Thank you for contacting us about scheduling an initial appointment. Your care is important to us and the forms and information included are intended to gather information from you, and to make sure you know what state and federal laws and codes are in place to make sure your treatment is safe and your information and rights are protected.

The forms which need to be returned to us are marked at the bottom of each form.

____ Adult or Child/Adolescent Contact Information and History Form (Please return)

____Informed Consent to Treatment and Telehealth Consent (Please return)

____ Billing Authorization and Notification of Fees (Please return)

____Notice of Privacy Practices (Keep for your records)

____ Summary of Patient Rights (Keep for your records)

Thank you for your patience as you complete the paperwork required. You may mail this information, or fax it to 715-384-0090. These forms must be completed prior to treatment. Please do not hesitate to contact us with any questions about the forms or the care that we provide.

We look forward to meeting with you. If you do not have an appointment already scheduled, we will be contacting you to arrange this.

WISE MIND
MENTAL HEALTH CLINIC, LLC

601 E 3rd St
Marshfield WI 54449
715-384-0080 Fax: 715-384-0090
www.wisemindclinic.com

Adult Contact Information and History Form

Name (First, Middle, Last): _____

Mailing Address: _____County _____

City, State, Zip: _____

Birthdate: _____ Age: _____

Preferred Phone#: _____Home___Cell___Work___ OK to call/text: Y/N

Second Phone#: _____ Home___Cell___Work___ OK to call/text: Y/N

Third Phone # :_____ Home___Cell___Work___ OK to call/text: Y/N

Email*:_____

Texting and email are not considered secure communication under Hipaa. No clinical information or communication with Wise Mind Staff is exchanged via email or text. If you choose to provide an email or to allow an automated text for the purposes of receiving appointment reminders, please initial here to indicate waiver and permission for us to send these notifications. Initials: _____

Emergency Contact: Name: _____ Phone: _____

Who referred you to us? _____

What are your primary reasons for contacting us? _____

_____

_____

_____

Insurance/Financial

(Please bring your insurance card to the first appointment)

Primary Insurance Company Name:_____

Insurance Company Phone: _____

Contract/ID#_____

Policy/Group #_____

Subscriber Name: _____

Subscriber Employer: _____

Subscriber Date of Birth: _____

Patient's Relationship to Subscriber: Self___ Spouse ____ Child____ Other_____

Do you have secondary insurance you would like billed? Y/N Copay: _____ $ or %

Have you contacted your insurance company about your mental health benefits? Y/N

Please complete and return this form to Wise Mind Mental Health Clinic, LLC

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Symptom Checklist

Please complete the following chart as fully as possible. This helps us to better understand your concerns and guides your treatment and provides information for insurance companies to determine the medical aspects of your situation for payment.

Symptom/Impact	None	Slight	Moderate	Severe
Depressed Mood				
Poor Energy				
Crying Spells				
Social Withdrawal				
Concentration Problems				
Isolation				
Memory Problems				
Lack of Enjoyment				
Appetite Decrease				
Appetite Increase				
Sleep Problems (Too much or little)				
Thoughts of Death or Suicide				
Decreased Self Esteem				
Mood Swings				
“Keyed up” or Edgy				
Self-Harming/Self Injury				
Excessive Worrying				
Irritable/Cranky				
Headaches				
Muscle Tension				
Panic/Anxiety Attacks				
Feeling Overwhelmed				
Obsessive Thoughts or Behaviors				
Thoughts/Fears about Past Trauma				
Nightmares				
Jumpy/Startle Easily				
Past or Current Abuse/Assault				
Traumatic Event (Recent or Past)				
Alcohol or Drug Problem				
Anger Problem				
Major Life Change/Transition				
Physical Illness or Pain Concerns				
Legal Problem				
Domestic Violence				
Work Problem				
Relationship Problem				
Parenting Problem				
Grief or Loss				

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Mental Health History *(Where/When)*

Current or Past Therapy/Counseling: _____

_____

Current or Past Medications for Mental Health: _____

_____

Current or Past Drug/Alcohol Treatment: _____

_____

Prior Hospitalization for Mental Health: _____

_____

Medical History

Primary Care Provider: _____ Send Notes? Y/N

Major Medical Problems, Illnesses or Surgeries: _____

_____

Prescription Medications: _____

_____

Over the Counter/Herbal/Supplements: _____

_____

Caffeine: Servings/Day _____ Tobacco: # per Day _____

Alcohol: Amount per Day _____ Week_____ Month _____

Other Substance Use: _____

Family Mental Health History

Family History of: Anxiety Y/N Depression Y/N Alcohol/Drug Abuse Y/N

Violence/Abuse Y/N Bipolar Y/N Suicidal Thoughts/Behavior Y/N

Social History

Education: Graduation from High School Y/N What year? _____

Education after High School Y/N : Area of Study/Degree_____

Problems in School? _____

Occupation: _____ Employer: _____

Problems at Work? _____

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	First Name	Age	Occupation	Quality of Relationship?
Mother				
Father				
Step-parent(s)				
Siblings				
Spouse/Partner				
Children				

Previous marriages/significant relationships:_____
_____
History of Abuse or Trauma? _____
Legal Problems/Arrests: _____
Active Religious Practice: Y/N Religion?_____
Military Experience: Y/N _____

Support/Strengths

Who in your life provides you the most support? _____

_____

What helps you get through tough times?_____

_____

What activities do you normally enjoy? _____

_____

What are your main priorities/goals in seeking treatment? _____

_____

_____

Additional Comments/Information: _____

_____

Signature _____Date_____

Please complete and return this form to Wise Mind Mental Health Clinic, LLC

WISE MIND
MENTAL HEALTH CLINIC, LLC

Informed Consent to Treatment

I voluntarily agree to participate in an assessment and/or treatment with the Clinical Staff of Wise Mind Mental Health Clinic, LLC. I understand that if through mutual agreement with my therapist, I decide to engage in psychotherapy treatment the following information regarding risks and benefits applies:

Benefits: Psychotherapy is a safe and effective treatment for a wide range of mental health concerns and situational problems. Psychotherapy can help alleviate symptoms, improve coping, increase skills for dealing with difficult situations, help to increase functioning. You are encouraged to participate fully in your treatment planning, and to discuss ongoing feedback about progress with your therapist. The quality of your care can be greatly affected by the level your engagement in treatment and the accuracy of your report of your concerns. The National Institute of Mental Health web page on psychotherapies provides additional information about the benefits of this treatment.

Alternatives: Alternatives to psychotherapy treatment include medication treatment or no treatment at all. For disorders like depression, your therapist may refer you to speak with primary care provider or a psychiatric prescriber.

Treatment Administration: Psychotherapy is a time based dialogue between the patient and therapist. Individual session time ranges are set according to national standards and are 16-37 minutes, 38-52 minutes, and 53+. Wise Mind Clinic sessions generally run 45-50 minutes. Family or group psychotherapy may also helpful, and your therapist can discuss whether this would be right for you. Psychotherapy is provided by Licensed Clinical Social Workers as allowed under the laws of the State of Wisconsin, or an individual supervised by an LSCW.

Side Effects: Generally “side effects” to psychotherapy are minimal. Changes may occur that affect relationships, and some types of therapy can generate discomfort or an initial increase in symptoms. Please discuss these with your therapist if they are a concern for you.

Consequences of not receiving treatment: Many mental health concerns, particularly mood disorders and anxiety, can get significantly worse without treatment. Untreated mental health problems can worsen and cause job or family problems, or decrease overall functioning.

Charges: Fees are based on the length and type of therapy session. I understand that I am responsible for any charges not covered by insurance, including deductibles, or co-pays, or non-covered diagnostic or treatment codes. I understand that it is my responsibility to determine the coverage my insurance providers. I have received a copy of the current fee schedule which is subject to change with 60 days’ notice. The fee schedule includes the charge for no-showed or late cancelled appointments, which may be billed to you directly, which most insurance companies allow.

WISE MIND
MENTAL HEALTH CLINIC, LLC

Informed Consent to Treatment

Confidentiality: I understand that information about my treatment is kept confidential* by Wise Mind Mental Health Clinic, LLC and may not be released without my written consent. Staff within WMMHC has access to my protected health information and I agree to have my mental health treatment information submitted to my insurance company for billing purposes (if I provide my insurance company's information.)

**Exceptions to confidentiality include: emergency situations that present a possible danger to self or others, concerns about abuse or neglect, presentation of a court order to obtain records. Ethical standards also allow sharing of non-identifying information with other professions for collaboration and consultation about your care. Ask your therapist if you have any questions about exceptions to confidentiality.*

Notice of Privacy Practices and Patient Rights: I have received a current copy of the "Notice Of Privacy Practices" for Wise Mind Mental Health Clinic, LLC. I may request a copy at any time during my treatment. I have received a current copy of the "Summary of Patient Rights" and the opportunity to receive a full copy of rights afforded by the State of Wisconsin.

Discharge Policy: There are circumstances in which I may be involuntarily discharged from treatment services with Wise Mind Mental Health Clinic, LLC. Repeated late cancellations or no-showed appointments, a lack of effective treatment engagement, presenting a threat to the safety or wellbeing of staff or patients, or situations that present a conflict of interest may make me subject to involuntary discharge. The full written admission/discharge policy is available upon request.

I understand that I may be discharged from services if there are more than 3 late cancellations or no-showed appointments in a 6 month period. _____ (Initial)

Right to Withdraw Consent: I have the right to withdraw consent to treatment in writing at any time. A lack of participation in psychotherapy treatment for a period of 1 year, will be considered a self-determined voluntary discharge from treatment and re-admission to services will be re-evaluated based on the current admission/discharge criteria and availability of services at that time.

Length of Consent: This consent to treat will expire 15 months from the date of signature, unless I revoke it in writing.

I have had the opportunity to ask questions about the above information and I consent to assessment and treatment through Wise Mind Mental Health Clinic, LLC. I understand that I have the right to ask questions about any of the above information at any time.

_____

Signature Date

Please sign and return this form to Wise Mind Mental Health Clinic, LLC

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Telehealth Consent

Telehealth Informed Consent

Wise Mind Mental Health Clinic, LLC is providing an online resource for telehealth psychotherapy. All of the agreements from the general informed consent signed by patients at intake are still valid.

Additionally,

I understand that the Wise Mind telehealth platform (Doxy.me) is a Hipaa compliant resource, with encryption, no retention of any Personal Health Information, and discarding any residual video buffering traces.

I understand that Wise Mind Mental Health Clinic, LLC is not responsible for confidentiality in my environment. I am responsible for maintaining privacy in my environment, home, work, or other. I am encouraged to find a quiet and private place for telehealth sessions.

I understand that there are risks and limitations to telemental health. During transmission of my medical or mental health session; information could be disrupted or distorted by technical failures, the transmission of my medical or mental health information could be interrupted by unauthorized persons in my environment, and my treatment providers may have limited ability to respond to emergencies. In addition, I understand that telehealth based services and care may not be as complete as face-to-face services.

I understand that while Wise Mind Mental Health Clinic, LLC may have determined that my insurance company allows payment for telehealth services, it is still my responsibility to make sure that my specific benefits plan covers this service and I am still responsible for any co-pays or deductibles.

I agree to have invitations to Telehealth appointment sent via: (Choose at least one)

____ Text: Number _____

____ Email: Address _____

Name Date

Please sign and return this form to Wise Mind Mental Health Clinic, LLC

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Billing Authorization and Notification of Fees

I authorize Wise Mind Mental Health Clinic, LLC to disclose to my health insurance company protected health information for the purposes of verifying insurance benefits, including co-pays and deductibles, obtaining prior authorization and perform other administrative functions necessary to receive payment for services.

I understand that only the amount of information that is necessary will be shared with my insurance company. I understand that while the staff of Wise Mind Mental Health Clinic, LLC will work to determine benefits, I am responsible for working with my insurance company to insure that services are covered.

I understand that I am responsible for notifying Wise Mind Mental Health Clinic, LLC of any changes in my insurance coverage prior to or at the beginning of the appointment immediately following the change.

I understand that I am responsible for any charges not covered by insurance, including co-pays and deductibles, no-show or late cancellation (less than 24 hours notice) fees, and non-covered diagnostic and service codes. Payment is due at the time of the appointment.

I understand that Wise Mind Clinic does not provide services for legal purposes such as disability assessments, divorce/custody/placement determinations, workers' comp treatment, or court ordered/court recommended treatment or any other legal or forensic situations.

Wisconsin Medicaid/Badgercare Only* I understand that I may be responsible for obtaining a written prescription/referral for psychotherapy treatment from a physician.

_____

Signature Printed Name Date

Fee Schedule*

(Your insurance company may have a different contractual arrangement for fee payment to Wise Mind Mental Health Clinic, LLC. Insurance companies do not cover the no-show/late cancellation fees.)

Diagnostic Evaluation	$210	Crisis psychotherapy	$225
30 minute psychotherapy	$110	Family therapy	$195
45 minute psychotherapy	$170	No Show/Late Cancel Fee	$30
60 minute psychotherapy	$195	Returned Check Fee	$50
Group Psychotherapy	$60		

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NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

Wise Mind Mental Health Clinic, LLC is committed to protecting the privacy of your health care information. Federal Law (Hipaa), Wisconsin law (Wisconsin Statutes Sec 51.30 and Wisconsin Administrative Code HFS 92, and the National Association of Social Workers Code of Ethics govern and guide the protection of your health information.

We are required by law to guarantee the privacy of your information, notify you of our privacy practices and our responsibilities to follow the terms of this notice. This Notice applies to all **protected health information** (**PHI**) maintained by Wise Mind Mental Health Clinic, LLC for services provided by any employee of Wise Mind Mental Health Clinic, LLC in the course of their employment. If you have any questions after reading this Notice, please contact Patricia Faber, MSW, Privacy Officer.

How We May Use and Share Your Health Information With Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services when you sign the Consent to Treatment. This includes consultation in clinical collaboration or supervision with other treatment team providers. For example, a therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from Wise Mind Mental Health Clinic, LLC, so we can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may need to disclose PHI about you for business operations. These uses and disclosures are necessary for Wise Mind Mental Health Clinic, to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may need to share your PHI with third parties that perform various business activities (such as billing, accounting, computing, or electronic record providers). We will require these third parties to have a contract with us that require them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the effectiveness of treatment provided to you when compared to patients in similar situations.

Appointments: We may use your PHI for the purpose of sending to you appointment information or billing reminders through the mail or by telephone. We may also send appointment reminders by text or email if you request this and agree to a waiver of our responsibility for protecting that information. You can specify your preferences in how we contact you. Messages left for you will not contain specific medical/mental health information.

Required or Permitted by Law: Wise Mind Mental Health Clinic, LLC is required by law to disclose your PHI without your verbal or written consent in certain circumstances:

- If necessary to prevent or lessen a serious and imminent threat to the health or safety of yourself, another person or the public
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- For public health oversight activities
- To facilitate the functions of federal or state governmental or certification agencies
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes, or crimes against Wise Mind Mental Health Clinic, LLC.

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- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Worker's Compensation officials if your condition is work-related

When sharing PHI with others outside of Wise Mind Mental Health Clinic, LLC, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the following rights, please contact the Privacy Officer.

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by Wise Mind Mental Health Clinic, LLC for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care, unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by Wise Mind Mental Health Clinic, LLC. Requests for amendment or correction should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom Wise Mind Mental Health Clinic, LLC may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. Requests for an accounting of disclosures should be made by submitting a form requesting an accounting of disclosures to the Privacy Officer. This form is available from the Privacy Officer.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to Wise Mind Mental Health Clinic, LLC will be made only with your authorization. If you authorize us to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization, please notify your therapist.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with Wise Mind Mental Health Clinic, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

We reserve the right to revise or change this Notice. Each time you sign a consent for treatment we will provide a copy of this Notice in effect at that time.

Effective Date: March 31, 2014

How to Contact Us

Patricia Faber, 715-384-0080, Privacy Officer. Secretary of Department of Health and Human Services:……(877) 696-6775

You may keep this information for your records.

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OUTPATIENT MENTAL HEALTH
BRIEF SUMMARY OF PATIENT RIGHTS

All outpatient mental health patients are guaranteed the following rights under Wisconsin State law:

- The right to be informed of your rights as a patient/client.
- Nondiscrimination on the basis of race, religion, age, sex, or sexual orientation, ethnic origin, physical or mental impairment, financial or social status.
- The right to the least restrictive treatment conditions necessary.
- The right to receive prompt and adequate treatment.
- The right to be informed of your treatment and care and to participate in the planning of your treatment and care.
- The right to be free from any unnecessary or excessive medications at any time.
- The right to a humane psychological and physical environment.
- The right to confidentiality of all treatment records, as provided by state law and per exceptions provided by state law
- The right to request to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services.
- The right to be informed about the costs of treatment.
- The right to file a grievance about violation of these rights without fear of retribution.
- The right to go to court if you believe that your rights were violated.
- The right to be treated with respect and recognition of the your dignity and individuality by all employees of the treatment facility and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact.

Complete list of rights is available upon request

Grievance: If you have questions or complaints about your rights during your treatment, you are encouraged to discuss them with your therapist. If you feel your questions or complaints have not been resolved, you may speak with the Patient Rights Specialist who will advise you of the process for pursuing the grievance. Wise Mind Mental Health Clinic, LLC's Patient Rights Specialist is Tracy Olson, MSW LCSW.

Source: Ch. 51, Ch. 92, Ch. 94 Wisconsin Statutes

You may keep this information for your records