

Adult Data Sheet

Name: _____ D.O.B. _____ Age: _____

Address: _____ City: _____ Zip: _____

Home phone: _____ OK to call? _____ OK to leave message? _____

Cell phone: _____ OK to call? _____ OK to leave message? _____

Email: _____ Text: Y N

Primary Physician: _____ Clinic Name: _____

Emergency contact & phone: _____ Relationship: _____

What concerns bring you to see us? _____

How did you find us? _____

Acuity level: Please rate **EACH** symptom below from 0 -10 (10 being high):

_____ Anxiety

_____ Depression

_____ Trauma

_____ Alcohol / Substance Abuse

_____ Grief

_____ Family Issues

_____ Relationship Issues

_____ Adjustment issues

_____ _____

Presence of current suicidal thoughts or plans? Y N

Pregnant? Y N

Released from detox in the last 24 hours? Y N

Authorization to obtain funds

Patient Responsibilities (private pays, co-pays, co-insurance and deductibles)

Private pay clients: Assessment \$ _____ Session \$ _____ Group \$ _____ No Show/LC \$50

IOP Program \$ _____ No Show/LC \$50

OR

Insurance Clients: Copay / Coinsurance / Deductible \$ _____ per visit No Show/LC \$50

Insurance Company: _____ **Subscriber ID#:** _____ **Group #:** _____

COMPLETE THIS SECTION FOR AUTOMATIC WITHDRAWAL FOR COPAYS:

Credit / Debit # _____ **Exp.** _____ **Sec Code** _____

OceanHawk Counseling Alternatives, LLC.

Please read and initial each

- _____ You wish to receive services from OceanHawk Counseling Alt. LLC.
- _____ Have fully read and understand the Informed Consent for Behavioral Services form
- _____ Have fully read and understand the Treatment Rights form
- _____ Understand there is a copy of HIPPA and Privacy Practices at the Front Desk or at www.oceanhawk.net (under Client Forms), and accessible at any time
- _____ Understand there is a copy of Complaint and Grievance Resolution at the Front Desk or at www.oceanhawk.net (under Client Forms), and accessible at any time
- _____ Acknowledge this consent for treatment will remain in effect until treatment is terminated, but not longer than 12 months have a right to withdraw this consent, in writing, at any time.
- _____ Have fully read and understand the terms of the Financial Policy and Consent to Bill form and agree to pay for services provided in accordance to OceanHawk Counseling Alternatives fee structure.
- _____ A 24 hour cancellation notice is required. CALL or TEXT (608) 873-7838 – 24 hrs. day/7 days a week.
- _____ A 48 hour notice, AND \$25.00 fee, is required when you need a letter written on your behalf by your therapist.

Insurance & Private Pay Clients:

- _____ I give my consent to OCA to bill my insurance company on my behalf. I authorize payment of medical benefits directly to OceanHawk Counseling Alternatives, LLC.. I understand the information exchanged between OCA and my insurance provider will include a diagnosis, which may be detrimental in the future (for example denial of insurance coverage due to existing illness).
- _____ A \$50 fee will be charged for any “late cancel or no show” payable at your next appointment, or charge automatically, if debit or credit information is on file.
- _____ Medicaid 2 late cancels / no shows will put a client on “therapeutic vacation” for 2 months.

Client or Responsible Party Signature:

Date

Client or Responsible Party **PRINT** NAME

Date

Staff witness signature



Date

CLIENT CONSENT FOR TREATMENT








Informed Consent for Behavioral Services

OceanHawk Counseling Alt wants you to be aware of your rights as a client, and asks for your informed consent to receive treatment (according to HFS 94, Wisconsin Administrative Code).







The following are general points of information about the therapy process and treatment:

-  The purpose of therapy is to help alleviate the problems and symptoms that you present.
-  Your therapy is a cooperative effort between you and your counselor talking about the problems presented. Your counselor will suggest alternative treatment modes and assist in referrals when appropriate and necessary. The content of all sessions will be held confidential consistent with Wisconsin Statutes Sec. 51.30.










Potential benefits of behavioral health services include:

-  Improved understanding of self and others
-  Progress toward defined goals and objectives
-  Increased perception of control over thoughts, feelings, and behaviors
-  Increase in positive thinking about and evaluation of self ("self-esteem")
-  Increase in assertive behavior
-  Improved relationships with others
-  Improved capacity for independent behavior






Potential risks of behavioral health services include: Discouragement if

-  Progress does not meet expectations
-  Upsetting insights
-  Feelings of distress
-  Change in relationships
-  Medication side effects if medications are prescribed (these will be discussed with you by the prescribing physician)
-  Involuntary termination of treatment as defined by policy

During the initial appointment the following will be discussed:

-  The presenting problems.
-  Measurable treatment goals, reviewed every three months.
-  Treatment recommendations and benefits of the treatment recommendations.
-  The outpatient mental health services that will be offered under the treatment plan.
-  Approximate duration and desired outcome of treatment recommended in the treatment plan.
-  Estimated length of treatment that will be updated as treatment progresses.
-  Fees the consumer or responsible party will be expected to pay for the proposed services.
-  How to use the clinic's grievance procedure under ch. [DHS 94](#).
-  Obtaining emergency mental health services during periods outside the normal operating hours.

Grounds for Discharge:

-  Not following treatment plan
-  Danger to self or others
-  Not taking medications as prescribed
-  Non-payment of outstanding monies
-  2 or more no-shows – discharged for a period of 2 months (Medicaid and Medicare clients only) (Insurance and private clients are charged a “late cancel / no show” fee of \$50.

Consultation:

If you wish to speak to another member of the clinic staff during the course of your counseling to get a second opinion, receive a different type of therapy, make a complaint or for other reasons, please make this known to your clinician or the Clinic Director, who will assist you in making such an appointment.

In summary – You have the right to be treated fairly and effectively and to participate in and know what is going on with your treatment.

Treatment Rights

- ✚ You have the right to receive prompt/adequate services. If you meet OCA program criteria, services will be provided as described in the mission above, within the limits of available funding and in the least restrictive manner and setting appropriate to your treatment needs.
- ✚ You have the right to receive services in a clean and safe environment.
- ✚ You have the right to be treated with respect and dignity by all OCA employees, free from humiliation and free from verbal, emotional, and sexual abuse. You will not be treated in a hurtful or harmful way or discriminated against because of your race, ethnic background, gender, sexual orientation, physical appearance, age, religious preference, disability or other class protected under local, state/federal law.
- ✚ You have the right to request a reasonable accommodation, if necessary, to participate in treatment services.
- ✚ You will be actively encouraged to participate in the planning of your services and the makeup of your treatment team. If you disagree with your treatment plan or the makeup of your treatment team, you may be entitled to a second consultation.
- ✚ You will not be given unnecessary or excessive medications/treatment.
- ✚ You (and your guardian, if any), will be informed of decisions that affect your treatment on an ongoing basis, including benefits and possible side effects of medications/treatment as well as alternatives.
- ✚ You will have a confidential treatment record kept by OCA that contains information specifically related to your treatment. You (and your guardian, if any) may inspect, request a copy and/or challenge the record in ways that are specified by law (s. 51.30, ch. HFS 92, 42 CFR part 2 and 45 CFR). For more complete information about how your health information may be used and disclosed and how you can get access to this information, please refer to the Clinic's "HIPAA and Privacy Practices" available from any OCA staff.
- ✚ You will not be recorded, photographed, filmed or taped without your informed consent (or the consent of your guardian, if any).
- ✚ You will be informed of any costs associated with your treatment that you or your relatives may have to pay.
- ✚ The clinic shall notify the consumer in writing of the reasons for the discharge, the effective date of the discharge, resources for further treatment, and of the consumer's right to have the discharge reviewed, prior to the effective date of the discharge
- ✚ Request that we place additional restrictions on, our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in case of emergency).

Financial Policy and Consent to Bill

Your Appointments: Time is very valuable. When you schedule an appointment, that time is reserved for you. Your counselor will always write down the appointment information for you. OceanHawk Alternatives has an automatic reminder system. You will get a phone call or email reminding you of your appointment 24 hours in advance. The system allows you to cancel via the automated call. This gives us plenty of time to go through the "cancellation list" and offer the time to another client. Please do not wait until the last minute to call.

Cancellation Policy: 24 hour notice required

You will receive a warning letter after your first "late cancel / no show". If you are also receiving medication from our prescriber, you will be given one month of medications only. You will need to find another prescriber during the time away. If you Medicare/Medicaid client, you may be put on a wait list after your 2 months has passed.

CALL OR TEXT (608) 873-7838 to reschedule your appointment 24/7.

Insurance & Billing

As a service to our clients, claims will be filed with the insurance company at no charge. Some insurance plans require that you get a written referral. **It is your responsibility** to get the appropriate authorizations. If you have a deductible, or if your insurance only pays a portion of the total fee, you are responsible for the balance. Collecting checking / credit information:

Private pay clients: Checking / credit information will be collected at the first appointment. Payments will be run & posted to your account by the end of the week.

Insurance clients: Checking / credit information will be collected at the first appointment. OCA will contact the insurance company to find out what, if any, out of pocket expenses the client will incur. Client will be notified of these expenses BEFORE the first time posting the payment. Thereafter, payments will be run & posted to your account by the end of the week.

- ✚ Any amounts invoiced and billed are due within 15 days of statement.
- ✚ If an account goes beyond 60 days past due it will be sent to collections. OCA reserves the right to seek legal means to secure reimbursement and / or may suspend counseling services until the account is brought up to date. Collection charges, interest fees, and any other legal fees will be applied.

- ✦ Services may be suspended for any client when their account balance goes beyond \$100 and a “Payment Plan” has not been signed.
- ✦ OceanHawk Counseling Alternatives cannot accept responsibility for negotiating a settlement on a disputed claim (minor children, custody & insurance issues, for example).
- ✦ If you are court-ordered for treatment, you may not schedule a final appointment unless your account has a zero balance. THIS INCLUDES A DRIVERS SAFETY PLAN

Minor children: Any parent or legal guardian who brings a minor child to OCA for counseling will be held responsible for any part of the bill not paid by the insurance company. When there is insurance coverage by a non-custodial parent, we must have that insurance information at the initial session. As a service to you, we will file a claim with any insurance company in which the minor is covered

Fees not covered by insurance: There are some services offered through OCA that are not covered by some insurance carriers. These may include court ordered evaluations, counseling summary letters, and reports to third parties. If you request such services, you will be billed as per our fee chart.

CLIENTS WITH MEDICAID:

- Dean Health Plan
- MHS Health Wisconsin
- iCare Health Plan -- SSI ONLY
- Care Wisconsin -- SSI ONLY
- Network Health Services
- Molina Health

HMO ENROLLMENT SPECIALIST: 1-800-291-2002

Fee Schedule: Clients without third party coverage are billed according to the below fee structure.

SERVICE	PRIVATE PAY RATES		
Assessment	\$175.00		
Session - 55 min	\$125.00		
Session - 45 min	\$100.00		
Session - 30 min	\$65.00		
Group - 2 hour	\$88.00		
Group - 3 hour	\$132.00		
LC/NS	\$50.00		
Drug Screen - in house	\$15.00		
Drug Screen - mailed	\$50.00		
Breathalyzer	\$15.00		
Hr chrg court testimony	\$250.00		
Hr chrg requested reports	\$25.00		
IOP PROGRAM		PRIVATE PAY RATES	
4 weeks IOP client group (2 days x 3 hrs) & family group (1 day x 3 hrs) 8 weeks Relapse Prevention (1 day x 2 hrs) 8 Individual and/or family sessions		\$\$ Per Session / Group	
Assessment		\$175.00	
IOP - (4 weeks)		\$132.00	
Relapse Prevention - (8 weeks)		\$88.00	
Individual and/or family - 8 sessions		\$125.00	
8 random UA		\$15 each	

Notice of Privacy Practices and Your Health Information Rights

Protected Health Information as it relates to
Mental Health & Alcohol and Other Drug Abuse Services
provided by OceanHawk Counseling Alternatives, LLC
Effective May 1, 2006

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OceanHawk Counseling Alternatives, LLC (OCA) is committed to protecting the privacy of health information about you and the services you receive at OCA. Your privacy rights and our responsibilities are governed under provisions of State and Federal Law, including but not limited to:

- Sec. 51.30, Wisconsin Statutes
- HFS 92, Wisconsin Administrative Code
- 42 Code of Federal Regulations, Part 2, Confidentiality of Alcohol & Drug Abuse Patient Records
- 45 Code of Federal Regulations, pts 160 & 164, Health Insurance Portability/Accountability Act of 1996 (HIPAA)

OCA is required by law to:

- Maintain the privacy of your health information
- Provide you with this notice of our duties and practices with respect to your health information; and
- Abide by the terms of this notice.

In general, OCA must obtain your written consent before giving anyone outside OCA information which identifies you as someone who has applied for or received services at OCA or before disclosing any personally identifiable information from your treatment record. You may revoke any such authorization at any time, except to the extent that information has already been shared. This can be done by giving written notice to your OCA service provider(s) or to OCA's Records Department.

The following page lists exceptions in which information about you may be disclosed without your consent. In all cases—with or without consent—information given will be limited to that information needed to meet the purpose for the disclosure and/or to the extent provided for by law.

Within OceanHawk Counseling Alternatives, LLC — Without Consent

OCA is made up of a number of clinical and administrative. Your health information may be shared for purposes of treatment, payment and healthcare operations, but this is done only where there is a need to know the information. For example, your counselor at OCA may need to consult with your APNP about prescribing medications, program assistants may need access to information to send you an appointment reminder or a description of new services, management and staff may access your health information for purposes of evaluating services or the performance of your health care provider, etc.

Outside OceanHawk Counseling Alternatives, LLC — Without Consent

To Avert a Serious Threat to Health or Safety: As required or permitted by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your health or safety or to the health or safety of the public. Examples might include reporting of child abuse, a threat made to harm a specific individual, sharing of information with physicians in a hospital emergency room, etc.

The law specifically requires the clinician to report any knowledge of child abuse. If the client is being investigated for child abuse, child neglect, sexual molestation or other such offense, this clinic may be lawfully contacted for information bearing upon these charges and required to cooperate with this request for information.

If any client reveals to their clinician or other staff that they intend to seriously injure themselves or someone else, or there is reasonable probability of such harm, the clinician has the legal responsibility to alert the endangered individual, the client's family, or the appropriate law enforcement agency to protect against this danger. **The client agrees to this disclosure by signing this form and entering into counseling.**

Business Associates: Certain services (for example, lab testing, pharmacy, legal services, etc.) are performed through contract with outside persons or organizations known as "Business Associates." Your health information may be shared with one of these business associates as it is necessary to the service they provide for us. OCA signs an agreement with these business associates that obligates them to appropriately safeguard privacy of the information.

For Payment: OCA may need to submit a bill identifying you, your diagnosis and treatment provided to an insurer or other agency paying for your mental health services (for example, Medicare or Medicaid, grant funders, private insurance, etc.). If you are receiving alcohol or other drug abuse treatment, however, your signed release is required to release information for payment purposes.

Health System Oversight Activities: Certain information may be shared with government agencies who provide funding to or oversight of OCA's services. Examples of such agencies include the Wisconsin Department of Health and Family Services and the Dane County Department of Human Services. Purposes for disclosing the information might include service coordination, financial or program audits, program certification, death investigation, etc.

Research: OCA may use or disclose information about you for research purposes under conditions that meet the stringent requirements of both State and Federal law and OCA's Research Committee. In most cases, however, OCA will first remove information that personally identifies you or seek your approval to participate in a research study before sharing the information.

Judicial Proceedings: OCA may disclose information in response to a specific legal proceeding, court order or other legal process, as stipulated by law. For example, law enforcement officers often consult with OCA's Emergency Services staff in the process of an emergency detention.

Crime on Premises or Against Program Personnel: In certain circumstances, OCA may disclose limited information to law enforcement officers when a consumer commits or threatens to commit a crime at any OCA facility or against OCA staff.

Family Members: Limited information may be shared with your spouse, parent, adult child or sibling, but only if OCA treatment staff have verified that the family member is directly involved in providing or monitoring your treatment.

Confidentiality: Unless a specific exception exists, your clinician will not speak to anyone, outside of the parent or guardian of a minor child or the guardian of an adult adjudged to be incompetent, without the express written consent on a legally viable "Release of Information" form.

Communication methods: OCA, its therapists/staff use telephone, U.S. mail, facsimile and email to communicate as necessary.

No one who joins you in the therapy session is entitled to have access to your therapy records without signed, written permission by you or your parent or guardian.

No client is videotaped, audio taped, or photographed without their written permission. The clinician is required to state the purpose of any taping or photographing and received approval from the Clinical Director.

At the time that they are hired, each staff member is subjected to a Caregiver Background check and is required to sign a statement acknowledging his or her responsibility to maintain confidentiality of personal information about clients.

All client information is kept securely in a chart in a locked file cabinet. OceanHawk Counseling uses Practice Mate, a web-based, HIPPA compliant program, to hold patient demographics, schedule appointments, file claims, record progress notes and any communications related to the client (i.e. phone calls from clients or to insurance companies, for example).

Health Information Rights - you have the right to:

Receive Confidential Communications: You have the right to request that we communicate with you by alternative means or at an alternative location. For example, you may ask that we phone you at work rather than at home. We will try to accommodate reasonable requests.

Access your Treatment Record: You have the right to inspect (within one working day) and obtain (within five working days) a copy of your treatment record, except for specific documents where access is prohibited by law. This information will be provided at no cost to you for the first copy. Requests for additional copies may result in a customary fee to cover the cost of duplication.

Amend your Treatment Record: You have the right to request an amendment to your treatment record if you believe information in the record is incorrect or incomplete. If the staff person working with you disagrees with the requested amendment, you may submit a written request to OCA's Medical Director specifying the information you would like to have changed and the reason for the change. Your request will be granted or denied by the Medical Director within 30 days. You will receive either a copy of the information as amended in your record or written explanation of why the request was denied. If the request is denied, you have the right to insert a statement in the record disputing the accuracy or completeness of the information which was not changed. This statement will become part of your treatment record.

Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information for payment of services or OCA's service related operations. OCA is not obligated to agree to your request but will give every reasonable request careful consideration. For example, if your neighbor works at OCA as transcriptionist, we may be able to have someone else type any information dictated by a clinician for your treatment record.

Obtain an Accounting of Disclosures: You have the right to an accounting of disclosures of your health information made by OCA. This accounting will list the date of each disclosure, a brief description of information disclosed and the reason for disclosure. The first accounting in any 12-month period is free; you may be charged a reasonable fee for any additional accounting requested by you within the same 12-month period.

Request a Paper Copy of this Notice: you may request a copy of this notice at any time.

Client Rights, Privacy Practices, and Complaints:

If you have any questions regarding these matters, please feel free to discuss such with your clinician. If you believe that your *client* rights have been violated, you may contact our Client Rights Specialist, Maria Hanson, Client Right Specialist Inc., P. O. Box 14533, Madison, WI 53708-0533. If you believe that your *privacy* rights have been violated, you may ask to speak with the Privacy Officer or submit a written complaint to the U.S. Department of Health and Human Services.

FOR FURTHER INFORMATION ABOUT THIS NOTICE
Contact: Kelly Miller, Patient & Practice Coordinator
OceanHawk Counseling Alternatives, LLC



6. TeleTherapy Consent

Introduction of TeleTherapy

As a client or patient receiving behavioral services through OceanHawk Counseling Alternatives LLC, I understand:

- TeleTherapy is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.
- The interactive technologies used by TheraNest contains security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:

- Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

- This service is provided by technology (including but not limited to video, phone, text, apps and email) and does not involve direct face to face communication. There are benefits and limitations to this service.

Technology Requirements:

- I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
- I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Exchange of Information:

- The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
- During my teletherapy counseling session, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Self Termination:

- I may decline any TeleTherapy health services at any time without jeopardizing my access to future care, services, and

benefits.

Risks of Technology:

- These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Practitioner Communication:

- My practitioner may utilize alternative means of communication in the following circumstances: phone, text, or email

Laws & Standards:

- The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Electronic Transmission of Information:

- I agree to participate in technology-based consultation and other healthcare-related information exchanges with my counselor. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff assisting with setting clients up with a client portal.

Mobile Application:

- It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an "application" (abbreviated as "app") via TheraNest.
- I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time.

Electronic Presence:

- In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from myself and my practitioner.

Limitations:

- Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in an in-person session may not be available in teletherapy. Body language, for example. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

- I understand that teletherapy is a new delivery method for professional services and may have potential risks, possibly including some that are not yet recognized.
- Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the

consultation(s), and that the information will be intercepted by an unauthorized person or persons.

- In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

Limits of Confidentiality:

- I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Emergency Care:

- I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a teletherapy consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

Release of Liability:

- I unconditionally release and discharge my therapist and OceanHawk Counseling Alt LLC from any liability in connection with my participation in the remote consultation(s).

Final Agreement:

- I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.
- With this knowledge, I voluntarily consent to participate in the TeleTherapy counseling services including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Type your name as an electronic signature

Signature:

Consent to treat a minor:

Signature for Minor:

Minor's Name and Date of Birth: