Client Name: _____

Be The Change Health and Wellness
INTAKE QUESTIONNAIRE

Personal Information:

Today's Date:_____

Name_____ Birthdate_____

Address_____

Cell Phone Number_____ Home Number_____

Emergency Contact Person:

Name_____Relationship:_____

Address:_____

Phone(s): cell:_____Home:_____

E-mail: _____

GOALS FOR TREATMENT

Describe the issue/issues that have been problematic to you:

What do you hope to gain from participating in services at Be the Change Health and Wellness?

Client Name: _____

What strengths do you possess that would help you reach these goals?

What might get in the way of your reaching these goals?

Is there anything that would be helpful for us to know about you?

MEDICAL HISTORY

Date of last physical exam: _____

Physician :_____

Have you, or are you, being treated for any of the following, or are you currently having symptoms related to any of the following? (Please circle those that apply.)

Migraines Headaches Dizziness Head Trauma Stroke Vision Problems/Loss

Hearing Loss or Ringing in Ears. Allergies-Seasonal or Other Heart Attack

High or Low Blood Pressure Other Heart Conditions Asthma. Gastric Reflux or Ulcers,

Pancreatic Gall Bladder Disease Other Digestive Problems Urinary Problems

Sexual Dysfunction Thyroid Problems Diabetes Bleeding Problems/Easy Bruising

Skin Problems Back or Joint pain/Arthritis Nerve Numbness or Sensitivity Seizures

Muscle Weakness/Injury Arthritis Menstruation Irregularity/Pain Hysterectomy

HIV Hepatitis STD

Insomnia Sleep Apnea Other Neurological Disorder(s),

Client Name: _____

Please comment on any above concerns:

_____
_____
_____

List current exercise routine/classes:

_____
_____

MEDICATIONS

Please list any current prescription medication:

Medication Dosage: _____ Date First prescribed: _____

_____
_____
_____
_____

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

_____

Do you have any allergies and/or adverse reactions to medications:

_____

If yes, please list:

_____
_____

Other treatments/healing modalities (Acupuncture/Reiki/Massage/Yoga/Coaching):

_____

Mental Health:

What are your Mental Health concerns?_____

_____
_____
_____

Have you had a mental health diagnosis in the past? If so what was your diagnosis?

_____

Client Name: _____

What mental health treatment have you had in the past? Please list dates and therapists/hospitalizations/intensive outpatient or residential care._____

_____

_____

Any self-harm in the past or currently?_____

_____

Please circle what you are currently experiencing:

sad/depressed teary/crying angry/hostile fearful shame/guilt anxiety euphoric ambivalent jealous hopeless helpless grief panic indifference confusion

negative thinking positive thinking preoccupied obsessive thoughts ruminating religiosity hearing voices seeing things that aren't there thoughts to harm self

thoughts to harm others memory issues sleeping changes eating changes/poor appetite

Comments about above:_____

_____

_____

SUBSTANCE USE HISTORY

Please list the frequency and amount of uses for the following substances/age started:

Tobacco_____

Caffeine_____

Alcohol_____

Marijuana_____

Cocaine_____

Crack_____

Ecstasy_____

Heroin_____

Inhalants_____

Client Name: _____

Methamphetamines_____

Pain Killers_____

PCP/LSD_____

Steroids_____

Tranquilizers_____

Other_____

How has your drug or alcohol us caused you problems?_____
_____
_____

Have you been treated for drug and alcohol issues? If so, outpatient, detox, intensive outpatient inpatient or residential treatment? (List dates and where did you receive treatment)_____
_____
_____
_____

COMPULSIVE BEHAVIOR HISTORY

If you have a history of any of the following compulsive behaviors or addictions, please circle:

Gambling spending sex computer games eating disorders relationship addiction/co-dependency exercise work pornography caffeine

Please describe the frequency for above addictions:
_____
_____

How have they caused you problems?_____
Have you been treated for any of the above issues? If so, outpatient, intensive outpatient inpatient or residential treatment?_____

ABUSE/NEGLECT/TRAUMA HISTORY

Please circle if you have experienced any of the following types of trauma or loss:

Emotional abuse Neglect Lived in a foster home Sexual abuse Violence in the home

Multiple family moves Physical abuse Sexual Trauma Homelessness Parent substance abuse

Parent illness Loss of a loved one Teen Pregnancy Miscarriage Abortion Abandoned

Placed a child for adoption Financial problems Betrayal/Relationship Trauma

Work Place Trauma Discrimination Racism Micro-aggressions Harassment Crime Victim

Client Name: _____

FAMILY PSYCHIATRIC HISTORY:

Please indicate if your biological relatives have experienced any of the following.

___Anxiety ___Completed or Attempted Suicide ___ADHD ___Psychosis_____ Schizophrenia ___Bipolar Disorder ___Depression ___Substance Abuse_____ Other Addictions_____Other Mental health issues

Please describe the severity and time course for any of these conditions and describe any other psychiatric conditions that run in your family:

._____
_____
_____

Please list any family history of mental health issues or substance use:

Name Relation to you Issue

_____
_____
_____
_____
_____

FAMILY/RELATIONSHIP HISTORY (please circle)

Do you live alone? No / Yes List who lives with you:

Are you married or in a relationship currently? No / Yes

Name of significant other:

Significant other's employment:

Describe relationship with current significant other:

How many previous marriages or long- term relationships have you had?

Client Name: _____

Do you have children? No / Yes (List)

Name	Age	Relationship	Living with you?

Do you have any pets? No / Yes

Where did you grow up?

What was your childhood like?

Did your parents stay together while you were growing up? No / Yes

How old were you if/when they separated?

Who did you live with after the separation?

Father's occupation while you were growing up:

Mother's occupation while you were growing up:

How many siblings do you have/ages? None ___ Brothers _____
Sisters_____
_____

Describe your current family:

Client Name: _____

SOCIAL HISTORY

Do you have a social support system? Describe:
_____
_____
_____

What are your barriers to social relationships?
_____
_____
_____

Do any addictive processes limit or affect your social relationships? Y / N Please explain:
_____
_____
_____

EDUCATION/LEARNING

Where did you go to school?

Highest education/degree completed:

Any problems in school? Academic/Social/Behavioral/Substance Use:

List further professional training:

Current occupation_____ Are you working? Yes/No_____Hours/week_____
Where do you work?_____

What type of jobs have you had in the past?

Have you had any job related issues?

How do you best learn?

Client Name: _____

SPIRITUALITY:

Describe your spirituality:

_____
_____

What activities do you participate in that aids in your spirituality?:_____
_____
_____

How does your spirituality aid or negate your mind/body/spirit healing?:
_____
_____
_____

Has your spirituality been affected by addictions or other trauma experiences?:
_____
_____
_____

Client Name: _____

Clinician Notes (Client please skip this and move to the forms needing signature)

Clinician Name:_____Date:_____

Mental Status Exam:

Affect/Mood

Sad/Depressed	Teary/Sobbing	Angry/Hostile	Labile
Appropriate	Dramatic	Euphoric	Flat
Unresponsive	Paranoia	Panic	Fear
Ambivalence	Hopelessness	Anxiety	Indifference
Jealousy	Depreciation	Grief	Helplessness
Guilt/Shame	blocking	Distracted	Restricted
Alert	Lethargic	Other:_____	

Thoughts

Normal Limits	Repetitive	Incoherent	Psychotic	Religiosity
Accelerated	Retarded	Tangential	Labile	Preoccupation
Vague	Negative	Positive		Obsessive
Loose Associations	Narcissism	Grandiose	Other:_____	

Homicidal: Yes/No (if yes describe)_____

Suicidal: Yes/No (if yes describe)_____

Risk or History of Violence:_____

Orientation: Person Place Time Memory_____

Interaction: Involved Uninvolved Other:_____

Insight/Judgment: Excellent Good Fair Poor

Hygiene: Good Fair Poor Neglected

Client Name: _____

Speech_____

Estimated intelligence:_____

Change in Sleep_____ Change in Weight_____

Defenses
(Avoidance/Denial/Regression/Suppression/Minimizing/Rationalizing/Accepting/Intellectualizing/Blaming:

Strengths:_____

Diagnostic Impressions:

_____
_____
_____
_____
_____
_____
_____

Recommendations:_____
_____
_____

Does Client agree with recommendations?

_____

Diagnosis:

_____
_____
_____

Other Notes:

ASAM
Criteria:_____

_____
_____
_____

ACES Score:_____

DES Score:_____

Client Name: _____

Therapist
Signature:_____

Date:_____

Client move to forms below

Be the Change Health and Wellness

Patient Information and Consent Form for Zoom Teletherapy

Client Name: _____

Introduction

Teletherapy is the delivery of psychological services, including diagnosis, consultation, treatment and education using interactive audio and/or electronic systems in which the clinician and the patient are not in the same physical location. All protections and limitations of HIPAA are the same for online therapy as they are in person, as outlined in the Privacy Policies you have already received. Teletherapy sessions with Be the Change Health and Wellness (BTC) are typically conducted using the videoconferencing platform Zoom, which is HIPAA compliant. You do not need your own Zoom account to meet with your clinician through Zoom. However, you will need access to a computer, tablet, or smart phone with a video camera and microphone and you will need to download the Zoom application to your device.

Potential benefits of teletherapy

- Increased accessibility to psychological care
- Patient convenience

Potential Risks with teletherapy

As with any healthcare service, there may be potential risks associated with the use of teletherapy. These risks include, but may not be limited to:

- Despite reasonable efforts, information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate psychological decision making by Be the Change Health and Wellness (BTC) clinicians.
- BTC clinicians may not be provide for or arrange for emergency care that I may require.
- Delays in psychological evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, (although extremely unlikely) causing a breach of privacy of my confidential psychological information.
- A lack of access to all the information that might be available in a face-to-face visit but not in a teletherapy session may result in errors in psychological judgment.

Alternatives to the use of teletherapy

- Traditional face-to-face sessions with a local provider.

My Rights

1. I understand that the laws that protect the privacy and confidentiality of psychological information, including HIPAA, also apply to teletherapy.
2. I understand that during a teletherapy session, both locations shall be considered a private psychotherapy room regardless of a room's intended use. I understand that my BTC clinician has chosen a room that accommodates both audio and visual privacy.
3. I understand that the video conferencing technology used by BTC clinicians is encrypted to prevent unauthorized access to my private psychological information.
4. I have the right to withhold or withdraw my consent to the use of teletherapy during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment. I also understand that my BTC clinician has the right to withhold or withdraw consent for the use of teletherapy during the course of my care at any time.

Client Name: _____

5. I understand that the all rules and regulations which apply to the practice of psychotherapy in the state of Wisconsin also apply to teletherapy.
6. I understand that my BTC clinician will not record any of our teletherapy sessions without my prior written consent.
7. I understand that my BTC clinician will inform me if any other person can hear or see any part of our session before the session begins.
8. I understand that my BTC clinician will take every precaution to ensure the privacy of the consult and the confidentiality of the patient. All persons in the room shall be identified to the client prior to the consultation and the patient's permission shall be obtained for any visitors or clinicians to be present during the session.

My Responsibilities

1. I understand that if using the Zoom platform for teletherapy, I will need to download the Zoom application and I will need a broadband internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services.
2. I will not record any teletherapy sessions without prior written consent from my BTC clinician.
3. I will strive to keep my device on a steady surface throughout sessions, avoiding holding the device in my hand. If I must hold the device in my hand, I agree to hold it as steady as possible.
4. I agree to minimize distractions to the extent possible, including preventing children, pets and others from distracting the teletherapy session. I agree to refrain from playing games, engaging in social media or working on other things during a teletherapy session.
5. I will take every precaution to ensure the privacy of the consult and my own confidentiality. I will choose a room that accommodates both audio and visual privacy. I will inform my BTC clinician if any other person can hear or see any part of our session before the session begins.
6. I understand that third-parties may be required to join in the meeting with my provider and me to provide technical support. I understand that I may be asked to interact with the technical support person on camera in order to fix the problem. I understand that if I decline this request and my equipment is rendered unusable for video conferencing, I may forfeit my option to use teletherapy.
7. I understand that I, not my BTC clinician, am responsible for the configuration of equipment on my computer which is used for teletherapy. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I am responsible for the cost of equipment, internet applications and other costs associated with my end of the teletherapy conference. My therapist is responsible for the cost of their equipment, internet, application and other costs associated with being a teletherapy provider
8. I understand that I must be appropriately and fully dressed and sitting in an appropriate setting for our session.
9. I understand that I am responsible for any cost not covered by my insurance such as copays and deductibles and that my Insurance may not cover teletherapy, therefore, making it my responsibility to pay for uncovered services.

Payment for Sessions

Client Name: _____

Clients paying out-of-pocket for therapy will pay the same fee as paid for in-person sessions. For clients using health insurance, BTC will seek authorization for insurance payment for teletherapy. Co-payments will still apply. If the insurance company will not authorize this service, we will make other arrangements.

Patient Consent To The Use of Teletherapy

I have read and understand the information provided above regarding teletherapy, have discussed it with my BTC clinician and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of teletherapy in my psychological care and authorize my BTC clinician to use teletherapy in the course of my diagnosis and treatment.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____

Client Name: _____

Be the Change Health and Wellness

Informed Consent for Treatment

I want you to be aware of your rights as a client and ask for your informed consent to receive treatment. Please be aware of the practice regarding confidentiality for your health information. Your rights as a patient are shown below. Privacy practices are shown in a separate document provided to you.

1. The benefits of being a recipient of services may include, but are not limited to, being better able to meet your personal needs: improved communication skills, clearer thought process, and more stable mood.
2. Services provided may include psychiatric assessment, case management, group, individual, family, and couples therapy. If medication is a part of your treatment program, the purpose of the medications will be discussed with you by your psychiatrist.
3. The risks of receiving services may include feelings of anxiety, depression, frustration, loneliness, helplessness or other intense emotions when you discuss life problems or experiences with your treatment providers. Certain medications may have common side effects that will be discussed with you at the time that you see the psychiatrist for a medication evaluation. It is your right, unless under court order, to decide whether or not you want to take any medication.
4. If you disengage from services or elect not to participate, it is possible your problems may not be addressed or may become worse than they are at the present time.
5. The treatment staff will discuss treatment recommendations, benefits of treatment, duration of treatment and outcome of treatment as well as associated fees with services.
6. The possible **benefits of EMDR** treatment include the following:
   • The memory may be remembered but the painful emotions and physical sensations and the disturbing images and thoughts may no longer present.

   • EMDR may help the mind reintegrate the memory and store it more adaptively. The client's own mind reintegrates the memory and does the healing

   The possible **risks of EMDR** treatment include the following:

   • Reprocessing a memory may bring up associated memories. This is normal and those memories will be contained so that they may be processed with a therapist at a later date.

   • During EMDR, the client may experience physical sensations and retrieve images, emotions and sounds or smells associated with the memory.

   • Reprocessing of the memory normally continues after the end of the formal therapy session. Other memories, flashbacks, feelings and sensations may occur. The client may have dreams associated with the memory. Frequently the brain is able to process these additional memories without help, but arrangements for assistance will be made in a timely manner if the client expresses difficulty coping.

_____**Initial Here** if you have any of these **medical issues: pregnancy, epilepsy, eye issues** such as retinal tear or contacts, as they may require medical consent before participating in EMDR.

7. The treatment plan may suggest alternate treatment modes and will make referrals to other services when appropriate or necessary.
8. You may be discharged from treatment for failure to follow through with treatment recommendations, failure to show up for appointments or abuse of medication.
9. Services never involve sexual contact between therapist and client; this is unethical and against the law.
10. This informed consent will be in effect no longer than fifteen months from the time that consent is given
11. You have a right to withdraw this informed consent, in writing, at any time.
12. Emergency after hours procedure will be reviewed by treatment staff.
13. Your therapist will not communicate with you via their private social media.

Denial of patient rights

Client Name: _____

Your rights may only be denied in certain circumstances such as:

1. When there is a danger to life or health of the client or potential harm to others.
2. Suspected cases of child or elder abuse or neglect. (s. 48.98)
3. A lawful order of the court to which you must comply.

By my signature below, I attest that my rights as a patient have been explained to me and I give my consent for treatment. I have also received a copy of the Rights and the Grievance Procedure, and a copy of the Notice of Privacy Practices.

_____ _____

Client/Guardian Signature* Date

_____ _____

Client's Name (Please Print) Date of Birth

_____ _____

Witness Date

* If client does not sign, please document reason:_____

Client Name: _____

Be the Change Health and Wellness

Written Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the notice of privacy practices and have been provided an opportunity to review and understand it. The notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of this evaluation, or performance of Be the Change Health and Wellness's health care operation. This notice also describes my rights and Be the Change Health and Wellness's duties with respect to my protected health care information.

_____ _____/_____/_____

Name of Patient (Please Print) Patient Date of Birth

_____

Name of Personal Representative (if applicable)

_____ _____/_____/_____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (if applicable)

Telephone Communication

Be the Change Health and Wellness may leave messages for me at the following numbers:

1)_____ 2)_____

3)_____ 4)_____

_____ Be the Change Health and Wellness may leave a name and return number only at the above numbers. (Indicate which numbers if not all)

_____ Be the Change Health and Wellness may leave a detailed message at the above numbers (indicate which numbers if not all)

_____ Be the Change Health and Wellness may text message me at the above numbers (indicate which numbers if not all)

Client Name: _____

Be the Change Health and Wellness

240 N. Milwaukee St #202 Milwaukee, WI 53202
Phone: 262.646.8288
BetheChangeHealth@gmail.com
Taken from : Division of Community Services Department of Health and Social Services Wisconsin PCS-195. Rev.5/95

Notice of Privacy Practices

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

Your personal information is personal and private. Securing and maintaining the confidentiality of that health information has always been of utmost importance for Be the Change Heath and Wellness, LLC.
"We" or "us" or "BTC" refers to Be the Change Heath and Wellness, LLC hereinafter. "HIPPA" hereinafter refers to privacy regulations promulgated by the United States Department of Health and Human Services Portability and Accountability Act of 1996. HIPPA provides Be the Change Heath and Wellness, LLC the opportunity to reaffirm that commitment to your privacy.

In order to provide you with quality care, We need to use and disclose your health information. BTC is dedicated to maintaining the privacy of your health information (also known as "protected health information" or "PHI") that is in the possession of BTC in accordance with applicable state and federal law. As required by HIPPA, We are providing you with this Notice of BTC's Privacy Practices (hereinafter referred to as "Notice"). BTC is required to follow these terms and any revision to it that is an effect.

I. How Be the Change Health and Wellness May Use and Disclose Your Protected Health Information.

BTC is generally required to obtain your written authorization to disclose your PHI. There are, however, instances where BTC may use or disclose your PHI without your prior written authorization. The following are examples of instances where BTC may use or disclose your PHI; both of those instances of use or disclosures with your prior written authorization, and those instances of use or disclosure without your prior written authorization.

A. Uses and Disclosures that Require Your Authorization

1. BTC may disclose your PHI to provide treatment to you or for others to provide treatment to you. We may disclose your PHI to physicians, nurses, other health care personnel, hospitals, nursing homes, and other health care facilities who are involved in you care. For example, we may disclose your PHI to hospitals or other facilities outside of BTC to schedule admissions.
2. BTC may also use or disclose your PHI to your insurance company in order to receive payment for the treatment or services provided to you. For example, we will use your PHI to create that claims we submit to your insurance company, or we may provide copies of portions of your medical record to your insurance company to obtain payment of your claim for the insurance company to determine preexisting conditions. We may also disclose your PHI to another health care provider or insurance company for their payment-related activities to enable them to receive payment for the treatment or services provided to you or to process claims under your health insurance plan.
3. BTC may also use or disclose your PHI for our operations related to health care. For example, we may use your PHI to evaluate the quality or care you received from us, or to evaluate the performance of those involved with your care. We may also provide your PHI to

our attorneys, accountants, and other consultants to make sure we are complying with the laws that affect us. In addition, we may disclose your PHI to another health care clearinghouse for purposes of their operations related to health care.

B. Uses and Disclosures that Require Be the Change Health and Wellness to Give you the Opportunity to Object

1. Unless you object (see privacy notice form), BTC may use your PHI to contact you to remind you that you have an appointment at one of our locations, or to tell you about or recommend possible treatment options or alternatives, or about health related benefits or services that may interest you.
2. Unless you object, BTC may provide relevant portions of your PHI to a family member, friend, or other person involved in your health care or in helping you get payment for your health care. For example, unless you object, statements sent to members of your family who have had services at BTC. Or in an emergency, or when you are not capable of agreeing or objecting to these disclosures, we will disclose your PHI as we determine what is in your best interest. Unless you object, we may disclose your PHI to persons performing disaster relief activities.

C. Uses and Disclosures that Do Not Require Your Authorization

Be the Change Health and Wellness may also use and disclose PHI without your authorization and without providing you with the opportunity to object in the following circumstances:

1. As Required or Permitted by Law. BTC may disclose your PHI to legal authorities, such as law enforcement officials, court officials, correctional institutions, or government agencies, when required to do so by law. For example, we may have to disclose your PHI to report suspected child abuse, neglect or a crime, and are permitted to report suspected elder abuse.
2. For Public Health Activities. BTC may be required to report your PHI to authorities to help prevent or control disease, injury, or disability. This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration or information related to child abuse or neglect. BTC may also have to report to your employer certain work-related illnesses and injuries for workplace safety purposes.
3. For Health Oversight Activities. We may disclose your PHI to authorities and agencies for oversight activities authorized by law, including audits, investigations, inspections, licensure, disciplinary actions or legal proceedings. These activities are necessary for oversight of the health care system, government programs and civil rights laws.
4. For Activities Related to Death. We may disclose your PHI to coroners and medical examiners so they can carry out their duties related to your death, such as identifying the body or determining cause of death, and to funeral directors to carry out funeral preparation activities.
5. For Organ, Eye, or Tissue Donation. We may disclose your PHI to organ procurement agencies who are involved in obtaining, storing, or transplanting organs, if you have indicated your desire to be a donor.
6. For Medical Research. In limited circumstances, We may disclose your PHI to researchers affiliated with BTC who request it for medical research projects that are approved by BTC. However, these disclosures must receive special approval by our privacy officer before any PHI is disclosed to such researchers.
7. To Avert Threat to Health or Safety. In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
8. For Worker's Compensation. We may disclose your PHI in order to comply with the law related to worker's compensation or other similar benefits for work-related injuries or illness.

Client Name: _____

If you revoke your authorization, we will no longer use or disclose your PHI for the purposes specified in the authorization, except to the extent we have already taken action in reliance upon your authorization.

II. Your Rights Related to Your Protected Health Information.

You have the following rights as a patient, client or customer of Be the Change Health and Wellness.

A. The Right to Inspect and Copy Your PHI.

Except for limited circumstances, you may look at and receive a copy of your PHI by providing BTC with a written request. Such request must be submitted to our Privacy Officer. We will respond to your request within 30 days (or 60 days if we provide written notice extra time is needed). However, you do not have the right to any psychotherapy notes. These are comprised of notes recorded in a medium by a mental health professional documenting or analyzing conversations during a private counseling session or a group, joint, or family counselling session and are separate from the rest of your medical record. Psychotherapy notes will be privileged information and held confidential in accordance with Wisconsin and Federal law. BTC may deny your request to inspect and copy your PHI. But if we do, we will tell you in writing of the reason for the denial and explain your rights with regard to having the denial reviewed. If you ask us to copy your PHI, we will charge for those copies based on the purpose of your request and any regulatory directives. Alternatively; we may provide you with a summary or explanation of your PHI, as long as you agree to that and the cost, in advance.

B. The Right to Correct or Update Your PHI.

If you believe that the PHI we have in our records for you is incomplete or incorrect, you may ask BTC to amend it. Such request must be made in writing to our Privacy Officer. The request must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if we provide written notice that extra time is needed). We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask whether you want us to notify anyone else of the amendment. If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement and/or to request inclusion of your original amendment request in your PHI.

Client Name: _____

Your Rights and the Grievance Procedure

Taken from : Division of Community Services Department of Health and Social Services Wisconsin PCS-195. Rev.5/95

For Clients Receiving Services for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities.

Bill of 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: Your service provider must post this bill of rights where anyone can easily see it. Your rights must be explained to you. You may also keep this pamphlet.

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 can decide whether you want to participate in religious services
- You cannot be made to work except for personal housekeeping chores. If you agree to do other work you must be paid.
- You can make your own decisions about things like getting married, voting and writing a will.
- You cannot be treated differently because of your race, national origin, sex, age, religion, disability, or sexual orientation.
- Your surroundings must be kept safe and clean
- You must be given the chance to exercise and go outside for fresh air regularly and frequently

Treatment and Related Rights

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for 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 mediation may be given to you without your consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, **or a court orders it.** (If you have a guardian, however, your guardian can consent to treatment and medications on your behalf)
- You must not be given unnecessary or excessive medication
- You cannot be subject to electro-convulsion therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed of any costs of your care and treatment that you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to safely and appropriately meet your needs.
- You may not be restrained or placed in a locked room (seclusion) **unless in an emergency** when it is necessary to prevent physical harm to you or others.

Communication and Privacy Rights

- You may call or write to public officials or your lawyer or advocate
- You may not be filmed or taped unless you agree to it
- You may use your own money as you choose, within some limits

Client Name: _____

- You may send and receive private mail. (Staff cannot read your mail unless you or your guardian asks them to do so. Staff may check your mail for contraband. They can only do so if you are watching.)
- You may use a telephone daily
- You may see (or refuse to see) visitors daily
- You must have privacy when you are in the bathroom
- You may wear your own clothing
- You must be given the opportunity to have your clothes
- You may keep and use your own belongings.
- You must be given a reasonable amount of secure storage space.

Some of your rights may be limited or denied for treatment or safety reasons. Your wishes and the wishes of your guardian should be considered. If any of your rights are limited or denied, you must be informed of the reasons for doing so. You may ask to talk with staff about it. You may also file a grievance about any limits of your rights.

Record Privacy and Access Laws

Under Wisconsin Statute sec. 51.30 and HSS 92, Wis. Admin. Code

- Your treatment information must be kept private (confidential).
- Your records cannot be released without your consent, unless the law specifically allows for it.
- You can ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you can see of the rest of your records while you are receiving services. You must be informed of the reasons for any such limits. You can challenge those reasons in the grievance process. After discharge, you can see your entire record if you ask to do so.
- If you believe something in your record is wrong, you can challenge its accuracy. If staff will not change the part of your record you have challenged, you can put your own version in your record.

Rights of Access To Courts

- You may sue someone for damages or other court relief if they violate any of your rights.
- Involuntary patients can ask a court to review the order to place them in a facility.

Informal Resolution Process

- If you feel your rights have been violated, you may file a grievance.
- You cannot be threatened or penalized in any way for filing a grievance
- The service provider or facility must inform you of your rights and how to use the grievance process
- You may, at the end of the grievance process, or any time during it, choose to take the matter to court.
- Contact your Client Rights Specialist, whose name is shown below, to file a grievance or to learn more about the specific grievance process used by the agency from which you are receiving services.

Your Client Rights Specialist is:

Alexandra Moeller

240 N. Milwaukee St #202

Client Name: _____

Milwaukee, WI 53202 Phone: 262-646-8288

Be the Change Health and Wellness

AUTHORIZATION FOR USE AND RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Individual/Patient/client Insured:

_____ _____ _____

Name of Individual Previous Name (s) Birth Date

_____ _____(_____)_____

Street Address city, State, Zip Phone

AUTHORIZES DISCLOSURE OF PROTECTED HEALTH INFORMATION BY AND BETWEEN:

Be the Change Health and Wellness, LLC _____

Individual(s)/agency/organization making disclosure Individual/agency/organization making

And/or receiving information disclosure and/or receiving information

240 N Milwaukee Street #202 _____

Street Address Street Address

Milwaukee, WI 53202 _____

City, State, Zip Code City, State, Zip Code

(262) 646 – 8288 _____

Phone/Fax Phone/Fax

INFORMATION TO BE USED AND/OR DISCLOSED:

The following is a specific description of the health information I authorize to be used and/or disclosed:

In compliance with applicable law, which require permission to release otherwise privileged information, please release records pertaining to: (Check all that apply)

( ) Mental Health ( ) Developmental Disabilities ( ) Alcohol and/or Drug Abuse

( ) HIV test results ( ) Other (Specify) _____

For the Following Date(s): From_____To_____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

Client Name: _____

( ) Further Medical Care ( ) Coordinating Care for Dependent/Spouse

( ) Insurance Eligibility/Benefits ( ) Claims Resolution ( ) At the request of the individual

( ) Other: (specify)_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Receive Copy of this Authorization- I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization-I understand that I am under no obligation to sign this form and that Be the Change Health and Wellness, LLC may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke This Authorization-I understand that I have the right to revoke this authorization at any time by providing a written statement of revocation to Be the Change Health and Wellness, LLC. I am aware that any revocation will not be effective until received by Be the Change Health and Wellness, LLC and will not be effective regarding the use and/or disclosures of my health information that Be the Change Health and Wellness, LLC, has made prior to receipt of my revocation statement. I understand that the revocation will not apply to my insurance company (if applicable) when the law provides my insurer with the right to contest a claim under my policy. **Marketing-**I understand if Be the Change Health and Wellness, LLC uses this authorization for marketing activities, I will be informed if they receive any direct or indirect payment in connection with the use or disclosure of my information. **Right to Inspect or Copy Health Information to BE used or Disclosed-**I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form, to the extent allowed by law and Be the Change Health and Wellness, LLC. I may arrange to inspect such health information or obtain copies thereof by contacting Be the Change Health and Wellness, LLC.

RE-DISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to redisclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicate date or event) _____

If no date, event or condition is indicated, this authorization will expire one (1) year following the date of signature. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _____DATE:_____

If signed by other than individual, state relationship or legal authority: _____

Client Name: _____

Be the Change Health and Wellness

FINANCIAL POLICY AND AGREEMENT

Welcome to Be the Change Health and Wellness and thank you for choosing us as your health care provider. We look forward to providing you quality treatment and professional service. Please understand that payment of your bill is considered a vital part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to your treatment.

Regarding Insurance and Managed Care

We may accept assignment of insurance benefits. If you are covered by insurance we will bill your insurance company if you provide us with your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, we will give you credit for the amount covered by insurance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to you. Please be aware that the cost of the services provided will become your responsibility if covered in part or not at all by your insurance company. **In addition, you are expected to pay the difference between the amount covered and amount owed each time you come for an appointment. All co-pays and deductibles are due at the time of treatment. If your therapist is not in your insurance network, you will be charged the full rate unless other arrangements have been made with your therapist.** If you are a subscriber to a managed care policy, it is your responsibility to ensure that the first session is authorized by your insurance company. We also request that you understand the requirements of your insurance carrier and inform us of what procedures we must comply with to ensure payment. **While our therapists may be members of several managed care networks, it is your responsibility to ensure that your therapist is a provider for your individual policy.**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $___200_____ per session. Insurance carriers will not pay for missed or cancelled appointments. **Please help us serve you better by keeping scheduled appointments.**

Treatment Plan

Your therapist is responsible for informing you of a tentative treatment plan regarding your therapy. Together, you and your therapist can modify or alter this plan as treatment continues.

Fee Agreement

The agreed upon fee for professional services is:

$_____250_____ for initial session and $_____200_____ per 45-50 minute session

I agree to pay a minimum of $____TBD_____ toward the professional fees at each session. This includes any co-payment or deductible of which I am aware.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this policy. I also hereby authorize my insurance benefits to be paid directly to Be the Change Health and Wellness and acknowledge that I am financially responsible for any unpaid balance.

_____

Signature of Patient or Responsible Party Date

_____

Relationship of Responsible Party

Client Name: _____

Client Name: _____

PATIENT INFORMATION **PROVIDER**_____**DX**_____

First Name | Middle Initial | Last Name

Address | City | State/Zip | Home Phone:

Date of Birth | Sex: M F | Social Security Number

Employer: | Work Phone | Responsible Party (name & phone)

INSURANCE INFORMATION

Insurance Name | Mailing address for claims:

Phone Number: (required for benefit verification) | Subscriber Name, relationship, date of birth, Social Security number

Identification Numbers (We must have all numbers to process claims) | Group/Employer

Secondary insurance | Subscriber | ID Numbers | Address

**** We also offer the opportunity to use MasterCard/Visa or Discover if you prefer.**

TREATMENT CONSENT: I consent to treatment as agreed upon with my therapist. I understand my patient rights and that I may receive a copy of these rights upon request.

I understand that any copayment and/or deductible determined by my insurance policy is my personal responsibility, assuming that my insurance carrier covers any portion of the bill. I further understand that I am personally responsible for payment of any amount not covered by my insurance for any reason. I am also aware that there may be a charge for a late cancellation or a missed appointment which will not and cannot be billed to insurance.

I HAVE READ THE ABOVE INFORMATION AND I AGREE

Signature – Patient or Responsible Party | Date

BENEFIT VERIFICATION

Benefits: In Net

Benefits: Out of Net

Claims Address

Deductible | Precert required: Y N | Phone # for precert dept.

Verified by: | Contact Person | Date:

This verification does not guarantee coverage. The benefits indicated above are the basic benefits of your insurance policy. Benefits will be determined at the time the claim is received and are payable under your policy assuming they are medically necessary based on your policy guidelines. For additional information contact your insurance carrier or policy handbook.