaches who will be on-site at various points during the school week to provide a mental health screening and individual coaching sessions to students.

Along with the GPS Ed instructors, ACS is also committed to student success. With that goal in mind, we want to be available for students as they navigate their way toward graduation. Each academic year, all students will complete a mental health screening that will be in part a paper and pencil self-report and also a brief in-person screening with an ACS program success coach. From there, students will be provided with a summary of their screening and recommended coaching next steps. After the screening is completed, students will then participate in the individual coaching sessions at a frequency to be determined with the student and intern. All coaching sessions will be conducted on-site and in-person during normal academic hours.

ACS interns will be available to support students throughout their academic years with GPS Ed. Interns may change from year to year as they complete their training and new interns enter the final semesters of their own academic and clinical training. Regardless, ACS provides supervision to all interns and oversees the coaching program to ensure high standards are maintained and to provide students with the best support possible. However, if the needs of the student would exceed the scope of the coaching services, further recommendations for a higher level of care can be made in conjunction with the student and their parents.

We are very excited to be working with all GPS Ed students and instructors to provide another step to student success. Our ACS team looks forward to meeting each student and seeing you reach your graduation day.

Craig Groskreutz, PsyD  
Licensed Psychologist  
Mental Health Services Director  
Affiliated Clinical Services

West Bend  
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## Student Information Form

\_\_\_\_\_  
First Name M.I. Last Name

**Home Address:**

\_\_\_\_\_  
Street City

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

**Phone Number:** \_\_\_\_\_

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

**Parent/Guardian Name:** \_\_\_\_\_

**Relationship to Student:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

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

The Parent/Guardian listed above will also be used as the Emergency Contact.

**Student Signature:** \_\_\_\_\_

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

For Office Use:

Client Number: \_\_\_\_\_



## Informed Consent

This document contains important information about professional coaching services and business policies. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign this agreement or at any time in the future.

### COACHING SERVICES PROVIDED TO STUDENTS

Coaching services are a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a student in these sessions, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your coach, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Coaching sessions have both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of coaching often requires discussing the unpleasant aspects of your life. However, coaching has been shown to have benefits for individuals who undertake it. Coaching 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. But, there are no guarantees about what will happen. Coaching 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.

Coaching sessions are not a replacement to psychotherapy or to be considered psychotherapy as provided by a licensed professional. Coaching sessions are designed to allow you to be empathetically supported to learn skills and receive psychoeducation to help you in everyday life.

The initial information collected by staff will include a mental health screening. By the end of the screening evaluation, I will be able to offer you some initial impressions of what our coaching work might include. At that point, we will discuss your goals and create an initial goal 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.

### SESSIONS

Sessions will ordinarily be 20-30 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your session is assigned to you and you alone. If you need to cancel or reschedule a session, please contact me or your GPS teacher as soon as possible prior to the scheduled appointment.

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### PROFESSIONAL RECORDS

I am required to keep appropriate records of the coaching services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking coaching, the goals and progress we set for the sessions, and topics we discussed. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

### CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Limits of Confidentiality. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

### PARENTS & MINORS

While privacy in the coaching sessions is crucial to successful progress, parental involvement can also be essential. For students 14 and older, I request an agreement between the student and the parent(s) allowing me to share general information about coaching progress as well as a coaching summary upon completion of our work together. All other communication will require the student's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the student of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

### CONTACTING ME

I am often not immediately available by telephone. If you need to reach me, please contact your GPS Education Partners' teacher or advisor and they will be able to arrange for us to be in contact.

### OTHER RIGHTS

If you are unhappy with what is happening in our coaching sessions, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You are free to end coaching sessions at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin. You have the right to ask questions about any aspects of coaching and about my specific training and experience.

### CONSENT TO COACHING SESSIONS

Your signature below indicates that you have read this Agreement and agree to the terms.

I accept the provisions of this agreement

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

Craig Groskreutz, PsyD, Licensed Psychologist  
Mental Health Services Director  
262-338-2717      Ext 118



## Intern Service Agreement

I understand that Affiliated Clinical Services provides opportunities for graduate students in the fields of psychology, social work and counseling to receive training in psychotherapy. I understand that interns are supervised by licensed clinicians with a minimum of three years postgraduate clinical experience. The supervisor will have responsibility for the quality of services that I receive. I further understand that the availability of interns makes it possible for me to access supportive/coaching services at no cost to me.

I understand that interns have a specific starting and ending time frame for their internships. Due to circumstances beyond our control, occasionally students will withdraw from the internship program unexpectedly. After internships are completed, I may be reassigned to another intern if one is available. ACS may terminate supportive/coaching services if I do not attend scheduled appointments without cancelation in a timely manner.

I understand my intern is currently a student in a graduate level counseling or social work program and the intern may have a course requirement for them to present client cases to their class for consultation and educational purposes. This presentation may include a transcription of a session. Transcriptions will be destroyed at the end of the course semester. If the intern would present any aspects of my case with the class, no identifying information will be presented to the class, and thus my confidentiality will be protected.

I understand that due to the intern status of my coach, my sessions and corresponding records are not intended for use in court and the intern will not appear in court. I understand that these supportive/coaching services provided by the intern cannot be used for any court related services.

I accept the provisions of this agreement

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

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Mental Health Services Director  
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## AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

**For File Only**
**To the Student:**

- 1) Be sure the release is in your best interest.
- 2) Be sure all lines are filled in before you sign the form
- 3) The information to be released to the specific individual as specified below cannot be passed to any other individual without your authorization.

**I authorize and request Affiliated Clinical Services to:**

Release to and Obtain from:

Parent: \_\_\_\_\_

**STUDENT NAME:** \_\_\_\_\_

**STUDENT DATE OF BIRTH:** \_\_\_\_\_

 Specific information to be **RELEASED BY**  
 Affiliated Clinical Services, Inc.

 Specific information to be **RELEASED TO**  
 Affiliated Clinical Services, Inc.

**Release Format:** Written or Verbal

**Information to be released would include: treatment recommendations, school records, behavioral observations, concerns of harm to self or others, screening results, or any clinically relevant information for coordination of services. Only the parent(s) and/or guardian(s) listed above and signing this document would be included for this release.**

**This authorization will expire at the termination of services being provided by GPS Educational Partners through their educational program and the above named student.**

**Purpose or need for information:** Coordination of care.

I understand that I may revoke this authorization, in writing, at any time except when information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date stated above. A copy of this authorization may be used in lieu of the original. The student who is the subject of the records covered by this authorization in most cases has the right to inspect and receive a copy of the material disclosed pursuant to this consent form. The subject individual has the right to inspect or receive a copy of any information to be disclosed as required under ss.HSS92.05 and 92.06; 34CFR 99, Ch. 118.125. A uniform and reasonable fee is charged for a copy of records. This information was disclosed to you from records by State and Federal law (WSS 51.30, WSS 118125, 34 CFR 42 Part 2). These laws prohibit you from making any further disclosure and/or re-disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient. 022388.04. Our practice will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

Signature of Student

Date

Signature of Parent or Legal Guardian

Date

Signature of Parent or Legal Guardian

Date

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## LIMITATIONS ON CONFIDENTIAL NATURE OF COMMUNICATIONS

Communications between the student and licensed psychologist, licensed mental health therapists, or student interns under licensed supervision are confidential and will not be released without the express authorization of the student. However, certain communications may be made or certain situations may occur for which confidentiality does not exist, and these include:

- (a) Situations in which the psychologist, therapist, counselor, student intern under licensed supervision believe the student is a threat to himself/herself or others; or
- (b) When the communications involve information regarding child abuse or abuse of the elderly.

I hereby acknowledge that these limitations on confidentiality have been explained to me.

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Student Name	Date of Birth
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Signature of Student	Date
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Signature of Parent or Legal Guardian	Date
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