Acct #_____ Diagnosis _____

Appointment Date _____ Referred by _____

Therapist _____

NORTHSHORE CLINIC, LLC
805 NORTH 6TH STREET
SHEBOYGAN, WI 53081
920-457-8866

INTAKE FORM/INSURANCE INFORMATION

Client Information:

_____
Last Name* First Middle *Maiden Name, if applicable

_____
Date of Birth Sex Marital Status

_____
Address City State Zip Code

_____
Employer Address of Employer City State

Your therapist or the billing staff may need to contact you regarding scheduling, billing questions, etc. Please review the following questions and respond accordingly:

May we call you at home? **Y** **N** _____ (Please initial) Phone #_____

May we call you on your cell phone? **Y** **N** _____ (Please initial) Phone #_____

May we call you at work and leave a message? **Y** **N** _____ (Please initial) Phone #_____

Are there any restrictions to leaving a message at any of the above? _____

May we correspond with you by email? **Y** **N**_____ (Please initial)

Email address_____

Please turn this page over for insurance information

INSURANCE INFORMATION

PRIMARY INSURANCE:

_____

Subscriber Name (Last, First, Middle) Birthdate Sex

_____

Subscriber Address City State Zip Code

_____

Subscriber Home Phone Subscriber Work Phone Employer

_____

Insurance Company Name Phone Number

_____

Insurance Company Address City State Zip Code

_____

Subscriber ID Number Group Number

Relationship to Patient: _____

SECONDARY INSURANCE

_____

Subscriber Name (Last, First, Middle) Birthdate Sex

_____

Subscriber Address City State Zip Code

_____

Subscriber Home Phone Subscriber Work Phone Employer

_____

Insurance Company Name Phone Number

_____

Insurance Company Address City State Zip Code

_____

Subscriber ID Number Group Number

Relationship to Patient: _____

It is your responsibility to inform our office if your insurance changes or you acquire any type of Medicaid coverage at a later time. If you do not provide us with the updated/accurate information in a timely manner you may be responsible for the balance of your bill.
_____ (Please initial)

NORTHSHORE CLINIC, LLC
805 N 6th Street • Sheboygan WI 53081 • 920-457-8866

NOTIFICATION OF TREATMENT

TO: _____ (Doctor Name)

_____ (Doctor Location/Address)

RE: _____ (Client Name)

DOB: _____

CLIENT ADDRESS: _____

Your patient(s) was seen at our clinic on _____ and requested psychotherapy and consultation. After an assessment of the presenting problem(s), symptoms, and other information, an initial diagnosis of _____ will be used for beginning treatment.

This recommendation will remain in effect for one year.

,

The type(s) of service that will be needed include(s) individual family conjoint group.

We welcome your participation in helping us work with your patient. If you have any questions or concerns regarding therapy with your patient or the work we do at Northshore Clinic, please contact us.

_____ _____

Date Therapist Signature

CLIENT AUTHORIZATION:

I DO/DO NOT (circle one) authorize Northshore Clinic, LLC to send a copy of this notification to the physician named above regarding my treatment for the physician's record. Any additional contact with my physician would be discussed with me and requires a separate authorization.

_____ _____

Date Client Signature (Parent or guardian if minor)

NORTHSHORE CLINIC, LLC
805 North 6th Street

Sheboygan WI 53081
(920) 457-8866

CONSENT TO USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION

Client Name _____ **Account Number** _____

Date of Admission _____

By signing this form, you are agreeing to let us use your personal health information (PHI) here and to send it to those outlined in our Notice of Privacy Practices. You are acknowledging that you have read Northshore Clinic's Notice of Privacy Practices (summarized or full version) and understand how your health information can be used or disclosed (shared), as described therein. You are agreeing that you have been offered a copy of our Notice of Privacy Practices (NPP) and have been encouraged to discuss any concerns you may have. You have also been given a copy of your rights as a patient of Northshore Clinic, LLC, including your right to restrict, review or stop this consent.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you. In addition, if you choose to revoke this consent at any time, treatment will terminate.

If in the future, we change our Notice of Privacy Practices, we will post and date any changes made and provide copies of our new NPP for your review.

_____ _____
Signature of client or legal representative Date

_____
Description of legal representative's authority

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and assign payment directly to Northshore Clinic, LLC, located at 805 North 6th Street, Sheboygan, Wisconsin of insurance and other benefits and payments otherwise payable to me. I also permit a photocopy or other facsimile of this authorization to be used in place of the original assignment.

I understand that I am financially responsible to Northshore Clinic and promise to pay all charges which are not paid by my insurance, PPO, HMO or other coverage in addition to co-payments and deductible charges. I am aware that the unpaid balance will be referred to Small Claims Court or a collection agency, as well as the necessary information to process such actions. I will discuss any concerns about payment or insurance billing with the billing agency or my therapist.

_____ _____
Signature of Client or Legal Representative Date

TO BE COMPLETED BY ADMITTING CLINICIAN

Was the client asked if they had any questions or concerns about Northshore's Notice of Privacy Practices?

☐ YES

_____ _____

Signature of Staff Member Date

TO BE COMPLETED BY OFFICE STAFF

Briefly describe the efforts made to obtain the client's signature and explain why the client was unable or unwilling to sign this form:_____

_____

_____

_____

_____

_____ _____

Signature of Staff Member Date

NORTHSHORE CLINIC, LLC ATT 35.18-A
805 North 6th Street
Sheboygan WI 53081

TREATMENT AGREEMENT

Informed Consent

Each patient, or person acting on the patient's behalf (parent, legal guardian, advocate), will be provided with specific, complete and accurate information and time to study the information or to seek additional information concerning the proposed treatment or services made necessary by and directly related to the person's mental illness, developmental disability, alcoholism or drug dependency including:

A. The recommendations and benefits of the proposed treatment and services;
B. The way the treatment is to be administered and the services to be provided;
C. Possible side effects or risks of the recommended treatment;
D. Alternative treatment modes and services;
E. The probable consequences of not receiving proper treatment and services;
F. The right and responsibilities in developing and implementing an individual treatment plan.

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.

Involuntary Discharge

A client may be terminated from receiving services from Northshore Clinic, LLC non-voluntarily: (a) when the client exhibits physical violence, verbal abuse, carries/threatens with weapons or engages in illegal acts at the clinic; (b) when the client refuses to comply with stipulated program rules and treatment recommendations; (c) when the client does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter and may appeal the decision.

Patient's Rights and Grievance Procedure/Confidentiality

I have received information orally and in writing about my rights as a patient and my right to file a Grievance on an informal or formal basis should I or my representative believe my rights have been violated.

I further understand that my treatment and records are confidential, and no information about me or my treatment will be given to anyone without my written permission. I have received information regarding the format of written permission to release confidential information and the exceptions to the confidentiality rule.

I have had an opportunity to review the points listed in the above document, have had time to consider those points and to ask questions for clarifications. I agree to receive treatment at Northshore Clinic and understand that this consent for treatment is in effect for a period of 15 months and that I have the right to withdraw the informed consent in writing at any time.

_____ _____

Signature of patient, parent or legal guardian Date

TREATMENT BILLING POLICY

Fee Schedules: A therapy session normally consists of 53-minutes of face-to-face contact. The fee for sessions lasting less/more than 53 minutes will be pro-rated accordingly. Your service provider's fees are indicated below:

Psychologist	**Masters/Psychotherapist**	**Discounted Cash Rate**
Initial Assessment $245.00	Initial Assessment $215.00	Initial Assessment PhD $170.00
Psychotherapy $210.00	Psychotherapy $175.00	Psychotherapy PhD $130.00
	Group Therapy $120.00 (90 minutes)	Initial Assessment Masters $140.00
No Show/Late Cancellation-$66.00	No Show/Late Cancellation-$66.00	Psychotherapy Masters $100.00

Estimated Cost for Service: The average length of service time is 8-10 sessions. Your approximate costs of treatment: Initial Assessment Cost + # of sessions x Service Provider Rate (above). You will subtract any insurance payments and discounts your insurance company receives. You will then add any deductible amounts, co-pay, coinsurance and costs of sessions if the maximum benefits of your insurance coverage are reached.

Insurance Responsibility

It is your responsibility to know what coverage your insurance provides. Information our office is given over the phone is **not guaranteed** by the insurance company and may not be correct. We advise reviewing your statements as they arrive and contacting our billing company with questions/concerns. Co-pays must be made at the time of service. **All charges are the sole responsibility of the client or party who accepted responsibility at intake, regardless of insurance payment**.

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**. Negotiated fee: _____/hour.

Cancellation or Failed Appointments

Cancellations must be made 24 business hours in advance or you will be billed a late cancel fee; clients will also be billed for not appearing for a scheduled appointment. Insurance companies will not reimburse for failed or improperly cancelled appointments and therefore you will be billed personally.

Collection Policy

Past Due accounts will be turned over to Small Claims Court/Collection Agency.

Non-sufficient Funds

A $35.00 charge will be added for any non-sufficient funds notice from the bank.

Hours of Service

The clinic office is open: Mon-Thurs from 8:30 AM to 7:00 PM, Fridays from 8:30 AM to 12:30 PM. Clinical hours vary with each therapist. Your therapist is available by calling the main number (920-457-8866).

Telephone/Emergency

The clinic has a 24-hour pager system so you can contact the on call therapist in the event of an emergency.

I UNDERSTAND AND AGREE TO THE ABOVE ADMINISTRATION/BILLING POLICIES IN THIS AGREEMENT.

_____ _____

(Client Signature/Responsible Party) (Date)

MEDICAL HISTORY

NAME: _____ AGE: _____ DATE OF BIRTH: _____ DATE: _____

Have you ever had or been treated for the following conditions:

❒ Allergies	❒ Blood Disease	❒ Blood Pressure	❒ Back Trouble
❒ Hay Fever	❒ Cancer	❒ Heart Disease	❒ Arthritis
❒ Asthma	❒ Diabetes	❒ Kidney Disease	❒ Chronic Pain
❒ Emphysema	❒ Low Blood Sugar	❒ Bladder Problems	❒ Headaches
❒ Skin Problems	❒ Thyroid Problems	❒ Prostate Disease	❒ Injury/Fracture
❒ Constipation	❒ Liver Disease	❒ Menstrual Problem	❒ Epilepsy/Seizure
❒ Stomach Problems	❒ Hearing Problems	❒ Abortion/Miscarry	❒ Eating Disorder
❒ Irritable Bowel	❒ Vision Problems	❒ Sexual Problems	❒ Drinking Problem
❒ Weight Problems	❒ Dental Problems	❒ Sleep Problems	❒ Drug Abuse

Please list any hospitalizations (dates and reasons):_____
_____

Please list all prior mental health services received:

With Whom:	Year:	How Long:	For What:

Have you ever been: physically abused ❒ or sexually abused ❒ ?

Are you currently under the care of a doctor for any physical or emotional condition?
If so, please list doctor's name, reason for treatment, date last seen: _____
_____

Current medications you are taking: _____
_____

Current Health Concerns: Please check any area where you think you may have a problem:

❒ Hearing/Vision	❒ Anxiety/Nervousness	❒ Interpersonal Relationships
❒ Speech	❒ Depression	❒ School Problems
❒ Dental Health	❒ Anger or Temper	❒ Work/Job/Career Problems
❒ Breathing	❒ Frequent Mood Changes	❒ Marital Problems
❒ Circulation	❒ Guilt	❒ Parenting Skills
❒ Digestion	❒ Self-Concept	❒ Sexuality
❒ Bowel Function	❒ Tiredness/Fatigue	❒ Problems with Relatives
❒ Urinary Function	❒ Sleep Disturbances	❒ Legal
❒ Joint/Muscle Function	❒ Suicide Ideas	❒ Exercise, Hobbies
❒ Skin Condition	❒ Indecision	❒ Drinking Problems
❒ Pain	❒ Memory/Concentration	❒ Drug Problems
❒ Menstrual Cycle	❒ Eating/Appetite	❒ Behavior Problems
❒ Menopause	❒ Weight Loss/Gain	❒ Other:_____
❒ Smoking	❒ Phobias	

Name of your physician: _____
Client Signature: _____ Date: _____

NORTHSHORE CLINIC, LLC

805 N. 6th Street
Sheboygan, WI 53081
(920) 457-8866

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

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), and regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

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. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various

business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive report of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Northshore Clinic:

- **Right of Access 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.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request 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.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Northshore Clinic or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Your Consumer Rights

When you receive any type of service for mental health, alcoholism, drug abuse or a developmental disability you have the following rights under Wisconsin Statute sec. 51.61(1) and HSS 94 Wis. Administrative Code. You also have rights under federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) explaining how we handle and use information about you. This brochure outlines the rights that are most applicable to individuals being treated in an outpatient setting. The full listing of your rights under Wisconsin Law and Federal Law are posted in our reception area.

I. Personal Rights

You must be treated with dignity and respect, free of any verbal or physical abuse.

You have the right to have staff make fair and reasonable decisions about your treatment and care.

You cannot be treated differently because of your race, national origin, sex, age, religion, disability or sexual orientation.

II. Treatment and Related Rights

You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate to you.

You must be allowed to participate in the planning of your treatment and care.

You must be informed of your treatment and care, including alternatives and possible side effects of medications.

No treatment or medication may be given to you without your consent.

You must be informed of any costs of your care and treatment that you or your relatives may have to pay.

III. Communication and Privacy

You have the right to request confidential communication. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.

You have the right to request restrictions on the uses and disclosures of your health information for treatment, payment or operations. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when against the law, in emergencies, or when the information is necessary to treat you.

You may not be filmed or taped unless you agree to it.

IV. Record Privacy and Access Law

You have been asked to read our Notice of Privacy Practices and to sign a consent form so that we can use/disclose your health information for treatment, payment and healthcare operations.

You have a right to a paper copy of our Notice of Privacy Practices.

You have the right to see and copy your health information. This includes your medical record and billing record but **does not include psychotherapy notes.** We may ask a reasonable charge for copying.

You have the right to amend or change your health information if you believe it is incorrect or incomplete. You must make this request in writing and you will need to explain your reasons for requesting the change.

You have the right to ask for a list of the disclosures we have made of your health information. You can ask for a listing of what information we sent, when we sent it and to whom it was sent. You will be asked to fill out a form so that we can provide this list to you.

VI. Authorizations

Other than is stated previously, Northshore Clinic will not disclose your health information unless you have signed an **authorization for disclosure**. You have the right to revoke this authorization at any time but disclosures made before your revocation cannot be recovered or undone. In some cases, the law requires some disclosures and these cannot be revoked.

VII. Complaints

You have the right to file a complaint if you believe your privacy rights have been violated in any way. You cannot be threatened or penalized for filing a complaint. Any member of our staff can explain your rights and the complaint process. We also have an anonymous "How are we doing" box in our reception area. Please feel free to give us suggestions or comments at any time.

Our Privacy Officer is: **Patricia A. Brinkman, MSW, LCSW**

You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing.

Northshore Clinic, LLC

805 N 6th Street
Sheboygan, WI 53081

Phone (920) 457-8866
Fax (920) 457-8867