Sebastian Family Psychology Practice, LLC
6025 N. Green Bay Ave, 2nd Floor
Glendale, WI 53209 Phone (414) 247-0801; Fax: (414) 247-0816

Program _____
GROUP_____
AC#_____
Payer_____
Referral
Source_____

CLIENT REGISTRATION FORM

DATE: _____

We are pleased that you have chosen to receive services from us. Please complete the following information to be registered as a client. Let us know if you have any questions or need any assistance.

Demographic Information

First Name: _____ Last Name: _____ MI: _____

Soc. Sec. #: _____ Date of Birth: _____ Age: ____ Gender: M ___ F ___

Insurance ID # or Forward Card #: _____

Ethnicity: ☐African American (Black) ☐Asian/Pacific Islander ☐Caucasian (White)

☐Hispanic/Latino ☐Native American ☐Other, specify: _____

Home Address

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary No.: ( ) _____-_____ Who's No.: _____ Leave Messages? ☐Yes ☐No

Cell No.: ( ) _____-_____ Who's No.: _____ Leave Messages? ☐Yes ☐No

Emergency Contact

First Name: _____ Last Name: _____ MI: _____

Phone: ( ) _____-_____ State Relationship: _____

Work and School Information

Are you employed? ☐Yes ☐No If yes, name of employer: _____

Are you attending school? ☐Yes ☐No If yes, name of school: _____

Health Insurance Information

Do you have health insurance? ☐Yes ☐No If yes, please specify: _____

Who is your primary physician? _____ Name/Number of clinic: _____

Do you have any special needs? ☐Yes ☐No If yes, please specify: _____

By my signature below, I certify that the information I have given is correct to the best of my knowledge.

Client Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

Witness: _____ Date: _____

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CLIENT CONSENT FORM

I. Consent for Treatment
I hereby consent to receive mental/behavior health, psychological assessment, psychiatric, and supportive services from Sebastian Family Psychology Practice, LLC (SFPP, LLC).

I consent to the following services:

_____

_____

_____

II. Consent for Outpatient Mental Health Services (DHS 35.18)
If a clinic determines that a consumer is appropriate for receiving outpatient mental health services, the clinic shall inform the consumer of the consumer's legal representative of the results of the assessment. In addition, the clinic shall inform the consumer or the consumer's legal representative, orally and in writing, of all the following:

a. Treatment recommendations and benefits of the treatment recommended
b. Treatment alternatives
c. Possible outcomes and side effects of treatment recommended
d. Approximate duration and desired outcome of treatment recommended
e. The rights of a consumer receiving outpatient mental health services, including the consumer's rights and responsibilities in the development and implementation of an individual treatment plan
f. The outpatient mental health services that will be offered under the treatment plan
g. The fees that the consumer or responsible party will be expected to pay for the proposed services
h. How to use the clinic's grievance procedure under CH. DHS-94
i. The means by which a consumer may obtain emergency mental health services during periods outside the normal operating hours of the clinic
j. The clinic's 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

III. Permission to Bill
I give permission for SFPP, LLC to bill my insurance or appropriate payers for mental/behavioral health, assessment, psychological, psychiatric, and supportive services provided by SFFP, LLC.

I have read, have been explained to, and understood the above. I hereby give my consent and understand that I have the right to ask questions about the above information at any time. I understand that this consent is applicable for 1 year and may be canceled at any time with written notification.

_____ _____
Signature of Client Date

_____ _____
Signature - Person Authorized to Consent for Client Date

_____
Relationship to Client

_____ _____
Witness Date

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, the undersigned, hereby voluntarily authorize the disclosure of information to the person/institution name below.

NAME: _____ **DOB:** _____

II. The information is to be released from: **And is released to:**

☐ Sebastian Family Psychology Practice, LLC	☐ Sebastian Family Psychology Practice, LLC
☐ Name/Facility: _____	☐ Name/Facility: _____
Address: _____	Address: _____
Fax Number: _____	Fax Number: _____
☐ Name/Facility: _____	☐ Name/Facility: _____
Address: _____	Address: _____
Fax Number: _____	Fax Number: _____
☐ Name/Facility: _____	☐ Name/Facility: _____
Address: _____	Address: _____
Fax Number: _____	Fax Number: _____

III. Release of health information to insurance or appropriate payer

☐ I voluntarily authorize the release of health information to the insurance or appropriate payer, necessary to determine and assign benefits.

IV. Release of health information among treatment staff at Sebastian Family Psychology Practice, LLC

☐ I voluntarily authorize the sharing of health information among treatment staff at Sebastian Family Psychology Practice, LLC to increase the quality care provided to me. I understand that treatment staff include Psychiatrists, Psychologists, Therapists, AODA counselors, Therapist- In-Training, Student Interns, Case Aides, Parenting Assistants, and Interpreters/Translators.

V. The information to be disclosed: *(check appropriate box(es))*

☐ Mental Health ☐ Alcohol, Drug Abuse ☐ School Records ☐ Medical Records ☐ Psychiatric Record

☐ Psychological Reports

☐ Psychotherapy Notes (*by checking this box, I am waiving any psychotherapist-client privilege)*

☐ Other (specify): _____

VI. The purpose or need for this disclosure is: (*check appropriate box(es))*

☐ Further Health Care ☐ Coordinating Care for Dependent/Spouse ☐ Eligibility for Insurance or Benefits

☐ Legal Purposes ☐ Immigration services

☐ Other (specify): _____

VII. Your rights with respect to this authorization:

Right to Refuse: I understand that I am under no obligation to sign this form and that Sebastian Family Psychology Practice, LLC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding: a) research-related treatment b) health plan enrollment or eligibility c) the provision of health care that is solely for the purpose of creating PHI for disclosure to a third party.
Right to Withdraw: I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal. I understand that my withdrawal will not be effective until received and will not be effective regarding the uses and/or disclosure of health information that has been made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my heath information or obtain copies (at a reasonable fee) of my heath information by contacting Sebastian Family Psychology Practice, LLC.
Re-disclosure Notice: I understand that information used or disclosed on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.
Expiration Date: I understand that this authorization is good for 12 months from the date signed.

This information is to be released for the purpose stated above and may not be used for any other purposes. Client has been provided with a copy of this authorization or has declined a copy of this authorization. Photocopy and electronic interchange of this disclosure is as valid as original.

_____ _____
Signature of Client Date

_____ _____
Signature - Person Authorized to Consent for Client Date

_____
Relationship to Client

_____ _____
Witness Date

Disclaimer: This authorization is prepared in conjunction with the HIPAA-COW authorization/informed Consent for Use and Disclosure of Health Care Information Grid that enumerates requirements of State and Federal privacy laws.

Expiration Date _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT

The following items are essential to the care of you while participating in Sebastian Family Psychology Practice, LLC services. We want to ensure that you are fully informed. Please review each area and acknowledge the receipt of the following documents.

By signing below I attest that I have received a copy of the following:

1. Notice of Privacy Statement
2. Client Rights, Responsibilities & Grievance Resolution Procedure

_____ _____
Signature of Client Date

_____ _____
Signature - Person Authorized to Consent for Client Date

_____
Relationship to Client

_____ _____
Witness Date

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Notice of Privacy Statement

THIS NOTICE DESCRIBES HOW YOUR HEATH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE NOTICE CAREFULLY.

Sebastian Family Psychology Practice, LLC (SFFP, LLC) must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practice concerning your health information. We understand that information about you and your health is personal. This "Notice of Privacy Statement" defines and limits the circumstances in which your protected health information may be used or disclosed by this clinic. It also describes your rights and certain obligations we have regarding the use and disclosure of your personal health information. We may not use or disclose protected health information, except either 1) as this "Notice of Privacy Statement" permits; or 2) as the client or individual who is the subject of the information authorizes in writing. In general, no information about your treatment will be released without your written consent. However, there are exceptions.

As required by Law and Ethical Conduct, your confidentially my be disclosed without your written authorization for the following reasons:

1. CHILD ABUSE, SEXUAL ABUSE, and ELDERLY ABUSE: As required by law, suspicion of child abuse, sexual abuse, or elderly abuse must be reported to the appropriate authorities.

2. HARM TO SELF OR OTHERS: As required by law, health information may be release to the proper authorities if, we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to you or the public health/safety of others.

3. MANDATED BY COURT: As required by law, under the order of the court, certain information may be demanded for release.

Your health information may also be disclosed for the following purposes. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your records to accomplish the intended purpose of the disclosure.

1. TREATMENT STAFF (AT SFFP, LLC): SFFP, LLC will only use information in your health record for treatment purposes and to improve the quality of care that we deliver to you or your family members. In order to determine which treatment option best addresses your health needs, we may need to communicate and share your health information among our treatment staff. Our treatment staff includes Psychiatrists, Psychologists, Therapists, and Therapist in Training (graduate interns), Case Aids, Parenting Assistants, Case Managers, and Interpreters/Translators.

2. TREATMENT STAFF (OUTSIDE OF SFFP, LLC): We may disclose health information to outside treatment staff, such as your doctors (physicians), nurses, technicians, medical students, or other hospital personnel to ensure proper medical care to you.

3. TREATMENT PAYMENT: In order for an insurance company, government benefit programs, or appropriate payers to pay for your treatment, we may be required to disclose your health information to these entities as required by their polices.

4. COLLABORATING AGENCIES: There are some services that our clinic provides that are contracted through collaborating agencies. Examples include Wraparound, Wiser Choice, Bureau of Child Welfare, Refugee Resettlement Services, etc. These agencies may require claims or certain forms to be submitted. In the submission process, we may disclose your information to these collaborating agencies as required by their polices.

5. MINOR: If you (client) are under 12 years of age, your health information may be disclosed to your parents or legal guardians. If you are 12 years of age and under 18 years of age, your health information may be disclosed to your parents or legal guardians with your consent.

6. FOR PUBLIC HEALTH ACTIVITIES: We may be required to report your health information (ie. HIV status) to appropriate individuals or authorities to help prevent or control disease, injury, or disability. If you are engaging in behaviors

that are believed to be of significant harm or danger to self or others, your therapist will help you discuss these issues to ensure that the appropriate individuals or facilities are informed.

7. FOR NATIONAL SECURITY OR INCARCERATION/LAW ENFORCEMENT CUSTODY: If you are involved with the national security or you are in the custody of law enforcement or an inmate in a correctional institution, we may be required to disclose your health information to the proper authorities as required by their policies.

8. FOR WORKERS' COMPENSATION: We may disclose your health information to comply with the laws related to Worker's Compensation or other similar programs. These programs may provide benefits for work-related situations.

9. EMERGENCY SITUATIONS: We may use or disclose your health information in medical emergency situations. If the situation is life threatening and we are unable to obtain your consent, we may disclose your protected health information to ensure appropriate treatment or to prevent injuries to you.

10. APPOINTMENT REMINDER: We may use and disclose your health information to contact you as a reminder that you have an appointment with our clinic. Please notify the clinic if you do not wish to receive phone calls at home.

YOUR HEALTH INFORMATION PRIVICY RIGHTS

You have several rights with regards to your health information. If you wish to exercise any of the following rights, please contact your right specialist or the clinic.

1. INSPECT AND COPY YOUR HEALTH INFORMATION: With a few exceptions, you have the right to inspect and obtain copies of your health information given appropriate time and fees. This right does not apply to psychotherapy notes or information gathered for judicial proceedings.

2. REQUEST TO CORRECT YOUR HEALTH INFORMATION: If you believe your health information is incorrect, you may ask us to correct the information. You will be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we disagree with you and believe that your health information is accurate, we may deny your request or keep our current record along with your correction request.

3. REQUEST RESTRICTION ON CERTAIN USES AND DISCLOSURES: You have the right to ask for restrictions on how your health information is disclosed. You may want to limit the health information provided to family members, friends, treatment staff, or collaborating agencies involved in your care. In all circumstances, we will collaborate to ensure your privacy is maintained as much as possible or allowed.

4. RECEIVE CONFIDENTIAL COMMUNICATION AS APPLICABLE: You have the right to ask that we communicate your health information to you in different ways or places for proper protection of your health information. We must accommodate reasonable request.

5. REQUEST WHERE YOUR HEALTH INFORMATION IS BEING DISCLOSED TO: You have the right to ask for a list of the individuals/facilities in which your health information have been disclosed to during the previous six years.

6. COMPLAINT/GRIEVANCE: If you believe that your privacy rights have been violated, you may file a complaint with your right specialist and/or with the Federal Department of Health and Human Services.

7. OBTAIN A PAPER COPY OF THE AUTHORIZED DISCLOSURE FORM: Except for the situations listed above, we must obtain your written authorization for any other release of your health information. You must be given a paper copy of all authorized disclosure forms. You may deny copies of the authorized disclosure forms at your request.

We reserve the right to change the privacy statement described in this notice. Changes to our privacy statement would apply to all health information we maintain. If we change our privacy statement, you will be given a revised copy.

If you would like to exercise any of these rights, please contact your right specialist:

Lee R. Beitzel
229 E. Wisconsin Ave, Suite 500
Milwaukee, WI 53202
(414) 224-3737 ext. 200

Client Rights, Responsibilities & Grievance Resolution Procedure

At Sebastian Family Psychology Practice, LLC, we value you and your loved one as an integral part of the behavioral heath team. We want all clients and their families to know about the following patient rights, responsibilities, and grievance resolution procedures as required by law and the standard of practice. These rights and responsibilities are designed to help assure safe and effective delivery of behavioral health care at Sebastian Family Psychology Practice, LLC.

Client Rights

You have the right:

1. To be informed of this clinic's policy regarding patient rights, responsibilities, and grievance resolution procedures.
2. To receive treatment which values you without regard to your race, creed, color, language, national origin, religion, gender, lifestyle preference, disability or source of payment.
3. To be treated with respect, and recognition of your individuality and personal needs.
4. To regard respectfully, your personal dignity and the psychosocial, spiritual, and cultural variables that influence the perceptions of behavioral heath.
5. To access alternative psychological care and other non-traditional services that promote heath and wellness. At your request you have the right to a second opinion.
6. To be listened to and respect your need for confidentiality, privacy, and perceived security.
7. To know your diagnosis, what to expect about your behavioral healthcare, and the limits of counseling services.
8. To seek recommendation from your treatment staff, to refuse treatment, and to know the consequence of refusing treatment, which will be explained to you by your care providers.
9. To be informed of the risks, side effects, and expected results of the recommended counseling or medication procedures.
10. To give consent or refuse to participate in research related activities. You have the right to decline at anytime without compromising your access to care, treatment, and services.
11. To request discharge and be discharged against medical advise.
12. To know what your health record says, to request changes where appropriate, and to be informed of disclosures regarding your personal behavioral health information in a reasonable time frame.
13. To consent information regarding transfer to, consultation with, or treatment by another member of this health care provider.
14. To have your right explanations made in manners you can understand. You have the right to interpretation services, if needed at no cost to you.
15. To have your compliments, concerns, and complaints addressed in respectful and professional manners. Sharing your concerns and complaints will not compromise your access to care, treatment, and services.

Client Responsibilities

You have the responsibility:

1. To provide accurate and complete information about your health, medical history, and insurance benefits to the best of your knowledge.
2. To notify staff if you do not understand your health care plan, medical terminologies, and what is expected of you.
3. To discuss concerns about your care with your clinician and jointly plan your care together.
4. To follow your plan of care. If you are unable/unwilling to follow the plan of care, you are responsible for informing your care provider. Your care provider will explain the consequences of not following the recommended treatments. You are responsible for the outcomes of not following your plan of care.
6. To be considerate of the rights of other clients and/or clinic personnel, and property, as well to follow the rules and regulations pertaining to clients and family safety.
7. To cooperate in assigning insurance or payer benefits for services provided. You are responsible for meeting your financial obligation to the facility. You will be informed of fees and charges.
8. To cooperate with the advice, treatment plan, and prescription (s) you are given, including abiding with any changes recommended.

Grievance Resolution Procedure

Rights and process to grievance:

1. If you feel your rights have been violated, you may file a grievance with your service provider within 45 days of the time you became aware of the problem.
2. You cannot be threatened or penalized in any way for filing a grievance.
3. The right specialist must inform you of your rights and how to use the grievance process.
4. You may, at the end of the grievance process, or any time during it, choose to take the matter to the county, state, court, or other outside parties.

To know how to initiate a compliant or grievance against a staff member or this clinic within 45 days from the date of the grievance, please contact your Right Specialist:

Lee R. Beitzel
229 E. Wisconsin Ave, Suite 500
Milwaukee, WI 53202
(414) 224-3737 ext. 200

For any other concerns, please contact the clinic:

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Phone (414) 247-0801; Fax: (414) 247-0816
Email: admin@sebastianfp.com

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CLIENT INTAKE FORM

The following intake form is to be filled out by new clients, unless a thorough intake form has been provided by the referring agency. The answers you provide will become part of your confidential health records. Let us know if you have any questions or need any assistance.

Intake Date: _____/_____/_____

First Name: _____ Last Name: _____

Please indicate who referred you to this office: _____

Please describe, in detail, the kinds of concerns for which you seek psychological/counseling services.

_____

_____

_____

_____

_____

To enable us to further assist you, please fill out the following questions.

Have there been any recent crisis, death, or major changes in your life? ☐Yes ☐No
If yes, please specify:_____
_____

Have you experienced any trauma (any kind of abuse, neglect, victim of crime, natural disaster, war, etc.)?
☐Yes ☐No If yes, please specify: _____
_____

Have you ever received psychological/counseling services? ☐Yes ☐No
If yes, please specify (reason, place of service, how long ago, etc.): _____
_____

Has anyone else in your family received psychological/counseling services? ☐Yes ☐No
If yes, please specify (reason, place of service, how long ago, etc.): _____
_____

Are you presently taking any prescriptions or over the counter medications? ☐Yes ☐No
If yes, please specify: _____
_____

Are you allergic to anything, including allergic reactions to medications? ☐Yes ☐No
If yes, please specify: _____
_____

Do you have any work-related problems or difficulties in school? ☐Yes ☐No
If yes, please specify: _____
_____

Are you worried about any relationship problems? ☐Yes ☐No
If yes, please specify: _____
_____

Do you drink alcohol? ☐Yes ☐No
If yes, please specify (how much, how often, how long, etc.): _____
_____

Do you use any other recreational drugs? ☐Yes ☐No
If yes, please specify (what drug, how often, last use, etc.): _____
_____

Have you been involved with the legal system, protective services, or child custody issues? ☐Yes ☐No
If yes, please specify (reason, how long ago, etc.): _____
_____

Have you intentionally hurt yourself or made a suicide attempt? ☐Yes ☐No
If yes, please specify (reason, how long ago, etc.): _____
_____

Please check all symptoms that apply to your condition in the <u>past month</u>.

___ Feeling of sadness, emptiness, or hopeless
___ Uncontrolled crying
___ Sleep problems
___ Loss of appetite
___ Fatigue or tiredness
___ Unable to concentrate
___ Feeling of intense high and excessive energy
___ Elevated self-esteem
___ Excessive worrying
___ Feeling anxious, tense, or overwhelmed
___ Feeling of extreme fear
___ Shyness and nervousness
___ Chronic pain
___ Headache
___ Nightmares, obsessive thoughts, flashbacks
___ Feeling angry
___ Feeling guilty
___ Fear of gaining weight
___ Excessive exercise
___ Feeling hyper or fidgeting
___ Difficulty in controlling impulses
___ Concern with sexual performance
___ Distressing repetitive sexual fantasies, urges
___ Coming out or sexual orientation issues

What has moved you to this limit, where you choose to seek help?
_____
_____

Please provide us with any additional information that has not been asked.
_____
_____

Client Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____