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

Child Intake Form

Client's Last Name______________________________First______________________M.I.____

Address_______________________________________City____________________Zip____

Date of Birth____/____/________ Age________ Sex__________ Social Security Number______________

Mother's name______________________________ DOB____/____/____ SS#______________

Mother's phone number where messages can be left: ______________________________

Email address where messages can be sent: ______________________________

Father's name______________________________ DOB____/____/____ SS#______________

Father's phone number where messages can be left: ______________________________

Email address where messages can be sent: ______________________________

Client resides with: (circle) Both parents Mother Father Other______________

Responsible Party: (circle) Mother Father Other ______________________

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 #**__________________**Relationship to patient**______________

Secondary Insurance Company____

Subscriber Name ______________________________________ **DOB**______________

Subscriber ID __________________**Group #** __________________**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.

Parent/Guardian Signature______________________________________ **Date**______________

Child signature if 14 years old or older________________________________**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

<u>Insurance Responsibility</u> 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. <u>Self Pay Clients</u> Payment is expected at the time of service unless you have set up a payment plan with the office manager. <u>Collection Agency</u> 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 takes (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 Jaeckle 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:

___Panic Attacks
___Anxiety
___Depression
___Crying
___Uncontrolled Anger
___Irritability
___Hopelessness
___Sad/Down
___Low Energy
___Manic/Very High Energy
___Appetite Loss
___Appetite Increase
___Weight loss_____#'s
___Weight gain_____#'s

___Bingeing
___Purging Behavior
___Restricting Food Intake
___Obsessive Behavior
___Paranoia
___Hallucinations/Delusions
___Increased tobacco use
___Nightmares
___Difficulty falling asleep
___Difficulty staying asleep
___Loss of recent memory
___Loss of distant memory
___Confusion
___Social withdrawal

___Loss of interest in usual activities
___Mood Swings
___Problematic spending/shopping
___Problems with gambling
___High risk behavior
___Alcohol/drug abuse
___RX drug overuse/abuse
___Suicidal thoughts
___Wanting to hurt myself
___Wanting to hurt others
___Poor concentration_
___Overall poor judgment
___Allergy:medicine/food
Specify:_______________

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 probems 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________________________

List 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.____

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

1.________________________ 2.________________________

List your brothers, sisters & parents

Name Sex Age Living/Deceased Occupation Marital Status

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 (M 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?________

Parent(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

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers, and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow Therese Jaeckle to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include your diagnosis, treatment plan, progress and medications.

Patient Rights

1. You may end this authorization at any time by contacting our office.
2. If you make a request to end this authorization, it will not include information that may have already been used or disclosed by your previous permission.
3. You will not be required to sign this form as a condition of treatment or payment.
4. You have a right to a copy of this signed authorization.
5. If you choose not to agree to this request, your services will not be affected.

Patient Authorization

I hereby authorize the names or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis and treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and State laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires twelve (12) months from the date of my signature unless otherwise stated herein.

Therese Jaeckle, APNP is authorized to release protected health information related to the evaluation and treatment of:

______________________________ ____________________ ____________________

Patient Name **Social Security #** **Date of Birth**

Primary Care Provider Name:______________________________ **Phone #**______________

Address:____

Therapist Name: ______________________________________ **Phone #**_____________

Address: ____

Disclosure may include the following. Check all that apply:

___None of the below. I hereby refuse to give authorization for any release of information.

___All of the below

___ Lab/diagnostic testing results ___Medication records ___Behavioral health/psychological consult ___Psychiatric evaluation

___Substance abuse treatment record ___Summary of treatment records & contact date ___other(please specify)__________

______________________________________ ______________________________

Patient or Guardian Signature **Date**