Directions for School Based Mental Health Paperwork

1) Complete the forms in this document, as described below.
2) Save and upload or take pictures of the completed forms, and send to Prevea Behavioral Care's confidential e-mail: bcforms@prevea.com.
3) Please include "School Based Mental Health" in the subject line of the e-mail.

Call Prevea Behavioral Care at (920) 272-1200 with any questions.

School Based Mental Health Forms

1) **Notice of Privacy Practice - describes how medical information about you may be used and disclosed and how you get access to this information –** You can read over this notice if you would like. Signing the card/form verifies that you received a copy of the Privacy Practice.
2) **School Based Mental Health Policies and Procedures *brochure* –** this brochure explains the school based mental health program. A school based mental health therapist will go over the information in the brochure at the first session. **Acknowledgement of Program Policies and Procedures *form* –** Signing this form verifies that you acknowledge receiving the brochure information.
3) **Request for Medical Care –** This form gives authorization to be treated. It also allows Prevea to bill your insurance for session(s) and receive phone calls.
4) **Authorization to Communicate Health and Billing Information to Designated Persons –** This HIPPA form gives permission for health and billing information. Please check the "voice mail" box if it's okay for us to leave detailed information on your voice mail.
5) **Behavioral Care/CHILD *checklist* –** Please fill out the first page (front and back).
6) **Authorization for Disclosure of Health Information *for school* –** Allows school staff to communicate with school based mental health therapist and allows therapist to communicate with school staff. Please check information you want disclosed to school (please write "appointment information and attendance" on specific records line).
7) **Authorization for Disclosure of Health Information *for medical provider* –** Allows school based mental health therapist to communicate with medical provider and medical provider to communicate with therapist (if needed). Please check information you would like disclosed.
8) **Informed Consent Telemedicine –** School based mental health therapist will go over this in the session. This form goes over consent to treat, confidentiality, benefits of treatment, discharge and telemedicine information.

YOUR HEALTH INFORMATION RIGHTS.

You have the right to:

Inspect and Obtain a Copy of Your PHI. With a few exceptions, you have the right to review and obtain a copy of your PHI. If we deny your request for review or copy you have the right to have our denial reviewed. We may charge a reasonable cost-based fee for copying and mailing your PHI. Please contact our Health Information Management department to review or request a copy of your PHI.

Request an Amendment of Your PHI. If you believe your PHI is incorrect you have the right to request we amend it. We will review your request and notify you in writing of our final decision. If we deny your request you may appeal our decision. Please send your written amendment request to our Privacy Officer.

Request Restrictions on Certain Uses and Disclosures. You have the right to request restrictions on how we use or disclose your PHI for treatment, payment, health care operations, communications to family or friends or disclosure to disaster relief agencies. We are not required to agree to or grant restriction requests. We will honor your request to restrict disclosure of your PHI to your health plan for payment and healthcare operations purposes and if not otherwise required by law when you or someone on your behalf pays for your services in full. Please forward your written restriction request to our Privacy Officer.

Medical Device Tracking. If you receive certain medical devices, you may restrict release of your name, address, telephone number, social security number or other identifying information used for tracking the medical device.
Request to Receive Confidential Communications of Health Information. You have the right to receive your PHI through a certain method or at a certain location. Please make your request at the time of registration or send a written request to our Privacy Officer.

Receive an Accounting of Disclosures of Your PHI. You have the right to request an accounting of certain types of disclosures of your PHI. We will provide you with the first accounting in a 12-month period for free; we will charge the cost of producing the information for all other requests. Please contact our Privacy Officer to request an accounting.

Receive a Copy of This Notice. You have the right to receive a copy of our Notice of Privacy Practice. We may change our privacy practices described in this notice at any time. Changes to our privacy practices apply to all PHI we maintain. You may choose to review our current notice on our websites, at the registration/admitting desk of any of our facilities, or by contacting the Privacy Officer.

www.steliz.org
www.sacredhearteauclaire.org
www.stjoebreese.com
www.stjoeschipfalls.com
www.stjosephshighland.org
www.stmgb.org
www.stmarysdecatur.com
www.stvincenthospital.org
www.stanthonyshospital.org
www.prevea.com
www.st-johns.org
www.prairiecardiovascular.com
www.stfrancis-litchfield.org
www.hshsmedicalgroup.org
www.stclarememorial.org
www.hshsholyfamily.org
www.stnicholashospital.org

Receive Notice of a Breach of Your PHI. As required by law, you have the right to receive notification if your health information is acquired, accessed, used or disclosed in an unauthorized manner.

File a Complaint. You have the right to file a complaint. If you are concerned that your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services Office of Civil Rights. Your complaint will not affect the care and services we provide you in the present or in the future. To file a complaint with us please contact the Privacy Officer at:

Privacy Officer
Responsibility Department
PO Box 13508
Green Bay, WI 54307-3508
920-433-8513

This Notice of Privacy Practices is effective May 2, 2016 and will remain in effect until we revise it.

PRV_322 Rev. 04/16

PREVEA health

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal law requires Hospital Sisters Health System (HSHS) and our health care providers to maintain the privacy of your Protected Health Information (PHI). We are required by law to give you this notice and to comply with the terms and conditions of the most current notice. We reserve the right to change the terms of this notice and to make the new notice terms apply to all of your PHI we maintain. We will make you aware of our new notice terms by updating our Notice of Privacy Practices posted on our website and at our facility.

JOINT NOTICE

HSHS and entities under common ownership and control align with the medical staff and allied health professionals providing treatment at our facilities work together in an Organized Health Care Arrangement (OHCA). As part of the OHCA, we share your PHI as necessary for your treatment, to get paid for services, and to carry out other health care operations such as quality assessment and improvement. This joint notice describes how the health care professionals and workforce members, including colleagues, medical staff members, students and volunteers, participating in the OHCA use and disclose your health information. A Notice of Privacy Practice provided to you by any one of the following will also satisfy the HIPAA requirement to provide you with this notice.

The entities participating in the HSHS OHCA include;

In Illinois: HSHS St. Elizabeth's Hospital, Belleville; HSHS St. Joseph's Hospital, Breese; St. Joseph's Hospital Immediate Care 365; HSHS St. Joseph's Hospital, Highland; HSHS Holy Family Hospital, Greenville; St. Mary's Hospital, Decatur; St. Anthony's Memorial Hospital, Effingham; HSHS Home Care Southern Illinois; HSHS Hospice Southern Illinois; HSHS St. John's Hospital, Springfield; St. John's Hospital Home Health; St. John's Hospice; St. John's Hospital Home Infusion; St. John's Surgery Center, Montvale; St. John's Surgery Suites; Prairie Diagnostic Center at St. John's Hospital; St. John's Children's Hospital; HSHS St. Francis Hospital, Litchfield; Clinton County Rural Health; Prairie Cardiovascular Consultants; HSHS Medical Group; Joslin Diabetes Center – Affiliate at HSHS Medical Group

In Wisconsin: HSHS St. Vincent Hospital, St. Vincent Home Health Care, St. Vincent Hospital Renal Dialysis Center and St. Mary's Hospital Medical Center in Green Bay; HSHS St. Nicholas Hospital, St. Nicholas Home Health & Hospice and St. Nicholas Hospital Renal Dialysis Center in Sheboygan; HSHS St. Clare Memorial Hospital in Oconto Falls; HSHS Sacred Heart Hospital, Sacred Heart Heart & Vascular Center, Sacred Heart Obstetrics & Gynecology Clinic and Sacred Heart Behavioral Health Center in Eau Claire; and Sacred Heart Renal Dialysis Center in Eau Claire and Chippewa Falls; Sacred Heart Family Care in Arcadia and Osseo; St. Joseph's Hospital and St. Joseph's Home Health & Hospice in Chippewa Falls; St. Joseph's Hospital Occupational Health and Medicine and St. Joseph's Hospital Wound Care in Chippewa Falls and Eau Claire; LE Phillips-Libertas Treatment Center in Chippewa Falls; and Libertas Treatment Center in Green Bay; St. Clare Memorial Hospital affiliated Clinics, Prevea Health; and St. Gianna Clinic

If you are unsure if your health care provider is part of this notice or you have additional questions regarding our privacy policies you may contact our Privacy Officer.

Each time you receive care, information may be documented electronically or on paper. The information we document includes identification and financial information as well as medical information such as your symptoms, diagnoses, test results, physical examination, and information about your treatment. This information allows us to:

- Plan for your care and treatment
- Communicate information among your health care professionals
- Legally record the care you receive
- Verify that services were provided
- Evaluate and improve the care we provide and the outcomes we achieve
- Provide a source of information for important health related research
- Educate health professionals and students
- Provide information for the hospital's planning and operations

BY LAW, WE ARE ABLE TO USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSES:

Treatment. We may disclose in person, by phone, mail, fax or electronically PHI about you to physicians, nurses, technicians, or other personnel who are involved in your care or treatment. For example, a physician may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. This information is documented in your medical record so that other health care providers may make informed decisions about your care. As required by Illinois and Wisconsin law we will obtain your authorization before disclosing psychotherapy notes or HIV test results to other health care professionals for treatment purposes.

Payment. We may use or disclose your PHI to bill and collect payment from you, your insurance company or other parties responsible for paying for your services. For example, we may disclose your diagnosis, treatment plan, results, and/or treatment progress to your health insurer in order to receive payment, unless otherwise restricted as further described in this notice. As required by Illinois and Wisconsin law we will obtain your authorization before disclosing psychotherapy notes or HIV test results for payment purposes.

Health Care Operations. We may use your PHI to assist us in improving the quality or cost of care we provide. This may include evaluating the care provided by your physicians, nurses and other health care professionals, or comparing the effectiveness of your treatment to patients in similar situations. We may also use your health information to educate students preparing for health-related careers and to further educate our current employees. We may disclose your PHI to accreditation, certification and licensing organizations who review the quality of our services.

Facility Directory. Unless you object, when you are admitted as an inpatient or for short stay services we will include your name, location in our facility and religious affiliation in our directory. We may provide the information in our directory to anyone who asks for you by name or to your church if requested.

Notification and Communication with Family and Friends. We may disclose your PHI to a family member, your personal representative or other person responsible for your care or payment for your care, to notify them of your location, general condition, or death. We may also disclose your PHI for notification purposes to public or private entities assisting in disaster relief efforts. We will give you the opportunity to agree or object before disclosing your information in these situations. If you are unable to agree or object to a disclosure, or in cases of emergency, we will use our best judgment in communicating with your family and others.

Communications to you. We may use your information to remind you of appointments, give you test results, or recommend treatment alternatives or wellness services that may be of interest to you or provide you with surveys regarding your care.

Judicial and Administrative Proceedings. We may disclose your health information in response to a court order. Under most circumstances when the request is made through a subpoena, a discovery request or involves another type of administrative order, your authorization will be obtained before disclosure is permitted.

Required or Permitted by Law. We may disclose PHI to law enforcement officials for purposes such as identifying or locating a suspect, fugitive or missing person, victims of abuse, neglect or complying with a court order or other law enforcement purposes. In addition, as required by law we may disclose PHI to the proper authorities for patient's in the custody of law enforcement or in a correctional institute.

Public Health Activities. We may disclose your PHI for public health activities. These activities generally include but are not limited to the following: to prevent or control disease, injury, or disability; to report deaths; to report to cancer registries or other similar registries; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to health oversight agencies responsible for overseeing our operations; this may include audit, investigation, and inspection related to oversight of the health care system or government benefit programs. For example, we may disclose your PHI to regulatory agencies conducting a review of our quality of care.

Death. We may disclose PHI to funeral directors as needed and to coroners or medical examiners to identify a deceased person, determine cause of death, or perform other functions required by law. For example, we may provide HIV test results to a funeral director or other persons who prepare a body for burial.

Organ, Eye or Tissue Donation. We may disclose PHI to facilitate the donation and transplantation of organs, eyes and tissue.

Research. We may use and disclose your PHI to conduct research only under certain circumstances and after a special approval process.

Philanthropy. We may use your information, including but not limited to name, address, gender, date of birth, treating physician, department of service and outcome information, to contact you for our own fundraising purposes which support important activities of our hospital ministries through the Hospital Sisters of St. Francis Foundation. You may opt out of receiving fundraising communications from us at any time.

Serious Threat to Health or Safety. We may disclose your PHI to the necessary authorities if we believe in good faith that it will prevent or lessen a serious and imminent threat to the health and safety of you or the public. For example, we may disclose your PHI to the Department of Transportation if your medical condition affects your ability to safely drive a car.

Essential Government Functions. We may use or disclose PHI to carry out certain essential government functions. For example, we may disclose PHI to a government agency for national security or intelligence activities, correctional institution and other law enforcement as required by law.

Worker's Compensation. We may disclose your PHI to the appropriate persons in compliance with workers' compensation laws. For example, we may provide your employer with information about your work-related injury.

Shared Medical Record/Health Information Exchange. We may maintain your PHI in a shared electronic medical record. List of participants utilizing the shared electronic medical record are available on the website or by contacting the Privacy Officer. Unless you object, we may also submit your PHI to an electronic health information exchange (HIE). Participation in an HIE allows us and other providers to see and use information about you for your treatment, payment and health care operations.

Marketing and Sales. We will obtain your authorization before using your PHI for marketing or sales purposes, as required by law. For example, we will obtain your authorization if we want to use your PHI in an article about the hospital. You may revoke this authorization at any time.

Other Uses of Your PHI. We will ask for your written authorization before using or disclosing your PHI for situations not described in this notice. You may revoke your authorization at any time.

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

Discharge policy

Prevea Behavioral Care seeks to provide quality care to all clients. Clients may be discharged from the clinic immediately if they are deemed to be abusive or threatening to the staff. Clients may also be discharged for the following reasons, but not limited to: failure to follow the treatment plan, not following the financial policies of the clinic, inability to build/maintain client-therapist relationship. In the event a discharge occurs, you will be provided a letter with information related to the discharge, and the effective date. At your request, you will have the right to have the decision reviewed by the Clinic Manager, Prevea Quality Resources and the Wisconsin State Grievance Examiner.

For *more information*

Please visit prevea.com for more information about Prevea Health. You also will find information about a wide range of health topics. Thank you for your time and welcome to Prevea Behavioral Care. We sincerely hope that you have a pleasant experience, and we welcome any suggestions you may have to better serve you.

Prevea Care *After Hours*

In case of emergency after normal working hours, you may call Prevea at **(920) 496-4700** or toll free **(888) 277-3832.** Prevea Care After Hours offers a convenient way for Prevea Health patients to seek the medical advice they need. Prevea Care After Hours is staffed by our experienced medical team to ensure the continued care of our patients after the office is closed.

When calling Prevea Care After Hours, the triage nurse will be able to individualize your care by having access to your medical records. This also enables us to keep your provider aware of any concerns you have after clinic hours. Your insurance will not be billed unless you are seen by a provider.

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

Testimony and *court proceedings*

We collect data for the purpose of helping you in treatment. Legal hearings have different goals than treatment or therapy. We do not usually testify in custody cases, divorce proceedings or criminal court unless we are hired for that purpose from the start. If we saw you with your spouse, we cannot ethically testify without permission from both partners in any divorce hearing.

If you cannot keep your appointment, please call Behavioral Care at least 24 hours in advance to cancel or reschedule.

We're here for you

With several locations throughout eastern Wisconsin, Prevea Behavioral Care is close to your home.

For more information or to schedule an appointment, call **Prevea Behavioral Care** at (920) 272-1200.

prevea.com

PREVEA health

PRV_BC000037-5 0318

School Based Mental Health
Policies and Procedures

PREVEA health

Initial *evaluation*

At the time of your initial evaluation, we will gather pertinent information relating to your presenting problem so we can determine the most appropriate treatment and make recommendations for you. If at any time your clinical needs require a level of care not provided in the school based mental health program, you may be referred to alternative services or programs within the community.

Treatment and *available services*

Each client comes here with his/her own unique set of circumstances. The purpose and goals of treatment, as well as the type and length of treatment will, therefore, vary with each client. Your active participation in your treatment is important and no decision about your treatment will be made without your involvement. It is important that you openly discuss your expectations, concerns or questions regarding your treatment with your therapist. The services available to our clients include diagnosis, referral, and individual and family therapy. Psychological testing and evaluation, and psychiatric assessments are available at Prevea Health as an insurance billable service.

Prevea Health Behavioral Care is licensed under DHS 35, whose providers are licensed under Statutes Chapter 440, 448, 455, or 457. Prevea Behavioral Care providers act as a team, and do consult with other skilled staff, as required by State Statute regarding the best treatment plan for care. Some providers may treat clients under the supervision of a provider in your insurance network. All providers participate in ongoing clinical collaboration within the department to allow for the review of treatment with other skilled staff.

Referral services

If we cannot provide you with the type of services you may require, we will make referrals to other agencies and help you with accessing these services.

Follow-up

In an effort to evaluate and improve our services, we may contact you by text, email or a phone call following your treatment to ask you to critique the services you received. If you require future services, you may return for treatment.

Informed *consent*

Prior to beginning any treatment, you will be asked to sign an Informed Consent for Treatment. This is intended to assist you in understanding your treatment and your consent to treatment.

Confidentiality

Confidentiality of client information is maintained in accordance with state and federal regulations. Information to those outside of Prevea Health only will be released with your written consent. 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.

Insurance

As a state certified mental health clinic, we are eligible for mandated insurance benefits. It is recommended that you contact your insurance company to determine if your insurance will cover outpatient mental health services, as well as what the limits are on this coverage, prior to beginning treatment. As a service to you, we will submit assigned insurance claims to your insurance carrier. If special claim forms are required, please provide these to us. You are responsible for payment of charges not paid by your insurance. You will be billed for copays and any portion not covered by insurance. If you do not have insurance that covers services at Prevea Behavioral Care, and will be paying cash for services, you will be eligible for a 30% discount of the listed fees. If you have commercial insurance, or Medicare that covers Behavioral Care Services, and choose not to use that insurance you will be responsible for the full fee, and not eligible for the discount. If your provider is listed as an out of network provider, you will not be eligible for the discount. If you have Medical Assistance, your insurance must be billed, and all Medicaid billing policies will be followed. If you are unable to pay for services, you will be directed to a patient advocate to discuss financial options, including the Prevea financial assistance program for school based mental health. For billing or insurance questions, please call Patient Accounts at **(920) 496-4775** between 8 a.m. and 5:30 p.m. Monday through Friday. You can also submit a billing question at prevea.com by selecting Contact Us.

Fee for service

Our fees are determined based on the type of treatment provided and the length of time needed for each session. Your treating provider has detailed fee information available at your request. The range of fees for each service depends on the provider seen.

- **Diagnostic evaluation**
  $354-$467 (50 minutes)

- **Psychotherapy**
  $165 (16 to 37 minutes)
  $219 (38 to 52 minutes)
  $328 (53+ minutes)

- **Family therapy**
  $296 (50 to 60 minutes)

Grievance procedure

You have the right to register any complaint or concern about your treatment or care, and the complaint will be processed by the Client Rights Specialist in Prevea Behavioral Care. There are informal and formal procedures in place to deal with client complaints. You also have the right to have any grievance reviewed by the Division of Quality Assurance, Behavioral Certification Section.

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 School Based Mental Health Services.
2. Right to be involved in the treatment planning of care.
3. Clinic hours.
4. Billing and insurance.
5. Treatment costs.
6. How to access emergency services.
7. Client rights and grievance procedure.
8. Criteria for discharge from treatment.
9. Follow-up services after ending of treatment.
10. 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

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

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)

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

❒ Clorzaril (clozapine)
❒ Haldol (haloperidol)
❒ Prolixin (fluphenanzine)

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

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

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

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

❒ Buspar (buspirone)
❒ Gabapentin (Neurontin)
❒ Lyrica (pregabalin)

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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 health - School Based Mental Health Staff / *

Name of Health Care Provider/Plan/Other

PO BOX 19070 Green Bay, WI 54307 Phone: 920-272-1200

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 Behavioral Health – School Based Mental Health Staff

Name of Health Care Provider/Plan/Other

Address _____ 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/Substance Use Disorder (SUD) ☐ 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: _____

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)/SUD 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: _____ **If signed by a person other than the patient, complete the following:**

1) Individual is: ☐ a minor (SUD 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

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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:

Name of Health Care Provider/Plan/Other _____

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-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: ☐ _____

Name of Health Care Provider/Plan/Other

Address _____ 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/Substance Use Disorder (SUD) ☐ 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: _____

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)/SUD 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: _____ **If signed by a person other than the patient, complete the following:**

1) Individual is: ☐ a minor (SUD 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

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

TELEMENTAL HEALTH FREQUENTLY ASKED QUESTIONS

Your insurance plan allows you to access Prevea Behavioral Care services through your computer, tablet or 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 the Zipnosis, 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).

You will also need to have a My Prevea account. If you do not have a My Prevea account, Prevea Health will be happy to assist you in obtaining an activation code to help you set up your account.

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 or Safari). 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 services completed.

How do I start my visit with my provider?

a. Go to www.prevea.com
b. Click on “virtual care”
c. Click on “log in”
    i. Can log in using my chart or
    ii. Create an account
d. Can also go through My Prevea/My chart

6) What if I have problems with the technology?
If you have questions or concerns about to access Prevea Health through the Zipnosis software, you may call (920) 843-5071.

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.

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.