Therapies East Associates, LLP 827 N. Cass Street, Milwaukee, WI 53202 (414) 278-7980

Information Form For Child/Adolescent

Therapist:____________________________________ Intake Date: ____________________________________

Name: ______________________________________ Date of Birth: __________________________________

Address: _____________________________________ Gender: _______________________________________

City/State/Zip: ________________________________

Father's Name ____________________ DOB ________

Address:_____________________________________

____

Phone: Home (_____) __________Work: (____) __________

Cell Phone: (_____) ___________

Relationship Status: M D S W P (Partnered)

Father may be contacted at home _______ work ______

Mother's Name ____________________ DOB ________

Address:_____________________________________

____

Phone: Home (_____) __________Work: (____) __________

Cell Phone: (_____) ___________

Relationship Status: M D S W P (Partnered)

Mother may be contacted at home _______ work ______

*I have specified contact/communication concerns on back of form: Yes or No (circle one)

Emergency contact person: ______________________________ Phone ( )________________________

Referred to therapist/Therapies East by ____

Bills should be sent to ____

Payment Information: (Please check) Self Pay ___ Insurance ___ MSA ___ HSA ____ Other ____

Insurance Information

Primary

Name of Insurance Co. __________________________

Policy Holder _______________________________

Effective Date _______________________________

Employer ___________________________________

ID#/Group# _________________________________

Type of Coverage Single/Family

Claims Address ______________________________

Phone Number _______________________________

Secondary

Name of Ins. Co.______________________________

Policy Holder _______________________________

Effective Date _______________________________

Employer ___________________________________

ID#/Group#__________________________________

Type of Coverage Single/Family

Claims Address ______________________________

Phone Number _______________________________

Benefits

In Network ____ Out of Network ____

Preauth needed for sessions? yes ___ no ___

Authorization # ________________________

Number of sessions authorized ___________

Authorization dates ______________to ________

Deductible $ _________

Copay per session $ or % _____________

Coinsurance ________________%

Benefits for calendar year $ ______________

In Network ____ Out of Network ____

Preauth needed for sessions? yes ___ no ___

Authorization # ________________________

Number of sessions authorized ___________

Authorization dates __________ to __________

Deductible $ _________

Copay per session $ or % _____________

Coinsurance ________________%

Benefits for calendar year $ ______________

ASSIGNMENT OF BENEFITS: Since my health insurance may cover the cost of service, I hereby authorize Therapies East Associates, LLP to release to my insurance company and/or associated professionals only pertinent billing/diagnostic information from my medical records which may be necessary to determine benefits payable under my policy. This information may be transmitted electronically. I authorize payment directly to TEA for services rendered. **I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits.**

Signature____ Date _________________________

Therapies East Associates, LLP, 827 N. Cass Street, Milwaukee, WI 53202

I am voluntarily seeking services with ___________________for myself (name)______________________

Or my minor child/ward named ________________________beginning _________________

Consent to Treatment

I understand that:

1. I have responsibility in the development of my own or my child's treatment plan. The treatment shall be developed with my understanding and approval.
2. one of my rights is the right to specific, complete and accurate information concerning the purpose of treatment, including the benefits and side effects of treatment.
3. I may request the opinion of a consultant or be given information concerning alternatives for treatment.
4. termination is usually an agreement between my therapist and myself, but I have the freedom to discontinue treatment at any time.
5. this consent shall be valid from the date specified above until termination of therapy.
6. my clinical information is confidential in accordance with the accompanying HIPPA agreement.
7. material concerning my rights and responsibilities, the "DHSS Patient Rights" brochure, is available in the waiting room areas.
8. confidential consultation between my therapist and the Therapies East Associates, LLP staff and their consulting psychiatrist will occur as deemed necessary.

Fee Agreement

I agree that:

1. _________________ charge for services is $_________ per hour.
2. my insurance will be billed at this rate if I choose to use my insurance to cover fee for services.
3. I shall be **responsible for any charges not covered by insurance plans**. If I do not choose to use/authorize the billing of my insurance company, I will be responsible for the full cost of services. If the above hourly fee creates a hardship for me, it is my responsibility to request a payment agreement that will be suitable for my current financial situation.
4. any and all costs associated with collection activities, legal fees, accounting and other related activities required to secure payment will be my responsibility.
5. my **deductible and/or co-payment fees will be collected at each appointment**.
6. telephone conversations with my therapist lasting longer than 15 minutes may be billed at a partial hourly fee thereafter. This fee is not covered by insurance. I will be informed at the time of the call if fees are being charged.
7. any additional services requested by a client for any reason will be billed as a separate charge. For example, all correspondence/phone calls requested by a client will be billed at a $______/hour rate. These additional services include sending a letter, treatment summary, etc. to courts, attorneys, state agencies, probation officers, etc. and all other service time not covered by insurance.
8. I will keep scheduled appointments or I will give a minimum of **a 24-hour notice of cancellation.** Failure to abide by this notice may result in my being billed $_______ for my session. (Insurance coverage does not apply).

Client Name (Please print) _______________________Adult Signature (For minor child) _____________________

Client Signature _________________________________Relationship to Child_________________________

Date ______________________

Therapies East Associates, LLP

Child & Adolescent Health & Psychosocial Assessment

To be completed by the parent or guardian.

Child's name____ Age: _________ DOB:______________
Date: ____________ Sex:____________ Race:_________________ Form Competed by [ ] Self [ ] Other____________
Accompanied by_______________________/Relationship____________________ Referred by_____________________

REASON FOR SEEKING TREATMENT:

____

____

GOALS YOU WOULD LIKE ACHIEVED IN TREATMENT: ____

____

Where does the problem occur: Home School Community

Age when problem began: ________ Duration: Less than 6 months Greater than 6 months

Child's Strengths and Limitations: ____

____

SOCIAL HISTORY:

Current school, grade, teacher____

Special Programming (M teams, IEP, etc.)____

Social/psychological services:____

Academic Functioning: Present____

Past History____

Behavior in School: Present____

Past History____

Juvenile Court Contacts: None Yes (Please Explain)____

____

SAFETY
Has your child had any suicidal/self-harmful thoughts recently (in the past month)? [ ] Yes [ ] No
Has your child ever had any suicidal thoughts? [ ] Yes [ ] No
Has your child ever made a suicide attempt? [ ] Yes [ ] No
Has any immediate family or "extended family" (i.e. aunts, uncles, cousins, grandparents) or close friends ever attempted suicide? [ ] Yes [ ] No Completed suicide? [ ] Yes [ ] No
If yes to any of the above, please explain ____

____

FAMILY HISTORY

MEMBERS OF HOUSEHOLD

Name **Age** **Occupation** **Relationship**

____

____

____

____

____

ADDITIONAL SIGNIFICANT FAMILY MEMBERS

Name **Age** **Occupation** **Relationship**

____

____

____

____

PRIOR OUTPATIENT AND/OR INPATIENT MENTAL HEALTH OR CHEMICAL DEPENDENCY TREATMENT FOR PATIENT OR IMMEDIATE FAMILY MEMBERS

Who	Where	When	Reason	Out Patient	In Patient
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]
				[ ]	[ ]

Extended family history of mental health or drug/alcohol problems. [ ] Yes [ ] No
Comments:

Please describe any significant stresses affecting your child/family at the present time. ____________________________

____

____

DRUG/ALCOHOL HISTORY

Does your child have any history of drug, alcohol, or cigarette use? [ ] Yes [ ] No (Please Explain) ________________

____

____

ABUSE ASSESSMENT

Has your child ever been...		
Yes	**No**	**Explain any "Yes" replies**
[ ]	[ ]	Physically abused
[ ]	[ ]	Emotionally abused
[ ]	[ ]	Sexually abused
[ ]	[ ]	Sexually assaulted (rape)
[ ]	[ ]	Verbally abused
[ ]	[ ]	Exposed to family domestic violence
[ ]	[ ]	Abusive to self (cutting, burning self)

Has this been reported? [ ] Yes [ ] No If yes, to whom?
Does your child have a history of physical, emotional, sexual, or verbal abuse towards others? [ ] Yes [ ] No Explain:

DEVELOPMENT HISTORY

Mother's health during pregnancy:____

Parental use of drugs, alcohol, or cigarettes during pregnancy: [ ] Yes [ ] No

Prenatal Care: [ ] Yes [ ] No **Postnatal Care:** [ ] Yes [ ] No

Complications during pregnancy or delivery:____

Health problems noted at birth:____

Full term: [ ] 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

Coordination Difficulties: [ ] Yes [ ] No **Bed Wetting:** [ ] Yes [ ] No

Other: ____

Please comment on the following regarding your child:

Appetite: [ ] Good [ ] Poor

Sleep Patterns: [ ] Normal [ ] Abnormal (Explain)____

Peer Relationships: [ ] Good [ ] Poor

Activity level: [ ] Inactive [ ] Average [ ] Over Active

How do you nurture your child?____

____

How do you discipline your child?____

____

SPIRITUALITY

Do you have a religious preference? [ ] Yes [ ] No (If yes, please describe)_______________________________

Is your spiritual belief system part of your support system? [ ] Yes [ ] No

Do you have any spiritual concerns that you or your child would like to address in therapy? [ ] Yes [ ] No

CULTURAL

Are there any cultural issues/customs related to your family, which your therapist should be aware of? [ ] Yes [ ] No
Please explain: ____

Are there any cultural expectations, values, or pressures causing conflict in your life? [ ] Yes [ ] No

Please explain: ____

____

MEDICAL HISTORY:

Pediatrician:____ **Phone:** ______________________

Clinic address: ____

Last visit______________________________ **Reason for visit**____

Please check if your child/teen is currently experiencing or has ever experienced:

[ ] Abnormal blood pressure
[ ] Acne
[ ] Anemia
[ ] Arthritis/ Rheumatism
[ ] Asthma
[ ] Broken Bones
[ ] Cancer
[ ] Changes in appetite
[ ] Chronic Fatigue Syndrome
[ ] Diabetes
[ ] Eating Disorders
[ ] Epilepsy/Seizure
[ ] Fainting Spells
[ ] Fibromyalgia
[ ] Hay Fever
[ ] Headaches
[ ] Hearing Impaired
[ ] Hepatitis Type A, B, or C
[ ] Heart (Disease/Surgery)
[ ] Heart Murmur)
[ ] HIV Positive/AIDS/ARC
[ ] Irritable Bowel Syndrome
[ ] Kidney or Bladder Problems
[ ] Liver Disease
[ ] Head injury
[ ] Neurological Disorders
[ ] Rheumatic Fever
[ ] Sickle Cell Disease
[ ] Skin Disorders
[ ] Stomachaches/problems
[ ] Thyroid Problems
[ ] Tumors
[ ] Ulcers/Abdominal Pain
[ ] Venereal Disease
[ ] Memory Loss
[ ] Visual Problems
[ ] Weight Changes
[ ] Other

Does your child have any allergies [ ] Yes [ ] No (Explain) ____

Does your child have any history of problem reactions to medications [ ] Yes [ ] No (Explain)__________________

____

Other significant health history or hospitalization:____

____

Has your child had any significant absences due to medical problems? [ ] Yes [ ] No

Current medications:

Current Medication	Dosage	Frequency	Prescribing Doctor	Any Side Effects

May we contact the child's primary physician? [ ] Yes [ ] No [ ] Don't have a physician

Additional Comments:

____
____
____
____
____

Parent Signature____________________ **Date:**_________ **Therapist Signature**__________________ **Date:**_________

Therapies East Associates, LLC

Electronic Communication Informed Consent

CLIENTS MUST CONSENT TO THE USE OF ELECTRONIC COMMUNICATION FOR CONFIDENTIAL MEDICAL INFORAMTION AFTER HAVING BEEN INFORMED OF THE FOLLOWING:

ELECTRONIC COMMUNICATION SECURITY AND CONFIDENTIALITY CANNOT BE GUARANTEED DUE TO THE FOLLOWING POTENTIAL RISK FACTORS:

- ❖ Unintended recipients may receive the information
- ❖ Information may forwarded to others without the client's permission
- ❖ Electronically transmitted information can be more readily falsified than written information
- ❖ Information may be sent to the wrong destination or recipient
- ❖ Despite deletions of electronic information, that information may still exist within the electronic systems

CONSENT TO THE USE OF ELECTRONIC COMMUNICATION FOR CONFIDENTIAL MEDICAL INFORMATION INCLUDES AGREEMENT WITH THE FOLLOWING CONDITIONS:

- ❖ Electronic communication includes email, text messages and faxed information
- ❖ The client and therapist must agree to the appropriate use of electronic communication
- ❖ All electronic communication regarding confidential medical information will be also printed and maintained in the client's file
- ❖ Due to security risks, caution in the use of electronic communication is essential
- ❖ Client's do not have a right to privacy within their employer's email systems, and therefore it should not be used to send or receive confidential medical information
- ❖ Client's who consent to use of electronic communication are responsible for informing the therapist of any type of information they do <u>not</u> want to be sent electronically
- ❖ Use of electronic communication with the therapist does not ensure immediate response from the therapist; urgent communication should be made through the Therapies East telephone system
- ❖ EMERGENCIES cannot be handled with electronic communication. Use the emergency procedures available through the Therapies East telephone system

This consent is valid for the entire course of treatment and may be withdrawn by the client, in writing, at any time.

Client's Signature____ Date _________________

Therapist's Signature____ Date _________________

DO NOT PRINT -- READ ONLY

Therapies East Associates, LLP

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"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. 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.

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

Elder Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of elder 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 payors 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

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Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

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 Lila Piraino, MS at 827 N. Cass St., Milwaukee, WI 53202:

- **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.

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- **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 Lila Piraino at 827 N. Cass St., Milwaukee, WI 53202 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 December 2014.

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Therapies East Associates, LLP

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:____
DOB: ____
SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Therapies East Associates, LLP's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lila Piraino, MS at 414-278-7980 x112 or by mail at 827 N. Cass Street, Milwaukee, WI 53202.

____
Signature of Patient/Client **Date**

____
Signature or Parent, Guardian or Personal Representative * **Date**

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* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

____
Signature of Staff Member **Date**

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