PREVEA health

Patient Label

Behavioral Care Intake Questionnaire

Please review and check any symptoms which pertain to you.

Current	Past	Symptoms	Current	Past	Symptoms
☐	☐	Depressed mood	☐	☐	Inflated self-esteem
☐	☐	Stopped enjoying usual activities	☐	☐	Don't seem to need sleep
☐	☐	Lost or gained weight without meaning to	☐	☐	Excessive talking
☐	☐	Sleep too much or not enough	☐	☐	Racing thoughts
☐	☐	Agitated or sluggish	☐	☐	Highly distractible
☐	☐	No energy/always tired	☐	☐	Try to do way too much
☐	☐	Feel guilty/worthless	☐	☐	Impulsive behavior
☐	☐	Can't think or concentrate	☐	☐	See or hear things that may not be real
☐	☐	Thoughts of death or suicide	☐	☐	Suspect or believe things that may not be real
☐	☐	Decreased libido	☐	☐	Increased libido
☐	☐	Often tense/unable to relax	☐	☐	Can't prevent repetitive thoughts
☐	☐	Excessive worry	☐	☐	Can't prevent repetitive behaviors
☐	☐	Panic attacks	☐	☐	Intrusive, upsetting memories of past events
☐	☐	Afraid/ unable to leave home	☐	☐	Always on guard/ never feel safe
☐	☐	Extreme unreasonable fears	☐	☐	Body overreacts to "stress"
☐	☐	Intense fear of social situations	☐	☐	Nightmares

Past Psychiatric History

Have you ever been treated by a mental health provider? ☐ Yes ☐ No Age of first contact: _____

Name of last provider: _____ Date last seen: _____

Number of mental health hospitalizations: ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more Date of last hosp: _____

Past Medication Trials (check all that apply)

☐ Prozac (fluoxetine)
☐ Zoloft (sertraline)
☐ Paxil (paroxetine)
☐ Celexa (citalopram)
☐ Lexapro (escitalopram)
☐ Effexor (venlafaxine)
☐ Cymbalta (duloxetine)
☐ Wellbutrin (bupropion)
☐ Remeron (mirtazapine)
☐ Viibryd (vilazodone)

☐ Seroquel (quetiapine)
☐ Zyprexa (olanzepine)
☐ Geodon (ziprasidone)
☐ Abilify (aripiprazole)
☐ Risperdal (risperidone)
☐ Symbyax (zyprexa/ prozac)
☐ Latuda (lurasidone)

☐ Clozaril (clozapine)
☐ Haldol (haloperidol)
☐ Prolixin (fluphenazine)

☐ Lithium
☐ Tegretol (carbamazepine)
☐ Trileptal (oxcarbamazepine)
☐ Depakote (valproate)
☐ Lamictal (lamotrigine)
☐ Topamax (topiramate)

☐ Ambien (zolpidem)
☐ Lunesta (eszopicione)
☐ Sonata (zaleplon)
☐ Rozerem (ramelteon)
☐ Restoril (temazepam)
☐ Desyrel (trazodone)
☐ Melatonin

☐ Adderall (amphetamine)
☐ Concerta (methylphenidate)
☐ Ritalin (methylphenidate)
☐ Vyvanse (lisdexamfetamine)
☐ Dexedrine (dextroamphetamine)
☐ Focalin (demethylphenidate)
☐ Strattera (atomoxetine)
☐ Intuniv (guanfacine)

☐ Xanax (alprazolam)
☐ Ativan (lorazepam)
☐ Klonopin (clonazepam)
☐ Valium (diazepam)

☐ Buspar (buspirone)
☐ Gabapentin (neurontin)
☐ Lyrica (pregabalin)
☐ Other: will discuss in session

Family Psychiatric History

Diagnosis	Your Child	Your Sibling	Mother's Side	Father's Side
Bipolar DO	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Alcohol/Drugs	☐	☐	☐	☐
Suicide	☐	☐	☐	☐

Alcohol and Other Drugs of Abuse

Current Alcohol Use: ☐ Yes ☐ No Number of Drinks per Week: ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 7-9 more

Have you ever attended an alcohol abuse, detox or rehab program? ☐ Yes ☐ No

Have you ever had a DUI? ☐ Yes ☐ No If yes, how many: ☐ 1 ☐ 2 ☐ 3 or more

History of withdrawal symptoms? ☐ Yes ☐ No

If yes, circle applicable: Shakes Sweats Blackouts Seizure Hallucinations Delirium temens

Drug Type	Past Use of Trial	Used in Last 12 Months	Considered a Problem
Marijuana	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Pain Pills	☐	☐	☐
Stimulants	☐	☐	☐
Hallucinogens	☐	☐	☐

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs per day? ☐ ¼ ☐ ½ ☐ 1 ☐ 2 ☐ more

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, number of 8 oz cups per day: ☐ 1-2 ☐ 2-4 ☐ 5 and up

Medical History

Have you ever lost consciousness? ☐ Yes ☐ No Have you ever had a seizure? ☐ Yes ☐ No

Sleep problems? ☐ Yes ☐ No Problem: ☐ falling to sleep ☐ staying asleep CPAP: ☐ Yes ☐ No

How many hours do you sleep at night? ☐ 1-2 ☐ 3-4 ☐ 4-5 ☐ 6-7 ☐ 8-9 ☐ 10 or more

Are you currently pregnant? ☐ Yes ☐ No Are you planning a pregnancy? ☐ Yes ☐ No

Social History

Where were you born? _____ Where were you raised? _____

Are you adopted? ☐ Yes ☐ No Number of brothers: _____ Number of sisters: _____

Education: ☐ Elementary ☐ HS Grad ☐ GED ☐ Some College ☐ College Graduate ☐ Post Graduate

Are you currently married? ☐ Yes ☐ No ☐ Widowed Number of marriages:_____ Number of children: _____

Employed? ☐ Yes ☐ No ☐ Retired ☐ Disability Current legal issues? ☐ Yes ☐ No

Have you ever been the target of discrimination due to identity, race, gender, ethnicity, disability, religion or culture?

☐ Yes ☐ No

Review of Systems

Please check any problems that may have significantly affected you:

General			
□ Fatigue □ Recent weight loss; how much: _____	□ Fever □ Recent weight gain; how much: _____	□ Trouble sleeping	
Eyes			
□ Redness □ Recurrent sensation of gravel or sand in eye	□ Eye pain □ Use tear drops more than 3 times/day	□ Decreased vision □ History of eye inflammation (i.e. uveitis, iritis, etc.)	□ Daily, troublesome dry eyes for more than 3 months
ENT			
□ Decreased hearing □ Oral ulcers or sores	□ Ear pain □ Daily feeling of dry mouth for more than 3 months	□ Frequent sinus infections □ Sores in nose	□ Nosebleeds □ Need to frequently drink liquids to help swallow dry food
Neck			
□ Lumps	□ Swollen glands	□ Thyroid problems	
Respiratory			
□ Chest pain with deep breathing (i.e. pleurisy) □ Coughing up blood	□ Cough	□ Shortness of breath	□ Wheezing
Cardiovascular			
□ Chest pain □ Leg swelling (edema)	□ Palpitations	□ Shortness of breath with activity	□ Difficulty breathing when lying flat
Gastrointestinal			
□ Heartburn □ Constipation	□ Nausea □ Diarrhea	□ Vomiting □ Blood in stools	□ Swallowing difficulties □ Stomach or abdomen pain
Genito-urinary			
□ Increased urinary frequency	□ Burning or pain during Urination Do you have menstrual periods? □ Yes □ No	□ Blood in urine Number of pregnancies: _____	□ Participate in HRT □ Received or underwent genital reassignment surgery Number of miscarriages: _____
Neurologic			
□ Headaches	□ Numbness or tingling in hands or feet	□ Memory loss	
Skin			
□ Butterfly or malar rash on face □ Color changes in fingers with cold exposure	□ Other rashes	□ Rash or feeling sick after going out in sun	□ Bald patches on scalp, or clumps of hair on pillow
Hematologic			
□ Ease of bruising	□ Ease of bleeding	□ Any h/o low blood counts (ex: low platelets)	
Musculoskeletal			

□ Joint pain □ Joint swelling □ Muscle tenderness □ Muscle weakness

Please complete this page only if your primary care physician is not a Prevea Health physician. Try to answer each question, even if you do not think it is relevant to you at this time.

Past Medical History

Do you now or have you ever had:

□ Diabetes
□ Heart attack
□ Other heart disease (please describe): _____
□ Asthma
□ COPD/Emphysema
□ Acid reflux or GERD
□ Crohn's disease/Ulcerative colitis
□ Blood clots in legs or lungs
□ Peripheral vascular disease
□ Infectious disease
□ Cancer (please describe): _____
□ High blood pressure
□ High cholesterol
□ Thyroid disease
□ Kidney disease
□ Stroke
□ Epilepsy (seizures)
□ Neurologic disease (multiple sclerosis or Parkinson's disease)
□ Angina
□ Congestive heart failure
□ Degenerative disk disease (back disease, spinal Stenosis or severe chronic back pain)
□ Hearing impairment
□ Vision impairment (cataract, glaucoma or macular degeneration)

□ Other significant illness (please list): _____

Please list any surgeries or operations you have had:

Current Medications

Please list all medications and prescriptions you are taking (include vitamins, aspirin, decongestants, birth control pills, over the counter medications, etc.):

OR

□ I will discuss current medications with the nurse.

Medication Allergies

Patient Name (please print) Patient Signature Date

Patient Label

PREVEA health

INFORMED CONSENT (INCLUDING TELEMENTAL HEALTH SERVICES)

Consent to Evaluate/Treat: I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Prevea Behavioral Care, 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, psychiatric nurse practitioner, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Wisconsin Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

Consent for Telemental Health Services:
I understand that telemental health services involve use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand online access to staff at Prevea Behavioral Care is provided through EPIC video visits.

Telemental health services have risks, including but not limited to, poor resolution of transmitted data such as images, delays in treatment and evaluation due to equipment failure, and unauthorized access to third parties during data transmission. I understand I will be informed on the nature of the telehealth visit, the potential benefits, and risks (including those identified above) in the visit.

1. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological or psychiatric interviews, psychological assessment or testing, psychotherapy, medication management, with expectations regarding the length and frequency of treatment provided. It may be beneficial in treatment to understand the nature and cause of any difficulties affecting daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Because treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and helplessness. Treatment can lead to better relationships, solutions to specific problems, improved cognitive or academic/job performance, health status, quality of life, awareness of strengths and limitations and significant reductions in feelings of distress

2. Consequences of not receiving treatment: Possible outcome of not receiving treatment include a deterioration of lifestyle, to include family life, effectiveness in school or work, and possible deterioration of physical health.

3. 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 that apply to my telemental health visit. Fees are available to me upon request.

4. Confidentiality, Harm, and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record at Prevea Health, and I consent to disclosure for use by Prevea Behavioral Care staff for the purpose of treatment planning and continuity of 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; 3) if a court order is issued to obtain records; or 4) situations of acute care where medical information is needed for treatment planning. I understand that the laws that protect the confidentiality of my personal information also apply to telemental health.

5. Discharge Policy: There are circumstances under which I may be involuntarily discharged. I have read and understand the discharge policy of the clinic.

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. I understand I have the right to withhold or withdraw my consent to the use of telemental health during my care at any time, without affecting my right to future care or treatment.

7. Expiration of Consent: This consent to treat will expire 15 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and services for treatment, including telemental health. 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.

_____ _____
Signature of client ages 14 years or older Date

_____ _____
Signature of parent/legal guardian if patient is a minor Date

_____ _____
Signature of Provider Date

TELEMENTAL HEALTH FREQUENTLY ASKED QUESTIONS

Your insurance plan allows you to access Prevea Behavioral Care services through your computer, tablet or smart phone.

1) How do I get started with scheduling a telemental health appointment?
At the initial virtual session, the provider will review your patient rights and consent, provide education on telemental health services, and gather information relating to your presenting problem so the provider can determine treatment and make recommendations for you.

In case of emergency after normal working hours, you may call Prevea at (920) 272-1200. Prevea Care After Hours offers a convenient way for Prevea Behavioral Care patients to seek guidance they may need. Prevea Care After Hours is staffed by our experienced team to ensure the continued care of our patients after the office is closed. When calling Prevea Care After Hours, the triage nurses will have access to your medical records, which will help them individualize your care.

In case of a mental health emergency, you may also call (920) 436-8888 to access the Crisis Intervention Center.

2) What are some benefits of telemental health?
Some benefits of telemental health include reduced travel time and/or costs, decreased childcare or elder care issues, increased access to specialized and overall better health.

3) Are there any risks related to telemental health ?
Online access to a Prevea Behavioral Care provider has risks, including, but not limited to, delays in treatment and evaluation due to equipment failure, inoperability of EPIC video visits, and unauthorized access by third parties during data transmission.

4) What equipment do I need for a telemental health appointment?
You can access telemental health services from any web-enabled device (smartphone, tablet, laptop or desktop).

A My Prevea/My Chart account is not required for virtual appointments. However, if you would like to set up a My Prevea/My Chart account, Prevea Health will be happy to assist you in obtaining an activation code.

5) How does my information remain confidential?
All laws and regulations related to confidentiality of mental health and substance use treatment will also apply to all telemental health visits. Your provider will review confidentiality policies at your initial appointment.

In order to make steps to protect your confidentiality, here is a list of recommendations:

- Participate in sessions in a private location where you cannot be heard by others.
- Use a modern browser (Chrome, Safari on MACS, Edge, Firefox). If you don't have one of these browsers, you may download Chrome or Safari for free.
- Password protect any technology you will be using for telemental health.
- Always hang up and log out once virtual services completed

How do I start my visit with my provider?

If I do not have My Prevea/My Chart account

a. Office will provide you a direct join link either e-mail or text depending on your preference that can be used to access your video visit
b. The link can be opened on a laptop, computer or smart phone
c. After you select the link, the web browser will open with the video visit and a hardware test will be run.
d. After the hardware test is completed, click "Join call" to enter the video visit

If I have a My Prevea/My Chart Account

a. Go to My Prevea/My Chart website
b. Log in using your username and password
c. From home screen access visits icon and select "appointments and visits"
d. Go to appointment and select "details" (E-check in is available but not required.)
e. To join the video visit, click "begin visit" (Box will be grey if more than 15 minutes prior to appointment)
f. After click "begin visit" browser will open "EPIC telehealth" which will run a hardware test
g. Click "join call" when prompted

6) What if I have problems with the technology?
If you have questions or concerns about to access My Prevea/My Chart, or logging onto your video visit, please contact the MyChart Patient Support Line Toll Free at 866-312-5023

In addition, if you are having any technical difficulties, please call Prevea Behavioral Care at (920) 272-1200 so your provider can be made aware.

7) Does insurance pay for telemental health?
Telemental health appointments are covered by your insurance.

8) How do I schedule , cancel or reschedule a telemental health visit?
Please call Prevea Behavioral Care (920) 272-1200 and staff will be happy to assist in scheduling, cancelling, or rescheduling a telemental health or future face-to-face appointments.

Acknowledgement of Program Policies and Procedures

This is to acknowledge that I have been provided, both orally and in writing, and understand the following information:

1. The general nature and purpose of outpatient treatment services and the services available through the clinic.
2. Right to be involved in the treatment planning of care.
3. Clinic Hours.
4. Billing and Insurance
5. Treatment Costs.
6. Medication Policy and Prescription Refills
7. How to access emergency services.
8. Client rights and grievance procedure.
9. Criteria for Discharge from treatment.
10. Follow-up services after ending of treatment.
11. Missed appointment policy, including fee for missed appointment.
12. Confidentiality of patient information.

_____ _____

Signature of client ages 14 years or older Date

_____ _____

Signature of parent/legal guardian if patient is a minor Date

P.O. Box 19070, Green Bay, Wisconsin 54307-9070
(920) 496-4700 ■ (888) 2PREVEA ■ www.prevea.com

PREVEA health

Request for Medical Care

Patient Name _____ _____
(Last) (First) (Middle) (Date of Birth)

I. Medical Care Request and Authorization

I understand that I may have a condition that requires medical care. I am requesting and authorizing medical care by Prevea Health, any of the physicians associated with Prevea Health and other health professionals who are associated either with Prevea Health or the facility at which the medical care is rendered.

I am aware that medicine is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of my medical care. I understand that unforeseen conditions may arise during the rendering of my medical care and I hereby authorize Prevea Health and its designees to perform any other procedures they deem appropriate in the exercise of their professional judgment to address such conditions if I am otherwise unable to consent.

I recognize that I may, at any time, be a participant in and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, the right to formulate advanced directives and to provide any such directive for my physicians and health care providers to be aware of and to rely on.

I understand that students under appropriate supervision may observe or participate in my care; however, I have the right to refuse such observation or participation at any time.

II. CONSENT TO TELEPHONE CALLS (including WIRELESS), EMAILS, TEXTS:

If at any time I provide a telephone number through which I may be contacted, I consent to receive calls (including autodialed calls and pre-recorded messages), emails and text messages at that number from Prevea Health, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, regarding the services rendered, or my related financial obligations. I understand I may receive calls, email and text message communication regarding services or activities conducted on behalf of Prevea Health.

III. Financial Agreement

I understand that I am financially responsible for charges incurred for medical care rendered by Prevea Health. I understand that government payers and insurance companies may have restrictions on reimbursement for medical care rendered by Prevea health. These restrictions may include pre-certification, use of designated facilities, frequency of tests performed, non-covered services, deductibles, co-payments and other requirements. I understand that it is my responsibility to comply with such restrictions and that I will be personally responsible for any charges not reimbursed by other payers, to the extent allowed by applicable law.

If you are here for an office visit, please be aware that we will bill you for your office visit. Additionally, we may also bill you for: (i) additional services ordered by your provider in connection with your visit, including, but not limited to, laboratory tests and radiology services; and (ii) additional procedures performed by your physician during your office visit. Please be advised that additional services and procedures may be subject to your insurance plan's benefits, as well as deductibles, coinsurance and copayments required under your plan.

If you have any concerns regarding potential charges, please contact your insurance company with specific questions about what may or may not be covered. We will be happy to assist you by providing any medical information your insurance may need to determine your coverage.

We would be happy to answer any questions you may have about prices associated with your care. You may contact Prevea Health's Price Estimation Line at (920) 496-4700 for assistance.

I hereby authorize my insurance company or their payer to make payment directly to Prevea Health for services provided to me or to anyone else covered by my insurance for whom I am responsible. I understand that I am financially responsible to Prevea Health for charges not paid by my insurance or other payer, to the extent allowed by applicable law. I understand all balances are due within 30 days. In the event of default, I agree to pay all costs of collection including reasonable attorney fees.

PHOTOGRAPHS, AUDIO/VIDEO RECORDINGS: I understand that photographs, videotapes, recordings, digital or other images may be recorded by Prevea Health to document my care. I understand that Prevea Health will retain the ownership rights to these images however; I may be allowed to access/listen to them or obtain copies whenever possible. Images that identify me will be released and/or used outside the organization only upon written authorization from me or my legal representative or as allowed by law.

Patient Label

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed Name of Patient or Patient Representative (e.g. guardian) Relationship to Patient

SV

HSHS St.Vincent St.Mary's St.Nicholas St.Clare | PREVEA Health

RI

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

Name | Address | City | State | Zip

Date of Birth | Daytime Phone | Previous Name(s)

2) AUTHORIZES:

PREVEA BEHAVIORAL CARE / Prevea Health providers
P.O. BOX 19070 / P.O. Box 19070
3860 MONROE RD / Green Bay, WI 54307-9070
Name of Health Care Provider/Plan/Other | Address | DE PERE, WI 54115 | Fax # of Health Care Provider

3) TO DISCLOSE TO: ☐ Self, Delivery Options: ☐ Pick up ☐ Mail to address above ☐ View on-site ☐ Electronic Format

☐ E-mail to: _____

If the e-email address is shared with another person or the e-mail password is known to others, consider other methods of delivery. HSHS will automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted email poses some level of risk, e.g., a third party could see the information without consent. HSHS is not responsible for unauthorized access to unencrypted email containing confidential information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in unencrypted electronic format or e-mail. By selecting the unencrypted e-mail option I acknowledge the risks have been communicated and I accept these risks. ☐ Unencrypted Email

☐ To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send To: ☐ Prevea Health providers / PREVEA BEHAVIORAL CARE
P.O. Box 19070 / P.O. BOX 19070
Green Bay, WI 54307-9070 / 3860 MONROE RD
Name of Health Care Provider/Plan/Other | Address | DE PERE, WI 54115 | Fax # of Health Care Provider

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ (Month/Year) to _____ (Month/Year) If left blank, only information from the past two (2) years will be disclosed. Note: Future dates will not be honored.

5) INFORMATION TO BE DISCLOSED:

☒ Abstract of record/Pertinent records ☒ History & physical ☒ Discharge summary
☐ Emergency Department report ☒ Consultation reports ☐ Operative reports
☐ Radiology/Imaging reports ☐ Laboratory/Pathology ☐ EKG
☐ Radiology/Imaging films/CD ☒ Progress notes _____ ☐ Billing records _____
Specific records and/or information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

6) EXPIRATION: This Authorization is good until the following date/event: _____
Or if this item is left blank, the authorization will expire in (1) year from the date signed.

7) PURPOSE (check all that apply – copy fees may apply): ☐ Patient Request ☒ Continuing Care
☐ Legal Investigation/Action ☐ Insurance Eligibility/Benefits ☒ Other: Verbal

8) YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I understand that I have the following rights: to inspect and/or receive a copy of the health information; to have information be used and/or disclosed by this Authorization; if I agree to sign this Authorization, I will be provided with a copy of it; I may be charged a fee for record copies; I am under no obligation to sign this form and treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this Authorization; Authorization may be needed to release information to payers for certain mental health services, AODA services and/or HIV testing, however, I can refuse to sign this Authorization form for such purposes but I may be responsible for paying the entire bill for such services; I may revoke this Authorization at any time by notifying the authorizing provider's health information department, as listed above, in writing and will not be effective as to uses and/or disclosures already made in reliance upon this Authorization, needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage, or to submit a claim to third party payers as provided in this Authorization after having provided treatment in reliance upon this Authorization; the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal privacy law, Wisconsin or Illinois Law. *Federal Regulation (42 CRF, Part 2)/AODA prohibits any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by regulations. However, I understand that any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy standards. I understand that if there is not an existing treatment provider relationship with the party to whom information is being sent, a general designation may be used. I understand that I may request a list of entities to which my information has been disclosed from the "Send To" entity listed above.*

9) SIGNATURE OF PATIENT: _____ Date: _____ **and/or**
SIGNATURE OF LEGAL REPRESENTATIVE: _____ Date: _____
WITNESS SIGNATURE (AODA/Mental Health Only): _____ Date: _____
If signed by a person other than the patient, complete the following:
1) Individual is: ☐ a minor (AODA exception) ☐ legally incompetent or incapacitated ☐ deceased
2) Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for Health Care ☐ next of kin/executor of deceased
*By signing above, I hereby declare that I have not been denied physical placement of this child.

OFFICE USE ONLY: Signature/ID verified: ☐ Yes ☐ No Date/Time Released: _____ Completed by: _____ Medical Record Number: _____
Original: Medical Record Copy: Patient A photocopy of this authorization will have the same force and effect as the original

Hospital Sisters HEALTH SYSTEM

Patient Label

AUTHORIZATION TO COMMUNICATE HEALTH AND BILLING INFORMATION TO DESIGNATED PERSONS

As the patient, I understand that I am the primary person to receive information from physicians and other caregivers regarding my health condition, treatment and progress. However, other individuals may desire or have a need to receive information about my condition and health care services. I authorize the staff & physicians at Hospital Sisters Health System on its own behalf and on behalf of all its affiliate hospitals and entities and Prevea Health (identified as "HSHS") to provide verbal information about my **TREATMENT (**health, plan of care, treatment, appointments, and my condition) and **BILLING (**information about my account in order to assist me with my insurance and payments) to the persons named below for the purpose of keeping them informed of my progress or assisting with my care. (Please note, we reserve the right to utilize clinical judgment in determining with whom we need to communicate based upon your health care needs, i.e. emergency situation.)

Patient Name:_____ Date of Birth:_____

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

Telephone Number: _____

I hereby authorize HSHS to verbally disclose protected health information to the following: (I agree that this authorization includes the release or disclosure of alcohol/drug abuse, HIV test results, and Mental Health/Developmental Disabilities unless I check the applicable box below)

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

☐ I decline HSHS verbally sharing my treatment information with others, excluding emergency situations as indicated above.

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

☐ **Voice Mail**: Except for appointment reminders and billing inquiries, I understand that I will not be left voicemail messages regarding my health unless I agree to the following. I understand that messages left on voice mail may be subject to access by others and therefore are not a secure way to communicate confidential information. I understand that because of this risk HSHS advises that protected health information should not be left on voice mail**. By checking this box, I agree that HSHS may communicate my health information noted above to me via my voice mail at the number listed above** and I release HSHS and its employees, officers, and directors from all liability for any unintended disclosure or consequence as a result of communicating my protected health information to me in this manner.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may possibly be re-disclosed by the recipient, and/or no longer be protected by Federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to Information Disclosed - I understand that I have a right to know what information was disclosed to the above individuals. **Right to Receive a Copy of This Authorization** – I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form. Treatment, payment, enrollment or eligibility for benefits may not be based upon my decision to sign this authorization. **Right to Revoke This Authorization** – I understand that I may revoke this authorization. A description of how to revoke the authorization and any exceptions are included in the Notice of Privacy Practices. This notice is available through our facility website or at the patient registration desk. **HIV Test Results:** HIV test results are protected under Wisconsin state statute 252.15 and the Illinois AIDS Confidentiality Act (410 ILCS 305 et seq) may not be disclosed without written informed consent/authorization, except to persons or organizations that have been given access by state law. A list of those persons/organizations is available upon request.

EXPIRATION: I understand that this authorization will remain in effect until_____ **or** I choose to revoke it.
(Indicate event or date)

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name

If signed by a person other than the patient, complete the following:
1) Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2) Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for Health Care ☐ next of kin/executor of deceased
*By signing above, I hereby declare that I have not been denied physical placement of this child.

Original: Chart Copy: Patient

Prevea Health *Questionnaire*

PHQ-9

Over the last two weeks, how often have you been bothered by any of the following problems? Please **circle** the number that best describes you.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless.	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

PREVEA health

Prevea Health *Questionnaire*

Generalized Anxiety Disorder 7-item (GAD-7) Scale

Over the last two weeks, how often have you been bothered by any of the following problems? Please circle the number that best describes you.

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Inern Med. 2006;166:1092-1097.

PREVEA health

PREVEA
health

By signing this card, I am acknowledging
that I have received a copy of Prevea
Health Notice of Privacy Practice.

Signature _____ Date _____

PRV_86 4/16

Changes to access to your records in My Prevea

MyPrevea has the benefit of allowing patients to request refill prescriptions and review portions of your medical information. We are excited to announce that beginning March 8, 2021, MyPrevea will be available for our Behavioral Care/Substance Use patients. As a patient, you will now be able to view your information on-line, including but not limited to progress notes, assessments, medications, telephone encounters, etc. We are making this change to comply with the 21st Century Cures Act, federal legislation designed to give patients improved access to their medical information allowing patient to actively engage in their care.

Please be aware that anyone you have granted proxy access to within MyPrevea will also be able to see this information. If you would like to adjust proxy access, you can do so directly through MyPrevea or you may ask a member of your care team.

Records of Minors

Patients 12 and under. Parents/guardians of children under the age of 12 may have full access to their children's health information via MyPrevea. This includes all notes, medications, appointments and immunizations.

Patients 12-17. Minors have added rights of privacy regarding aspects of their medical information. Parent/guardian access is automatically converted to limited access, which includes the ability to view immunizations. If parents/guardians would like full access to the minor's information the minor may provide written consent and access will be expanded to allow for an ability to review and track medications, view allergies, lab and test results and see all notes created, including HIV, STD and pregnancy test results, and all mental health notes and related care. The minor may revoke the parental/guardian MyPrevea access at any time.

Please note, patients and parents of patients under age 18 will continue to have the option to request past paper records with a signed release of information.

If you have any concerns about these changes, please discuss them with your provider at your appointment. For example, you may already have proxy access in place for your child or spouse that was signed with their medical providers. We may want to discuss this access in relation to mental health records now being viewable in MyPrevea and how that may impact your family. We also recognize the content of mental health and substance use records can be confusing to understand. We are happy to explain what a typical therapy or psychiatry note looks like and what you can expect to see with your access.

If you don't have access to MyPrevea, we will be happy to sign you up.

We welcome the opportunity to be involved in your care, and the care of your children, in any way we can.

Sexually Transmitted Infection, Communicable Disease Risk Factors, and/or Prenatal Care Coordination

Drugs and alcohol can lead to risky behaviors. This includes being exposed to the transmission of multiple diseases including HIV/AIDS, Hepatitis B, Hepatitis C, and TB.

HIV/AIDS

HIV/AIDS is a viral infection that can make a person very sick or even cause death. HIV can be transmitted through sexual contact, sharing needles to inject drugs, and mother to baby transmission during pregnancy, birth, or breastfeeding.

To protect yourself and others get tested at least once or more often if you are at risk. Use condoms during every sexual encounter. Limit your number of sex partners. Don't inject drugs, or if you do, don't share needles or syringes.

Hepatitis B

Hepatitis B is a liver infection caused by the hepatitis B virus (HBV). HBV can be transmitted through sexual contact; sharing needles, syringes, or other drug-injection equipment; or from mother to baby at birth. Chronic hepatitis B can lead to serious health issues, like cirrhosis or liver cancer
The best way to prevent hepatitis B is by getting vaccinated.

Hepatitis C

Hepatitis C is a viral infection that attacks your liver. It is spread, most commonly through the exposure to blood of an infected person by sharing contaminated needles. It is also spread by sexual contact, and mother to baby during pregnancy.

To protect yourself and others get tested and use condoms during every sexual encounter. Don't inject drugs or, if you do, don't share needles or syringes.

Tuberculosis

TB (tuberculosis) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body. TB is spread when an infected person sneezes, speaks, or sings. The germs stay in the air for several hours.

To protect yourself and others get tested if you think you have come in contact with a person with known TB.

If you have questions or concerns about any of these communicable diseases talk to your primary care provider or Behavioral Care provider for referral for care.

Using drugs and alcohol during Pregnancy

Using drugs and alcohol during pregnancy and lead to harm of the unborn child including premature birth, low birth weight, and behavior problems as the child gets older.

If you are or think you may be pregnant speak to your primary care physician immediately. If you do not have a primary care provider talk with Behavioral Care provider for a referral for medical care.

Sexually Transmitted Infection, Communicable Disease Risk Factors, and/or Prenatal Care Coordination

- ☐ Counseling and education about HIV and Tuberculosis (TB)
- ☐ Counseling and education about Hepatitis B
- ☐ Counseling and education about Hepatitis C
- ☐ Risk of needle sharing
- ☐ Risks of transmission to sexual partners and infants
- ☐ Steps that can be taken to ensure that HIV and TB transmission does not occur
- ☐ Referral for HIV or TB treatment services if necessary
- ☐ For pregnant women
  - ☐ Counseling on the effects of alcohol and drug use on the fetus
  - ☐ Referral for prenatal care

I, _____, understand this information is being provided to me in accordance with Federal Law 45 CFR 96.121, in response to interim substance abuse services for Pregnant Women and people who IV Drug Use. I have received information pertaining to the above from my provider.

_____ _____

Patient or Guardian Signature **Date**

_____ _____

Provider's Printed Name and Signature **Date**

P.O. Box 19070, Green Bay, Wisconsin 54307-9070
(920) 496-4700 ■ (888) 2PREVEA ■ www.prevea.com

PREVEA health

COMMUNICABLE DISEASE / TUBERCULOSIS SCREENING QUESTIONNAIRE

Patient Name:

COMMUNICABLE DISEASE SCREENING

Are you experiencing any of the following symptoms?

☐ Yes ☐ No	1. Sore Throat
☐ Yes ☐ No	2. Rash / vesicles on skin
☐ Yes ☐ No	3. Cold sore
☐ Yes ☐ No	4. Fever and rash
☐ Yes ☐ No	5. Fever and respiratory symptoms-cough, runny nose
☐ Yes ☐ No	6. Drainage from eyes, ears
☐ Yes ☐ No	7. Skin lesion, cyst, boil
☐ Yes ☐ No	8. Nausea, vomiting
☐ Yes ☐ No	9. Diarrhea
☐ Yes ☐ No	10. Cough lasting more than three weeks
☐ Yes ☐ No	11. Swollen lymph nodes
☐ Yes ☐ No	12. Non healing wound
☐ Yes ☐ No	13. Returned from travel in another country within the last month

Have you ever been told by a physician or other health care provider that you have any of the following conditions?

☐ Yes ☐ No	14. Hepatitis A, B or C
☐ Yes ☐ No	15. Tuberculosis
☐ Yes ☐ No	16. HIV / AIDS

TUBERCULOSIS (TB) SCREENING

Are you experiencing any of the following symptoms?

☐ Yes ☐ No	17. Persistent coughing
☐ Yes ☐ No	18. Coughing up bloody sputum or blood
☐ Yes ☐ No	19. Night sweats
☐ Yes ☐ No	20. Unexplained fatigue
☐ Yes ☐ No	21. Recurring fever
☐ Yes ☐ No	22. Unexplained weight loss
☐ Yes ☐ No	23. Positive for TB – either skin test or blood test
☐ Yes ☐ No	24. Have you ever been told by a health care provider that you have had active TB?
☐ Yes ☐ No	25. Have you ever cared for or lived with anyone diagnosed with active TB?
☐ Yes ☐ No	26. Have you worked or volunteered in a setting where TB may be more common, e.g. homeless shelter, nursing home, group home, prison?

Depending on the responses to the above questions, the counselor reviewing this document may refer you for a follow up appointment with your physician, nurse practitioner (NP), or physician's assistant (PA).

I acknowledge that the above information is true and correct to the best of my knowledge.

Patient Signature:	Date:

OFFICE USE ONLY

☐ Yes ☐ No I have conducted a review of the information on this form.

☐ Yes ☐ No Referral to Physician, NP, or PA

Provider Signature: Date:

Sexually Transmitted Infection, Communicable Disease Risk Factors, and/or Prenatal Care Coordination

HIV/AIDS

HIV/AIDS is a viral infection that can make a person very sick or even cause death. HIV can be transmitted through sexual contact, sharing needles to inject drugs, and mother to baby transmission during pregnancy, birth, or breastfeeding.

To protect yourself and others get tested at least once or more often if you are at risk. Use condoms during every sexual encounter. Limit your number of sex partners. Don't inject drugs, or if you do, don't share needles or syringes.

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PREVEA health

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I acknowledge that the above information is true and correct to the best of my knowledge. By signing this, I also acknowledge that I have received and reviewed the information provided about risks, transmission, and prevention of communicable diseases. I understand my provider may recommend further education and counseling on these issues as part of treatment.

Patient Signature: Date: