Intake Date:_____

THE CARING TREE
CHILDREN'S COUNSELING CENTER

New Patient Information

Patient's Legal Name:_____ Preferred Name: _____ DOB: _____

Address:_____ Apt : _____ City, State, ZIP:_____

Main Phone:_____ Other Phone:_____ Initial if ok to leave a voicemail message: _____

Email:_____ Initial if ok to email _____ Preferred contact method? _____

Name of School:_____ Birth Sex: ____ Gender Identity: _____ Sexual Orientation, if known: _____

Race (circle): American Indian Alaska native Asian African-American/Black
Hispanic/Latino Native Hawaiian/Pacific Islander White Decline

Languages: _____ Do you need an interpreter or a translator? Y N

Responsible Party Information: *Must bring a valid photo ID to the initial appointment for the responsible party.*

Name: _____ Parent or guardian? Y N Emergency Contact? Y N

Relationship to pt: _____ DOB:_____ Address: _____

City, State, Zip: _____ Phone: _____ Email: _____

Employer: _____

Primary Insurance: _____ **Member ID#:** _____ **Policy Group:** _____

Employer: _____ **Plan Name:** _____ **Insured Party:** _____

Secondary Insurance: _____ **Member ID#:** _____ **Policy Group:** _____

Employer: _____ **Plan Name:** _____ **Insured Party:** _____

Other Contact: Name:_____ Parent or guardian? Y N Emergency Contact? Y N

Relationship to pt: _____ DOB:_____ Address: _____

City, State, Zip: _____ Phone: _____ Email: _____

If the patient has a Case Manager through NCHCC or Social Services, what is his or her name?

_____

**Who will be bringing patient to his/her appointment? ***_____

**a note or signed consent form must be on file for a child to be seen without a parent or legal guardian present.*

How did you hear about us? _____

The Caring Tree will call to confirm your appointment 1-2 days before your scheduled appointment. Patients are expected to follow treatment recommendations, which includes attending recommended appointments. Our Cancellation/Missed Appointment Policy states that ***if a patient fails to show up for their appointment without giving at least 24 hours or 1 business days' notice prior to the scheduled appointment, this is considered a no-show/late cancel appointment.*** *Clients who have three no-show/late cancel appointments in one year can be subject to same-day appointments only or discharge from The Caring Tree's services.* **Initial here: _____**

Patient Name _____ DOB _____

Payment Policy, Financial Acknowledgement, and Insurance Assignment

The client is responsible for costs of services provided. This may include the client, the client's spouse, or the client's parent or legal guardian.

The Caring Trees policy is to pursue the collection of all monies due the facility from third-party sources, the client, or any other responsible party. Accounts greater than 90 days from the date of service are considered delinquent at which time it is the counselors discretion whether or not the counselor will continue to see the patient. Failure to make monthly payments or failure to make payment arrangements will cause collection efforts, which includes calls, emails, postal mail, etc. If collection efforts are unsuccessful the account will be sent to collections at 180 days after the date of service. If collection efforts are unsuccessful the account will be turned over to a collection agency thereafter all services provided may be on a cash only basis.

The Caring Tree will make every attempt to collect from your insurance company. Please check your insurance policy or discuss your coverage with your employer or insurance agent. The Caring Tree accepts MasterCard and Visa for payment of services.

Forward Health covers most outpatient services. Clients are required to pay their copayment at the time of their service. If you have questions, please call The Caring Tree at 715-301-0667 or email billing@caringtree.us. You have the right to request a copy of this paperwork.

I request and authorize The Caring Tree - Children's Counseling Center to release to:

Insurance Company Name(s):

Primary Insurance _____ **Secondary Insurance**_____

information from my records necessary to pre-certify/authorize services and process my claim for insurance benefits, Medicaid payment, for services provided by The Caring Tree. This includes mental health, alcohol/drug, developmental or other medical diagnoses, discharge summaries and clinical notes to include physician's orders, treatment plans (where required), and test results. The purpose of this authorization is to enable the recipient to pre-certify/authorize and process my claim. I understand I have the right to inspect and receive a copy of this form and the material to be disclosed as required under SS. DHS 92. 05 and 92. 06. This consent is given voluntarily and I understand that treatment services are not contingent upon my decision concerning this release of information. I may revoke this concerns at any time except to the extent that action has been taken in reliance on it (45 CFR 164. 508 (c)(2)(I). This consent unless expressly revoked earlier is valid for one year from signature date.

I authorize and request payment directly to The Caring Tree - Children's Counseling Center of all benefits otherwise payable to me for services provided by The Caring Tree, not exceeding its regular charges. I understand that, as a patient, I am financially responsible for all charges regardless of whether paid by the insurer. This assignment cannot be revoked without the written consent of The Caring Tree.

Also, if needed, to initiate or facilitate enrollment/recertification in the medical assistance program, I authorize The Caring Tree to contact and share information with the County Department of Social Services.

Client or Parent/Legal Guardian Signature _____ **Date** _____

Witness Signature _____ **Date** _____

I understand The Caring Tree will attempt to collect payment from this patient's insurance as a courtesy.

I, _____(Printed Name), parent or legal guardian of

_____(patient), Date of Birth _____ understand that I am financially responsible for services provided today.

Signature: _____ Date: _____

Patient Name _____ DOB _____

Consent for Outpatient Services

I understand that during enrollment for outpatient services and/or following an assessment/treatment, complete and accurate information have been/will be provided regarding each of the following areas:

- Results of the assessment.
- Treatment alternatives.
- Possible outcomes and side effects of treatment recommended in the treatment plan.
- Treatment recommendations and benefits of the treatment recommendations.
- Approximate duration and desired outcome of treatment recommended in the treatment plan.
- The rights of receiving outpatient services, including the consumer's rights and responsibilities in the development and implementation of an individual treatment plan.
- The fees that the consumer or responsible party will be expected to pay for the proposed services.
- How to use The Caring Tree's Grievance Procedure.
- The means by which clients may obtain emergency mental health services during periods outside the normal operating hours of the clinic.
- Outpatient services discharge policy including circumstances under which a patient may be involuntarily discharged for inability to pay or for behavior reasonably the result of mental health symptoms and,
- This consent is effective for 15 months from the time the consent is given.

I have read and understand the above information, I have had an opportunity to ask questions about this information, I understand that I can have a copy of this consent form, and I consent to an assessment and/or treatment. I understand that I have the right to ask questions of my outpatient service provider about the above information at any time.

Client or Parent/Legal Guardian Signature _____ **Date** _____

Witness Signature _____ **Date** _____

Animal Waiver & Release

I, _____ (printed name), the legal parent or guardian of _____ (patient's name), agree to release, discharge, indemnify, and hold harmless The Caring Tree, its contractors, and employees for any and all claims, demands, losses, costs, liabilities, settlement agreements, damages, expenses and suits at law or in equity to my personal property or the property of my child that arise out of my child handling animals used by The Caring Tree. I recognize handling animals poses a risk of injury, including but not limited to, personal physical harm. I hereby release, discharge, indemnify and hold harmless The Caring Tree, its contractors and employees for any and all claims, demands, losses, costs, liabilities, settlement agreements, damages, and expenses connected with my child's participation whether caused directly or indirectly by any negligence (active or passive) attributable to The Caring Tree, its employees and contractors.

I acknowledge that I have read and fully understand the terms and conditions of the foregoing Waiver and Release and, that as the legal parent or guardian, agree and will comply with the same. **If a patient, employee or contractor is injured, an Accident/Injury Report must be completed as soon as possible following the injury.*

Patient's Full Name: _____ **DOB:** _____

Parent/Guardian Printed Name: _____ **Date:**_____

Parent/Legal Guardian Signature: _____

_____**Initial here if you prefer to not** have animals in your child's session. *Please note that as a patient of The Caring Tree, you and your child may still have brief contact with our animals and animal dander.*

DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
F-22538 (09/2016)

STATE OF WISCONSIN
Wisconsin Statutes
§ 51.61 (1) (o)
Administrative Rule
DHS 94.18

CONSENT TO FILM OR RECORD

Patient Name (Last, First MI)	ID Number	

By my signature below, I authorize the filming / recording as listed; and I understand that I may view the photograph or film or hear recording prior to any release. This consent may be revoked at any time by giving written notification to the facility / institution director.

Type of Filming / Recording	Date – Consent Expires
Video & Audio	**Until revoked in writing**

Name – Individual / Group Doing the Filming / Recording

The Caring Tree Children's Counseling Center

Purpose / Reason for Filming / Recording	Resulting Materials Can Be Used By
Video security cameras are used for the safety of our clients and staff.	**The Caring Tree** **Local authorities**

I further understand that I may specify periods during which or situation in which client / patient may not be filmed or recorded. I understand that neither last names nor other identifying information will be used or made available.

Filming / Recording Limitation – Times / Situations

Recording is limited to the common areas of the clinic.

SIGNATURE – Patient – If Presumed Competent		Date Signed
SIGNATURE – Parent for Child (Minor) or Guardian	Relationship	Date Signed

DISTRIBUTION: Original—Patient Record

Patient Name _____ DOB _____

Patient Bill of Rights & Responsibilities

You have the right to all of the following:

Personal Rights **INITIAL_____**

- Be cared for in a safe and clean environment by competent healthcare professionals;
- Be free from chemical and physical restraints and involuntary seclusion unless medically necessary;
- Be free from abuse, neglect, and harassment. This includes physical, mental, emotional or financial abuse;
- Have staff make fair and reasonable decisions about your treatment and care;
- Participate in religious services and social, recreational, and community activities to the extent possible;
- Be paid, with some exceptions, for any work you do;
- Make your own decisions about things like getting married, voting and writing a well, if you are over the age of 18 and have not been found legally incompetent;
- Be given the chance to exercise and go outside for fresh air regularly and frequently, except for health and safety concerns;
- Receive treatment in a safe, psychologically, and physically humane environment;
- Be treated with dignity. We will respect your cultural and personal values, beliefs, and preferences;
- Not have your care affected by your race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, illness, handicap or ability to pay; and
- Contact the family member or representative and your personal physician to notify them of your admission, or have a staff member do so on your behalf. You may refuse to have others contacted.

Treatment Rights **INITIAL_____**

- Staff involved in your care will introduce themselves to you and explain what they are going to do;
- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate to 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 alternative to and possible side effects and/or risks of treatment or medications;
- You have the right to refuse treatment or medication unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders that. If you have a guardian however, your guardian may consent to treatment and medications on your behalf.
- You may not be given unnecessary or excessive medication;
- You have the right to leave against physician's order unless under a legal hold;
- You may not be subject to electroconvulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent;
- You must be informed, in writing, of any cause of your care and treatment for which you or your relatives may have to pay;
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding; and
- You have the right to formulate Advanced Directives.

Communication and Privacy Rights **INITIAL_____**

- You may call or write to public officials or your attorney;
- You may not be filmed taped or photographed unless you agree to it;
- You may use the telephone when you wish;
- You must be provided privacy when you are in the bathroom and receiving care for personal needs;
- You may use and wear your own personal articles and clothing;
- Your treatment information is kept confidential unless the law permits disclosure;
- Your records may not be released without your consent, unless the law specifically allows for; and
- You may ask to see your records.

Patient Responsibilities **INITIAL_____**

The care you receive depends partially on you. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities are presented in the spirit of mutual trust and respect.

The patient and family are responsible:

- To provide accurate and complete information concerning his or her present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- For reporting perceived risks in his or her care and unexpected changes in his or her condition to the responsible practitioner.
- For following the treatment plan established by his or her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- For keeping appointments and for notifying the center when he or she is unable to do so.
- For his or her actions should he or she refuse treatment or not follow his or her therapist's orders.
- For ensuring that the financial obligations of his or her care are fulfilled as promptly as possible.
- For following the organization's policies and procedures.
- For being considerate of the rates of other patients/clients and staff.
- For being respectful of his or her personal property and that of other persons.
- For asking questions about the patient's condition, treatments, procedures, lab and other diagnostic test results.
- For asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- For immediately reporting any concerns or errors that they may observe.

You have the right to address any concerns, complaints, file a grievance or learn more about the grievance procedure used by The Caring Tree. Please contact the Clinical Supervisor/Compliance Officer Trena 715-301–0667. You may also choose to communicate your concerns directly to the state of Wisconsin Department of Health Services, Division of Quality Assurance, PO Box 2969, Madison, WI 53701–2969, or call 608–266-8481.

Patient Name _____ DOB _____

Receipt of Privacy Notice Acknowledgment

Your signature on this form acknowledges that you have received a copy of The Caring Tree's Privacy Notice which explains how your health information will be handled in different situations. For minor children under the age of 18 who live with you, you also acknowledge that you have received this notice on their behalf.

Client or Parent/Legal Guardian Signature _____ **Date** _____

Printed Name _____ **Relationship to Patient** _____

Patient Name _____ DOB _____

Notice Of The Caring Tree's Policies And Practices To Protect The Privacy Of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **1.Uses and disclosures for treatment, payment, and healthcare operations.** The Caring Tree may use or disclose your protected health information ("PHI") for treatment and payment purposes without your informed consent or authorization. Other uses require authorization. Typically, we will ask for informed consent or authorization to communicate with other treatment providers in order for you to be aware of communication which may occur. *To help clarify these terms here are some definitions: "PHI" refers to information in your health record that could identify you. "Treatment and payment" treatment is when the center provides, coordinates, or manages your health care and other services related to your health care. Example of treatment include: working with you directly on your goals, or consulting with another healthcare provider, such as your family physician or another psychologist."Payment" is when we obtain reimbursement for your health care.Examples of payment or when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage. "Use" applies only to activities within our clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you."Disclosure and "applies to activities outside my clinic such as releasing, transferring, or providing access to information about you to other parties."Informed consent" and "authorization" are written forms that you sign permitting us to release specific information about you to specific recipients.* **2.Uses and disclosures requiring authorization.** We may use or disclose PHI for purposes outside of treatment and payment when your appropriate consent or authorization is obtained. In those instances, we will obtain a Release of Information from you before releasing this information.We will also need to obtain an authorization before releasing your psychotherapy notes."Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session. You may revoke an authorization at any time in the manner selected on the ROI form, or in writing. You may not revoke an authorization to the extent that 1.We have relied on that authorization; or 2. If the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy. **3. Uses and disclosures with neither consent nor authorization.** We may use or disclose PHI without your consent or authorization in the following circumstances: **Serious threat to health or safety**: if we have reason to believe using our professional care and skill that you may cause harm to yourself or another, we must warn the third-party and/or take steps to protect you. This may include contacting a third-party or may include instituting commitment proceedings. **Child abuse:** if we have reasonable cause to suspect that a child seen in the course of my professional duties has been abused or neglected, or have a reason to believe that he or she has been threatened with abuse or neglect him, and that abuse or neglect of the child will occur, we must report this to the relevant county department, child welfare agency, police, or sheriff department. **Adult and domestic abuse**: If we believe that another person has been abused or neglected we may report such information to the relevant county department or state official of the long-term care ombudsman. **Health oversight**: If the Wisconsin Department of Health Services requests that we release records to them for or an investigation or audit, we must comply with such a request.**Judicial or administrative proceedings**: if the patient is involved in a court proceeding and a request is made for information about his or her diagnosis and treatment in the record such information is privileged under state law and we will not release the information without written authorization from the patient or his or her guardian or legally appointed representative, or a court order. The privilege does not apply when the patient is being evaluated for a third-party or where the evaluation is court ordered. You will be informed in advance if this is the case. **Worker's Compensation:** If a patient files a Worker's Compensation claim, we may be required to release records relevant to the claim to the patient's employer or its insurer and we may be required to testify. There may be additional disclosures of PHI that we are required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common. **4.Patient's Rights and Therapist's Duties. Right to Receive Confidential Communications by Alternative Means and At Alternative Locations**-You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, if you did not want a family member to know that you are being seen here we can send your bills to a different address. **Right to Inspect and Copy**-You have the right to inspect or obtain a copy of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. **Right to Amend**-you have the right to request an amendment of PHI for as long as the PHI is in the record. Your request may be denied. **Right to Accounting**-In most cases you have the right to receive an accounting of disclosures of PHI regarding you. **Right to a Paper Copy**-You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically. *Contact info@caringtree.us to find out how to request these.* **5.Therapists Duties Regarding PHI:** Therapists are required by law to maintain the privacy of PHI and to protect patients with a notice of his or her legal duties and privacy practices. *The Caring Tree reserves the right to change the privacy policies and practices described in this notice and unless we notify you of such changes, we are required to abide by the terms currently in effect. If we revise the policies and procedures we will inform you at your next appointment. However, if the change is one that would affect your treatment or handling of your PHI prior to your next visit, you will be notified by mail.* **6. Questions/Complaints:** If you have questions about this notice or disagree with a decision made about access to your records or if you have concerns about your privacy rights you may contact Trena Loomans at The Caring Tree, or at 715–301–0667. Patients can bring their concerns to the Clinic Manager, other staff members who may be able to answer your questions, or the Clinical Supervisor Trena Loomans. **If you believe that your privacy rights have been violated and wish to file a complaint with you may send your written complaint to 2804 Rib Mountain Dr, Suite D., Wausau, WI 54401. You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The Caring Tree will not retaliate against a patient for exercising his or her right to file a complaint.**

Keep this page for your records