LAKE MONONA CENTER
Psychotherapy & Recovery

Office Use Only
Pt. Account #: _____
Intake Date: _____
Dx: _____
Dx: _____
Therapist: _____

Intake Form

Welcome to LMPRC. ***Please complete the following form.***
All information will be kept strictly confidential. Thank you for your assistance

Patient's Name			Date of Birth (required)	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Address	City	State	Zip	Home Phone (include area code)
Social Security Number (required)			Driver's License Number	
Parent or Guardian's Name if Patient is a child			Email Address	
Name of Employer/Occupation				Business Phone (include area code)
Person financially responsible for this account?			Address if different from above	
Will you be using medical insurance? ☐ YES ☐ NO			If no, how will you be paying? "Payment is required at time of service." ☐ CASH ☐ CHECK ☐ CREDIT CARD	
Whom may we thank for referring you to us?				

Primary Insurance Company Name		
Name of Insured Person/Relation to Client		Is the insurance through employer? ☐ YES ☐ NO
Date of Birth of Insured Person (required)	Social Security Number of Insured Person (required)	
Subscriber Number	Group Number	

Secondary Insurance Company Name		
Name of Insured Person/Relation to Client		Is the insurance through employer? ☐ YES ☐ NO
Date of Birth of Insured Person (required)	Social Security Number of Insured Person (required)	
Subscriber Number	Group Number	

I hereby authorize the above insurance company(s) to make payment directly to the provider for the benefits herein and otherwise payable to me. ***In addition, I understand that I am responsible for all charges, regardless of insurance coverage, and agree to pay for any services not covered by insurance.*** *I also authorize this office to release any information necessary to expedite processing of insurance claims.*

Client, Parent or Guardian
*Signature*_____*Date*_____

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Personal History Form

Please check areas in which you've noted difficulties or changes

☐ Sleep ☐ Appetite ☐ Crying ☐ Concentration ☐ Weight
☐ Sexual Activity ☐ Physical pains ☐ Sickness ☐ Panic
☐ Unusual behavior ☐ Depressive thinking ☐ Frightening thoughts
☐ Social interaction ☐ Suicidal thoughts

Have you previously been in therapy? ☐ Yes ☐ No

Please check issues that pertain to past treatment

☐ Anxiety ☐ Depression ☐ Relational ☐ Parenting
☐ Chemical abuse/dependency ☐ Original family/Adult Child
☐ Sexual abuse ☐ Other _____

Please list previous clinic / therapist(s) and dates:

_____

Your current health _____

Are or have you recently been on any medication? ☐ Yes ☐ No

List type and dosage _____

Physician's Name and address _____

Have you ever been hospitalized? ☐ Yes ☐ No

Dates and reason _____

Do you use alcohol? ☐ Yes ☐ No Tobacco? ☐ Yes ☐ No

Amount and frequency _____

Please check any of the following that are applicable. Do you use or have you used?

☐ Tranquilizers (Valium, Librium, Xanax, etc.) ☐ Narcotics ☐ Cocaine
☐ Marijuana ☐ Amphetamines ☐ Other_____

Family History

Where did you grow up? _____

Father

Name_____Age____Occupation_____

Health_____

Location/Living Arrangement_____

Divorces/Remarriage_____

If deceased, age, year, cause of death_____

Mother

Name_____Age____Occupation_____

Health_____

Location/Living Arrangement_____

Divorces/Remarriage_____

If deceased, age, year, cause of death_____

Older Siblings _____

Younger Siblings _____

(Please include any deceased siblings)

Do illness or disorders tend to run in your family? ☐ Yes ☐ No

Have any of your family (Grandparents, parents, parents' siblings, your siblings, children) had or might have had problems with the following?

	Relative	**Treatment**
Alcohol / drug abuse		
Depression		
Bi-polar disorder		
Suicide		
Other emotional disorders		

What is your present living situation? ☐ Single ☐ Married

☐ Partner ☐ Divorced ☐ Separated ☐ Widowed

Length of marriage / relationship _____

Spouse / Partner's Name _____Age _____

Education _____Occupation _____

Previous Marriages _____

Children from previous marriage _____

Have you ever been previously married? ☐Yes ☐No

Dates of previous marriage(s) _____

Children	Age	Living arrangement
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any children are deceased please give age and cause of death.

Any difficulties / concerns with children? _____

Have you been in the Armed Forces? ☐Yes ☐No

Please list branch, dates, type of discharge _____

Check the education level you've completed ☐6th ☐7th ☐8th ☐9th ☐10th ☐11th ☐12th ☐13th ☐14th ☐15th ☐16th ☐More _____

Degrees received _____

Other education / training _____

Present occupation _____

How long have you been with this job? _____

Are you satisfied with this job? ☐Yes ☐No

Religious upbringing _____

Are you presently active in a church or spiritual program? _____

Please list any hobbies or special interests you have

_____

_____

How do you spend your free time? _____

Do you have a supportive circle of friends that you spend time with? ☐ Yes ☐ No

Is there any other information we should have about you or your family regarding your treatment here?

LAKE MONONA CENTER
Psychotherapy & Recovery

Informed Consent for Treatment

Lake Monona Psychotherapy & Recovery Center, in accordance with HFS 94.03, presents you with the following information:

1. The benefits of mental health treatment are to help alleviate the problems and symptoms that you present.
2. We only do treatment and evaluations on a voluntary basis. You have the right not to participate in any treatment.
3. If medications are recommended, side effects will be discussed. Medication recommendations can be refused.
4. The therapist will suggest alternative treatment modalities and make referrals when appropriate or necessary.
5. The possible consequences of not receiving treatment will be discussed.
6. Informed consent is given for a period of one year.
7. You have the right to withdraw informed consent at anytime, in writing.

Please ask your therapist if you have any specific questions about the therapy process.

We look forward to working with you.

_____ _____

Signature of Patient
(Parent or guardian if under 18)

Date

_____ _____

Signature of Therapist

Date

LAKE MONONA CENTER
Psychotherapy & Recovery

Consent to Treatment
Billing Policy and Payment Arrangement

Signing of this form acknowledges and agrees to the following:

A. I have been informed by my therapist of the general nature and purpose of services, hours during which services are available and procedures for follow up after discharge.
B. Outpatient consent to treatment at LMPRC.
C. Cost of treatment, billing policy and payment arrangement.

Payment In Full is due upon receipt of service unless insurance is being billed. Any balance remaining (co-pay, deductible, etc.) after the insurance payment is received is due immediately. Please be advised that all accounts with a balance overdue 30 days or more may be subject to a *Service Charge* in the amount of 1.5% per month.

Insurance Claims are filed as a courtesy to our clients; however, complete insurance information must be provided in order to submit a claim. In addition***, LMPRC Does Not Accept Responsibility For Collecting Or Settling A Claim***. It is the ***Client's Responsibility*** to determine what, if any, benefits are available for mental health and addiction services.

MasterCard/Visa are both accepted at LMPRC.

Clients will be charged for *Missed Appointments* not cancelled at least *24 hours in advanced*. All charges will be the *client's responsibility*. Insurance will not pay for missed appointments.

Fee Contract

I have read the above clinic policies regarding payment for services. I understand that I am responsible for immediate payment of any outstanding bills and I am also responsible to any agreements made here with my therapist.

_____

_____

_____

_____ _____
Client Signature Therapist/Doctor Signature

_____ _____
Date Date

LAKE MONONA PSYCHOTHERAPY & RECOVERY CENTER

STATEMENT OF PATIENT AND HEALTH INFORMATION RIGHTS—HIPAA 1996

When you receive any type of service for alcohol abuse, drug abuse, mental health, or a developmental disability you have the following rights under Wisconsin Statute sec. 51.61(1) and HSS 94 Wis. Administrative Code:

Each 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 a copy of this form.

Statement of Patient Rights

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.

TREATMENT & 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 medication 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-convulsive 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.

COMMUNICATION & 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.

Protected Health Information/HIPAA 1996

It is your right as a patient of LMPRC to be notified of how your health care provider (LMPRC) maintains the privacy of your Protected Health Information (PHI). This notice of LMPRC's Privacy Practices is intended to give you this information. If you need further information, please set up an appointment with the Office Manager to talk to the Privacy Officer.

RESPONSIBILITIES OF LMPRC:

- It is your right as a patient of LMPRC to be informed of our responsibilities with respect to the privacy of your PHI
- We maintain the privacy of your health information. We provide you with the information that delineates our responsibilities regarding Protected Health Information collected and maintained about you.
- We will abide by this document
- We will inform you promptly in writing form of any privacy changes that affect you.
- We will not disclose your PHI without your authorization, except where described in this notice.

YOUR HEALTH INFORMATION RIGHTS:

You have the right to:

Request a restriction on certain uses and disclosures of your health information.

- Receive confidential communications
- Inspect and obtain a copy of your health care record.
- This request must be submitted to the Privacy Officer in writing, and LMPRC can charge a reasonable fee for a copy of your record. It is suggested that you consider talking with your therapist about your record and discuss any questions you may have with your therapist.
- Amend your record if you believe it is incorrect. You have the right to amend or add information to your health care record if you feel this is necessary. This request must be submitted to the Privacy Officer in writing and the reason explained why an amendment or addition is to be included. LMPRC has the right to discuss the reasons with you why this information may not be advisable to add to your record. Additionally, the therapist does not have to agree to what you believe needs correction and requests on the patient's part should be reasonable requests.
- Obtain an accounting of disclosures of your PHI, in compliance with State and Federal law.

Protected Health Information/HIPAA 1996 Continued

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.
- A therapist may disclose PHI without consent or authorization to prevent or lessen a serious and imminent threat to public safety of a person or the public.
- As required by law, LMPRC will disclose your PHI to relevant authorities if your therapist reasonably believes that an individual is a victim of child or elderly abuse.
- LMPRC is permitted by the Federal Privacy Rule to disclose your PHI for treatment, payment or clinic operations.

USES AND DISCLOSURES OF YOUR PHI PERMITTED WITHOUT YOUR AUTHORIZATION

As required by Law:

- Disclosures to show compliance with the privacy rule
- Disclosures about victims of elderly or child abuse
- Disclosures for judicial and administrative proceedings
- Disclosures for law enforcement purposes
- Disclosures for the coroner and the medical examiner in the case of death
- Disclosures for Worker's Compensation
- Disclosures to avert a serious threat to health or public safety
- Disclosures in response to a court order or subpoena

PRIVACY RULE FOR MINORS:

The privacy rule indicates that because parents usually are the legal personal representatives for their children, they can access PHI about their children.

Three exceptions to this provision:

- If a state law allows a minor to access mental health services without the consent of a parent.
- When the court makes the determination or law provides for someone other than the parent to make health care decisions for the minor.
- When the parent/guardian or individual responsible for the minor assents to an agreement of confidentiality between the minor and the health care provider.

RIGHT OF ACCESS TO COURTS:

- You may sue someone for damages or other court relief if they violate any of your rights.

GRIEVANCE RESOLUTION PROCEDURE

If you feel your rights have been violated, you may file a grievance as follows without being threatened or penalized.

- Informal Process: You may contact the Executive Director of LMPRC in writing or by telephone outlining your complaint within 45 days of the problem occurring.
- Formal Process: If the informal process does not meet your needs you may contact the LMPRC Client Rights Specialist by telephone or in writing.

Your Client Rights Specialist is:

Name: Maria Hanson, JD
Phone: 608-446-8957

- State Level Review Process: If the above options do not meet your needs, you may contact the Administration of the Division of Supportive Living

I hereby acknowledge that I have received a copy of "Statement of Patient Rights" as well as a copy of "Protected Health Information/HIPAA 1996" at the time of my intake at LMPRC.

Date	Client's Signature
Staff Person Explaining Rights	Parent/Guardian (if client is a minor**)

** If patient is a minor who is age fourteen (14) or older, obtain the signature of both the minor and parent or guardian. If the minor is under the age of fourteen (14), obtain the signature of parent or guardian.