DELTA CENTER, LLC

www.deltactr.com

Sharon A. Teschke, MSW, MSE, LCSW, LMFT
Aimee M. Meyer, MS, LPC
Amanda R. Draxler, MS, LPC
Dr. Cheryl Tapp, M.D.

CHILD/ADOLESCENT REGISTRATION

Please fill in this form to register as a new patient.

Part of new patient registration is completing the ***Biographical Checklist.***

Patient's Last Name:	
Patient's First Name:	
Patient's Middle Initial:	
Patient's Nickname:	
Date of Birth (e.g. 7/4/1976)**:**	
Patient's Gender:	◯ Female ◯ Male
Home Address:	
City/State/Zip Code:	
Email address:	
Cell Phone Number (999-999-9999):	
Phone Number – Other:	
School/Grade:	
Party Responsible for billing (name/address/phone)	
Parent Name/Step/Foster (name/address/phone)	
Parent Name/Step/Foster (name/address/phone)	
Parents Marital Status:	◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other
Emergency Contact : (name, relationship, phone contact)	
Permission to speak to Emergency Contact?	◯ Yes ◯ No

Name/Relationship of Family Members we have permission to speak with about appointments:

Briefly, explain the areas of concern you would like to address with your therapist.

Over

Have you experienced any of the following? (Please Check)

○ Conflict with friends ○ Conflict with parents ○ Truancy ○ Low self-esteem ○ Lack of energy

○ Early awakening ○ Trouble falling asleep ○ Nightmares ○ Difficulty concentrating ○ Weight loss

○ Weight gain ○ Nausea ○ Diarrhea ○ Other

Increase use of:

○ Alcohol ○ Drugs ○ Prescription ○ OTC ○ Street

Is there a family history of:

○ Drug Abuse ○ Alcohol Abuse

Do you find yourself feeling:

○ Afraid ○ Angry ○ Hurt ○ Guilty ○ Anxious ○ Depressed

Other feelings: ____

Do you find yourself having thoughts of suicide?

○ YES ○ NO

Medical History:

○ Allergies ○ Diabetes ○ Thyroid ○ Epilepsy ○ High Blood Pressure

Major Surgeries: ____

Physical Disabilities: ____

Appointment Reminders: ○ Yes* ○ No (choose one)	____text * ____call ____email ___ None *Cell phone carrier ______________________________
On-line Scheduling ○ Yes* ○ No	
E-mail Statements ○ Yes* ○ No	Make sure you've included your email address on the first page

*Appointment information is considered to be **Protected Health Information** under HIPAA.
By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted.

I acknowledge that I received the notice of Privacy Practices (HIPAA) from Delta Center, LLC.

I hereby authorize Delta Center, LLC to bill my insurance carrier (if applicable), release any medical or other information to process the claim, and authorize payment of medical benefits to Delta Center, LLC for the services that I and/or my family members receive.

X____ ________________________
Signature Date

Update ___________________________ ___________ Update ___________________________ ___________
Signature Date Signature Date

INFORMED CONSENT (DHS 94.03/35.18)

The Process of Treatment:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I/My child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or alternative treatments by staff from Delta Center, LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychiatrist, licensed certified social worker, a licensed professional counselor, or a marriage and family therapist. Treatment will be conducted within the boundaries of Wisconsin Law for Psychiatric, Social Work, Professional Counseling, or Marriage and Family Counseling.
2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, and intake assessment. During the first two sessions the therapist will discuss expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation may include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
3. **Technology Use:** All records are stored in a secure cloud based server and only your therapist has access to the information. Confidentiality of unencrypted communication such as email cannot be guaranteed. Please use the online secure email to communicate with your therapist, set up a secure password, and use a secure network to log in. Use of public WiFi is not a secure network.
4. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I will be responsible for a ***$92.50*** late cancellation fee if an appointment is cancelled without ***24*** hour notice.
5. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record on HIPAA compliant web account and in a file at Delta Center, LLC, and I consent to disclosure for use by Delta Center, LLC staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records. Confidentiality also applies to the waiting room. Should you see someone you know, please keep that information confidential.
6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.
7. **Expiration of Consent:** This consent to treat will expire 15 months from the date of signature, unless otherwise specified.
8. **Discharge Policy:** There are circumstances under which I may be involuntarily discharged which include unpaid balance or inability to pay for services. I understand the discharge policy of the clinic. If Delta Center, LLC, is not able to provide appropriate services, Delta Center, LLC will refer me to alternative resources within the community and other agencies that can provide services.
9. **Grievance Policy:** If you feel that your rights have been violated or not respected please speak with Aimee Meyer, LPC. If you feel that your rights have not been respected or heard you have the right to contact: State Grievance Examiner, DHS, P.O. Box 7851, Madison, WI 53707-7851.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time. *If applicable:* I give permission for my child to receive evaluation and treatment by a therapist at Delta Center, LLC. The types of services I am requesting from Delta Center, LLC, have been explained to me. I voluntarily consent to become actively involved in the treatment process. I have read and understand the rights of a patient and informed consent.

____

Client Signature (Parent/Guardian Signature) Date

____

Clinic Staff Signature Date

FINANCIAL AGREEMENT - Delta Center, LLC.
OUTPATIENT COUNSELING SERVICES

I UNDERSTAND AND AGREE TO THE FOLLOWING

- Delta Center, LLC will bill my insurance as a courtesy to me and I understand that I am ultimately responsible to pay all charges incurred. We invite you to contact your insurance provider with any questions, concerns or clarifications needed.
- Check in before each session to pay my co-pay, co-insurance and/or deductible.
- If my account reaches a balance of $100.00, my services can be suspended until the balance has been paid.
- In the event I am sent an insurance check, I will sign it over and deliver it to Delta Center, LLC immediately.
- To notify Delta Center, LLC within **24 hours prior to a scheduled appointment** if I am unable to attend, or I will pay one-half the current hourly rate ($92.50) for the missed appointment. **Please note:** Appointment reminders are a *courtesy* not a *certainty*. If an appointment is missed due to a failed reminder, the No Show fee will still apply.
- I will be billed at the current hourly rate for services that require a therapist's appearance, correspondence or phone calls related to legal, medical, educational or psychological assessment.
- Telephone conferences or collaboration with client in excess of 15 minutes will be billed at an hourly rate and payments for these services will be billed to client's account, which **may not be** covered by insurance, unless otherwise noted.
- Delta Center, LLC will be reimbursed by me for fees that are not covered by my insurance i.e., unexcused/missed appointments, deductibles, insurance co-payments, and psychological assessments.
- I will be charged a NSF fee/processing fee of $30.00
- I may be sent to collections for any unpaid bills.

INSURANCE

- The initial visit will is **billed** at the cost of **$277.00.** The initial visit is the diagnostic interview where the clinician will develop my treatment plan and then collaborate with peer therapists to form a diagnosis.
- Additional session is **billed** at the cost of $**185.00**, Masters Level, Psychotherapy
- My insurance information and is only an estimate of benefits not a guarantee and I will contact my insurance with questions or any further need of verification or clarification.

I hereby authorize Delta Center, LLC to bill my insurance carrier for the services that I and/or my family members receive. I have been informed of Delta Center, LLC's fee schedule and policy regarding insurance reimbursement. I further agree to pay my co-payment on the day I receive service. Co-payments include the percentage of charges not paid by my insurance company, deductibles and unexcused/missed appointments.
Delta Center, LLC. reserves the right to unsolicited discharge from treatment.

Signed ____ ________________
Client or Responsible Party Date

Signed ____ ________________
Delta Center, LLC Staff Date

CLIENT RIGHTS OUTPATIENT DIVISION

Under Wisconsin Statute (x.51.67) you have certain rights as an outpatient.

Your rights are:

- To a humane psychological and physical environment within the facility.
- To refuse to take excessive or unnecessary medication and to refuse medication if your religion forbids it.
- To refuse to take part in experimental research.
- To receive prompt and adequate treatment.
- To meet with the supervising psychiatrist upon request.
- To have your conversation with staff and all medical and health care records kept confidential in accordance with Wisconsin Law (s.51.30).
- To refuse to be filmed or taped.
- To bring action for damages (ss.51.61(7)) against persons violating your rights or confidentiality.
- To see your health care record after termination of treatment according to Center policy.
- To see parts of your health care record during treatment if your physician or case manager agrees.
- To receive a list of medications and somatic treatments upon request and at the time of your termination of treatment.
- To have a grievance procedure available to you and to have an advocate represent you during the grievance process.
- Some of the above rights may be restricted because of your treatment or security needs.

I acknowledge receipt of the above rights both orally and in writing.

________________________________ ________________________________

Client Signature | Parent/Guardian/Next of Kin

________________________________ ________________________________

Delta Center, LLC Staff | Date

Other rights listed under Wisconsin Statute (s.51.67) pertain to inpatient status. If you are interested in a copy of the complete text of the law or a copy of the grievance procedure, feel free to contact the receptionist.

Aimee M. Meyer and/or Sharon A. Teschke are client rights officers and can be reached by calling Delta Center's phone number: 920-921-3343.

CLIENT
MEDICATION LIST

Family Physician:____________________ **CLIENT NAME:**__________________

Pharmacy:_________________________ Therapist:_______________________________

Pharmacy phone #:__________________ Adverse reaction to:_______________________

Past medications: ____

Date of Rx	Current Medication(s)	Dosage	Time of day	Purpose	Doctor	Comments

NO MEDICATIONS AT THE CURRENT TIME ☐ Date ____________________

Update: ____________________________________ Date:________________

Update:____________________________________ Date:________________

Delta Center
Counseling Services

Child Biographical Information

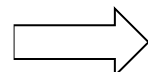
We ask that you complete this form, which will provide information useful in treatment. It will take around 30 minutes to complete. Please bring this with you to your first appointment.

*If you are filling this form out for your child please have them participate in answering as many questions as possible.

Symptoms:

Check each concern experienced recently

	☐ abuse/ physical	☐ anger/mad	☐ anxiety/ nervous	☐ appetite	☐ avoidant	☐ blended families
☐ boundaries	☐ bullying	☐ compulsions	☐ concentration problems	☐ conduct	☐ conflict with friends	☐ crying spells
☐ depression/ sadness	☐ disappointment	☐ disorganized	☐ distractible	☐ emptiness	☐ family conflict	☐ fear/scared
☐ feeling misunderstood	☐ grades	☐ grief	☐ guilt	☐ hopelessness	☐ hyperactivity	☐ impulsivity
☐ inactivity	☐ inattention	☐ inhibition	☐ irritability	☐ isolation	☐ jealousy	☐ meaning-lessness
☐ medical	☐ memory loss	☐ mood swings	☐ nausea	☐ obsessions	☐ oppositional/ defiant	☐ pain
☐ panic	☐ parents' divorce/ separation	☐ perfectionism	☐ poor motivation	☐ rage/upset	☐ rejection	☐ relationship difficulties
☐ resistance	☐ restlessness	☐ ruminative/ racing thoughts	☐ school difficulties	☐ self-esteem	☐ sexual abuse	☐ shame
☐ shyness	☐ sibling conflict	☐ sleep	☐ social skills	☐ social withdrawal	☐ stress	☐ thoughts of suicide
☐ trauma	☐ treated unfairly	☐ trust	☐ unusual thoughts	☐ unusually sensitive	☐ weight change	☐ worry

More on next page 

Presenting Problem

What is happening or has happened that motivated you/your parents to seek counseling for

yourself?____

____

____

____

____

____

____

Describe the progression of the problem or behavior (When did it begin, How long has it lasted?)

____

____

____

____

Under what conditions/things do the problems usually get worse?

____

____

____

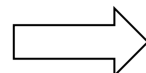
Under what conditions/things are the problems usually improved?

____

____

____

More on next page



Family History

With whom do you live with at this time?

____

____

____

Were your parents ever married? ________Yes ________No

Are parents divorced or separated? ____

If so how old were you when that happened? ___________________________________

Who has primary placement/custody? ____

What is the visitation schedule? ____

Parents

(Please include step-parents and significant others)

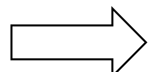
Name	Relationship	Quality of Relationship

Siblings

(Please include half and step siblings. If you need more space, continue below)

Name	Age	Relationship	Quality of Relationship

More on next page



Is there any mental health history in the family? (depression, anxiety, addiction, bipolar, etc.)

____

____

Education and Occupations:

The school I attend is: ____

I am currently in __________________________ grade.

My teachers name is: ____

My favorite subject in school is: ____

My least favorite subject in school is: ______________________________________

After school activities that I'm involved in (sports, clubs, etc.):

____

____

____

How do you spend your free time? (List hobbies, sports, clubs, groups, family activities, etc.)

____

____

____

Health:

List any health problems you may have:____

____

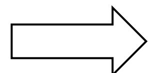
____

How many hours do you sleep in an average night?

Do you exercise? How often?

How much caffeine do you drink in an average week?

More on next page



Who is your primary physician? ____

When was your last physical? ____

Have you seen a therapist in the past (therapist name, year, issues/concerns, how long)?

____

____

____

Additional Information:

What do you feel you are good at? (I.e. strengths)

____

____

____

List any additional information that it might be important for me to know:

____

____

____

____

____

____