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 by a third party, Zipnosis.

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 in the course of 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

Patient Label

PREVEA
health

Acknowledgement of Program Policies and Procedures

This is to acknowledge that I have been provider, 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**

PREVEA health

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1) PATIENT INFORMATION:

Name _____ Address _____ City _____ State _____ Zip _____

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

2) AUTHORIZES:

WWD Prevea Health-Behavioral Care / Prevea Physicians and Providers

Name of Health Care Provider/Plan/Other

P:715-717-5899 F: 715-717-5898

Address _____ 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 Physicians and Providers / WWD Prevea Health-Behavioral Care

Name of Health Care Provider/Plan/Other

Address _____ Fax # of Health Care Provider

4) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____ If left blank, only information from the past two (2) years will be disclosed. (Month/Year) (Month/Year) 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: Mental health & substance use assessment, treatment plan, ongoing progress in therapy, staffing note appointments, medication

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/written communication & coordination of care

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

Patient Label

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❒	❒	Withdrawn/isolates	❒	❒	Destruction of Property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

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	☐	☐	Marijuana	☐	☐	Hallucinogens	☐	☐
Benzodiazepines	☐	☐	Meth	☐	☐	Heroin	☐	☐
Cocaine	☐	☐	Pain pills, opiates	☐	☐	Vaping, jule	☐	☐
Cigarettes	☐	☐	Stimulants	☐	☐	Other drugs:	☐	☐

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):

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

- ☐ Clorzaril (clozapine)
- ☐ Haldol (haloperidol)
- ☐ Prolixin (fluphenanzine)

- ☐ Lithium
- ☐ Tegretol (carbamazepine)
- ☐ Trileptal (oxcarbamazepine)
- ☐ Depakoe (calproate)
- ☐ Lamictal (lamotrigine)
- ☐ Topamax (topiramate)

- ☐ Adderral (amphetamine)
- ☐ Concerta (methylphenidate)
- ☐ Ritalin (methylphenidate)
- ☐ Vyvanse ((lisdexamfetamine)
- ☐ Dexedrine (dextroamphetamine)
- ☐ Focalin (demethylphenidate)
- ☐ Stattera (atomoxetine)
- ☐ Intuniv (guanfacine)

- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzapine)
- ☐ Geodon (ziprasidone)
- ☐ Abililfy (aripiprazole)
- ☐ Risperdal (risperidone)
- ☐ Symbyax (zyprexa/Prozac)
- ☐ Latuda (lurasidone)

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

- ☐ Xanax (alprazolam)
- ☐ Ativan (lorazepam)
- ☐ Vistaril (hydroxyzine)
- ☐ Klonopin (clonazepam)
- ☐ Valium (diazepam)

- ☐ Buspar (buspirone)
- ☐ Gabapentin (Neurontin)
- ☐ Lyrica (pregabalin)