**NORTH SHORE PSYCHOTHERAPY ASSOCIATES**

**5555 N. Port Washington Rd., Suite 300**

**Glendale, WI 53217**

**Phone: (414) 962-6764**

**Patient/Client Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M \_\_F\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Client Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message on your home phone: Yes\_\_\_\_ or No\_\_\_\_

May we contact you by email? Yes\_\_\_\_ or No\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party:**  Relationship to Client: Parent\_\_\_\_\_\_ Guardian\_\_\_\_\_\_\_ Spouse\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check one: \_\_\_\_\_\_ Bill Insurance (Please present card) \_\_\_\_\_\_\_\_Self Pay**

**NOTE: Without insurance information, responsible party will be billed.**

**Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Employed By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance Yes \_\_\_\_\_\_\_\_\_ (Present Card) No \_\_\_\_\_\_\_\_\_\_\_**

**Collateral Contacts Name and Phone Number:**

**Prescriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELEASE OF INFORMATION**:

I hereby authorize North Shore Psychotherapy Associates to release to the above insurance company any information, which said company may request concerning payment of the evaluation and or treatment to the above named client provided by North Shore Psychotherapy Associates. North Shore Psychotherapy Associates follows the HIPAA Harmonization Law to allow for the release of treatment, payment, and healthcare information without authorization to provide coordination of care.

**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:**

I hereby authorize my insurance company to make payment directly to North Shore Psychotherapy Associates for insurance benefits otherwise payable to me, but not to exceed charges for those services. I agree that a photocopy of this, my original authorization, shall be considered authentic.

**FINANCIAL RESPONSIBLITIES**:

Co-pays are due at time of service.

I understand that I am financially responsible for those charges not paid by my insurance company on a monthly basis**. Any sessions, which I fail to keep or cancel with less than twenty-four (24) hours notice** **in non-emergency situations, will be billed to the responsible party at the FULL hourly rate.**

**LIMITS ON CONFIDENTIALITY:**

* I understand that doctoral externs or recent graduates pursuing licensure may provide services under the supervision of a licensed provider. A provider’s trainee status will be disclosed to me in the initial session. I understand that such providers routinely receive supervision from a licensed supervisor, who has access to the clinical record.
* I understand that North Shore Psychotherapy Associates or its business associates may make the use, disclosure, or request for disclosure in any of the following circumstances:
  1. For purposes of treatment.
  2. For purposes of payment.
  3. For purposes of health care operations.
  4. For purposes of disclosing information about a patient in a good faith effort to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
  5. For purposes of disclosing any threat made by a patient regarding violence in or targeted at a school in a good faith effort to prevent or lessen a serious and imminent threat to the health or safety of a student or school employee or the public.
* I understand that support staff may see my records in the performance of her or his clerical duties. All staff members have been given training about protecting my privacy and have agreed not to release any information except as noted in this agreement.
* I understand that each provider has designated a colleague as a professional executor in the case of her or his death or disability. I understand that this executor will have access to my records for the purposes of notification and practice management. The executor may provide psychological services if needed, or refer to another qualified professional if needed.

**INFORMED CONSENT FOR EVALUATION AND/OR TREATMENT:**

In consideration of evaluation and/or treatment to be rendered to me at North Shore Psychotherapy Associates,

I hereby consent to such care and treatment, i.e., psychological testing or evaluation, psychotherapy, assessment for a prescription of medications as may be deemed proper for my best interests in the judgment of the professional staff of North Shore Psychotherapy Associates.

The following information is provided for your review:

1. The benefits of the proposed treatment and services:
2. The way the treatment is to be administered and the services are to be provided:
3. Alternative treatment mode and services:
4. Possible treatment risks and side effects:
5. The probable consequences of not receiving the proposed treatment and services:
6. The time period for which the informed consent is effective, which shall be no longer than

15 months from the time the consent is give: and

1. The right to withdraw informed consent at any time, in writing:
2. The approximate duration and desired outcome of recommendations in the treatment plan;
3. How to use the clinic’s grievance procedure:
4. The clinic’s discharge policy, including circumstances under which a patient may be involuntarily discharged for inability to pay or behavior reasonably the result of mental health symptoms.

If you have concerns about any of these issues, please feel free to discuss them with your therapist.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT AGREEMENT**

**Confidentiality –** All contacts with our therapists and clinic are confidential except in situations where you may be harmful to yourself or others. If your insurance has managed care, information will be shared for the purpose of coverage by your insurance. No information regarding you or your family members will be given to anyone outside the clinic without your written consent.

**Hours of service** \_ Clinic hours are flexible and vary with each therapist. Your therapist is available by calling the main number 414-962-6764. The clinic has a 24-hour answering service so you can contact your therapist in the event of an emergency.

**Cancellations or Failed Appointments** – **Cancellations must be made 24 hours in advance or you will be billed for the professional fee; clients will also be billed for missed** **appointments.** Insurance companies will not reimburse for failed or improperly cancelled appointments and therefore you will be billed.

**Treatment Billing Policy**

**Insurance Responsibility** – It is your responsibility to know what coverage your insurance provides. All charges are the sole responsibility of the responsible party, regardless of insurance payments. If the insurance check is paid directly to you, you are obligated to turn the check over to the clinic. Failure to do so will result in an 18% monthly interest fee which will be added to your account. **COPAYMENTS ARE DUE AT TIME OF SERVICE.**

Information about Fees:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Licensed Psychologist | Licensed Therapist | Social Worker |
| Initial Assessment | $225 | $175 | $175 |
| Follow up appointment | $200 | $150 | $135 |
| Psychological Testing | $225 |  |  |
| No Show/No call | Full Rate | Full Rate | Full Rate |

**Self-Pay Clients** – Our clinic expects that you and your therapist will make arrangements for the professional fee. Clients are expected to keep the balance current and pay at each session.

**Collection Agency** – Past due accounts will be given to our collection agency. All fees incurred by this action will be the responsibility of the client. If you have any concerns about payment or insurance billing, please feel free to discuss them with your therapist or the office manager.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yearly Reviews:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**North Shore Psychotherapy Associates**

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**Glendale, WI 53217**

**Phone: (414) 962-6764**

WE ARE REQUIRED BY LAW THAT YOU READ AND SIGN THIS FOR OUR RECORDS

**Patient Bill of Rights**

When you receive services for mental health, alcoholism, drug abuse, or developmental disability as an inpatient or outpatient, you have the following rights under Wisconsin Statute 51.61.

TREATMENT AND RELATED RIGHTS:

* To be free from having unreasonable arbitrary decisions made about you.
* To receive prompt and adequate treatment.
* To refuse treatment.
* To be free from unnecessary or excessive medication.

COMMUNICATION AND PRIVACY:

* To refuse to be filmed or taped without your consent.
* To have your treatment records and conversations about your treatment kept confidential (Section 51.30 Stats).
* To have access to your treatment record after discharge (or during treatment if the facility director approves it) and to have access at all times to records of medications you take or any treatment you receive for physical health reasons.

RIGHTS OF ACCESS TO COURTS:

* To bring legal action for damages against those who violate your rights.

YOUR RIGHT TO COMPLAIN:

If you feel that your rights have been violated, you have the right to a grievance procedure. Our agency has a grievance process through which you may file your complaint. Grievances must be filed in writing within forty-five (45) days if the incident or issue. The staff will supply you with a copy of North Shore Psychotherapy Associates’ Grievance Procedure upon request. You may at the end of the grievance process, or at any time during it, choose to take the matter to court.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF CLIENT/GUARDIAN DATE

**North Shore Psychotherapy Associates**

**5555 N. Port Washington Road, Suite 300**

**Glendale, WI 53217**

**Phone: (414) 962-6764**

**Notice of Privacy Practices/Patient Acknowledgement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice’s legal duties with respect to my protected health information. The Notice includes:

* A statement that this practice is required by law to maintain the privacy of protected health information.
* A statement that this practice is required to abide by terms of the notice currently in effect.
* Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
* A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
* A description of other uses and disclosers that will be made only with my written authorization and that I may revoke such authorization.
* My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
* The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
* The right to request restrictions on certain uses and disclosures of my protected health, information, and that this practice is not required to agree to a request restriction.
* The right to inspect and copy protected health information.
* The right to amend protected health information.
* The right to receive an accounting of disclosures of protected health information.
* The right to obtain a paper copy of this Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is maintains. I understand that I can obtain this practice’s current Notice of Privacy Practices on request.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client chooses not to accept copy \_\_\_\_\_