

Behavioral Care/CHILD

Please review and check any symptoms that pertain to your child. Leave blank if not applicable.

Current	Past	Symptoms	Current	Past	Symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Bouts of crying	<input type="checkbox"/>	<input type="checkbox"/>	Arguing, defiant
<input type="checkbox"/>	<input type="checkbox"/>	Sadness, depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	Aggression toward others
<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn/isolates	<input type="checkbox"/>	<input type="checkbox"/>	Destruction of Property
<input type="checkbox"/>	<input type="checkbox"/>	No energy/always tired	<input type="checkbox"/>	<input type="checkbox"/>	Stealing
<input type="checkbox"/>	<input type="checkbox"/>	Lack of motivation	<input type="checkbox"/>	<input type="checkbox"/>	Lying
<input type="checkbox"/>	<input type="checkbox"/>	Feels guilty or worthless	<input type="checkbox"/>	<input type="checkbox"/>	Law violations in community
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of death or suicide	<input type="checkbox"/>	<input type="checkbox"/>	Referrals for violations at school
<input type="checkbox"/>	<input type="checkbox"/>	Problems with focusing	<input type="checkbox"/>	<input type="checkbox"/>	Attendance issues
<input type="checkbox"/>	<input type="checkbox"/>	Talks excessively	<input type="checkbox"/>	<input type="checkbox"/>	Runs from home or school
<input type="checkbox"/>	<input type="checkbox"/>	Problems with organizing	<input type="checkbox"/>	<input type="checkbox"/>	Sexual acting out
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty holding still, fidgety	<input type="checkbox"/>	<input type="checkbox"/>	Wets or soils self (urination/defecation)
<input type="checkbox"/>	<input type="checkbox"/>	Impulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>	Blames others
<input type="checkbox"/>	<input type="checkbox"/>	Energetic , excessive energy	<input type="checkbox"/>	<input type="checkbox"/>	Sleep issues
<input type="checkbox"/>	<input type="checkbox"/>	School work difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Appetite issues
<input type="checkbox"/>	<input type="checkbox"/>	Difficulties in social situations	<input type="checkbox"/>	<input type="checkbox"/>	Weight changes
<input type="checkbox"/>	<input type="checkbox"/>	Nervous, worries excessively	<input type="checkbox"/>	<input type="checkbox"/>	Upsetting memories of past events
<input type="checkbox"/>	<input type="checkbox"/>	Fears	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive thoughts or behaviors
		(_____)			
<input type="checkbox"/>	<input type="checkbox"/>	Nightmares/night terrors	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices/seeing things
<input type="checkbox"/>	<input type="checkbox"/>	Afraid to leave home	<input type="checkbox"/>	<input type="checkbox"/>	Tantrums, meltdowns
<input type="checkbox"/>	<input type="checkbox"/>	Sudden bouts of terror or panic	<input type="checkbox"/>	<input type="checkbox"/>	Seems excessively giddy or high
<input type="checkbox"/>	<input type="checkbox"/>	Hurting self	<input type="checkbox"/>	<input type="checkbox"/>	Low self-esteem:
<input type="checkbox"/>	<input type="checkbox"/>	Afraid to be alone	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Past Psychiatric History:

Has your child ever been treated by a mental health provider? No Yes Age of first contact: _____

Name of therapist or mental health provider: _____ Date last seen: _____

Number of mental health hospitalizations: 0 1 2 or more Date/s: _____

Family Psychiatric History

Diagnosis	The Child	Siblings	Mother	Mother's side	Father	Father's side
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Education Information:

What grade is the child in: _____ What school does the child attend: _____

Special education supports: No Yes, _____

History of suspensions or expulsions: No Yes, _____



Social History:

Is the child adopted? No Yes, how old was the child? _____

Where was the child born: _____ Where was the child raised: _____

Number of sisters: _____ Number of brothers: _____

The child is the oldest middle youngest

The child lives with: one parent split custody both parents a relative foster parent guardian

Have you ever been the target of discrimination due to identity, race, gender, ethnicity, disability, religion or culture? Yes No

Alcohol or Drug Use:

Type:	Past Use:	Current Use:	Type:	Past Use:	Current Use:	Type:	Past Use:	Current Use:
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	Meth	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	Pain pills, opiates	<input type="checkbox"/>	<input type="checkbox"/>	Vaping, jule	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs:	<input type="checkbox"/>	<input type="checkbox"/>

Developmental History:

Pregnancy complications: No Yes, _____

Milestones delays (walking, talking, toilet training, etc.): No Yes, _____

Birth to Three Early Childhood Speech therapy Occupational therapy Other: _____

Legal History:

Police contact: No Yes, _____

Any ongoing court involvement: No Yes, _____

Trauma History:

Exposure to mental, physical, or sexual abuse: No Yes, _____

Children & Protective Services Involvement: No Yes, _____

Witnessed domestic violence No Yes, _____

Frequent moves or homelessness No Yes, _____

Past Medication Trials (check all the apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Prozac (fluoxetine) | <input type="checkbox"/> Clorzaril (clozapine) | <input type="checkbox"/> Adderral (amphetamine) |
| <input type="checkbox"/> Zoloft (sertraline) | <input type="checkbox"/> Haldol (haloperidol) | <input type="checkbox"/> Concerta (methylphenidate) |
| <input type="checkbox"/> Paxil (paroxetine) | <input type="checkbox"/> Prolixin (fluphenazine) | <input type="checkbox"/> Ritalin (methylphenidate) |
| <input type="checkbox"/> Celexa (citalopram) | | <input type="checkbox"/> Vyvanse ((lisdexamfetamine) |
| <input type="checkbox"/> Lexapro (escitalopram) | <input type="checkbox"/> Lithium | <input type="checkbox"/> Dexedrine (dextroamphetamine) |
| <input type="checkbox"/> Effexor (venlafaxine) | <input type="checkbox"/> Tegretol (carbamazepine) | <input type="checkbox"/> Focalin (demethylphenidate) |
| <input type="checkbox"/> Cymbalta (duloxetine) | <input type="checkbox"/> Trileptal (oxcarbamazepine) | <input type="checkbox"/> Stattera (atomoxetine) |
| <input type="checkbox"/> Wellbutrin (bupropion) | <input type="checkbox"/> Depakoe (calproate) | <input type="checkbox"/> Intuniv (guanfacine) |
| <input type="checkbox"/> Remeron (mirtazapine) | <input type="checkbox"/> Lamictal (lamotrigine) | |
| <input type="checkbox"/> Viibryd (vilazodone) | <input type="checkbox"/> Topamax (topiramate) | <input type="checkbox"/> Xanax (alprazolam) |
| | | <input type="checkbox"/> Ativan (lorazepam) |
| <input type="checkbox"/> Seroquel (quetiapine) | <input type="checkbox"/> Ambien (zolpidem) | <input type="checkbox"/> Vistaril (hydroxyzine) |
| <input type="checkbox"/> Zyprexa (olanzapine) | <input type="checkbox"/> Lunesta (eszopiclone) | <input type="checkbox"/> Klonopin (clonazepam) |
| <input type="checkbox"/> Geodon (ziprasidone) | <input type="checkbox"/> Sonata (zaleplon) | <input type="checkbox"/> Valium (diazepam) |
| <input type="checkbox"/> Abilify (aripiprazole) | <input type="checkbox"/> Rozerem (ramelteon) | |
| <input type="checkbox"/> Risperdal (risperidone) | <input type="checkbox"/> Restoril (temazepam) | <input type="checkbox"/> Buspar (buspirone) |
| <input type="checkbox"/> Symbyax (zyprexa/Prozac) | <input type="checkbox"/> Desyrel (trazodone) | <input type="checkbox"/> Gabapentin (Neurontin) |
| <input type="checkbox"/> Latuda (lurasidone) | <input type="checkbox"/> Melatonin | <input type="checkbox"/> Lyrica (pregabalin) |



Review of Systems

Please check any problems that may have significantly affected you:

General

- | | | |
|--|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Recent weight loss; how much: _____ | <input type="checkbox"/> Recent weight gain; how much: _____ | |

Eyes

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Redness | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Decreased vision | |
| <input type="checkbox"/> Recurrent sensation of gravel or sand in eye | <input type="checkbox"/> Use tear drops more than 3 times/day | <input type="checkbox"/> History of eye inflammation (i.e. uveitis, iritis, etc.) | <input type="checkbox"/> Daily, troublesome dry eyes for more than 3 months |

ENT

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Frequent sinus infections | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Oral ulcers or sores | <input type="checkbox"/> Daily feeling of dry mouth for more than 3 months | <input type="checkbox"/> Sores in nose | <input type="checkbox"/> Need to frequently drink liquids to help swallow dry food |

Neck

- | | | |
|--------------------------------|---|---|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Thyroid problems |
|--------------------------------|---|---|

Respiratory

- | | | | |
|---|--------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Chest pain with deep breathing (i.e. pleurisy) | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Coughing up blood | | | |

Cardiovascular

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Shortness of breath with activity | <input type="checkbox"/> Difficulty breathing when lying flat |
| <input type="checkbox"/> Leg swelling (edema) | | | |

Gastrointestinal

- | | | | |
|---------------------------------------|-----------------------------------|--|--|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Swallowing difficulties |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Stomach or abdomen pain |

Genito-urinary

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Increased urinary frequency | <input type="checkbox"/> Burning or pain during Urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Participate in HRT
<input type="checkbox"/> Received or underwent genital reassignment surgery |
| | Do you have menstrual periods? <input type="checkbox"/> Yes <input type="checkbox"/> No | Number of pregnancies: _____ | Number of miscarriages: _____ |

Neurologic

- | | | |
|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness or tingling in hands or feet | <input type="checkbox"/> Memory loss |
|------------------------------------|--|--------------------------------------|

Skin

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Butterfly or malar rash on face | <input type="checkbox"/> Other rashes | <input type="checkbox"/> Rash or feeling sick after going out in sun | <input type="checkbox"/> Bald patches on scalp, or clumps of hair on pillow |
| <input type="checkbox"/> Color changes in fingers with cold exposure | | | |

Hematologic

- | | | |
|---|---|---|
| <input type="checkbox"/> Ease of bruising | <input type="checkbox"/> Ease of bleeding | <input type="checkbox"/> 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

High blood pressure

Angina

Heart attack

High cholesterol

Congestive heart failure

Other heart disease (please describe): _____

Asthma

Thyroid disease

Degenerative disk disease (back disease, spinal Stenosis or severe chronic back pain)

COPD/Emphysema

Kidney disease

Acid reflux or GERD

Stroke

Hearing impairment

Crohn's disease/Ulcerative colitis

Epilepsy (seizures)

Vision impairment (cataract, glaucoma or macular degeneration)

Blood clots in legs or lungs

Neurologic disease (multiple sclerosis or Parkinson's disease)

Peripheral vascular disease

Infectious disease

Cancer (please describe): _____

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



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

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





AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

Name	Address	City	State	Zip
Date of Birth	Daytime Phone		Previous Name(s)	

2) AUTHORIZES:

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

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

E-mail to: _____
 If the e-mail 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
 Name of Health Care Provider/Plan/Other: _____ P.O. BOX 19070
 Address: Green Bay, WI 54307-9070 DE PERE, WI 54115

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____
 (Month/Year) (Month/Year) Note: Future dates will not be honored.

5) INFORMATION TO BE DISCLOSED:

- Abstract of record/Pertinent records
- Emergency Department report
- Radiology/Imaging reports
- Radiology/Imaging films/CD
- History & physical
- Consultation reports
- Laboratory/Pathology
- Progress notes
- Discharge summary
- Operative reports
- EKG
- 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 CFR, 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

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

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.

REDISCLASURE 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.



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 *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 Intern Med. 2006;166:1092-1097.





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.