SPECTRUM
BEHAVIORAL HEALTH LLC

REGISTRATION FORM

CLIENT INFORMATION

DATE: __/__/____

Client Name (First, MI, Last):			
Address (Street, City, State, Zip):			Contact Information: Cell Phone: ( )_____ Work Phone: ( )_____
Date of Birth: __/__/____	Gender: Male Female	Social Security # ___-___-____	May we contact you for appointment reminders? Y/N Circle preferred method: Cell# Work# Email
Email:			
Occupation:		Name of Employer:	
Emergency Contact Information: Name: _____ Cell Phone:( )_____ Work Phone:( )_____ Relationship to Client: _____		Race/ethnicity with which you identify self (optional): __Caucasian __Hispanic/Latino __East Asian __Native American __Pacific Islander __African American __Other: _____	

PARENT OR GUARDIAN

f Client is a minor, please complete parent/guardian information. *Address need only be completed if different than Client.

Parent/Guardian Name:	Parent/Guardian Name:
Date of Birth (Parent/Guardian):	Date of Birth (Parent/Guardian):
Relationship to Client:	Relationship to Client:
Address:	Address:
Name of Employer:	Name of Employer:
Cell Phone: ( )_____ Work Phone: ( )_____ Other Phone: ( )_____	Cell Phone: ( )_____ Work Phone: ( )_____ Other Phone: ( )_____
Email: _____	Email: _____
May we contact you for appointment reminders? Y/N Circle preferred method: Cell # Home# Email	May we contact you for appointment reminders? Yes/No Circle preferred method: Cell# Home# Email

OTHER HOUSEHOLD OR FAMILY MEMBERS

Name:	Relationship:	Date of Birth:	Age:
		__/__/____	
		__/__/____	
		__/__/____	
		__/__/____	

PHYSICIAN INFORMATION

Physician's Name:	Address:
Phone Number:	Fax Number:

INSURANCE INFORMATION

□ I do not have insurance benefits to cover the services and I agree to pay for services before they are rendered.

Primary Carrier*		Phone Number
Address		
Policy Holder		
Policy/Member #	Person Code (If known)	Group #

*Please provide copy of the front and back of insurance card

Secondary Carrier*		Phone Number
Address		
Policy Holder		
Policy/Member #	Person Code (If known)	Group #

*Please provide copy of the front and back of insurance card

My signature indicates that the above information is accurate and true to the best of my knowledge. I understand that this registration form must be updated yearly.

Client Name:		Date of Birth: __/__/____
Signature of Client (Adult or Minor age 14 years of older):	Print Name:	Date: __/__/____
Signature of Parent/Guardian if signer is under the age of 18 years:	Print Name:	Date: __/__/____
Signature of Witness:	Print Name:	Date: __/__/____

SPECTRUM
BEHAVIORAL HEALTH LLC

CONFIRMATION OF UNDERSTANDING FOR POLICY, PROCEDURE, HIPPA, CLIENT RIGHTS AND OTHER PERTINANT INFORMATION FOR SPECTRUM BEHAVIORAL HEALTH LLC CLIENTS

Client Name: _____ Date of Birth: _____

My signature below indicates that I have read understand and attest to the following:

- The information that I have provided on this registration form is current and true to the best of my knowledge.
- I permit a copy of this authorization to be used in place of the original.
- I understand that this consent may be revoked by me at any time, except to the extent that action has already been taken. This consent remains valid unless expressly revoked.
- I hereby release Spectrum Behavioral Health LLC from and legal responsibility or liability that may arise from the act of filing my insurance claim.
- I have been advised of the cost of treatment (Please see Financial Agreement (page 4) & Important policy and procedure information for Spectrum Behavior Health LLC clients (pages 6-7).
- I understand that it is ultimately my responsibility to ensure that my insurance carrier will cover the cost of services received at Spectrum Behavioral Health LLC and if I do not have other coverage, I will be responsible for the bill.

My signature below indicates that I have been given a copy of "Spectrum Behavioral Health LLC's "Important Policy and Procedure Information for Clients" handout, the "**Client Rights and the Grievance Procedure for Community Services**", "**Informed Consent for Mental Health Evaluation and/or Treatment**" and "**Financial Agreement**" information and the ***Spectrum Behavioral Health LLC Notice of Privacy Practices".*** For clients age 12-17, I have been given a copy of the "Rights of Children and Adolescents in Outpatient Mental Health Treatment" brochure.

_____

Signature of Client (Adult or Minor age 12 years of older) Date

_____

Signature of Parent/Guardian if signer is under the age of 18 years Date

_____

Signature of Clinician Date

FINANCIAL AGREEMENT

*Guarantor: Refers to the person responsible for receiving and paying the bill for medical services. The guarantor may or may not be the client. A parent or legal guardian/trustee is the guarantor for clients 18 years old and under. This is also the case for clients with a decreased mental capacity.

As a guarantor, you are responsible for the costs of services provided by Spectrum Behavioral Health LLC. We ask that you pay any expected co-pay/personal fees at the time of each visit. If we underestimate your co-pay, you will be billed at the end of each month, and we ask that you make payment within 30 days. Should you over pay, any payment will be promptly refunded. As a service to our clients, insurance claims will be submitted to your insurance carrier(s).

If you have HMO coverage and have a current referral, your policy may cover the initial costs if benefits have not already been used elsewhere. If your HMO requires you to have a referral for services that we provide at our office, it is your responsibility to obtain a referral and keep that referral current. You will personally be responsible for the co-pay portion of the benefits, for costs incurred during any period in which you do not have a current referral, and for services you receive that are not covered by your HMO.

If you have non-HMO insurance, you will be responsible for deductible and co-pay portions. You are responsible for any prior authorizations that may be needed. You are also personally responsible for any costs that exceed the benefit limits of your insurance policy or are not covered by your policy. If you have questions about what your insurance may cover, you should contact your insurance company and check benefits.

If you or your child have a Wisconsin ForwardHealth Medicaid plan you are responsible for keeping your ForwardHealth Medicaid coverage current. If you have a lapse in Wisconsin ForwardHealth Medicaid coverage, or coverage is cancelled, you will be responsible for payment of services. We will always bill your private insurance first for services provided. If your private insurance will not cover services, we will then bill your Wisconsin ForwardHealth Medicaid plan.

Although we are in network with many insurance carriers, this coverage can vary from clinician to clinician. You are responsible to contact your insurance carrier to verify "in network" status.

Fees for professional services:

Diagnostic Interview and Intake Assessment	$ 150.00
Ongoing Psychotherapy Treatment Services	$ 30.00 per 15 minute unit (ex. 45 minutes = $90.00)
No Show Fee (Insurance does not cover)	**See below

**If you fail to attend or fail to cancel a previously scheduled session with at least 24 hours' notice you may be charged a fee which could equal the fee for the services in which you were scheduled to receive. **

Certain situations and/or services are not reimbursed by insurance and must be paid in advance. These billable tasks include: School visits, letter preparation, court visits, copying records, paperwork completed for outside agencies, and telephone consultations over 5 minutes. A fee schedule for these expenses can be obtained from each individual clinician.

Accounts must be kept current and monthly statements must be paid upon receipt unless written arrangements have been made. If your account balance goes above $500, and you have not made payment arrangements with our office, we may ask that you temporarily stop services until your account is brought up to date. For your convenience, our office does accept MasterCard and Visa. If you have any questions regarding your account, please ask our account manager. Spectrum Behavioral Health, LLC reserves the right to seek legal means to secure reimbursement.

My signature below indicates that I have read, understand, and agree to the policies described above and that I understand that I am responsible for my bill with Spectrum Behavioral Health LLC regardless if I have insurance coverage or not.

Client Name:		Date of Birth: / /
Signature of Guarantor:	Print Name:	Date: / /
Witness:	Print Name:	Date: / /

INFORMED CONSENT FOR MENTAL HEALTH EVALUATION AND/OR TREATMENT—CHILD/ADOLESCENT

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Spectrum Behavioral Health LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a Level I or Level II psychotherapist, psychiatric nurse practitioner, an individual supervised by a qualified professional. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling.
2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.
4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential record at Spectrum Behavioral Health LLC, and I consent to disclosure for use by Spectrum Behavioral Health staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
5. **Discharge Policy:** There are circumstances under which my child may be involuntarily discharged. The agency may discontinue services if: (1) all treatment goals have been met; (2) fails to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments (more than 2 no call/no shows may result in clinic discharge) (3) I fail to pay for services as agreed upon in your Financial Agreement; or (4) upon the professional recommendation of the clinician. I have read and understand the discharge policy of the clinic.
6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.
7. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Client Name:		Date of Birth: / /
Signature of Client (Adult or Minor age 12 years of older):	Print Name:	Date: / /
Signature of Parent/Guardian if signer is under the age of 18 years:	Print Name:	Date: / /
Signature of Witness:	Print Name:	Date: / /

I, the clinician, have discussed the information above with the client and/or minor client's parent or legal representative.

Clinician Signature:
Printed Name of Clinician:
Date:

CLIENT: SIGN THIS FORM WITH CLINICIAN
CLINICIAN: ONCE SIGNED, PLACE IN "SCAN TO FILE" BOX IN FRONT OFFICE