STRESS MANAGEMENT AND MENTAL HEALTH CLINICS

CONFIDENTIAL
Diagnosis Code: _____
Therapist: _____
Account #: _____

Client Information Sheet (Confidential)

Complete all information carefully.

Date: _____

Client Name: _____ Birth date: _____ Age: _____ Sex: _____
(last) (first) (m.i.)

Home Address: _____ Marital Status ☐ S ☐ M ☐ Sep ☐ Div ☐ Widowed

_____ Employment Status: ☐ Employed ☐ Full Time Student
(city) (state) (zip) ☐ Part Time Student

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Occupation: _____ School: _____

Employer Name: _____ Address: _____ Work Phone: _____

Person Responsible: _____ Relationship: _____
(If patient is a minor) (If different than above)

Address: _____ Birth Date: _____ Home Phone: _____
(If different than above)

Social Security #: _____ Work Phone: _____

Spouse Name: _____ Birth Date: _____

DEPENDENT CHILDREN

Name(s)	Birth Date(s)	Name(s)	Birth Date(s)

Primary Care Physician's Name: _____ Phone No.: _____

Address: _____
(street) (city) (state) (zip)

Referring Source: _____

May we contact your primary physician about your care? ☐ Yes ☐ No ☐ NO PRIMARY PHYSICIAN

We need a signed release in order to contact your primary physician.

Present all your insurance cards.

We will *(Please check one)* ☐ Bill insurance company, I will pay all co-pays if I use insurance ☐ Self Pay Only

INSURANCE INFORMATION

Primary Insurance or Workers Comp Insurance: _____

Address to Submit Claims: _____ Phone No.: (_____) _____
(street) (city) (state) (zip)

Policy Holders Name: _____ Insured's Social Sec. No.: _____

Policy Holders Address (if other than on reverse): _____
(street) (city) (state) (zip)

Insured's Birth date: _____ Insured's Employer _____

_____
(street) (city) (state) (zip)

Subscriber ID: _____ Group #: _____ Effective Date _____

Single or Family Coverage: _____ Is this an HMO? ☐ Yes ☐ No

Is this a workers compensation claim? ☐ Yes ☐ No If yes, date of injury: _____

File of claim number: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Name: _____

Address to Submit Claims: _____ Phone No.: (_____) _____
(street) (city) (state) (zip)

Insured's Name: _____ Insured's Social Sec. No.: _____

Insured's Address (if other than on reverse): _____
(street) (city) (state) (zip)

Subscriber ID: _____ Group #: _____ Effective Date _____

Single or Family Coverage: _____ Is this an HMO? ☐ Yes ☐ No

If insurance coverage is provided as a result of a divorce settlement, a copy of the divorce decree outlining such must be provided to the Clinic immediately.

STRESS MANAGEMENT
AND MENTAL HEALTH CLINICS

CONFIDENTIAL

NAME:_____ **DATE:** _____

EMERGENCY CALL INFORMATION

Name: _____ _____ **Relationship to Client:** _____

Any one else we should call?: _____

FAMILY HISTORY

YES	NO		WHO? at what age?
		Cancer	
		Diabetes	
		Heart disease	
		High blood pressure	
		Allergies	
		Neurological Problems	
		Mental Health Problems	
		Alcohol/Drug Problems	
		Family Violence	

Ages of	LIVING-L	DECEASED-D
Father		
Mother		
Brothers		
Sisters		
Spouse		
Children		

COMMENTS: _____

PERSONAL HISTORY

YES	NO		What Years?
		Allergies	
		Asthma	
		Blackouts	
		Cancer	
		Chronic Pain	
		Diabetes	
		Drug allergies	
		Eye disease	
		Fibromyalgia	

YES	NO		What Years?
		Headaches/Migraines	
		Head injury	
		Heart disease	
		Kidney problem	
		Liver disease	
		Prostate disease	
		Seizures	
		Skin disease	
		Thyroid (overactive)	
		Thyroid (under active)	
		Other (please list below)	

COMMENTS: _____

EMOTIONS Do you experience the following symptoms sometime in the day more days than not?

YES	NO		YES	NO	
		Depressed			Irritability
		Fatigue			Anxiety/Panic episodes
		Hopelessness			Muscle tension/aches
		Concentration problems			On edge/restlessness

Please complete reverse side

Comments: _____

HABITS Do you experience problems with sleep/eating sometime in the day/night more days/nights than not

SLEEP typical hours per night _____

YES	NO	
☐	☐	Wake up to early
☐	☐	Trouble falling asleep
☐	☐	Interrupted/agitated sleep
☐	☐	Nightmares

EATING typical meals per day_____

YES	NO	
☐	☐	Skip meals frequently
☐	☐	Lose appetite/not hungry
☐	☐	Overeating frequently

Current Height:_____ Weight:_____

Comments:_____

Are you currently using:

YES	NO		How Often?
☐	☐	Sedatives	_____
☐	☐	Alcohol	_____
☐	☐	Tobacco	_____
☐	☐	Medication misuse	_____
☐	☐	Non-prescription drugs (i.e. marijuana, cocaine, inhalants, opiates)	_____

Relaxation

YES	NO	
☐	☐	Participate in Sports
☐	☐	Hobbies
☐	☐	Relaxation Methods
☐	☐	Spiritual Methods

List past history of Drug and Medication use: _____

Comments:_____

Current Medication Name	Dosage	Frequency	Prescribing Doctor	Past Meds Psychiatric	Any Side Effects	Describe what Relaxes you

PREVIOUS TREATMENT

YES	NO		FACILITY	DATES	TX	MD
☐	☐	Have you ever received inpatient or partial hospitalization for Alcohol/Drug problems?				
☐	☐	Have you ever received inpatient or partial hospitalization for Mental Health issues?				
☐	☐	Have you ever received outpatient treatment for Mental Health and/or Alcohol Drug issues?				

Comments:

RELATIONSHIPS Are there any issues you would like to address in treatment regarding:

YES	NO		COMMENTS:
☐	☐	Parenting	
☐	☐	Family you grew up in	
☐	☐	Work/School/Financial	
☐	☐	Intimacy	
☐	☐	Sexuality	
☐	☐	Social/Personal Interactions/Peers/Friendships	
☐	☐	Legal Issues	

Financial Agreement for Psychotherapy Between Stress Management & Mental Health Clinics and Its Clients.

Charges: The rate of $392 is charged for the initial assessment, and $205 is the standard and customary fee for your psychotherapist per each therapeutic session. Additional fees for services beyond the usual session may result in additional charges which would be discussed with you in advance. It is important to note that if the psychotherapist is under contract with an insurance company, Health Maintenance Organization, managed care contract, or Employee Assistance Program agreement, the charges will be in compliance with that contract. The rates are based on a standard 40-50 minute session and include a minimum of 5-10 minutes for charting after the session, and the time necessary for discussion of treatment goals, homework, etc. which will be regularly reviewed along with the risks and benefits of treatment choices.

Client's responsibilities: The client is responsible for all charges, including any charges that their insurance coverage contract allows for any out of pocket fees including deductibles and co-pays that are spelled out in your insurance contract. All deductibles, co-pay, or other required charge is due at the time of each appointment. It is the client's responsibility to understand the terms of their insurance contract. If you do not know your coverage or understand your coverage it is your responsibility to contact your insurance carrier directly. It is critical to immediately inform the Stress Management & Mental Health Clinic Office of any changes to insurance coverage, residence, employer, or type of coverage. Failure to inform the office of these changes could result in the client being responsible for the full standard and customary charges for and sessions that are not covered because of this lapse in information. Remember that the client is fully financially responsible and the clinic only bills insurance, or others, as a convenience to the client. Your treatment contract with Stress Management & Mental Health Clinics, Inc., precedes the beginning of any therapeutic relationship or treatment. It also precedes the agreement with your insurance carrier, or other payor relationship including any contract between the psychotherapist and managed care companies, EAP's etc.

Cancellation Policy: In order that professional services are utilized in the most productive levels, and in order that services can be promptly provided to those in need, it is Stress Management & Mental Health Clinic's policy to require a 24 hour advance notice of cancellations of any appointment. If the cancellation is not made in compliance with this policy, the client assumes financial responsibility for the cost of the missed appointment. This charge is $205 for each standard therapy session. These charges will be billed directly to the client and is not eligible for insurance reimbursement, due at the time of the next appointment.

Request for Records: Any requests for records (or partial records) to be transferred to any location/source (including the client themselves) for any reason will require an advance payment of $15.oo, which is in compliance with Wisconsin State Laws. Records will only be sent after receiving payment. Any record greater than ten (10) pages will require and additional $0.25 per page that is requested to be sent. A signed release of information, in compliance with Wisconsin State Law is required prior to the release of records.

Other Charges: Telephone conversations with psychotherapists/psychiatrists that last longer than 5 minutes will be billed at $2.00 per minute thereafter. This is a standard clinic policy and is not reimbursable from insurance carriers. By signing this document, you are agreeing to this policy.

Any additional services requested by any client for any reason will be billed as a separate charge and must be paid prior to the next clinical session. The rate for this psychotherapist is $205 per hour for sending a letter, treatment summary, etc. to courts, attorneys, state agencies, probation officers, etc. and for all service time not covered by insurance. This will be charged under all circumstances.

Statement of Agreement:

I have read and understand the statement of policy and financial responsibilities and I agree to them. Any exceptions or variations will be discussed with my therapist and Stress Management & Mental Health Clinics, Inc. and will have a written agreement, by both parties, of any changes with any part of this contract.

_____.	_____/ _____/ _____.	_____
Client/Responsible Party	Date	Therapist/SMMHC Witness

Confidentiality Policy for Stress Management & Mental Health Clinics, Inc.

Providing Services: It is the policy of Stress Management & Mental Health Clinics, Inc. to provide appropriate mental health services to any client requiring treatment, or to provide the name(s) of another service which could provide an appropriate service. Treatment is contracted with a specific psychotherapist/psychiatrist and Stress Management & Mental Health Clinics, Inc.

All information gained through the psychotherapeutic process is considered confidential and would only be released to another individual or agency as a professional consultation for a specific purpose, in compliance with state and federal laws governing protected health information, and only when it is deemed to be in the best interest of the client. The exceptions that are required include 1) releasing information to any court if the information is subpoenaed, 2) in situations requiring information based on professional ethical standards and legal requirements (e.g., protection from harm to self or others) as well as protecting individuals by reporting child or elder abuse or neglect.

If you agree to utilize an insurance company, health maintenance organization, managed care company, employee assistance program or other third party to pay for all or part of your treatment, information may be required to be sent to authorize payment. If you agree to cover your treatment with one of these third party payors, you are agreeing to authorize release of information required by your contract and in accordance with Wisconsin State Law.

Information is often sent or a call may be made to your residence or place of business for billing or notification purposes to provide/receive necessary information to receive payments, change appointments, etc. In addition, information may be required or offered by electronic communication and is only as confidential as the equipment, programs, or personnel sending or receiving the information.

Any psychotherapist required to be supervised or situations requiring clinical director intervention, will have to make information available to as appropriate.

Other than these specific situations, no information can or would be released to any person or agency unless the client/responsible party provides written consent to the psychotherapist/psychiatrist/Stress Management & Mental Health Clinics, Inc.

If a collection agency in used to collect delinquent accounts, appropriate necessary information will be released.

Minors: It is the policy of this clinic to release all information, pertaining to minors, to their legal parents or legal guardians upon their request and with the written consent of any minor, unless it would seriously affect the therapeutic process. The legal parent or guardian is responsible for

any and all financial obligations incurred by their minor(s). Please note that the verification of your status as a legal parent or legal guardian may be required.

Federal regulations allow us to use or disclose protected health information from your records in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as "health care operations (for example, quality improvement activities).

With this consent form, we are asking you to make this permission explicit. These uses and disclosures are described more fully in our Notice of Privacy Practices. You have the right to review this Notice before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the waiting room. You may ask for a printed notice at any time. You may ask us to restrict the use and disclosure of certain information. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. The consent is voluntary and you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted of if the consent is later revoked.

I hearby consent to the use or disclosure of my protected health information as specified above:

_____ ____/____/_____

Client/Guardian Date

CONTACT INFORMATION

Staff should place this form in a prominent location in the chart to remind the staff to use alternative addresses and/or phone numbers if applicable.

Patient Name: _____

Request Accommodations (For example special room / Hearing Impaired / Visual Impairment)

_____

_____

_____

Address Where We Can Send Information:

_____

_____

_____

Phone Numbers:	(CIRCLE IF OKAY) Okay to Call?	Okay to Leave Message?
Home: _____	Y	Y
Work: _____	Y	Y
Cellular: _____	Y	Y
E-mail: _____	Y	Y

Special Billing or Communication Arrangements:

_____

_____

_____

_____

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient: _____

Our scheduling system is in the process of being updated.

You will now have the option of receiving appointment reminders via **text message OR automated phone calls.**

Please **choose one** for us to send for your reminders.

Name:_____

Birthdate:_____

Choose One:

☐ Text Message

Please give us the cell number you would like your text reminders to go to on the space below:

Cell #:_____

☐ Automated Phone Call

Please give us the phone number on which the message can be left:

Phone:_____

☐ I do not wish to receive appointment reminders. I understand that it is my responsibility to keep my appointments or to call at least 24 hours in advance to cancel.

Signature:_____

Date:_____

PERSONAL HISTORY

Name: _____ Date: _____

1) Please describe what your life was like as a child, and growing up. Also, note such things as delays in learning to speak; childhood trauma; school related problems. Significant problem with concentration, periods of depression or worry; behavioral problems at school or at home; learning disabilities or special education classes, etc., you may have experienced:

2) Please describe your educational history, and what diplomas/degrees you earned:

Level of Education	Dates

3) Employment History

Job	Type of Work	Dates

4) Describe your family of origin – *as well as any medical or psychological problems they have had*

Father (or male adult):

Mother (or female adult):

Brother(s) (or male children):

Sister(s) (or female children):

5) Any other significant live in persons:

5A) Describe your past and present personal relationships – (history of dating frequency, of separation and divorce, of current relationship(s) :

5B) List the number, ages, and gender of your own children and any problems or concerns:

6) Describe your medical history – (physical problems, emotional problems, hospitalizations, treatment dates, etc.):

7) Describe your legal history – (the nature of any arrests, imprisonments, etc.):

8) Describe your history of abuse or neglect – (inflicted on you or by you):

9) Describe your financial history – (for example: poverty in childhood), as well as any current financial concerns – (for example: bankruptcy):

CLIENT GOALS

1) Please briefly describe what specific difficulties bring you to this clinic.

2) Please describe what goals You wish to accomplish through Therapy (Example: to feel less depressed, to be calmer, etc.)

1.

2.

For each of these goals, describe specifically how things would be different if the goals were met, (Example: sounder, longer sleep, fewer fights, etc.)

1.

2.

3) Do you believe any cultural or spiritual issues will affect your treatment?

____Yes ____No

4) List any other issues you wish to discuss before treatment is started.

Client:_____ Date:_____

Information and Rules of Operation for Stress Management & Mental Health Clinics, Inc.

The Waukesha Office of Stress Management & Mental Health Clinics, Inc. provided outpatient mental health services for adults, children and adolescents. These services may include both psychotherapy and psychiatric medication. Our psychotherapists offer individual, couples, family, and group psychotherapy. Our psychiatrists offer medication and ongoing prescribing of psychotropic medications to treat diagnosable mental disorders.

We do not provide intensive outpatient or residential mental health services, but we can assist you in determining if these are appropriate levels of care for you and can refer you to other professionals who do provide these services.

Our office is open Monday through Friday.
The office manager is Patricia Reynolds. The clinic director is John Weaver, Psy.D.
The phone number for the Waukesha office is (262)544-6486.
The phone number for the billing office is (414)329-7000.

Hours of Operation:

Monday	8:00 AM to 6:00 PM
Tuesday	8:00 AM to 5:00 PM
Wednesday	8:00 AM to 6:00 PM
Thursday	8:00 AM to 5:00 PM
Friday	8:00 AM to 12:00 PM

Appointments with a psychotherapist or a psychiatrist may be scheduled at times when the office is closed, by arrangement with the mental health professional.

Mental Health Professionals at the Waukesha Office:

John Weaver, Psy.D., Psychologist, Clinic Director
David Holloway, M.D., Psychiatrist
Mindas Siliunas, M.D., Psychiatrist
Amy Gurka, Psy.D., Psychologist
Laura Hempe, MS,LPC
Charles Lawler, L.M.F.T., Licensed Marriage and Family Therapist
Trish Torzala, LPC-IT, Licensed Professional Counselor, in Training
Terry Bruett, Ed.D., Psychologist
Jennifer Vann, Psy.D., Psychologist
Robert VerWert, Ph.D., Psychologist

When you seek services at our clinic, you will undergo an assessment to determine if the services we provide are appropriate for you. We will share that information with you; obtain your informed consent prior to the start of treatment, and the work with you to establish a treatment plan. If the assessment results in a determination that another form of treatment or level of care is necessary, we will help you to identify the appropriate resources and make referrals, if appropriate.

In our mental health outpatient services, we will work with you to provide evidenced-based treatment. Your treatment will be reviewed with you on a regular basis, to ensure that the help you are receiving is effective and satisfying for you.

Patient Bill of Rights

When you receive services for mental health, alcoholism, drug abuse, or a developmental disability, as an outpatient or inpatient, you have the following rights under Wisconsin Statute Section 51.61.

Treatment and related rights

- To give informed consent to treatment.
- To be free from having unreasonable arbitrary decision made about you.
- To receive prompt and adequate treatment.
- To refuse any treatment.
- To be free from on necessary or excessive medication.

Communication and privacy rights

- To refuse to be filmed or taped without your consent.
- To have your treatment record and conversation about your trip kept confidential (Sec. 51.30, Stats.)
- To have access to your treatment record after discharge (or during treatment if the facility director approves it) and to have access at all times to records of medications you take or any treatment you received for physical health reasons.

Right of access to courts

- To bring a legal action for damages against those who violate your rights.

Your right to complaint

If you feel that your rights have been violated, you have the right to a grievance procedure. Grievances must be filed in writing within 45 days of the incident or issue. The staff will supply you with a copy of the grievance procedure upon request. You may, at the end of the grievance process, or at any time during it, choose to take the matter to court. The Client Rights Specialist for the Waukesha Office of Stress Management & Mental Health Clinics, Inc. is John Weaver, Psy.D., (262) 544-6486

Exceptions to confidentiality

- Indication of threat to yourself or others.
- Child abuse/neglect.
- Court ordered records.

Informed Consent for Telepsychology Sessions during the Coronavirus outbreak.

During the Coronavirus outbreak public health officials are recommending restricted travel and social distancing as an effort to mitigate the effects of the pandemic. If you would like to engage in your psychotherapy sessions and psychiatric sessions by phone, please read and sign this informed consent.

Confidentiality: Confidentiality protections remain fully protected. No information will be shared without your written permission, with the exceptions provided by legal statute.

Telephone sessions will originate within the office of the psychotherapist or psychiatrist and will be placed on a telephone with a landline. If you have Caller ID, it will read "Private" so that anyone else who sees the Caller ID will not be informed that the call is originating from Stress Management & Mental Health Clinics. We use a landline because there is a small risk that communications from a mobile phone could be intercepted and a third party could listen in on the conversation. If you choose to provide us with your mobile telephone number, please consider this risk to your confidentiality.

When you answer the telephone for your session, consider taking the call in a place that is private so that no one else can overhear your call.

The clinical record keeping for these telephone sessions is the same as in-person sessions. Clinical case notes are recorded in your medical chart by date and time of the session. We do not use electronic medical records and the telephone session will not be recorded so there is no electronic record of the session.

Billing procedures for the telephone services will remain the same as the procedures for in-person treatment. If you are using insurance for your treatment you will still be responsible for payment of all deductibles and co-pays as defined by your insurance coverage. You will be able to pay your portion of the bill online. Please visit our website at www.stressmangagementclinic.com for information about paying your bill.

Clinical information: Telephone sessions do not have a face-to-face component. There is information from facial expressions and body language that is not available during a telephone session, so your psychotherapist/psychiatrist may need to ask you more detailed questions to make a full assessment of your condition.

In cases where there is active suicidal ideation, the psychotherapist/psychiatrist will need to make a full assessment to ensure your safety. If the result of the assessment is that it is uncertain that you will be safe, the psychotherapist/psychiatrist may need to request a wellness check from the local police department.

If there are indications that you are experiencing delusions or hallucinations, the psychotherapist/psychiatrist may need to ask you more detailed questions to make a full assessment of your condition.

Telephone sessions are being provided due to the outbreak of the Coronavirus. As the public health situation improves, sessions will return to normal and you will be seen in the offices of Stress Management & Mental Health Clinics. These telephone sessions are only available to residents of Wisconsin.

Patient/Guardian _____. Date: ___/___/_____.