

PSYCH MED MANAGEMENT, LLC

Therese Jaeckle, APNP

11431 N Port Washington Rd, Ste 115, Mequon WI 53092 in the Galleria building

333 Bishops Way, Ste 102, Brookfield WI 53005 in Arbor Terrace

Mailing Address: PO Box 603, Port Washington, WI 53074

Adult Intake Form

Client's Last Name _____ First _____ M.I. _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ Age ____ Sex ____ Social Security Number _____

Home Phone _____ OK to leave a message? Yes or No

Cell Phone _____ OK to leave a message? Yes or No

Work Phone _____ OK to leave a message? Yes or No

Employer _____ Occupation _____

Spouse's Name _____ Spouse's Date of Birth _____

Please check one _____ Bill Insurance (Please present card) _____ Self Pay

Note: Without insurance information, responsible party will be billed.

Primary Insurance Company _____

Subscriber Name _____ DOB _____

Subscriber ID _____ Group Number _____

Employed By: _____ Relationship to patient: _____

Secondary Insurance Company _____

Subscriber Name _____ DOB _____

Subscriber ID _____ Group Number _____

Employed By: _____ Relationship to Patient: _____

I hereby authorize Psych Med Management, LLC to release such information as may be requested by my insurance company for the purpose of billing and coverage clarification and that payment from my insurance company will be assigned to PMM. I also permit a photograph or other facsimile of the authorization to be used in place of the original assignment.

Patient Signature _____ Date _____

**PSYCH MED MANAGEMENT, LLC
PRIVACY POLICY**

PMM agrees to hold in the strictest of confidence any health information pertinent to the client either disclosed directly by the client or received via third party. We agree to receive signed permission by the client or guardian prior to release of information in any manner (verbal or written), which includes but is not limited to: diagnosis, history, treatment, and compliance with treatment, treatment progress, and appointment times/dates. It is also noted that legally, confidentiality may be broken when client's actions or stated intent pose a risk to client or another person (in the therapist's professional judgement).

In addition, PMM professional staff, clerical staff and billing department agrees to hold in the strictest of confidence any information provided to us by client or third party that is not generally available to the public and that personal information will not be distributed or shared with other persons or organizations without written permission/approval by the client or guardian.

Information released to a third party, with your permission, may be subjected to re-disclosure by anyone who has access to the documents. In that case, PMM reminds you that the information disclosed may no longer be protected by our privacy policy or federal rules.

This notice is effective as of the date at the bottom of this form. This authorization will expire seven years after the date on which you last receive services from us.

Treatment Billing Policy

Insurance Responsibility It is your responsibility to know what coverage your insurance provides. All charges are the sole responsibility of the responsible party, regardless of insurance payments. If there is a problem with receiving payment from your insurance carrier or if the claim process extends over two months, you will be expected to make payments. We will then reimburse you when the insurance company makes payment. If the insurance check is paid directly to you, you are obligated to turn the check over to our clinic. If you are a member of a managed health care plan, your fee may be reduced due to a contract. **Self Pay Clients** Payment is expected at the time of service unless you have set up a payment plan with the office manager. **Collection Agency** Past due accounts will be given over to our collection agency. All fees incurred by this action will be the responsibility of the client. If you have any concerns about payment or insurance billing, please feel free to discuss them with the office manager.

By signing this document, you agree to allow us to:

Use or disclose your health information in the manner described above.

Leave messages on your answering machine or voice mail at home/cell.

Leave messages with other persons at your home.

Send correspondence to your home, which may include bills for services.

Send correspondence to your home via e-mail. E-mail address: _____

Clearly identify and EXCLUSION to this agreement:

Your signature indicates your agreement to the above stated policy and manner of disclosure.

Patient or Guardian Signature

Date

PSYCH MED MANAGEMENT, LLC

INSURANCE AND PAYMENT INFORMATION

I understand that charges for the initial session comprise of two charges totaling \$280 and that follow up sessions also comprise of two charges totaling \$150.

I understand that if I have insurance, that it will be billed for me by PMM and that I am responsible for any balances, deductibles, co-payments or non-covered fees. I agree to pay my copays/deductible at each session. Unpaid balances will be sent to my home monthly and are payable at the time of receipt. I agree to notify PMM if my employment, insurance, marital status, address or phone number changes. I understand that if I am a self-pay client, that I am responsible to pay the agreed upon rate at the time of service. Non-payment of services rendered may lead to termination of service and referral to a collection agency. **I also understand that appointments missed by me or cancelled less than 24 business hours before my appointment will be billed to me at \$100, which is not covered by insurance and will not be billed to insurance.**

I also understand that PMM office policy is that if my account reaches 90 past due, I will not receive refills nor be able to schedule appointments. If my account reaches 120 past due, I will be released as a patient and be sent to a collection agency.

PMM accepts cash, personal checks and credit cards. We do not accept two party checks. Returned checks marked "Insufficient Funds" will result in processing fees from the bank and from PMM.

Patient/Guardian Signature

Date

PSYCH MED MANAGEMENT, LLC
PATIENT RIGHTS AND INFORMED CONSENT

PART ONE
PATIENT RIGHTS

Treatment rights and personal rights. Clients have the right to:

1. Receive prompt and adequate treatment
2. Complete and current information concerning their outpatient program
3. Confidentiality as it relates to their treatment program
4. Be informed of services available and their cost
5. Participate in the planning of their treatment program
6. Refuse to take medication
7. Refuse to participate in experimental research (PMM does not participate in experimental programs)
8. Refuse to be filmed or taped (PMM does not use taping or video devices)
9. Sign an Informed Consent document

Legal Rights. Clients have the right to:

1. Petition a court for a review of any civil commitment
2. Bring an action for damages against persons violating rights or confidentiality
3. Be considered to be legally competent unless a judge has found them to be incompetent

Other Rights. Clients have the right to:

1. See their treatment record after release or parts of it during treatment, if the provider agrees
2. Have a grievance procedure available to them and to have an advocate present during the process
3. See or contact the Therese Jaekle to discuss their treatment plan
4. Receive written notification if involuntary discharge occurs for behavior, non-compliance with treatment plan or payment plan and have the right to receive sources for ongoing treatment. In addition, patients have the right to have the involuntary discharge reviewed by the Dept. of Health, Certification Unit, prior to the effective date of discharge.

PART TWO
INFORMED CONSENT DOCUMENT

Clients have the right to know:

1. The proposed treatment and services
2. Benefits and risks of treatment and services
3. Administration of treatment and services
4. Side-effects (if any) of treatment and services
5. Alternative programs and/or methods of treatment
6. Benefits and risks of alternative programs and/or methods of treatment
7. The right to receive no treatment or services
8. The benefits and risks of receiving no treatment or services
9. The right to withdraw the informed consent at any time in writing
10. Bills not covered by my insurance will be mailed to my home
11. PMM has a comprehensive Discharge Policy that includes voluntary and involuntary discharge. Possible reasons for involuntary discharge include behavior, for example, reportable offenses to Law Enforcement, even if the behavior may be a side-effect of my mental health diagnosis, coming to PMM after using illegal drugs or alcohol, or non-payment of any account balance.

I understand that this Patient Rights and Informed Consent Document is in effect for one year or until I withdraw it in writing or until my case is closed. I will be required to sign a new form every 12-15 months.

I have read and understand these rights and I understand that a copy will be given to me upon request. My signature indicates that I give consent to treatment at PMM, LLC.

Patient or Guardian Signature

Date

**PSYCH MED MANAGEMENT, LLC
GRIEVANCE POLICY AND PROCEDURE**

Clients have the right to file a grievance if they feel their rights have been denied. This grievance procedure does not limit the client's right to pursue other remedies including legal action through the court system.

Stage 1 – Informal Discussion -Optional

The client is encouraged, where possible, to first informally discuss any problems with the person or people who are involved. If they still have a problem, they may file a complaint with the Grievance Rights Specialist, Therese Jaeckle.

Stage 2 – Complaint Investigation -First Decision

Within 45 days of the incident, the individual should submit a written complaint of the incident and the specific concerns or complaints. Information which should be included in this statement: Description of the specific incident, date of concern, time of incident and list of the parties who are involved. The written statement should be submitted to the Clinic Director who will investigate the facts and will document the investigation. The investigation will be completed within ten (10) working days. The decision and reasons for the decision will be made available to the person who filed the complaint at this time. A copy of the investigation and decision will be on file.

Stage 3 – Final Decision

If the complaint is not resolved, the Director will either hold a hearing of conduct and investigation and will then issue a final written decision within fifteen (15) working days. The person filing the complaint should also submit a written request for action to the Director to have the first decision reviewed. Complainants have the right to choose someone to represent them and/or accompany them to any hearings and/or interviews.

Miscellaneous

1. Complainants may at any time chose to use the court system, in which case, the grievance procedure will end.
2. The client or any other person acting on their behalf may use the grievance procedure.
3. There is no limit to the number of grievances which may be submitted.
4. Grievance proceedings may end at any time if all parties concerned agree.
5. No person may be denied services or be found in noncompliance with treatment for using the grievance procedure.

Appeal

If attempts at grievance resolution at the clinic level fail, the patient has a right to appeal to a State Grievance Examiner. The process for this appeal is that within 14 days of receiving the decision, request of copy of the written decision from PMM and send a copy with your written appeal to:

State Grievance Examiner
Division of Supportive Living
PO Box 7851
Madison, WI 53707-7851

I have read and understand the Grievance Policy and Procedures and may request a copy of it at any time.

Patient or Guardian Signature

Date

PSYCH MED MANAGEMENT, LLC
New Client Health and Personal Information

Date: _____ Client Name: _____

Gender M F DOB / / Age Marital Status Referred by

Highest level of education completed Occupation

Reason for today appointment

In case of emergency please contact:

Name Phone relationship

Please check any that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Bingeing | <input type="checkbox"/> Loss of interest in usual activities |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Purging Behavior | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Restricting Food Intake | <input type="checkbox"/> Problematic spending/shopping |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Obsessive Behavior | <input type="checkbox"/> Problems with gambling |
| <input type="checkbox"/> Uncontrolled Anger | <input type="checkbox"/> Paranoia | <input type="checkbox"/> High risk behavior |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Hallucinations/Delusions | <input type="checkbox"/> Alcohol/drug abuse |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Increased tobacco use | <input type="checkbox"/> RX drug overuse/abuse |
| <input type="checkbox"/> Sad/Down | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Wanting to hurt myself |
| <input type="checkbox"/> Manic/Very High Energy | <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Wanting to hurt others |
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Loss of recent memory | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Appetite Increase | <input type="checkbox"/> Loss of distant memory | <input type="checkbox"/> Overall poor judgment |
| <input type="checkbox"/> Weight loss <u> </u> #'s | <input type="checkbox"/> Confusion | <input type="checkbox"/> Allergy: medicine/food |
| <input type="checkbox"/> Weight gain <u> </u> #'s | <input type="checkbox"/> Social withdrawal | Specify: <u> </u> |

Please record major illness, injury or surgery you have had in the past 5 years. Begin with the most recent:

Health Problem	Treatment	Physician name	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Tobacco Usage: Alcohol Usage:

Medications I currently use and dosage: _____

Do you currently use illegal drugs? Yes No If yes, please itemize

Current Family Doctor: Location

This doctor will coordinate my care: Yes Or would you like us to coordinate with your physician Yes No

Have you been in counseling before? Yes No Name of therapist Year?

How many sessions? Was counseling helpful? Why or why not?

Have you seen a psychiatrist before? Yes No Name of doctor: Year?

Diagnosis Are you still seeing this doctor? Yes No

Have you ever been physically abused? sexually abused? emotionally abused? verbally abused?

Have you or any family member made a suicide threat? A suicide attempt?

Has any family member completed suicide?

My support for life's joys and problems is Excellent OK Not Good I have no support system

Who are the primary people in your support system, if one exist?

Name: Relationship to you

Do you want any family member or others to be involved in your education and learning? Yes No

I have a spiritual belief system that may impact my recovery Yes No Specify:

I regularly do these wellness practices:

I am currently involved in legal issues Yes No Nature of legal issue:

For Adults:

Spouse's name _____

Age _____ Occupation _____

Let all children, if any, and circle the names of those who are stepchildren or children by a previous marriage
Name _____ Living at home _____ Sex _____ Age _____ Grade/occupation _____ Marital Status _____

1. _____
2. _____
3. _____
4. _____
5. _____

Let all people living in your home and their relationship to you (other than spouse and children)

1. _____
2. _____
3. _____
4. _____
5. _____

For Children:

What is the concern that prompted you to bring your child for treatment?
Family _____ School _____ Explain Problem: _____
Emotional _____ Legal _____
Alcohol/Drugs _____ Other _____

Where does the problem occur: _____ Home _____ School _____ Community _____
Age when the problem began: _____ Duration: _____ Less than 6 months _____ Greater than 6 months _____
Child's strengths and limitations: _____

Social History:

Current school, grade teacher _____
Special programming (I team, etc.) _____
School academic functioning: Present _____ Past history _____
Behavior with teachers/peers: Present _____ Past history _____
Is your child involved in any clubs, sports, groups? _____
Activity level: _____ Inactive _____ Average _____ Overactive _____
Family History: _____

Parent presently married? Yes _____ No _____ How long? _____ Parents Divorced? Yes _____ No _____ How long? _____
Parent deceased? _____ Mother _____ Father _____ How long? _____
Parents (s) remarried Mother- to whom? _____ How long? _____
Father- to whom? _____ How long? _____

Members of household:

Name _____ Age _____ Occupation/grade _____ Relationship to child _____

1. _____
2. _____
3. _____
4. _____
5. _____

Contact with extended family members? _____ Grandparents _____ Aunts/Uncles _____ Cousins _____

