wellpoint care network

Child Registration Form

MRN: _____
FOR OFFICE USE ONLY

CLIENT INFORMATION

Client Name			
	(First Name)	*(Middle Name)*	*(Last Name)*
DOB		**Language**	☐ English ☐ Spanish ☐ Other: _____
Gender	☐ Female ☐ Male ☐ Other ☐ Transgender FTM ☐ Transgender MTF	**Race**	☐ African-American/Black ☐ Caucasian/White ☐ Asian ☐ Native American/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Bi-racial ☐ Multi-racial ☐ Other: _____
Phone			
Address			
Email		**Hispanic Ethnicity**	☐ Yes ☐ No
Living Arrangement		**Household Income**	

PARENT/GUARDIAN/PLACEMENT INFORMATION

	BIOLOGICAL PARENT CONTACT	PLACEMENT CONTACT	EMERGENCY CONTACT
Name			
Relationship			
Address			
Phone			
Email Address			
Marital Status			
Additional Info			

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Member ID #		
Member Group #		
Insurance Holder's Name		
Insurance Holder's Date of Birth		

MEDICAL CHECKLIST

Do you have issues with the following:	Check if YES	Comments	Do you have issues with the following:	Check if YES	Comments
Sleep Apnea			Overweight for age		
Sleeps excessively			Picky Eating		
Wakes often/throughout the night			Gorging Food (large amount of food at once)		
Difficulty falling asleep			Purging Food (throwing up after eating)		
Sleepwalking			Excessive Thirst		
Nightmares/terrors			Vomiting		
Excessive Yawning and/or sighing			Reflux Disorder		
Asthma			Rumination Disorder (regurgitation)		
Diabetes			Excessive Sucking/Swallowing		
Diarrhea and/or Irritable Bowel			Gagging when eating or drinking		
Constipation			Difficulty chewing food		
Encopresis (involuntary fecal soiling)			Refusal to eat certain foods due to texture		
Enuresis (involuntary urinating)			Pica disorder (eats inanimate objects)		
Hives and/or Dermatitis			Fast or slow eye-blink rates		
Skin Sensitivities			Frequent Headaches		
Always Cold or Always Hot			Blurred Vision		
Hoarding and/or Hiding Food			Sensitive to Light		
Lack of appetite			Complains of Dizziness/Blackouts		
Eats without gaining weight					

Consent for Mental Health Admission

MRN: _____
FOR OFFICE USE ONLY

1.**Consent to Evaluate/Treat:** I voluntarily consent that I or my child will participate in a mental health(e.g. psychological or psychiatric) evaluation and/or treatment by staff from Wellpoint Care Network. 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 psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, 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 Counseling.

2.**Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me or my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's 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. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations. Wellpoint Care Network supports the training and teaching of mental health professionals. Students may be involved in the treatment delivery.

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. Fees are available to me upon request.

4.**Confidentiality, Harm, and Inquiry:** Information from my evaluation or my child's evaluation and/or treatment is contained in a confidential record at Wellpoint Care Network, and I consent to disclosure for use by Wellpoint Care Network staff for the purpose of continuity of my child's care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I or my child is deemed to present a danger to myself or himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3)if a court order is issued to obtain records.

5.**Discharge Policy:** Most clients are discharged because they have successfully met the goals of their treatment plan and are no longer in need of services. If at any time, an assessment indicates that other services would be more beneficial to you, a referral to another provider will be provided. There are circumstances under which my child may be involuntarily discharged. If I or my child are noncompliant with treatment or pose a threat to the staff or other patients, my child may also be discharged.

6.**Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

7.**Expiration of Consent:** This consent to treat will expire 12 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 treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

Signature of Client: _____ Date: _____
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: _____ Date: _____
(Required for Clients under age 18)

Witness Signature: _____Date: _____

Telehealth Informed Consent

MRN: _____
FOR OFFICE USE ONLY

Telehealth services involve the use of electronic communications (telephone, email, video conference, etc.) to enable therapists to provide services to individuals who may otherwise not have adequate access to care. Telehealth may be used for services such as individual, couples, or family therapy. Telehealth is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and may be minor depending on the needs of the client and the care with which the technology (cell phone, computer, etc.) is utilized. It is important that both the client and the therapist be in a place where there is the most privacy as possible during their sessions, and that the security of their technology be as up to date as possible with appropriate security protection.

Additional Points for Client Understanding

- I understand that telehealth services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the telehealth sessions will be recorded or photographed without my written permission.
- I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.
- My therapist has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telehealth sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the video conferencing telephone connections are not adequate for the situation.
- I understand that I may experience benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
- I understand that if there is an emergency during a telehealth session, as with an in-person session, my therapist will call emergency services and my emergency contacts if needed clinically necessary.
- I understand that in advance of the telehealth session a plan will be in place about how to re-connect if the connection drops while I am in a session.
- I understand that my therapist and I will create and have in place a safety plan in case of an emergency (see below).
- I understand I have the right to withhold or withdraw this consent at any time.
- I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment document. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction will not be shared without my written consent.

Consent

I consent to engaging in telehealth as part of my treatment with The Clinic at Wellpoint Care Network. I understand that "telehealth" includes the practice of health care delivery, diagnosis, transfer of personal health information via conversation, and psychoeducation using interactive audio, video, or data communications.

I understand the information provided above regarding telehealth. I have discussed the consent with my therapist and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

Signature of Client: _____ Date: _____
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: _____ Date: _____
(Required for Clients under age 18)

Witness Signature: _____Date: _____

Confidentiality Policy

MRN: _____
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It is the policy of Wellpoint Care Network that the information discussed with all parties during the course of treatment will be kept private. This means clinic staff may not discuss with anyone outside of Wellpoint Care Network the names of clients and family members they are working with.

However, there are instances when confidentiality cannot be maintained, such as:

1. A child or an adult reports a child has been abused or neglected (including sexual abuse or sexual activity between minors that is illegal), or clinic staff suspects abuse or neglect. In such instances, clinic staff are mandated by law to report the instance to Child Protective Services. Clinic staff must also report the incident to the case manager. It is not the responsibility of clinic staff to determine what constitutes "abuse" or "neglect". It is the responsibility and legal obligation of clinic staff to make a report.

2. A Child or an adult harms or threatens to harm another person. When threats are made, clinic staff are mandated by law to warn the person of the threat. Clinic staff must also report the incident to the care coordinator/case manager. A report to the authorities may also be made to ensure everyone's safety. A report to the authorities is made if a child or an adult harms another person.

3. A child or an adult threaten to harm herself/himself. Clinic staff are mandated to contact the authorities, must contact the case manager, and anyone else to ensure the person's safety.

4. Questionable physical punishment. It is not the responsibility of the Clinic staff to determine what constitutes appropriate and inappropriate punishment. It is the responsibility and legal obligation of Clinic staff to make a report to Child Protective Services. The case manager is also informed of the incident.

5. The legal guardian of a child or client, if an adult, signs a release of information form. Clinic staff is allowed to discuss the information discussed in sessions with certain individuals if given written permission.

Any questions regarding this policy may be directed to the VP of Clinical Services, Wellpoint Care Network at (414)463-1880.

I have received a copy of the Confidentiality Policy which has been explained to me. I understand the contents of each policy and have asked any questions I may have prior to signing this form.

Signature of Client: _____ Date: _____
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: _____ Date: _____
(Required for Clients under age 18)

Witness Signature: _____Date: _____

Information for Clients

MRN: _____
FOR OFFICE USE ONLY

The mission of Wellpoint Care Network is to provide innovative family-centered care and educational services that embrace diversity and empower children, families, and adults to improve the quality of their lives. Wellpoint Care Network is a dynamic provider advancing foster care, education, and mental health services. Wellpoint Care Network is a nonprofit organization providing counseling and psychotherapy for families. This sheet contains important information about our policies and procedures. Please read it carefully. Ask your therapist to answer any questions you may have.

Eligibility: Eligibility for Wellpoint Care Network mental health programs is based on the existence of a presenting problem. You may be referred to another community resource if you (1) do not meet the eligibility criteria; (2) there is not enough staff time available to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insurance company has another counseling resource for you. After you begin working with Wellpoint Care Network, services may continue; (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals. The agency may discontinue services if: (1) all treatment goals have been met; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern of regularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Appointments: Appointments are scheduled with individual therapists. A therapy hour consists of a one 45-60 minute meeting with your therapist. If you need to cancel an appointment, please do so at least 24 hours in advance. You, not your insurance, will be billed for missed appointments.

Hours: The agency is open Monday through Friday 8:00 a.m. to 7:00 p.m. Evening hours are available by appointment.

Consultants: Your therapist collaborates with other licensed therapist in his/her clinical work. Your therapist also has a supervisor who may be contacted if you have questions or concerns. The supervisor will meet with you when necessary or at your request.

Confidentiality: All contacts between staff and clients are strictly confidential and will not be revealed to any person or agency outside of Wellpoint Care Network, without your written consent. The primary exception to this rule is those situations in which reporting is mandatory under Wisconsin law (e.g. child abuse, child neglect, sexual abuse, etc.). In addition, please note that your signature on the fee agreement give the agency permission to release information necessary for the processing of claims for payment.

Emergencies: In an emergency, you may call the office 24 hours, 7 days a week at 414-465-5770 to speak to your/a therapist. During non-working hours our answering system instructs you on how to contact a therapist and other emergency services. Following are a list of additional numbers to call in the event of an emergency:

Wellpoint Clinic On-Call	**Milwaukee County Crisis Line**	**Cope Services**
414-531-1407	**414-257-7222**	**262-377-2673**

My signature below indicates that I have been given a copy of this information sheet, **"Information for Clients",** the **"Client Rights and the Grievance Policy"**, and the **"HIPAA Notice of Privacy Practices"**. For Clients age 12 – 17, I have been given a copy of the **"Rights of Children and Adolescents in Outpatient Mental health Treatment**". I understand the contents of each policy and have asked any questions I may have prior to signing this form.

Signature of Client: _____ Date: _____
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: _____ Date: _____
(Required for Clients under age 18)

Witness Signature: _____Date: _____

In the case that written acknowledgement could not be obtained, please provide reason here: _____

Staff Signature: _____ Date: _____

Informed Consent for In-Person Services During Covid-19 Public Health Crisis

MRN: _____
FOR OFFICE USE ONLY

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face: We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet virtually. If you have concerns about meeting virtually, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to virtual visits for everyone's well-being. If you decide at any time that you would feel safer staying with, or returning to, virtual visits, I will respect that decision, as long as it is feasible and appropriate.

Risks of Opting for In-Person Services: You understand that by coming to the office or meeting with me in the community or your home, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure: To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, other staff and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting/returning to a virtual visit arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time, if you are coming to meet with me in the office.
- You will wash your hands or use alcohol-based hand sanitizer prior to meeting with me or when you enter the office.
- You will adhere to the safe distancing precautions we have set up in the waiting room and appointment room. For example, you won't move chairs or sit where we have signs asking you not to sit.
- You will wear a mask when meeting with me (I and my staff will too).
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me or staff.
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands.
- If you are with child(ren), you will make sure that the child(ren) follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID-19.
- If you have a job that exposes you to other people who are infected, you will immediately let me know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know.
- If you or a resident of your home tests positive for the infection, you will immediately let me know and we will then begin/resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure: Wellpoint Care Network has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick: You understand that I am committed to keeping you, me, other staff and all of our families safe from the spread of this virus. If you show up for an in-person visit and I or other staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require us to discontinue our in-person visit. We can follow up with services virtually as appropriate. ***If I test positive for the coronavirus, I will notify you so that you can take appropriate precautions.***

Your Confidentiality in the Case of Infection: If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent: This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together. Your signature below shows that you have read this form and agree to these terms and conditions.

Signature of Client: _____ Date: _____
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: _____ Date: _____
(Required for Clients under age 18)

Witness Signature: _____Date: _____

Permission to Observe

MRN: _____
FOR OFFICE USE ONLY

Wellpoint Care Network participates in clinical education programs with area colleges and universities to give students engaged in a course of study related to a therapeutic career, including interns gaining experience in clinical practice.

By granting permission for a master's degree counseling student to observe and participate in my/my child's counseling sessions, I understand:

- I/My child will continue to meet with my clinician that has been assigned and my/my child's identity and all related information will remain confidential.
- A master's degree counseling student will observe and participate in my counseling sessions for the purpose of observation and participation to assist in his/her professional training.
- I can revoke this permission at any time by verbal or written request to the clinician.
- My decision to agree or disagree with this request will have no effect on services provided.

Do you grant permission to observe as stated above?

☐ I do grant permission.
☐ I do NOT grant permission.

Signature of Client: _____ Date: _____
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: _____ Date: _____
(Required for Clients under age 18)

Authorization for Release of Information

MRN: _____
FOR OFFICE USE ONLY

SECTION 1: Person Whose Records Will be Released
Name: _____ **Date of Birth:** _____ **Phone:** _____
Address: _____ **City:** _____ **State:** _____

SECTION 2: Release type: (Check one) ☐Release To ☐Obtain From ☒Exchange information
SECTION 3: Release Format: ☒Verbal ☒ Written

Section 4: Agency/Organization Making Disclosure
Wellpoint Care Network, Inc.
8901 W. Capitol Drive
Milwaukee, WI 53222
(414) 465-5770

SECTION 5: Agency/Organization I Authorize to Release Information
Agency/Professional: _____
Address: _____
City, State and Zip: _____
Phone: _____ **Email:** _____

SECTION 6: Dates of records being requested (if applicable): _____
SECTION 7: Type of records being requested:
I understand that the information may include diagnosis, prognosis, and/or treatment for physical, mental disorder, developmental disabilities, alcohol/drug abuse, or HIV results (excludes psychotherapy notes as defined in 45 CFR 164.501)

☐ Letter/Treatment	☐Summary Psychosocial History	☐Discharge Summary
☐Therapy Progress Reports	☐Psychiatric/ Psychological Evaluations	☐Prescriptions/Medications
☐Academic Progress Reports	☐Alcohol/Drug Abuse	☐Physical Examination
☐All	☐ Other (specify) _____	

SECTION 8: Purpose or need for information: This authorization will expire in one year from date of signature unless otherwise specified: _____

PATIENT RIGHTS PERTAINING TO THIS AUTHORIZATION

Right to revoke this authorization: I understand that I may revoke this authorization, in writing, at any time except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration time I have indicated and initiated above.

Right to receive a copy of this authorization: I understand that I have a right to receive a copy of this authorization.

Right to know potential for re-disclosure: I understand that the health information disclosed as a result of this authorization may no longer be protected by federal privacy standards and my health information might be re-disclosed without my authorization.

Right to receive a copy of records to be released: The patient who is the subject of the records covered by this authorization, in most cases, has the right to inspect and receive a copy of the material to be disclosed pursuant to this consent form. This authorization form is intended to be in conformance with Section 51.30(4)(d), Wisconsin Statutes and Sections HFS 92.03(3)(d) and 92.06, Wisconsin Administrative codes.

AODA records: Whenever records or communications concern alcohol and drug abuse (AODA), the release of such records will be in accordance with and under protection of 42 CFR, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records, which state: AODA treatment records which have been discloses are protect4ed by Federal Laws. Federal Regulation (42CFR Part 2) prohibits you from making any further disclosure without specific written consent, conforming to 2.31 of these regulations, of the person to whom these records pertain. The general authorization for the release of medical or other information is not sufficient for this purpose.

Right to refuse to sign this authorization: I understand that I am under no obligation to sign this form and that treatment, payment, enrollment in health plan, or eligibility for health care benefits may not be contingent on my signing this authorization.

I authorize the release of copies of any medical treatment records accumulated after my signature through the expiration date of this consent form.

Signature of Client: _____ Date: _____
(Required for Clients age 14 and older)

Signature of Parent/Legal Guardian: _____ Date: _____
(Required for Clients under age 18)

Witness Signature: _____Date: _____

Client Copy

Mental Health Services Welcome Letter

New Client Information

Welcome to our clinic! We understand that the amount of paperwork presented for review and signatures during the first session can be overwhelming. We urge you to let us know if you need a break or if you have any questions as you complete the required paperwork. We thank you for your patience.

Forms

Enclosed you will find several items for your review. You may keep the following documents for your records:

- HIPPA Notice of Privacy Practices
- Client Rights and Grievance Policy
- Confidentiality Policy
- Information for Clients
- Rights for Minors (for clients age 14 - 17)

Please review and sign all paperwork prior to your first appointment. If you are seeing a therapist in-person, please bring the completed packet with you to your first appointment.

Contacts numbers

You may call the clinic number at 414-465-5770 to make an appointment. Clients may also call this number to speak to someone in the case of a mental health crisis. Additional support numbers are listed under emergency coverage on the back of the Informed Consent. **Always, in the case of an emergency, dial 911.**

Fees

We at Mental Health Services are committed to providing services for all clients in need. Our standard fees follow. (Separate charges apply for any testing or additional assessments.)

80-Minute Initial Assessment $225 - $260
60-Minute Individual Session $200 - $225
50-Minute Family Session $175 - $200

You may be assessed a $25 charge for late cancellations and missed appointments. Exceptions to this policy will be made at the therapist discretion.

Payment

We accept most forms of Medicaid and many private insurances. **Please contact your insurance company to verify coverage of our services**. We will submit claim forms to your insurance company, but we cannot guarantee that they will provide payment. You are responsible for any charges not covered. If you are uninsured or your insurance does not cover our services, payment is expected at time of service unless other arrangement is made in advance. Co-Payments are also due at the time of service.

If you don't have insurance and you are unable to pay the full charge for services, you may ask the receptionist about applying for our discount sliding fee and/or billing plan.

Clinic Hours

Clinic hours are Monday – Friday 8 a.m. to 7 p.m.

We look forward to working with you!

Sincerely,
Jody Pahlavan, Psy.D.
Vice President of Clinical Services

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Confidentiality Policy

Client Copy

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However, there are instances when confidentiality cannot be maintained, such as:

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3. A child or an adult threaten to harm herself/himself. Clinic staff are mandated to contact the authorities, must contact the case manager, and anyone else to ensure the person’s safety.
4. Questionable physical punishment. It is not the responsibility of the Clinic staff to determine what constitutes appropriate and inappropriate punishment. It is the responsibility and legal obligation of Clinic staff to make a report to Child Protective Services. The case manager is also informed of the incident.
5. The legal guardian of a child or client, if an adult, signs a release of information form. Clinic staff is allowed to discuss the information discussed in sessions with certain individuals if given written permission.

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Information for Clients

Client Copy

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Wellpoint Clinic On-Call	Milwaukee County Crisis Line	Cope Services
414-531-1407	**414-257-7222**	**262-377-2673**

Client Copy

Client Rights and Grievance Policy

Policy Statement:
All children, parents and guardians have the right to file a grievance expressing dissatisfaction with treatment received, disposition of a consequence and/or dissatisfaction with services offered. Suggestions for changes in policy are also dealt with through grievance procedures.

Procedure:
Before using the grievance procedure, clients/parents/guardians are encouraged to discuss perceived problems with staff. If the problem cannot be resolved at this level, then the following procedure is to be followed:

1.The complainant contacts the Director of Quality Outcomes to report his/her complaint (8901 W. Capitol Dr. Milwaukee, WI 53222 800-840-1880) Upon enrollment into a program, a client/parent/guardian is given a copy of the grievance policy and procedures along with a copy of the grievance form. Additional copies of the procedure and form are provided to the client/parent/guardian upon need. However, a client or parent/guardian receiving services from any program may choose to file a grievance using Wellpoint Care Network's grievance procedure independent or as an augmentation to any other state or contracted procedures.
2.If complainant is a minor, legal guardians are informed of the nature of the complaint and the process for resolution. A copy of the complaint will also be placed in the client's file. This is done within 24 hours of the initial complaint.
3.Complainant must fill out the "nature of grievance" section on the Client Grievance Form. If the complainant requires assistance in completing this form, the Director of Quality Outcomes will provide assistance as necessary.
4.Within 48 hours of writing of "Nature of Complaint" a meeting is held between the complainant and the director/coordinator of the program in which the problem occurred. The director/coordinator of the program provides a typed summary of the meeting to the Director of Quality Outcomes, including steps taken to ensure an appropriate resolution.
5.If the complaint was unable to be resolved, a meeting will be held between the complainant, Division Director and ultimately the President and Chief Executive Officer.
6.Every attempt will be made to resolve the grievance within a two-week period. When the complaint is resolved the "response" section of the Grievance Form will be completed by the Director of Quality Outcomes after he/she is notified of the resolution by the program director/coordinator and/or Division Director. A copy will begiven to the client as well as placed in the client's permanent file.
7.The CQI committee will review grievances on a quarterly basis and the governing body will review resolution of client grievances annually. (Identifying information will be alerted to protect client confidentiality).

Wellpoint Care Network assumes responsibility in providing the resources necessary (e.g., interpretive services, TDD phone line, etc.) in order to effectively and appropriately communicate this process.
In the event that the grievance has not been resolved to the client's satisfaction, the Director of Clinical Services will refer the issues to the appropriate party (Director of Quality Outcomes, Wellpoint Care Network Chief Clinical Officer, etc.) for resolution.

GRIEVANCE PROCEDURE: Wellpoint Care Network shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance. At anytime a complaint occurs, the client or other complainant shall be provided with a copy of the agency's Client Grievance and Requests for Administrative Review Policies and Procedures. Program staff shall be familiar with client rights and with these agency procedures. The program staff and their supervisor will forward the complaint to the local Clients Rights Specialist.
No sanctions will be threatened or imposed against any client who files a grievance, or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filling a grievance of participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.
If you have a concern about the services you are receiving, you are encouraged to discuss it with your therapist. If this does not resolve the issue, you may present a written complaint to the Program Supervisor or Clinic Administrator. If you are still not satisfied, please request a written copy of the Grievance Procedure.

CLIENT ACCESS TO RECORDS: Under Wisconsin law, you have a right to review your treatment records. Ask your therapist for the procedures used in sharing your file with you. If you feel that it contains incorrect information, ask your therapist for the procedure used to request a change in record information.

FEE POLICY: A fee is charged for professional services provided by the therapists at Wellpoint Care Network (please refer to the Fee Policy & Fee Agreement). If you have private insurance or medical assistance, we will bill for services at the established rate. If you do not have insurance, or if our insurance does not pay in full, you will be responsible for paying the rate established on

your Fee agreement. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.
If you are receiving services under managed care, health insurance, medical assistance, or an EAP, the agency will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes Wellpoint Care Network to release any information necessary to process insurance claims

Your Client Rights Specialist is: Director of Quality Improvement, Wellpoint Care Network, Inc., 8901 W. Capitol Drive, Milwaukee, WI 53222 Phone: 414-463-1880

Parental Rights

As parents who have a child in one of Wellpoint Care Network's treatment programs, you and your child have a right to:

- be treated with respect and dignity at all times
- participate in the treatment decision-making process
- expect a safe, clean environment
- speak and visit with your child as frequently as permitted by the treatment plan
- to meet with the treatment team or contact individual members of the Team to discuss goals, interventions, and progress
- be informed of any injury, illness, runaway or other significant occurrences within a reasonable period of time

Parents/guardians are informed of and receive a copy of these rights upon enrollment into a program. If there is a need to address any special communication or language barriers, Wellpoint Care Network, assumes responsibility in providing the resources necessary (e.g., interpretive services, TDD phone line, etc.) in order to effectively and appropriately communicate these rights.

Statement of Children's Rights

As an organization we believe every child, no matter the level of program involvement, is entitled to the following:

1. The right to enjoy freedom of thought, conscience, and religion.
2. The right to reasonable enjoyment of privacy.
3. The right to receive non-coercive service that protects the person's right to self-determination.
4. The right to have his/her parents or guardians, family members, and his/her opinions heard and to be included, to the greatest extent possible, when any treatment decisions are being made affecting his or her life.
5. The right to receive appropriate and reasonable adult guidance, support and supervision.
6. The right to be free from physical abuse and inhumane treatment. Every child has the right to be protected from all forms of sexual exploitation.
7. The right to receive adequate and appropriate medical care.
8. The right to receive adequate and appropriate food, clothing and housing.
9. The right to live in clean, safe surroundings.
10. The right to receive an educational program, which will maximize his/her potential.
11. The right to communicate with “significant others”. “Significant others” include family members and close friends whom the family has approved.

Clients are informed of and receive a copy of these rights upon enrollment into a program. If there is a need to address any special communication or language barriers, Wellpoint Care Network assumes responsibility in providing the resources necessary (e.g., interpretive services, TDD phone line, etc.) in order to effectively and appropriately communicate these rights.

The caregiver and child should receive a copy of this document.

HIPAA Notice of Privacy Practices

Client Copy

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You May Receive Access To This Information.
Please Review It Carefully.

Our Commitment to You

Wellpoint Care Network is committed to maintaining the privacy of your health information. During your treatment with us, physicians, nurses, and other personnel may collect information about your health history and your current health status. This Notice explains how that information, called "Protected Health Information" may be used and disclosed to others. The terms of this Notice apply to health information produced or obtained by Wellpoint Care Network.

Our Legal Duties

The HIPAA Privacy Law requires us to provide this Notice to you regarding our privacy practices, our legal duties to protect your private information and your rights concerning health information about you. We are required to follow the privacy practices described in this Notice whenever we use or disclose your protected health information (PHI). Other companies or persons that perform services on our behalf, called Business Associates, must also protect the privacy of your information. Business Associates are not allowed to release your information to anyone else unless specifically permitted by law. There may be other state and federal laws, which provide additional protections related to communicable disease, mental health, substance or alcohol abuse, or other health conditions.

Your Health Information May Be Used and Disclosed

The HIPAA Privacy Law permits Wellpoint Care Network to make uses and disclosures of your health information for purposes of treatment, payment and health care operations.

- **Treatment:** We will use and may share health information about you for your health care and treatments. For example, a nurse or medical assistant will obtain treatment information about you and record it in a medical record. Alternatively, one of our physicians may use information about you for a consultation with, or a referral to, another physician to diagnose your illness and determine which treatment option, such as surgery or medication, will best address your health needs. Except in emergency circumstances, we will make a "good faith effort" to get your permission prior to making disclosures outside Wellpoint Care Network for treatment purposes.
- **Payment:** We may use and disclose health information about you to obtain payment for the care and services that we have provided to you. For example, we may need to provide your health plan provider with information about you, your diagnosis, and the treatment provided to you at Wellpoint Care Network so that your health insurer will pay us, or reimburse you, for the treatment. We may also contact your health insurance to obtain prior approval about a potential treatment.
- **Health Care Operations:** We may use and share health information about you for Wellpoint Care Network's health care operations, which include planning, management, quality assessment, and improvement activities for the treatments that we deliver. For example, we may use your health information to evaluate the skills of our physicians, nurses, and other health care providers in caring for you. We also may use your information to review quality and health outcomes. We will obtain your written permission before making disclosures to others outside Wellpoint Care Network for health care operations purposes.
- **Appointment Reminders:** We may use and disclose PHI to contact you for appointment reminders and to communicate necessary information about your appointment.
- **Health-Related Benefits, Services and Treatment Alternatives:** We may also contact you about new or alternative treatments or other health care services. For example, we may offer to mail to you newsletters, coupons, or announcements.
- **People Assisting in Your Care:** In certain limited situations, Wellpoint Care Network may disclose essential health information to people such as family members, relatives, or close friends who are helping care for you or helping you pay your health care bills. We will disclose information to them only if these people need to know the information to help you. For example, we may provide limited information to a family member so that they may pick up a prescription for you. Generally, we will ask you prior to making disclosures if you agree to such disclosures. If you are unable to make health-related decisions or it is an emergency, Wellpoint Care Network will determine if it would be in your best interest to disclose pertinent health information about you to the people assisting in your care.
- **Research:** Federal law permits Wellpoint Care Network to use or disclose health information about you for research purposes, if the research is reviewed and approved by an Institutional Review Board to protect the privacy of your health information before the study begins. We may disclose your information if we have your written authorization to do so. In some instances, researchers may be allowed to use information about you in a restricted way to determine whether the potential study participants are appropriate. We will make a "good faith effort" to acquire your permission or rejection to participate in any research study prior to releasing any protected information about you.
- **As Required by Law:** We must disclose health information about you if federal, state, or local law requires us.

• **Serious Threat to Health or Safety:** Consistent with applicable laws, we may disclose your PHI if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
• **Public Health Risks:** As authorized by law, we may disclose health information about you to public health or legal authorities whose official responsibilities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- 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.

• **Organ and Tissue Donation:** Consistent with applicable law, we may release your health information to organ procurement organizations or others engaged in the transplantation of organs to enable a possible transplant.
• **Specialized Government Functions:** If you are a member of the military or a veteran, we will disclose health information about you as required by command authorities; or if you give us your written permission. We may also disclose your health information for other specialized government functions such as national security or intelligence activities.
• **Employers:** We may release health information to your employer if we provide health treatment to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will provide you with written notice of such information disclosure. Any other disclosures to your employer will be made only if you sign a specific authorization for the release of that information.
• **Health Oversight Activities:** We must disclose health information to a health oversight agency for activities that are required by federal, state or local law. Oversight activities include investigations, inspections, industry licensures, and government audits. These activities are necessary to enable government agencies to monitor various health care systems, government programs, and industry compliance with civil rights laws. Most states require that identifying information about you, such as your social security number, be removed from information releases for health oversight purposes, unless you have provided written permission for the disclosure.
• **Lawsuits and Disputes:** If you are involved in a lawsuit, dispute, or other judicial proceeding, we may disclose health information about you in response to a court order or subpoena, other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
• **Law Enforcement:** We may disclose your health information to a law enforcement official if required or allowed by law, such as for gunshot wounds and some burns. We may also disclose information about you to law enforcement that is not a part of your health record for the following reasons:

- To identify or locate a suspect, fugitive, material witness, victim of a crime, or missing person
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our location
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

• **Correctional Facilities:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official only as required by law or with your written permission. We may release your health information for your health and safety, for the health and safety of others, or for the safety and security of the correctional institution.
• **Coroners, Medical Examiners, and Funeral Directors:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duties.
• **Required by HIPAA Law:** The Secretary of the Department of Health and Human Services (HHS) may investigate privacy violations. If your health information is requested as part of an investigation, we must share your information with HHS.

<u>Situations in Which Your Health Information May Be Disclosed with Your Written Consent</u>
For any purpose other than the ones described above, we may only use or share your health information when you give us your written authorization to do so. For example, you will need to sign an authorization form before we can send your health information to your life insurance company. You may revoke an authorization at any time.
• **Marketing:** We must also obtain your written authorization before using your health information to send you any marketing materials. The only exceptions to this requirement are that: We can provide you with marketing materials in a face-to-face

encounter or a promotional gift of very small value, if we so choose we may communicate with you about products or services relating to your treatment, to coordinate or manage your care, or provide you with information about different treatments, providers or care settings.

• **Highly Confidential Information:** Federal and state law requires special privacy protections for certain "Highly Confidential Information" about you, including any part of your health information that is about:

- Child abuse and neglect
- Domestic abuse of an adult with a disability
- Mental illness or developmental disability treatment or services
- Alcohol or drug dependency diagnosis, treatment, or referral
- HIV/AIDS testing, diagnosis, or treatment
- Sexually transmitted disease
- Sexual assault
- Genetic testing
- In Vitro Fertilization (IVF)
- Information maintained in psychotherapy notes

Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.

<u>Your Rights Regarding Health Information We Maintain About You</u>

• **Right to Inspect and Copy**: You have the right to inspect and receive a copy of your PHI. A request to inspect your records may be made to your therapist or to the For PHI in a designated record set that is maintained in an electronic format, you can request an electronic copy of such information. There may be a charge for copies of your PHI.

• **Right to Request Amendment:** If you believe that any health information we have about you is incorrect or incomplete, you have the right to ask us to change the information, for as long as Wellpoint Care Network maintains the information. To request an amendment to your health information, your request must be in writing, signed, and submitted to Wellpoint Care Network. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be maintained with your records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

• **Right to Request Restrictions on Use and Disclosure:** You have the right to request a restriction or limitation on certain uses and disclosures of your health information.

To request restrictions, you must make your request in writing to Wellpoint Care Network. In your request, you must tell us:

- What information you wish to limit
- Whether you wish to limit our use, disclosure, or both
- To whom you want the limits to apply – for example, if you want to prohibit disclosures for insurance payment, health care operations, for disaster relief purposes, to persons involved in your care, or to your spouse.

You or your personal representative must sign it.

*We are not required to agree to your request***,** but we will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.

• **Right to an Accounting of Disclosures:** With some exceptions, you have the right to receive an accounting of certain disclosures of your PHI. Your accounting request must be in writing and signed by you or your personal representative and submitted to Wellpoint Care Network. Your request must specify the time in which the disclosures were made. These disclosures may not go back further than six years from the date of the request.

• **Right to Request Alternate Communications:** You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box. *You must submit your request in writing to The Clinic at Wellpoint Care Network.* We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

• **Right to Receive a Copy of this Notice:** You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

• **Right to Cancel Authorization to Use or Disclose:** Other uses and disclosures of your health information not covered by this Notice or the laws that govern us will be made only with your written authorization. You have the right to revoke your authorization in writing at any time, and we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you.

For further information: If you have questions, or would like additional information, you may contact the HIPAA Compliance Officer at Wellpoint Care Network

To File a Complaint: You may submit any complaints with respect to violations of your privacy rights to Wellpoint Care Network. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from Wellpoint Care Network for making a complaint.

Changes to this Notice: If we make a material change to this Notice, we will provide a revised Notice available at our reception desk or on our website.

Contact Information: Unless otherwise specified, to exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact the HIPAA Compliance Officer, Charity Bower at 414-463-1880 or cbower@wellpoint.org.

Effective Date: This Notice is effective as of June 1, 2018.

Treatment Rights

You must be provided prompt and adequate treatment.

If you are **14 years or older**, you can refuse mental health treatment until a court orders it.

You must be told about your treatment and care.

You have the right to and are encouraged to participate in the planning of your treatment and care.

You and your relatives must be informed of any costs they may have to pay for your treatment.

Record Access and Privacy Rights

Staff must keep your treatment information private (confidential). However, it is possible that your parents may see your records.

If you want to see your records, ask a staff member.

If you are **younger than 14-years-old**, you must view your records in the presence of a parent/guardian, attorney, judge, or staff member. You may always see your records on any medications you take.

Regardless of your age, staff may limit how much you may see of your records. They must give you reasons for any limits.

If you are **at least 14-years-old**, you can consent to releasing your own mental health treatment records to others.

If you are **at least 12-years-old**, you can consent to releasing your substance use treatment records to others.

Personal Rights

You must be informed of your rights.

Reasonable decisions must be made about your treatment and care.

You cannot be treated unfairly because of your race, national origin, sex, gender expression, religion, disability or sexual orientation.

Patient Rights Help

If you want to know more about your rights or feel your rights have been violated, you may do any of the following:

- **Contact patient rights staff.** Their contact information should be provided to you by your treatment provider. Treatment providers should also list this information on a poster.
- **File a complaint.** Patient rights staff will look into your complaints. They will keep your complaints private (confidential); however, they may need to ask staff about the situation.
- **Contact Disability Rights Wisconsin.** They are the protection and advocacy organization for Wisconsin. Their advocates and attorneys can help you with patient rights questions. Call **608-267-0214** or **800-928-8778**.

For more information, visit:
www.dhs.wisconsin.gov/clientrights/minors

Wisconsin Department of Health Services
Division of Care and Treatment Services
P-20470B (06/2021)

Client Copy

WISCONSIN DEPARTMENT *of* HEALTH SERVICES

Rights Of Minors

Outpatient Behavioral Health Treatment

Information about the legal rights of children and adolescents in outpatient mental health and substance use treatment

Client Copy

Consent for Mental Health Treatment

If you are younger than 14-years-old, a parent or guardian must agree, in writing, to you receiving outpatient mental health treatment.

If you are 14 years or older, you and your parent or guardian must agree to you receiving outpatient mental health treatment.

If you want treatment but your parent or guardian is unable to agree to it or won't agree to it, you (or someone on your behalf) can petition the county mental health review officer for a review.

If you do not want treatment but your parent/guardian does, the treatment director for the clinic where you are receiving services must petition the mental health review officer for a review.

Regardless of your age, in an emergency, the treatment director for the clinic may allow you to receive outpatient mental health treatment, but no medication, for up to 30 days.

During the 30 days, the treatment director must get informed written consent of your parent or guardian, or file a petition for review for admission with the Mental Health Review Officer.

Review by Mental Health Review Officer and/or Court

Each juvenile court appoints a mental health review officer for their county. Find the mental health review officer for your county at: www.dhs.wisconsin.gov/clientrights/mhros

The juvenile court must ensure that you are provided any necessary assistance in the petition for review.

If you request it and the mental health review officer believes it is in your best interests, review by the mental health review officer can be skipped and the review will be done by the court (judicial review).

If the **mental health review officer** does the review, a hearing must be held within 21 days of the filing of the petition for review, and everyone must get at least 96 hours (4 days) notice of the hearing.

To approve your treatment (against your will or despite the refusal of your parent/guardian) the mental health review officer must find that all these are true:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

If you disagree with the decision of the mental health review officer, you and your parent/guardian will be informed of the right to a judicial review.

If the **court** does the review, within 21 days of the mental health review officer's ruling, you (or someone acting on your behalf) can petition the juvenile court for a judicial review.

A court hearing must be held within 21 days of the petition, and everyone must get at least 96 hours (4 days) notice of the hearing.

If you do not want the treatment, the court must appoint you an attorney at least 7 days prior to the hearing.

If it is your parent/guardian who does not want the treatment and you do not already have a lawyer, the court must appoint you one.

To approve your treatment (against your will or despite the refusal of your parent/guardian), the judge must find that all these are true:

- The refusal of consent is unreasonable.
- You are in need of treatment.
- The treatment is appropriate and least restrictive for you.
- The treatment is in your best interests.

A court ruling does not mean that you have a mental illness.

The court's ruling can be appealed to the Wisconsin Court of Appeals.

Consent for Substance Use Treatment

Any minor can consent to substance use treatment at a public facility as long as it is for prevention, intervention, or follow up.

If you are **younger than 12-years-old**, you may only get limited substance use treatment (such as detox) without a parent or guardian's consent.

If you are **12-years-old or older**, you can be provided some limited treatment (assessment, counseling, and detox less than 72 hours) without your parent or guardian's consent or knowledge.

If your parent or guardian agrees to it, you can be required to participate in substance use treatment, including assessment and testing.