

# 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)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Appetite Issues  | <input type="checkbox"/> Avoidance       | <input type="checkbox"/> Crying Spells   |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Guilt           |
| <input type="checkbox"/> Hallucinations   | <input type="checkbox"/> Impulsivity      | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Change in peers |
| <input type="checkbox"/> Loss of interest | <input type="checkbox"/> Panic Attacks    | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Risky Activity  |
| <input type="checkbox"/> Sleep Changes    | <input type="checkbox"/> Suspiciousness   | <input type="checkbox"/> _____           | <input type="checkbox"/> _____           |

## 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

- |                                  |   |  |  |
|----------------------------------|---|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco          | <input type="checkbox"/> Marijuana     | <input type="checkbox"/> Hallucinogens (LSD) |
| <input type="checkbox"/> Heroin  | <input type="checkbox"/> Methamphetamines | <input type="checkbox"/> Cocaine       | <input type="checkbox"/> Stimulants          |
| <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Methadone        | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> 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 \_\_\_\_\_

# 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 disclosures 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      Date  
(if applicable)

# West Central Wisconsin Behavioral Health

N36647 County Road QQQ, Whitehall, WI 54773

Phone: (715) 538-9134

---

---

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

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

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

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

- Increased ability to cope with life stressors
- Improved personal relationships
- Deeper personal insight and awareness
- 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      Date  
(if applicable)

# West Central Wisconsin Behavioral Health

N36647 County Road QQQ, Whitehall, WI 54773

Phone: (715) 538-9134

---

---

## 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)

# West Central Wisconsin Behavioral Health

N36647 County Road QQQ, Whitehall, WI 54773

Phone: (715) 538-9134

## 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:

<u>TREATMENT DESCRIPTION</u>	<u>Fees</u>				
	<u>20 Min</u>	<u>½ Hour</u>	<u>1 Hour</u>	<u>1 ½ Hours</u>	<u>2 Hours</u>
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      Date  
(if applicable)