West Central Wisconsin Behavioral Health

N36647 County Road QQQ, Whitehall, WI 54773
Phone: (715) 538-9134

Client Face Sheet

Today's Date: _____

Client Name: _____

Address: _____

City, State, Zip: _____

Home/Cell Phone: _____

Gender: ☐ Male ☐ Female

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ American Indian ☐ White

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Date of Birth: _____ **Age:** _____

SSN: _____

Insurance Information/Referral – please fill out completely

Insurance Provider: _____ **Group #:** _____

Referral Source: _____ **Member ID#:** _____

In Case of An Emergency Contact:

Name: _____ **Relationship:** _____

Home/Cell Phone: _____

If Client Is A Minor

Guardian: _____

Address: _____

City, State, Zip: _____

Home/Cell Phone: _____

If Client Is an Adult with A Guardian

Guardian: _____

Address: _____

City, State, Zip: _____

Home/Cell Phone: _____

Intake Form

Personal Information

Name:_____ Name you like to be called:_____

DOB:_____ Primary Physician:_____

Complaint/Concern

What is your major complaint/concern?_____

Previous treatment_____

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Change in peers
☐ Loss of interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐ _____	☐ _____

Medical History

Allergies:_____

Current Medications:_____

Previous Diagnoses/Behavioral Health Treatment:_____

Previous Medications:_____

Other medical conditions:_____

Previous Surgeries:_____

Family History

Who resides with you currently?_____

Mother's name:_____ Father's name:_____

Siblings:_____

Family member medical conditions:_____

Family member behavioral health conditions:_____

Early Development

Where did you grow up:_____ Have any immediate family members died?_____

Highest Education level completed:_____ Date completed:_____

Have you ever served in the military?_____ Dates of service:_____

When did you meet developmental tasks (crawling, walking, talking)_____

Any concerns during pregnancy, labor, or delivery?(explain)_____

Any medication or substance use during pregnancy?(explain)_____

Present Situation

School:_____ Grade:_____ IEP services:_____

Place of Employment:_____ Position:_____

Are you married?_____ If yes, date of marriage:_____

Are you divorced?_____ If yes, date of divorce:_____

Children (Names & Ages)_____

Substance Use

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain Killers

If yes to any, list frequency and dates of use:_____

Have you ever been treated for drug/alcohol use?_____ When/Where:_____

Do you use tobacco?_____ What kind?_____ Frequency?_____

Do you drink caffeinated beverages?_____

Do you have addiction to internet?_____ Any other compulsive behaviors?_____

Daily Functioning

Exercise Frequency:_____ Exercise Type(s):_____

Sleep (average hours/day):_____ Concerns with sleep:_____

Concerns with Nutrition/Weight:_____

Dental Concerns:_____

Suicide Risk

Current thoughts of suicide or wishing you were dead:_____ If yes, explain:_____

Any suicide attempts?_____ When/How?_____

Any current self-harm_____

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E-Mail, Text or Voice Messaging
Appointment Reminder Consent Form

Due to the changing world of healthcare and technology, West Central Wisconsin Behavioral Health has the ability to provide our clients with reminders for upcoming appointments via e-mail, text or voice messaging. You will receive a reminder seven days and one day prior to your scheduled appointment.

West Central Wisconsin Behavioral Health believes strongly in protecting the privacy of our clients. When you provide this information to us, it is only used to communicate with you for your appointments. West Central Wisconsin Behavioral Health does not share/sell the names, e-mail addresses, and/or telephone numbers of clients with any other company, or with any other client.

E-mail Appointment Confirmation: Yes ☐ No ☐

E-mail Address: _____

Text or Voice Appointment Confirmation:

Please check at least one:

☐ Text messaging Phone Number: _____

☐ Voice messaging Phone Number: _____

☐ I do not wish to be contacted by either text messaging or voice messaging

I hereby give West Central Wisconsin Behavioral Health permission to send messages regarding my upcoming appointments as means of communication as indicated by my selection above.

_____
Name (please print) Date of Birth

_____ _____
Client Signature Date Witness Signature Date

_____
Parent/Legal Guardian Signature Date
(if applicable)

WEST CENTRAL WISCONSIN BEHAVIORAL HEALTH

TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Messages regarding my care may be left on the phone number below: **Yes** ☐ **No** ☐

_____

1. **Permission to Use and Disclose Your Health Information.**
   Authorize us to use and/or disclose your health information for *treatment, payment or health* care operations. You have the right not to sign this acknowledgement. Refusing to sign this acknowledgement may give us the right to refuse to treat you.
2. **Your Rights with Respect to This Acknowledgement.**
   a. **Right to Review Notice of Privacy Practice.** We have provided you a copy of our Notice of Privacy Practices. You have the right to review this Notice before signing this acknowledgement. You may obtain a copy of our Notice, including any revisions we have made by contacting ***our office***.
   b. **Right to Request Restrictions on Use/Disclosure.** You have the right to request that we restrict how we use and/or disclose your health information for providing treatment, obtaining payment for our services, and/or conducting health care operations. All requests must be made in writing. We are not required to agree to any restriction you may request. If we agree to a restriction you have requested, we must restrict our use and/or disclosure of your health information in the manner described in your request. To obtain a restriction request form, please contact ***our office***.
   c. **Right to Revoke Acknowledgement.** You have the right to revoke this acknowledgement at any time. Your revocation of this acknowledgement must be in writing. Note that your revocation of this acknowledgement will not be effective for disclosers we have already made in reliance on your prior acknowledgement. We have the right to refuse to provide further treatment if you revoke this acknowledgement. To obtain a revocation form, please contact ***our office***.
   d. **Right to Receive a Copy of This Acknowledgement Form.** You have the right to receive a copy of this acknowledgement form after you sign it.
3. **Effective Period.**
   This acknowledgement is effective on the date of signing and shall remain in effect indefinitely, unless you revoke it earlier in writing.

I hereby authorize West Central Wisconsin Behavioral Health to use and/or disclose my health information for treatment, payment or health care operations.

Name (please print) Date of Birth

Client Signature Date

Witness Signature Date

Parent/Legal Guardian Signature (if applicable) Date

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Informed Consent

This acknowledges that I have received and have had explained to me the contents of the information packet that includes:

- Client Intake Information
- Clinic Brochure
- Privacy Notice
- Insurance & Billing Information
- Client Rights & Grievance Procedure
- Emergency Contact Procedure
- No Show Policy

I acknowledge potential risks of treatment, which may include but are not limited to:

- Emotional discomfort (anger, sadness, fear, guilt)
- Feeling worse before feeling better
- Physical discomfort (stomach aches, headaches, nausea)

I acknowledge potential benefits of treatment, which may include but are not limited to:

- Increased ability to cope with life stressors
- Deeper personal insight and awareness
- Improved personal relationships
- Improved awareness of personal goals

Difficulties in these areas are likely to occur without proper treatment.

I understand that unauthorized use of alcohol and or other drugs while I am in this program is prohibited and may result in my discharge from counseling or psychiatric services.

Confidentiality: Clinic staff cannot guarantee other patients will respect your confidentiality. Other risks that surface relative to your situation will be addressed on an individual basis. I understand that WCWBH staff are mandated to report threats of potential harm to self or others as well as incidents of physical, sexual, and/or emotional abuse of a minor or vulnerable adult that are disclosed within the course of treatment.

Service options: Treatment programs, alternatives and/or options may include inpatient, outpatient, individual counseling sessions, group counseling sessions, community self-help groups and possible referral to other agencies to address individualized needs. WCWBH utilizes a multi-disciplinary approach. All staff play an important role in your treatment, monitoring and enforcement of rules. I agree to follow all directives of staff. Training of each professional varies and will be addressed on an individual basis based on services being provided.

Attendance: I understand that I am committing to regular attendance as this is important to get the most benefit out of the therapeutic process and reaching personal goals. I understand that if I continue to miss scheduled appointments I may be discharged from counseling or psychiatric services. WCWBH requires that clients are contacted at least every six months to maintain services. Upon discharge we may send you a questionnaire regarding your experience in therapy.

I voluntarily enter the WCWBH program and agree to abide by the rules explained to me. This form is valid for one year from the date of signing. I can revoke this form at any time.

Name (please print)	Date of Birth
Client Signature	Date
Witness Signature	Date
Parent/Legal Guardian Signature (if applicable)	Date

Form date: 5/2005; revised 1/2019; updated 11/2020

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Consent for Telehealth Services

- I have been asked to receive mental health services through telehealth—telehealth refers to the use of having services provided through interactive audio/video and/or telephone equipment rather than having the provider be physically present in the room.
- I understand that my participation in telehealth is voluntary and that I have the right to refuse participation in telehealth services at any time.
- I understand that information about my telehealth appointments will be documented within my clinical record through West Central Wisconsin Behavioral Health. I understand that I have the right to request my records, inspect any information transmitted during a telehealth appointment, and to receive copies of this information for a reasonable fee.
- Confidentiality still applies to telehealth services and the appointments will not be recorded without the permission from the other person(s).
- I understand that I will be present in the state of WI for appointments unless otherwise discussed with the provider or the appointment may be rescheduled.
- It is important to be in a quiet, private location that is free from distractions (i.e. other people, cellphones, televisions) during the appointment.
- It is important to use a secure internet connection rather than public/free Wi-Fi connections.
- It is important to be on time for your appointment and attend regularly. If you need to cancel or reschedule the appointment, please notify the behavioral health clinic in advance by telephone.
- West Central Wisconsin Behavioral Health staff may determine that due to certain circumstances, telehealth is no longer an appropriate option. If this becomes applicable, staff will try to assist you in connecting with in-person resources.
- There are potential risks and benefits of telehealth services:
    - Potential benefits:
        - Reduced travel for myself and the provider
        - Quicker access
        - This may be the only service option available during COVID-19 pandemic situation
    - Potential risks:
        - Audio/video connection could fail or be disrupted during appointment
        - Connectivity issues may result in an unclear picture and/or sound
        - There is a very small chance someone could be utilizing electronic tampering to access the appointment
- We will need a phone number you can be reached at in the event of a technical problem.

  Phone number: _____

- We need a safety plan that includes at least one emergency contact and the closest emergency room (ER) to your location, in the event of an emergency/crisis situation.

  Emergency contact: _____ Closest ER: _____

_____
Name (please print) Date of Birth

_____ _____
Client Signature Date Witness Signature Date

_____
Parent/Legal Guardian Signature Date
(if applicable)

Form date: 11/2020

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Outpatient Charges/Financial Responsibility

There is a fee for the outpatient services you are receiving at the West Central Wisconsin Behavioral Health. Fees are as follows:

TREATMENT DESCRIPTION	Fees				
	20 Min	½ Hour	1 Hour	1 ½ Hours	2 Hours
Individual AODA Counselor Assessment				$158.00	$236.00
Individual AODA Counseling Session		$75.00	$120.00	$158.00	$236.00
Group AODA Counseling Session			$25.00	$37.00	
Master Level Clinician – Assessment				$170.00	$238.00
Master Level Clinician – Group Therapy			$27.00	$39.00	
Master Level Clinician – Psychotherapy		$90.00	$165.00	$170.00	$238.00
Psychiatrist – Intake/Diagnostic Interview			$360.00		
Psychiatrist – Pharmacologic Management	$216.00	$285.00	$350.00	$368.00	
Psychologist – Intake/Diagnostic Interview			$165.00		

(Many of the services that are provided may be covered by various health insurance plans, but there is a considerable variability regarding psychological assessment services. You may be responsible for all the costs.)

Once you are registered as a client of the West Central Wisconsin Behavioral Health, you will receive a statement from West Central Wisconsin Behavioral Health. This is a statement of your account but may not be the amount actually owed, due to delays in settlement from your insurance company, Medical Assistance and etc. If you have any questions about your statement, please inquire at the front office at West Central Wisconsin Behavioral Health or call (715) 538-9134. I understand that I must inform the business office of my insurance and any changes that may occur. WCWBH will prepare and file claims to your insurer as a courtesy. It is vital that the clinic have accurate insurance information to assure rapid resolution of claims.

Medical Assistance or health insurance may cover many of the outpatient services. As a courtesy to you, the West Central Wisconsin Behavioral Health will bill your funding source. However, you may be responsible for all or part of your bill, depending on your insurance plan or source of funding. Please be prepared to present your insurance or Medicaid card each visit so we can check your records for accuracy. Patients are encouraged to call their insurance company to determine benefits before scheduling an appointment. If your insurance company requires a referral, please present the referral upon registration.

If you are an OWI client, please be advised that failure to fulfill your financial obligation for treatment may result in suspension of your driver's license. I understand that all charges are my personal responsibility regardless of insurance or other funding sources. I have read the above information and agree to my responsibility as an outpatient client of the West Central Wisconsin Behavioral Health Clinic.

Name (please print) _____ Date of Birth _____

Client Signature _____ Date _____ Witness Signature _____ Date _____

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

Form date: 11/2020

Communicable Disease Assessment

If a client answers yes to 3,4, or 5 on the front, or questions which put him/ her at risk for HIV, Hepatitis or STD's on the back, obtain a release of information and send a copy of this completed form to his / her primary physician or local Health Department.

Answer all questions to the best of your knowledge.

Client Information:

Name:

_____

Primary Physician:

Name: _____Phone #: _____

Address:_____

City: _____ State: _____

Tuberculosis

1. **History of Tuberculosis:**

Have you ever had active TB? (Positive sputum culture, chest x-ray, symptoms)

☐Yes ☐No ☐Unknown

If yes, when: _____ Where (city, state): _____

Have you ever had a TB skin test? ☐Yes ☐No ☐Unknown

If yes, when: _____ Where: _____ Results: _____

Have you ever been treated for TB? ☐Yes ☐No ☐Unknown

If yes, name of medications: _____ How long: _____

Was treatment completed? ☐Yes ☐No ☐Unknown

2. **Last Chest X-ray:** When: _____ Where: _____

3. **Exposure to Tuberculosis**

Have you been around anyone with active TB within the last 90 days? ☐Yes ☐No ☐ Unknown

If yes, name and address: _____

4. Current symptoms	No	Yes	Description/Comments
Persistent coughing (more than 2 wks)			
Coughing / spitting up blood			
Hoarseness / chest pain			
Fever			
Night sweats			
Unexplained / unintentional weight loss			
Loss of appetite			

5. Risk Factors	No	Yes	Comments (where, when, how long, etc.)
Homeless shelter			
Prison/jail			
Use of injectable drugs or crack			
From area w/high incidence of TB: (SE Asia, Africa, Haiti, Caribbean, S. Cent. Am.)			

Continue on back

Encourage follow-up testing for Hepatitis B and C, HIV and STD's through their primary MD or Health Dept. if drug paraphernalia has been shared, there has been bisexual or male–to-male sexual contact, or sexual contact with 5 or more partners, especially if condoms are not used.

6. Have you been tested for:

Hepatitis A: ☐yes ☐no ☐unsure if yes—when: _____ results: _____
Hepatitis B: ☐yes ☐no ☐unsure if yes—when: _____ results: _____
Hepatitis C: ☐yes ☐no ☐unsure if yes—when: _____ results: _____
HIV / AIDS: ☐yes ☐no ☐unsure if yes—when: _____ results: _____

7. Have you had the vaccine for:

Hepatitis A ☐yes ☐no ☐unsure
Hepatitis B ☐yes ☐no ☐unsure

8. Have you ever shared any drug paraphernalia?

☐ Yes	☐ No	Snorting straws	☐1-4 times	☐5-10 times	☐>10 times
☐Yes	☐No	Crack pipes	☐1-4 times	☐5-10 times	☐>10 times
☐Yes	☐No	Needles(skin popping or intravenous	☐1-4 times	☐5-10 times	☐>10 times
☐Yes	☐No	Other: _____	☐1-4 times	☐5-10 times	☐>10 times
☐Yes	☐No	Shared tattoo needles or skin piercing needles			

9. Have you had sexual contact with anyone with a known STD? ☐ Yes ☐ No ☐ Unsure

10. Have you ever been tested for STD's? ☐ Yes ☐ No

If yes, when: _____ Where: _____
Comments:_____
_____
_____

Follow-up:

☐ No further follow-up care indicated.
☐ Follow-up care refused.
☐ Follow-up care recommended and information provided to:
Physician / agency: _____
Address: _____
Tel. No.: _____ Date: _____

I do not want to be given information on communicable diseases or referred to a health care provider at this time. I understand this service had to be made available to me. I can request information about communicable diseases at any time.

Signature: _____ Date: _____

Interviewed by: _____ Date: _____

Form date 4/05
Form date: 11/2020