Stress Management
& Mental Health Clinics

Confidential
Diagnosis Code: _____
Therapist: _____

CLIENT INFORMATION SHEET

Complete all information carefully:
Date: _____

Client Name: _____ Birth Date: _____ Age: _____ Sex: _____

Home Address: _____ Marital Status: __ S __ M __ Sep __ Div __Widowed
(Street)
_____ Employment Status: _____
(City) (State) (Zip)

Home Phone: _____ Mobile Phone: _____

Social Security #: _____ Occupation: _____ School: _____

Employer Name: _____ Address: _____ Work Phone: _____

Person Responsible: _____ Relationship: _____

Address: _____ Birth date: _____ 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: _____

Address: _____
(Street) (City) (State) (Zip)

Referring Source: _____

May we contact your primary care physician about your care? ____ Yes ____ No ____ No Primary Care Physician
We need a signed release in order to contact your primary care physicians. Please present all insurance cards.

We will (Please check one): ____ Bill insurance company. I will pay all deductibles and copays. ____ Self-Pay

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Diagnosis Code: _____
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INSURANCE INFORMATION

Primary Insurance or Workers Comp Insurance: _____

Address to Submit Claims: _____ Phone: _____
(Street) (City) (Zip)

Policy Holder Name: _____ Insured's Soc. Sec. # _____

Policy Holder's Address (if different than above): _____
(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 a Worker's Compensation Claim: _____

Date of Injury: _____

File of Claim Number: _____

SECONDARY INSURANCE INFORMATON

Secondary Insurance: _____

Address to Submit Claims: _____ Phone: _____
(Street) (City) (Zip)

Policy Holder Name: _____ Insured's Soc. Sec. # _____

Policy Holder's Address (if different than above): _____
(Street) (City) (State) (Zip)

Insured's Birth Date: _____ Insured's Employer: _____

_____
(Street) (City) (State) (Zip)

Subscriber ID: _____ Group #: _____ Effective Date: _____

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.

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CONFIDENTIAL BACKGROUND INFORMATION

Name: _____ Date: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Phone #: _____

FAMILY HISTORY

YES	NO		Who? At what age?		Ages of?	Living = L Deceased = D
		Cancer		Father		
		Diabetes		Mother		
		Heart Disease		Brother(s)		
		High Blood Pressure				
		Allergies				
		Neurological		Sister(s)		
		Mental Health		Spouse		
		Alcohol/Drug		Children		
		Family Violence				

Comment: _____

PERSONAL HISTORY

YES	NO		What years?	YES	NO		What years?
		Allergies	_____			Head Injury	_____
		Asthma	_____			Heart Disease	_____
		Blackouts	_____			Kidney Problems	_____
		Cancer	_____			Liver Disease	_____
		Chronic Pain	_____			Prostate Disease	_____
		Diabetes	_____			Seizures	_____
		Drug Allergies	_____			Skin Disease	_____
		Eye Disease	_____			Thyroid (underactive)	_____
		Fibromyalgia	_____			Thyroid (overactive)	_____
		Headaches/Migraines	_____			Other	_____

Comment: _____

EMOTIONS

YES	NO		YES	NO	
		Depressed			Irritability
		Fatigue			Anxiety/Panic Episodes
		Hopelessness			Muscle Tension/Aches
		Concentration Problems			On Edge/Restlessness

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CONFIDENTIAL BACKGROUND INFORMATION

SLEEP typical hours per night: _____

YES	NO	
		Wake up too 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: _____

Are you currently using:

YES	NO	Substance Use	How often?
		Sedatives	_____
		Alcohol	_____
		Tobacco	_____
		Prescription misuse	_____
		Non-prescription drugs	_____
		marijuana, cocaine, opiates, etc.	

YES	NO	Relaxation
		Participate in sports
		Hobbies
		Relaxation methods
		Spiritual methods

Current Medication Name	Dosage	Frequency	Prescribing Doctor	Past Meds Psychiatric	Any Side Effects

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 problems?				
		Have you ever received outpatient treatment for Alcohol/Drug problems?				
		Have you ever received outpatient treatment for mental health problems?				

RELATIONSHIPS/ AREAS OF CONCERN

YES	NO	
		Parenting
		Family you grew up in
		Work/school/financial
		Intimacy
		Sexuality
		Social/personal interactions/friendships
		Legal issues

COMMENTS

_____
_____
_____
_____
_____
_____
_____
_____

Stress Management
& Mental Health Clinics

CONFIDENTIALITY POLICY

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 payers, 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 the clinical director to intervene, will have to make information available 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 is 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 know 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 as 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 if the consent is later revoked.

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

_____ _____

Client/Guardian Date

Financial Agreement for Psychiatric Treatment 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 provider 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 provider 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 45 minute assessment session and 15-30 minute medication checks after the assessment, including the time necessary for discussion of treatment goals, medication side effects, 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 and 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 any 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 and 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 provider 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 $100 for each standard 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 $15.00, which is in compliance with Wisconsin State Laws. Records will be sent only after receiving payment. Any record greater than ten (10 pages will require an 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 providers 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 provider is $392 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 provider 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	Provider/SMMHC Witness

.

Stress Management
& Mental Health Clinics

INFORMED CONSENT FOR TELEPSYCHOLOGY

If you would like to engage in your psychotherapy sessions and psychiatric sessions virtually or by phone, please read and sign this informed consent. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be if the client or clinician is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. We will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, and there is a small risk calls made over cellular networks could be intercepted by a third party.
- Crisis management and intervention. Your provider may request you meet in person during crisis situations. Your therapist will let you know how to reach them in case of a clinical emergency.
- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand nonverbal information when working remotely.

Telehealth options

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

Communication

For communication between sessions, your provider can be reached at their office by phone. For administrative matters such as scheduling, billing and related issues, the reception staff can be reached by phone to help with these matters.

Confidentiality
It is our legal and ethical responsibility to make our best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).
The extent of confidentiality and the exceptions to confidentiality that are outlined in our Informed Consent still apply in telepsychology. Please let your provider know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology
From time to time, we may schedule in-person sessions to "check-in" with one another. Your provider will let you know if they decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. Your provider will work with you to create and update an emergency plan as appropriate.

Fees
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client/Guardian Date

_____ _____
Psychotherapist Date

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

The Waukesha Office of Stress Management & Mental Health Clinics, Inc. provides 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 evaluation 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.

The Waukesha clinic director is John Weaver, PsyD.
The West Allis and Glendale clinic director is Gregory Bushman, LCSW.

Phone numbers:
Waukesha office 262-544-6486
West Allis office 414-329-7000
Glendale office 414-962-9156
Billing office 414-329-7000

Our office is open Monday through Friday. Hours of Operation:
Monday through 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:
John Weaver, PsyD
David Holloway, MD
Mindas Siliunas, MD
Ann LeBaron, PA-C
Mary Kay Bultman, PMHNP-BC
Mary Ket Bolton, PsyD
Amy Gurka, PhD
Gary Michael Major, PhD
Jennifer Vann, PsyD
Thomas Marx, PhD
Linda Bell, LCSW
Gregory Bushman, LCSW
John Jendusa, MSW, BCD
Patricia Modell, LCSW
Charles Lawler, LMFT
Amanda Anderson, LPC
Trish Torzala, LPC
John Ernst, LPC
Tana Rodriguez-Buck, LPC

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 then 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 evidence-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 decisions made about you.
- To receive prompt and adequate treatment.
- To refuse any treatment.
- To be free from unnecessary 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 treatment is 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 Stress Management & Mental Health Clinics, Inc. is John Weaver, PsyD, 262-544-6486

Exceptions to confidentiality

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

Stress Management
& Mental Health Clinics

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 number, if applicable.

Name: _____

Request for accommodations (for example: special room/hearing impaired/visually impaired)

_____

_____

Address where we can send information: _____

_____

_____

Phone numbers:	OK to Call? (Circle if OK)	OK to Leave Message?
Home: _____	Yes	Yes
Work: _____	Yes	Yes
Cell: _____	Yes	Yes

You have the option of receiving appointment reminders via text message OR automated phone calls

Choose one:

_____ Text Message to cell number above

_____ Automated Phone Call

____Use cell number

____Use home number

Special Billing or Communications Arrangements:

_____

_____

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to Patient: _____

Stress Management
& Mental Health Clinics

PERSONAL HISTORY & GOALS

Name: _____ Date: _____

Childhood
What was your life was like as a child and growing up? Be sure to include any delays in learning to speak or walk, experience childhood trauma, have issues with concentration, periods of depression or worry, behavioral problems or receive special help at school?

Education
Level Dates

Employment
Job Dates

Family
Please 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):

Sister(s):

Any other significant live-In persons:

Stress Management
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Please describe your past and present relationships, including dating history, separation and divorce, and current relationship (if any):

If you have children, do you have any problems or concerns?

Please describe your history of abuse or neglect:

Please describe your medical history, physical and/or emotional problems, hospitalizations, treatment dates, etc. :

Any legal concerns we should know about (legal history, arrests, imprisonments, etc.)?

Financial issues that might impact treatment (e.g., poverty in childhood, current financial concerns, bankruptcy, etc.):

Goals

Please Describe what specific difficulties bring you to this clinic:

What goals would you like to accomplish through therapy (feel less depressed, to be calmer, etc.)	For each goal, describe specifically how things would be different if the goal were met (longer sleep, fewer fights, etc.).
1.	1.
2.	2.
3.	3.

Do you have any cultural or spiritual beliefs that may impact your treatment?

List any other issues you wish to discuss before treatment is started:

_____ _____

Signature Date