CATHOLIC CHARITIES
SERVING NEIGHBORS IN NEED

Behavioral Health Intake Form

Patient Information

Intake Date: _____

Last Name: _____ First Name: _____ Initial_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ **Gender:** ☐ M ☐ F

Race: _____ **Date of Birth:** _____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Estimate Annual Income: _____ **Household Size:** _____ Health Insurance: ☐ Y ☐ N

Emergency Contact: _____ Phone: _____ Relationship: _____

Brief description of why the client needs to be seen:

_____

_____

_____

Legal Guardian Information/Parent Information ☐ **Self (if marked self, please skip this section)**

Last Name: _____ First Name: _____ Initial_____

Phone Number: _____ Date of Birth: _____

Primary Insurance

Insurance Name: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____ S.S. #: _____

Secondary Insurance

Insurance Name: _____ Policy #:_____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____ S.S. #: _____

Provider: _____ **Appointment Date/Time:** _____

PATIENT AUTHORIZATION: I authorize Catholic Charites and its agents and contractors to contact me by telephone, email, or letter regarding payment for services. I understand that calls placed to my cellular telephone or other wireless devices, may result in charges to me depending on my telephone service.

I request that payment of authorized Medicare or other payor benefits be made on my behalf to the therapist for any services provided to me at this facility, realizing that I am responsible to pay non covered services. I also authorize the therapist to release any medical information to the Centers for Medicare and Medicaid Services and its agents or other authorized payors needed to determine benefits payable for related services. This authorization is in effect until I choose to revoke it or, in the case of a minor, the minor becomes legally responsible for himself/herself.

I CERITIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AND THAT I AM COMPETENT TO EXECUTE IT OR AUTHORIZED TO EXECUTE IT ON ANOTHER'S BEHALF.

Signature: _____ Date: _____

(If signed by someone other than patient, please state relationship which gives authority to sign)

☐ Parent ☐ Legal Guardian

Intake Coordinator: _____ Date: _____

Reviewed By: _____ Date: _____

(Billing Use only)

CATHOLIC CHARITIES
of the Archdiocese of Milwaukee, Inc.

CONSENT FOR TREATMENT
Rights and Responsibilities

I am voluntarily seeking services at Catholic Charities. These services may include an initial assessment, supportive services, individual, group, conjoint, and/or family treatment.
In seeking these services, **I understand the following**:

- An effective treatment plan can only be developed with my active participation, understanding, and approval. My signature on the plan will verify my participation, understanding, and approval.
- My treatment will be conducted and supervised only by qualified, trained professionals.
- If I take medication prescribed by a psychiatrist/medical practitioner that is not associated with Catholic Charities, any questions about risks and side effects of the medication need to be addressed by that psychiatrist or other medical practitioner.
- I may request the opinion of a consultant or may request information regarding alternative treatment methods at any time.
- I have both rights and responsibilities as a client of Catholic Charities. I have received a copy of the Client Rights pamphlet and of Catholic Charities Notice of Privacy Practices.
- I have the responsibility to be alert and able to participate in therapy/counseling, that is, not to be under the influence of an intoxicating substance when attending therapy/counseling.
- I have the responsibility to speak and act in a manner consistent with generally accepted standards of conduct.
- I have the responsibility to assure that my children's behavior will not disrupt others, if I choose to bring them with me.
- My therapist/counselor is mandated by Wisconsin State Law (Section 48.981) to report any suspicion or belief that a child seen in the course of his/her professional duties has been abused or neglected or has been threatened with injury. Such a report would be made to the County Department of Human or Social Services, and this agency is mandated to investigate any and all such reports.
- If my therapist/counselor, in his/her professional judgment, believes that I am a serious risk of harm to another person, my therapist/counselor has a duty to warn that person of the potential risk. If my therapist/counselor believes that I am at risk of suicide, he/she has a duty to inform my nearest relative.

I also agree to the following provisions:

- I have been informed of both benefits and risks of treatment, including but not limited to, the side effects or risks of side effects from medication.
- I have been informed of treatment alternatives.
- I am aware that there are consequences of not receiving treatment or services.
- I am aware that I can terminate treatment at any time.
- I am aware that Catholic Charities may use and disclose my protected health information for the purposes of treatment, payment, and operations as identified in Catholic Charities' Notice of Privacy Practices in compliance with HIPAA's Privacy Rule.
- I am aware that Catholic Charities may disclose an discuss my care/treatment information and conditions with the following identified individuals: (please check all that apply):
  ☐ Spouse ☐ Parent ☐ Grandparent ☐ Adult Child(ren) ☐ Sibling ☐ Other Caregiver

Unless otherwise stated, this consent is effective until 7/1/2020

I understand that I have the right to withdraw this consent at any time.

_____ _____
(Client/Parent/Guardian/Personal Representative Signature) (Date)

_____ _____
(Catholic Charities Representative Signature) (Date)

4/05

CATHOLIC CHARITIES
Serving people of all faiths in southeast Wisconsin

FEE FOR SERVICE AGREEMENT
(Private Pay and Insurance)

As a client of Catholic Charities Counseling Program, I understand that fees are a requirement for these services.

I further understand the following:

- The initial assessment visit is 90 minutes in length, with a fee of $190.00
- All other counseling sessions are **60** minutes in length, with a per session fee of $145.00
- **If I have health insurance** of any kind that could pay for counseling services, I must provide the insurance information before scheduling an appointment. I am also responsible for paying my required co-payment and un-met deductible.
- In the event the insurance claim is denied, it will become the responsibility of me to pay for the services.
- If I have no available health insurance coverage, I will be charged on a sliding fee scale instead of the standard cost of care. I am aware that this is only possible because of funds received by the agency from local United Ways, the Catholic Stewardship Appeal and individual donors who support the work of the agency.
- My sliding fee scale is based on both my family's total annual income and on the number of family dependents less than 18 years of age, and I am responsible to inform Catholic Charities of any changes to income, family size or health insurance.

My family's annual income is_____.

My Family size is _____

My sliding fee scale per session is_____.

My co-payment is_____.

I further understand and agree to the following provisions:

- I will pay the required fee prior to each session.
- I will pay a $15.00 fee for each check returned for insufficient funds.
- I will inform Catholic Charities of any changes in my income, address, telephone number and insurance status as soon as I am aware of those changes.

* Insurance is billed when available
* Sliding fee applies to uninsured or high deductible

This Fee Agreement is effective for one year from the date of my signature, unless there are changes or circumstances that can affect my eligibility. The agreement will, therefore, expire on_____.

_____

Client Signature Date

_____

Agency Representative Date

Revised **06/2017**

* Fees can be waived by completing a fee-waiver application (attached)

CATHOLIC CHARITIES
Serving people of all faiths

Whole or Partial Waiver of Fee Application

Name: _____

Address: _____

_____

Phone Number: _____

☐ Home ☐ Work ☐ Cell

Current household income per month: $ _____

Number of people currently in your household: _____

Provide complete information about your household monthly income and expenses,

All Monthly Income

Wages: _____

UC Benefits: _____

Rental Income: _____

Social Security: _____

SSI: _____

Family/Child Support: _____

W-2 Benefits: _____

☐ Quest Card ☐ Medical Assistance

Other Income: _____

All Monthly Expenses/Debt

Rent/Mortgage: _____

Food/Household Supplies: _____

Transportation: _____

Health Costs: _____

Utilities (All): _____

Family/Child Support Payments: _____

Loans: _____

Insurance total: _____

☐ Car ☐ Homeowners/renters ☐ Medical

Other Debts and Expenses: _____

All information provided is true and correct. I understand that all information with this application will be kept confidential. I understand that any fee waiver will be provided up to six months at which time I understand that I will be billed for the services if I do not request and submit another fee waiver application. Insurance co-payments and deductibles cannot be waived.

_____
Name (Print)

_____
Signature

_____
Date

For Official Use Only – Submit to the Program Supervisor

☐ Approved ☐ Denied

_____
Mandy Bibo
Behavioral Health Director

Waiver valid for 6 months from the date of approval

Amount waived: $ _____ Backdated to: _____

_____
Date

CATHOLIC CHARITIES
Serving people of all faiths

Health Assessment

Client Name: _____ Clinician _____

Age: _____ Gender: _____ Marital Status: _____

Primary Care Physician: _____

Please select any of the following that you have had or currently suffer from

Diabetes		Sight disorders		
Kidney problems		Joint pains		
Liver problems		Body aches		
Migraines / Headaches		Sleeping disorders		
Stomach problems		Alcohol abuse		
Intestinal problems		Drug abuse		
Cancer		Smoking		
Skin disorders		Self-harm or thoughts of suicide		
Allergies		Other		

1. Does your family have a history of any particular illness, pain or other condition? Yes___ No ___

Describe: _____

2. How often do you visit a doctor for a regular health checkup?

Rarely_____ Every 6 months_____ Every 3 months_____ When needed_____

3. Are you currently taking any medications? If yes please explain

4. Do you exercise regularly?

5. Do you consider yourself a healthy individual?

Signatures

Client's Signature, Parent/Guardian (for minor client) Date

Created 09/18/14

Effective Date: January 25, 2005

CATHOLIC CHARITIES OF THE ARCHDIOCESES OF MILWAUKEE, INC.
NOTICE OF PRIVACY PRACTICES SUMMARY

This notice gives you basic information about how medical information may be used and disclosed by Catholic Charities. This information is more completely and fully stated in Catholic Charities' *Notice of Privacy Practices* that has been provided to you.

PLEASE REVIEW IT CAREFULLY

We are required by law to: make sure that protected health and service information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to that information about you; and, follow the practices of our *Notice of Privacy Practices* that is currently in effect.

Use and Disclosure Without Written Authorization:

- For planning for and providing services to you (*treatment/service delivery*).
- To get *payment* for services provided to you (for example, in order to bill a third party payor).
- To meet the requirements for running the *operations* of our agency (for example, when we conduct a review of your file to make sure that it is complete or to ensure the appropriateness of our services to you, etc.).
- When Catholic Charities is permitted or required: by law (for example, in cases of abuse); by a public health authority (for example, required reporting of some diseases); to avoid a threat to health or safety (for example, if a person is in danger of harming self or others); or, by another government agency (for example, for eligibility for benefits like workers' compensation).

Not every use or disclosure is listed in the categories above, however, all the ways Catholic Charities is permitted to use and disclose protected health and service information without your written authorization (permission) will fall within one of the categories above.

All other uses and disclosures by Catholic Charities of your protected medical and service information needs your written authorization (permission). You may end an authorization by written request at any time.

Your Rights Regarding Protected Health and Service Information:

- To ask to inspect and copy health and service information (For example, this may include service and billing records, but does not include psychotherapy notes).
- To ask to amend health and service information that you feel is incorrect or incomplete.
- To ask to restrict or limit the health and service information we use or disclose about you (For example, to a family member who is involved in your care or payment for services).

- To ask that Catholic Charities communicate with you about health and service matters in a certain way or at a certain location (For example, you could ask that we only contact you at work or by mail).

For each of the above, your request must be in writing. Catholic Charities is not required to agree to your request. If Catholic Charities agrees to honor your request, we will do so unless the information is needed to provide you with emergency treatment or required or permitted by law to be disclosed.

Additional Rights:

- To ask for an accounting of disclosures, if any occurred, of your protected health and service information that were not part of Catholic Charities' treatment, payment, or operations, or, not made with your written authorization (permission), or, disclosures made directly to the individual patient/client, or, disclosures made which state law permit us not to disclose to you.
- To ask for a paper copy of Catholic Charities' current Notice of Privacy Practices.
- To file a complaint any time you feel your privacy rights have been violated. (No one will be angry and nothing will happen to you if you file a complaint.)

ALL REQUESTS OR COMPLAINTS MUST BE IN WRITING. SEND YOUR REQUEST OR COMPLAINT OF CATHOLIC CHARITIES TO:

Associate Director (Privacy Officer), Catholic Charities, P.O. Box 070912, Milwaukee WI 53207-0912.

CHANGES TO CATHOLIC CHARITIES' NOTICE OF PRIVACY PRACTICES

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health and service information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in all of Catholic Charities' service locations. The notice will contain, on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to Catholic Charities for services, you may request a copy of the current notice in effect.

I HAVE BEEN GIVEN A COPY OF THIS CATHOLIC CHARITIES' *NOTICE OF PRIVACY PRACTICES*.

_____ _____

Signature Date

Signature Declined: _____ Date: _____

(Catholic Charities' Staff Person Signature)

- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Mental Health and Substance Abuse Services (DMHSAS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Mental Health and Substance Abuse Services or designee. Send your request to the DMHSAS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:

Sarah Chidester, MSW, APSW
2021 N.60th Street
Milwaukee, WI 53208
(414) 771-2881

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. And/or DHS 94, Wisconsin Administrative Code is available upon request.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Mental Health & Substance Abuse Services
www.dhs.wisconsin.gov
P-23112 (12/2008)

* For parents to keep*

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

* For parents to keep

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate for 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 alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, unless it is needed in an emergency to prevent serious physical harm to you or others, or a court orders it. [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 may not be subject to electro-convulsive 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 costs 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.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)
You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.