NORTHSHORE CLINIC & CONSULTANTS

W62 N248 Washington Ave., Suite 207, Cedarburg, WI 53012

207 E. Buffalo St., Suite 510, Milwaukee, WI 53202

2363 S. 102nd St., Suite 203, West Allis, WI 53227

1615 Barton Ave., West Bend, WI 53090

Main Office Phone 262-375-1116

For Clinic Use Only:

Diagnostic Code_____

CHILD INTAKE FORM

Therapist _____Appointment Date_____

Client's Last Name _____ First _____M.I. _____

Date of Birth _____/_____/_____ Age_____ Sex _____ Social Security Number_____

Address _____City _____ State_____ Zip _____

Email Address _____

Mother's Name _____Date of Birth _____/_____/_____ SS #_____

Mother's Home Phone_____ **OK to leave a message? Yes or No**

Mother's Cell Phone_____ **OK to leave a message? Yes or No**

Mother's Work Phone_____ **OK to leave a message? Yes or No**

Father's Name_____Date of Birth _____/_____/_____SS #_____

Father's Home Phone_____ **OK to leave a message? Yes or No**

Father's Cell Phone_____ **OK to leave a message? Yes or No**

Father's Work Phone_____ **OK to leave a message? Yes or NO**

Emergency Contact Information: Name _____ Phone_____

Client resides with: (circle) Both Parents Mother Father Other _____

Responsible Party - (circle) Mother Father Other _____

Social Security Number if Other _____

Please check one: _____ Bill Insurance (Please present card) _____Self Pay
NOTE: Without Insurance Information, responsible party will be billed.

Primary Insurance Company _____

Subscriber Name_____DOB_____Subscriber ID_____

Employed By:_____

Relationship to Patient:_____

Secondary Insurance Yes_____ (Present Card) No_____

Subscriber Name_____

I hereby authorize Northshore Clinic & Consultants, Inc. to release such information as may be requested by my insurance company for the purpose of billing or coverage clarification.

I hereby authorize any insurance coverage providing benefits or payments for treatment received from Northshore Clinic and Consultants, Inc., to be assigned to Northshore Clinic and Consultants, Inc. I also permit a photograph or other facsimile of this authorization to be used in place of the original assignment.

Responsible Party Signature _____ Date _____

Please Turn Over

TREATMENT AGREEMENT

Confidentiality – All contacts with our therapists and clinic are confidential except in situations where you may be harmful to yourself or others. This includes physical or sexual abuse of a child. If your insurance has managed care, information will be shared for the purpose of coverage by your insurance. No information regarding you or your family members will be given to anyone outside the clinic without your written consent. Within the agency, information regarding your case is shared with the other clinic therapists for consultation purposes to enhance the services you receive.

-Hours of Service – Clinic hours are flexible and vary with each therapist. Your therapist is available by calling the main number (262-375-1116) or the Waukesha number, if applicable (262-446-9981)

-Telephone – The clinic has a 24-hour answering service so you can contact your therapist in the event of an emergency. If your call is urgent, please let the answering service know so that your therapist, or the therapist on call, can be contacted.

-Cancellation or Failed Appointments – **Cancellations must be made 24 hours in advance or you will be billed for the professional fee; clients will also be billed for missed appointments.** Insurance companies will not reimburse for failed or improperly cancelled appointments and therefore you will be billed.

-Psychiatric/Psychological Evaluation/Consultations – Evaluations/consultations are available by our staff. The client or the therapist may request an evaluation/consultation. The client may ask the therapist or clinic director about this procedure. Your therapist may also want to refer you to a consultant outside our agency. Our staff does meet on a regular basis for case consultation. .

TREATMENT BILLING POLICY

Insurance Responsibility – It is your responsibility to know what coverage your insurance provides. All charges are the sole responsibility of the responsible party, regardless of insurance payments. If there is a problem with receiving payment from your insurance carrier or if the claim process extends over two months, you will be expected to make payments. We will then reimburse you when the insurance company makes payments. **If the insurance check is paid directly to you, you are obligated to turn the check over to the clinic. Failure to do so will result in an 18% monthly interest fee which will be added to your account.**

Information About Fees:

	Nurse Practitioner	Doctorate level	Masters level
Initial Assessment Fee	**$280.00**	**$185.00**	**$165.00**
Follow up appointment	**$150.00 per ½ hour**	**$175.00**	**$150.00**

If you are a member of a managed health care plan, your fee may be reduced from that stated above. A therapy session normally consists of a **60 min. therapy hour** of face-to-face contact. The fee for sessions lasting less or more than 60 minutes will be prorated accordingly. The smallest billable unit is 30-minutes.

Self Pay Clients – Our clinic expects that you and your therapist will make arrangements for the professional fee. Clients are expected to keep the balance current and pay at each session. Collection Agency – Past due accounts will be given to our collection agency/attorney. All fees incurred by this action will be the responsibility of the client. If you have any concerns about payment or insurance billing, please feel free to discuss them with your therapist or the office manager.

I/We understand and agree to the above administration/billing policies in this agreement. My therapist has reviewed this billing with me and I/We agree to pay the deductible and any amount my/our insurance does not cover. I/We are aware that an unpaid balance will be referred to an attorney/collection agency as well as necessary information.

Informed Consent HFS 94.03

The listed items have been reviewed with me:

a)The benefits of the proposed treatment and services; b) The way the treatment is to be administered and the services are to be provided; c) The expected treatment side effects or risks of side effect which are a reasonable possibility, including side effects or risks of side effects from medications; d) Alternative treatment modes and services; e) The probable consequences of not receiving the proposed treatment and services; f) The time period for which this consent is effective is no longer than 12 months from the time given; g) The right to withdraw informed consent at any time, in writing.

I received a copy of my Patient Rights and Grievance Procedure.

Patient Signature _____ Date _____

Therapist Signature _____ Date _____

PERSONAL HISTORY – CHILD

Name_____ Age _____ Date of Birth_____ Sex_____
Referred by _____ Date of Assessment _____

What is the concern that prompted you to bring child in for treatment?
____ Family ____ School Explain Problem: _____
____ Emotional ____ Legal _____
____ Alcohol/Drugs ____ Other _____

What do you expect from treatment? _____
_____
Where does the problem occur: ____ Home ____ School ____Community
Age when problem began _____ Duration: ____Less than six months ____Greater than six months

Child's strengths and limitations: _____
_____

Social History:
Current school, grade, teacher _____
Special programming (M team, etc.) _____
School academic functioning: Present _____
Past history _____
Behavior with teachers, peer group: Present _____
Past history _____
Structured activities: Is your child involved in any clubs, religious organizations or community groups?
____ Yes ____ No If yes, which _____
Activity level of your child ____ Inactive ____ Average ____ Overactive
Family History:
Parents presently married? ____ Yes ____ No How long? (months/years) _____
Parents divorced? ____ Yes ____ No How long? (months/years) _____
Parent deceased? ___Mother ___ Father How Long? (months/years) _____
Parent(s) remarried? Mother-to whom _____ How long?_____
Father -to whom_____ How long?_____
Members of household:

Name	Age	Occupation/Grade	Relationship to Child
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

Additional significant family members in another household-step-parent, step-siblings, non-custodial parent,etc.

Name	Age	Occupation/Grade	Relationship to Child
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

Contact with extended family members? Yes ___ No___ Grandparents ___ Aunts/Uncles___ Cousins ___

OVER

MEDICAL HISTORY - CHILD

Physician _____ Physician's address_____
Last visit_____ Reason for visit _____
Current health concerns:

___ Headaches	___ Stomachaches	___ Bowel Function	___ Urinary Function
___ Depression	___ Joint/muscle Function	___ Skin Condition/Allergies	___ Chronic Pain
___ Self-Esteem	___ Menstrual Cycle	___ Alcohol Use	___ Drug Use
___ Frequent Mood Changes	___ Indecision	___ Anxiety/Nervousness	___ Smoking
___ Tiredness/Fatigue	___ Weight Loss/Gain	___ Eating/Appetite	___ Eating Disorders
___ Suicide Ideas	___ Sleep Disturbances	___ Breathing	

Other concerns:

___ Interpersonal Relations	___ Anger/Temper	___ Phobias	___ Memory
___ Guilt	___ Sexuality	___ School Problems	
___ Problems w/Relatives	___ Parent's Marital Issues	___ Concentration Level	

Other_____
Has your child been abused? ___ physically ___ sexually ___ emotionally ___ verbally

Has your child or any family member made a suicide threat? ___ yes ___ no Whom?_____
Has your child or any family member made a suicide attempt? ___ yes ___ no Whom? _____
Has any family member completed suicide? ___ yes ___ no Whom?_____
Please list all prior mental health services received by your child.

With Whom	Year	How Long	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Is your child currently under the care of a physician for any physical or emotional condition? If so, with whom and reason for treatment. _____
_____
Current medications your child is taking (list all, even non-prescription & occasional): _____
_____
Please list any hospitalizations (dates & reasons): _____
_____
Are there any medical and/or physical problems in the family that concern you? _____
_____
Are there any emotional problems in the family that concern you? _____
_____

Developmental History

Mother's health during pregnancy: _____ Prenatal care? ___ yes ___ no
Use of alcohol during pregnancy: ___ yes ___no cigarettes ___ yes ___no drugs ___ yes ___no
Did or does your child have any of the following:
Delayed sitting up ___ yes ___ no Speech delay ___ yes ___no
Delayed walking ___ yes ___ no Bed Wetting ___ yes ___no
Coordination difficulties ___ yes ___no

Thank you for completing this form. The information will be helpful in treatment planning for your child.

Parent Signature _____ Date:_____

Therapist Signature _____ Date:_____

HIPAA NOTICE OF PRIVACY PRACTICES

NORTHSHORE CLINIC & CONSULTANTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician/psychologist/psychotherapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s/psychologist’s/psychotherapist’s practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician/psychologist/psychotherapist to whom you have been referred to ensure that the physician/psychologist/psychotherapist has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s/psychologist’s/psychotherapist’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician psychologist/ psychotherapist. We may also call you by name in the waiting room when your physician/psychologist/ psychotherapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, As Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization ore Opportunity to Object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician/psychologist/psychotherapist or the physician’s/psychologist’s/psychotherapist’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician/psychologist/psychotherapist is not required to agree to a restriction that you may request. If physician/psychologist/psychotherapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician/psychologist/psychotherapist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you, by mail, of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

Your Client Rights Specialist is:

Joy Myers
W62 N248 Washington Ave. #207
Cedarburg, WI 53012
262-375-1116