Demographics & Collateral Sources

(Please print)

Today's Date: _____

Personal Information:

Legal Name: _____ Date of Birth: _____ Age: _____ Social Security # (last 4 digits): _____

Preferred Name: _____ Gender: ____ Preferred Gender Pronouns: _____

Race: _____ Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐Widowed

Address: _____ ___City: _____ State: _____ Zip: _____

Address identification: ☐ Private residence ☐ Family/Friend ☐ Group Home – name of group home _____

Telephone #: _____

Email Address: _____

Insurance Provider: _____ Member ID #: _____

Emergency Contact:

Name: _____ Relationship: _____Telephone #: _____

If client is a minor (below the age of 18):

Parent/Guardian Name: _____ Telephone #: _____

Address: _____ ___City: _____ State: _____ Zip: _____

If client is an adult with a guardian:

Parent/Guardian Name: _____ Telephone #: _____

Address: _____ ___City: _____ State: _____ Zip: _____

I understand that collateral sources may be used for my screening and intake process for services at WCWBH. These sources include but are not limited to:

- Review of the Wisconsin Enhanced Prescription Drug Monitoring Program (ePDMP).
- Records of the patient's legal history.
- Information from referral sources.
- Consultation with the patient's physician, medical and/or behavioral health provider.
- Consultation with the Department of Corrections (DOC) and/or Child Protective Services when applicable.
- Information from the patient's family and/or significant others.
- Results of toxicology testing.

Some of these sources are public records and do not require written permission to access them. When permission is required, a release of information (ROI) will be utilized and explained to me.

_____

Name (please print) Date of Birth

_____ _____

Client Signature Date Witness Signature Date

_____

Parent/Legal Guardian Signature (if applicable) Date

Intake Form *(Please print)*

Name: _____

*Please explain your concern(s)/reason(s) for seeking services at the clinic: _____

Education:

Highest education level completed: _____ Date completed: _____

Are you currently attending school? ☐ Yes, current school: _____ Grade: _____ ☐ No

Employment:

Are you currently employed? ☐ Yes (see below) ☐ No (see below)

If yes, current employer: _____

If no, indicate status: ☐ Actively looking ☐ Disabled ☐ Retired

Military:

Have you served in the military? ☐ Yes, dates of service: _____ ☐ No

Legal:

Have you been arrested in the past 30 days? ☐ Yes, date(s) of arrest(s): _____ ☐ No

Current Symptoms:

I am currently experiencing (check all that apply):

☐ Anxiety
☐ Depression
☐ Seeing/hearing things that are not there
☐ Loss of interest in activities
☐ Sleep changes/difficulties
☐ Excessive energy
☐ Fatigue/exhaustion
☐ Appetite changes/difficulties
☐ Impulsivity
☐ Panic attacks
☐ Suspiciousness
☐ Avoidance of tasks/activities
☐ Isolation
☐ Irritability
☐ Racing thoughts
☐ Crying spells
☐ Guilt
☐ Difficulty making or keeping friends
☐ Thoughts of hurting myself/suicide/wishing I was dead
☐ Thoughts of hurting others
☐ Self-injurious behaviors (cutting, burning, pinching self, etc.)
☐ Other (please list): _____

Substances I currently use (check all that apply):

☐ Tobacco	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Alcohol	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Marijuana	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Hallucinogens (LSD)	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Heroin	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Methamphetamine	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Cocaine	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Stimulants	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Ecstasy	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Methadone	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Tranquilizers	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Pain killers	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____
☐ Other _____	How often? _____	Method of use: ☐ Oral ☐ IV ☐ Inhale ☐ Other _____

_____

Date of last use of substance(s): _____

Do you drink caffeinated beverages? ☐ Yes, If yes, what kind and how often. _____ ☐ No

Do you have addiction to the internet? ☐ Yes ☐ No

Do you have any other addictions (i.e., shopping, computer, or video games use)? ☐ Yes ☐ No
If yes, please explain. _____

Medical History:

Primary Care Provider: _____ Primary Care Provider Location: _____

Psychiatrist: _____ Psychiatrist Location: _____

Current Medications: _____

Previous Medications: _____

Any known diagnose (s)? _____

Any known medical condition (s)? _____

Are you currently pregnant? ☐ Yes (please see below) ☐ No

If yes, are you receiving prenatal care? ☐ Yes ☐ No
If yes, list the provider? _____

Any dental concerns? _____

Any known allergies? _____

Any previous suicide attempts? ☐ Yes ☐ No If yes, please list when and where you received treatment.

_____

Have you had any mental health or substance use treatment, including previous hospitalizations? ☐ Yes ☐ No
If yes, please list when and where you received treatment.

_____

Did you experience any delays in developmental milestones when younger (i.e., not walking/talking on time)? ☐ Yes ☐ No
If yes, please explain.

_____

Did your mother experience any pregnancy, labor, or delivery concerns? ☐ Yes ☐ No
If yes, please explain.

_____

Did your mother use any substances during her pregnancy with you? ☐ Yes ☐ No
If yes, please explain.

_____

Family History:

Who currently lives with you? _____

Mother's Name: _____ ☐ Living ☐ Deceased Father's Name: _____ ☐ Living ☐ Deceased

Siblings (please list names and ages): _____

Children (please list names and ages): _____

Have any immediate family members died? ☐ Yes ☐ No
If yes, please explain.

_____

Family history of any medical conditions? ☐ Yes ☐ No
If yes, please explain.

_____

Family history of any mental health conditions? ☐ Yes ☐ No
If yes, please explain.

_____

West Central Wisconsin Behavioral Health

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

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

West Central Wisconsin Behavioral Health

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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

West Central Wisconsin Behavioral Health

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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.

  Closest ER: _____

_____
Name (please print) Date of Birth

_____ _____
Client Signature Date Witness Signature Date

_____
Parent/Legal Guardian Signature Date
(if applicable)

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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.

The clinic reserves the right to stop services until payment is made. Efforts to set up a payment plan will be made.

Name (please print) Date of Birth

Client Signature Date

Witness Signature Date

Parent/Legal Guardian Signature (if applicable) Date

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.)			

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