

VALENTIN CLINIC S.C.
1220 Dewey Avenue □ Wauwatosa, WI 53213 □ 414-454-6514

Date: _____
PATIENT: _____ PT. SSN: _____
THERAPIST: _____

Last Name, First, MI: _____, _____, _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M _____ F _____ Date of Birth: ____/____/____ Marital Status: S _____ M _____ W _____ D _____ SEP _____

Home Phone: (____) _____ Cell: (____) _____

Parent(s) Name (if Minor): _____ Spouse/Partner: _____

Employer: _____

Address: _____ City: _____ St: _____ ZIP: _____

Work Phone: (____) _____ Can we call? Y/N Referred By: _____

INSURANCE INFORMATION

PRIMARY:

Subscriber: _____

Address: _____

(if different): _____

Phone: (____) _____

Date of Birth: ____/____/____

Soc. Sec. No: _____

Relationship to Insured:

Self _____ Spouse _____ Other _____

Child _____ Step-child _____ Adopted-child _____

Insurance Co: _____

Claims _____

Address: _____

Phone No: (____) _____

Effective Date: ____/____/____

Subscriber No: _____

Group No: _____

Employer/Group Name: _____

Address: _____

Phone: (____) _____

SECONDARY:

Sub: _____

(____) _____

DOB: ____/____/____

SSN: _____

Relationship to Insured:

Self _____ Spouse _____ Other _____

Child _____ Step-child _____ Adopted-Child _____

Insurance Co: _____

Claims _____

Address: _____

(____) _____

Eff Date: ____/____/____

Sub No: _____

Group No: _____

Emp/Group: _____

Addr: _____

(____) _____

EMERGENCY CONTACT(S)

Name: _____

Relation: _____

Home Ph: (____) _____

Work Ph: (____) _____

Cell/Other: (____) _____

VALENTIN CLINIC, S.C.
1220 Dewey Avenue <Wauwatosa, WI 53213 > 414-454-6514
CONSENT FOR TREATMENT

I, the undersigned, have been informed of the following:

- Type of treatment to be provided; psychotherapy, hypnotherapy, and play therapy.
- Goals or benefits expected.
- Therapist's credentials.
- Estimated length of treatment.
- Probable consequences of not receiving proper treatment.
- Possible risks, if any, associated with treatment.
- If I disagree with any part of the treatment plan, I can request a second opinion and will be assisted in obtaining the opinion.
- Name of the therapist's supervisor and that he/she is available to answer any questions, concerns, or complaints about the treatment.
- Estimated cost of treatment (subject to change without notice):
 - Initial Assessment (50-60 minutes) by psychologist is \$200.00
 - Standard session (45-50 minutes) by psychologist is \$175.00
 - Initial session (50-60 minutes) by psychotherapist is \$190.00
 - Standard session (45-50 minutes) by psychotherapist is \$160.00
 - Medication Management (30 minutes) by Nurse Practitioner is \$115.00
- Insurance will be billed by clinic. However, the client is encouraged to call their insurance carrier in order to obtain current out-patient mental health coverage. Any services not covered by the clients insurance will be the responsibility of the client and be billed to them.
- Payment of deductible, co-pay, co-insurance, or self-pay sessions is required at the time of service.

My Rights as a Patient:

I understand that information given within the confines of the therapeutic relationship shall remain confidential excepting those circumstances outlined in the Wisconsin statutes which require a therapist to report the occurrences of homicide, suicide, physical assault, or child abuse.

I have the right to file a grievance should I believe that my rights were violated.

My consent to treatment does not include a consent to participate in any research or educational programs conducted by this facility/clinic unless a separate authorizations if given.

My signature to treatment below indicates my consent to the treatment plan described today. I understand that my consent automatically terminates at the end of my treatment. I do have the right to withdraw this consent at any time I choose.

Signature: _____ Date: _____

Printed Name: _____ Date: _____

**VALENTIN CLINIC
1220 DEWEY AVENUE
WAUWATOS, WI 53213
(414) 454-6514**

RELEASE OF INFORMATION (Billing Purposes)

I hereby authorize the Valentin Clinic, S.C., to release any health-related information which may be needed in connection with payment of medical/mental health services provided.

Signature

RELEASE OF INFORMATION (Referring Physician)

I hereby authorize the Valentin Clinic, S.C., to release pertinent medical information regarding my treatment to my referring physician.

Signature

ASSIGNMENT OF BENEFITS

I request that payment under any health insurance policy I may utilize be made directly to the Valentin Clinic, S.C. for services rendered. I understand that I am responsible for any amount not paid by my insurance.

Signature

APPOINTMENT CANCELLATION POLICY

I understand that any appointments canceled or missed without 24 hour notice shall be subject to charge for the appointment time reserved and **my insurance company does not cover this fee.**

Signature

MEDICAL HISTORY FORM

Name: _____ Date: _____

DOB: _____

In order to provide you with the service you expect, we need to begin with information from you. Therefore, we ask that you please complete the following:

Briefly describe your reason for seeking help: _____

Have you received treatment for this problem in the past? Y___ N___

Please provide dates of treatment and name of person treating you:

<i>In-Patient</i>	<i>Out-Patient</i>	<i>Treating Provider</i>

Primary Care Physician (name, address, phone): _____

Are you currently being treated by a psychiatrist? Y___ N___

If yes, please provide name, address, and phone: _____

List any medications you are currently taking: _____

MARITAL AND SEXUAL HISTORY:

Single _____ Married (times) _____ Divorced _____ Widowed _____

Reason for divorce(s): _____

	<i>Name</i>	<i>Age</i>	<i>In-Home</i>	<i>Occupation</i>	<i>AODA/MH Problems</i>	<i>Health</i>
Husband/ Wife						
Significant Other						
Children						
Children						
Children						

Patient's description of current marriage or significant relationship: _____

ALCOHOL AND DRUG HISTORY:

<i>Current</i>	<i>Past Use (Dates)_</i>	<i>Frequency</i>	<i>Amount</i>	<i>Alcohol</i>	<i>Drugs (Please List)</i>

<i>MEDICAL HISTORY</i>					
Check (X) the appropriate column to indicate medical problem you or your relatives may have or have had.					
<i>CONDITION</i>	<i>SELF</i>	<i>FATHER</i>	<i>MOTHER</i>	<i>BROTHER</i>	<i>SISTER</i>
Allergies					
Asthma					
Arthritis					
Alcoholism					
Blood Pressure – High					
Blood Pressure – Low					
Cancer					
Chronic Poor Health					
Diabetes					
Drug Addiction					
Drug Reactions					
Frequent Infections (Influenza)					
Hay Fever					
Headaches or Migraines					
Hearing Problems					
Heart Disease					
Indigestion					
Jaundice					
Liver Disease					
Menstrual Problem (describe)					
Mental Health Disorder					
Overweight					
Seizures					
Thyroid Disease					
Ulcers					
Underweight					
Visual Problems					
Other:					
Other:					
Other:					
Other:					

Please check (X) any of the following problems which apply to you. Thank you.

	<i>NOW</i>	<i>DURING PAST YEAR</i>	<i>COMMENTS (If any)</i>
Feel Sad			
Loss of Interest			
Feel Hopeless			
Nothing is Fun			
Weight Loss			
Weight Gain			
Loss of Energy			
Cry Easily			
Can't Fall Asleep			
Sleep Too Much			
Guilt Feelings			
Restless			
Irritable Mood			
Think of Suicide			
Waking Up Early			
Feel Worse in the Morning			
Little Need for Sleep			
Talking Too Much			
Racing Thoughts			
Spending Sprees			
Reckless Driving			
Overactive Sexually			
Muscle Aches			
Feel "On Edge"			
Worry to Much			
Impatient			
Dry Mouth			
Bowel Problems			
Hyperventilation			
Faintness/Dizziness			
Pounding Heart			
Trembling			
Sweating			
Choking Sensation			
Nausea			
Numbness/Tingling			
Chest Pain			
Fear of Going Crazy			
Fear of Dying			
Uncontrollable Urges			
Explosive Temper			
Easily Distracted			
Can't Concentrate			
Thinking Too Much			

Valentin Clinic, S.C.

1220 Dewey Avenue
Wauwatosa, WI 53213
Phone: (414)454-6514
Fax: (414)454-6751

I have received a copy of the Protected Health Information (PHI) information sheet for the Valentin Clinic.

Patient Name (print) _____

Patient Signature _____

Third Party Representative/Agent _____

Date _____

Valentin Clinic, S.C.
1220 Dewey Avenue, Wauwatosa, WI 53213

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.

I. Uses and disclosures for Treatment, Payment, and Health Care operations

I may *use or disclose* your *protected health information* (PHI), for treatment, payment and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
 - *Health care operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative service and case management and care coordination.
- “*Use*” applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for the purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization from you before releasing your psychotherapy notes. “*Psychotherapy notes*” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations of (PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I 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.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to suspect that a child seen in the course of my professional duties has been abused or neglected, or have reason to believe that a child seen in the course of my professional duties has been threatened with abuse or neglect, and that abuse or neglect of the child will occur, I must report this to the relevant county department, child welfare agency, police, or sheriff's department.
- **Adult and Domestic Abuse:** If I believe that an elder person has been abused, or neglected, I 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 Regulation and Licensing requests that I release records to them in order for the Psychology Examining Board to investigate a complaint, I must comply with such a request.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the record thereof, such information is privileged under state law and I will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance, if this is the case.
- **Serious Threat to Health or Safety:** If I have reason to believe exercising my professional care and skill, that you may cause harm to yourself or another, I must warn the third party and/or take steps to protect you, which may include instituting commitment proceedings.
- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to release records relevant to that claim to your employer or its insurer and may be required to testify.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights

- *Right to Request Restrictions:* You have the right to request restriction on certain uses and disclosures or protected health information about you. However, I am not required to agree to a restriction you request.
- *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, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting:* You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* you have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.