wellpoint care network

SUBMIT COMPLETED FORM TO INTAKE@WELLPOINTCARE.ORG

BEHAVIORAL HEALTH INTAKE-ADULT

Legal Name: _____ **Preferred Name:** _____ **Pronouns:**_____

DOB: _____ **Age:**_____ **Gender:**_____ **Race:**_____ **Ethnicity:**_____

Primary Language: _____ **Military Status:** **Disability Status:** _____

Marital Status: _____ **Translation/Accommodation Needs:** _____

Living Arrangement: _____ **Employment Status:** _____

Annual Household Income: _____ **Family Size:** _____ **Education:**_____

Address: _____ **City, State, Zip:** _____

Phone: _____ **Secondary Phone:** _____ ☐**N/A**

Email: _____ **Best Time to Contact:** _____

Emergency Contact: _____ **Phone:** _____ **Email:** _____

I would like _____ **to be involved in my treatment planning** ☐ ROI completed & signed

Individual has: ☐Advanced Directive ☐Healthcare POA ☐Supported Decision-Making Agreement ☐Guardianship

Other Program Involvement: ☐Child & Family Well-being ☐ Family Preservation ☐CCS ☐Adult Services-Other_____
☐N/A ☐Previous ☐Current- if current complete below:

Case Manager: _____ **Phone:** _____ **Email:** _____

Placement: _____ **Phone:** _____ **Email:** _____

Insurance/Payment Information **required-if uninsured, please contact our office for support**

Insurance Type: **Plan:** **Card Holder:** _____**DOB:** _____

Member ID: ___ _____ **Group #:** _____ **Only Insurance?** ☐ Yes ☐No-add below

Insurance Type:_____ **Plan:** _____ **Card Holder**: _____**DOB:** _____

Member ID: _____ **Group:**_____

Referral Details

Referral Source: _____ **Referral Type:** _____ **Contact (optional):** _____

Check any areas of concern:

☐Attention/Learning ☐Relationships ☐Social Emotional ☐Anger/Outbursts ☐Defiant/Oppositional ☐Abuse
☐Loss/Trauma ☐Self injury ☐Suicide Ideation ☐Previous Suicide Attempt ☐Impulsive Behaviors ☐Depression ☐Anxiety
☐Identity/Gender ☐Marijuana Use ☐Tobacco Use ☐Alcohol Use ☐ SU-Other

Service Interest: ☐Individual ☐Family ☐Group ☐Art/Play ☐Medication Management ☐ Telehealth/Virtual

Reason for Referral: _____

_____

Safety Screen

☐Current Safety Concerns, thoughts of harming themselves or others:☐Intent ☐Ideation ☐Plan

☐Previous Suicide attempt Date(s):_____

If present, call 414-465-5770 for a risk assessment or 988 the 24/7 crisis line

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Medical History

Primary Dr. Name/Facility: _____ **Contact:** _____ ☐No GP

Last Known Weight: _____ **Height:** _____ **Blood Pressure:** _____/_____

Are immunizations up to date? ☐Yes☐No Recent Dental Exam? ☐Yes☐No

Care Navigators are available to assist with resources to coordinate the above services

Allergies: _____ ☐ Carries an Epi-pen

Currently pregnant? ☐No ☐Unknown ☐Not Capable of Being Pregnant ☐Yes _____

Current Medications & Supplements:

Medication	*Dosage/Frequency*	*Prescribing Dr.*	*Symptoms Addressing*

Previous Behavioral Health Treatment and Diagnosis:

Type (therapy, hospitalization)	*Facility*	*Diagnosis*	*Dates:*

Family History

Diagnosis	*Family Member(s)*	*Diagnosis*	*Family Member(s)*
Substance Use Disorder		PTSD	
Anxiety		Intellectual/Learning	
Bipolar		Developmental	
Schizophrenia		Speech Disorder	
Depression		Attachment Disorder	
ADHD		Anorexia/Binge Eating	
Autism		OCD	

Medical Checklist:

☐Night Terrors ☐Constipation ☐Overweight ☐Sensory issues ☐Always Cold/Hot ☐Headaches ☐ Immunodeficiency ☐Thyroid disorder ☐Premature Birth ☐Autism	☐Wakes Often ☐Diarrhea ☐ Pica ☐Joint Pain ☐Excessive Thirst ☐Dizziness ☐Diabetes Type I ☐Neuropathy ☐TBI/Stroke ☐ADHD	☐Bedwetting ☐Incontinence ☐Nausea/Vomiting ☐Allergies ☐Light Sensitivity ☐Asthma ☐Diabetes Type II ☐Anemia ☐Developmental/ Speech Delay	☐Fatigue ☐Lack of appetite ☐Skin Problems ☐Blurred Vision ☐Bruising/Bleeding ☐Seizure disorder ☐Cancer ☐Celiac Disease ☐Cardiac Abnormality ☐FASD	☐Abnormal yawning ☐Underweight ☐Disordered Eating ☐Gerd/Reflux ☐High/Low BP ☐Tic Disorder ☐Kidney problems ☐Substance abuse Other:_____ _____

Name:_____
DOB:_____

Consent for Behavioral Health Treatment

Consent for Treatment: Behavioral Health treatment at Wellpoint Care Network is voluntary. The following information will outline the expectations of behavioral health treatment and allow you to make informed consent to treatment. You may revoke your consent at any time by providing a written request to your treating clinician. Unless revoked, this consent will expire 15 months after the date it is signed. Wellpoint Care Network utilizes a person-centered approach to treatment by working collaboratively with the person receiving care to develop a treatment plan. Prior to any changes in treatment, you will be provided the following information: a) The type of treatment recommended including manner, frequency and expected length of treatment, b) The possible benefits and desired outcomes of treatment c) Possible risks or side effects from treatment and alternative treatment options, d) Possible consequences of not receiving treatment. Clinicians will review information in your preferred communication method, if none specified information will be communicated verbally.

Client Rights and Responsibilities: Wellpoint Care Network is committed to providing high quality, equitable care to all individuals. A copy of Wellpoint Care Network's *Client Rights and Grievances Policy*, along with *Rights of a Minor in Outpatient Behavioral Health* and *Clinic Information* will accompany this document. If an issue arises please contact the Clinic Manager.

Clinician Competency: Behavioral Health evaluation and/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 is conducted within the boundaries of Wisconsin Law and Department of Health Behavioral Health Certification. Wellpoint Care Network supports the training and teaching of mental health professionals, students will only be involved in your treatment delivery if individual provides separate consent.

Charges: Service fees are based on the length and type of care; a list of fees is located in the Clinic Information Document. As a courtesy our clinic verifies insurance benefits, however, this is not a guarantee, and individuals should always call their insurance company to review and understand benefits prior to starting services. You will be responsible for any charges not covered by insurance, including unmet deductible, co-insurance, co-payment, and non-covered charges from your insurance. If your insurance changes, you must provide updated insurance information prior to your appointment, or you will be responsible for the entire session cost. A $25 fee will be charged for appointments missed/canceled without 24 hours notice. If you wish to self-pay for services, you will receive a 20% discount and a Good Faith Estimate/Self-Pay Waiver prior to services.

Financial Agreement: Payment is expected at the time of your visit. We accept cash, check, or credit card. If you are unable to pay your balance due at time of service, you must speak with a member of our staff about payment options. Wellpoint Care Network offers payment plans and Financial Assistance for those facing financial hardship. Financial assistance does not replace other funding sources. If an individual is eligible for Medicaid, they must work with a care navigator to apply for coverage. Financial assistance will only remain active if care navigation expectations are fulfilled.

Notice of Privacy Practices: Protected health information(PHI) is contained in a confidential Electronic Health Record. Wellpoint Care Network does not release PHI without the individual and/or guardian's consent, except in situations permitted by State and Federal regulations, including but not limited to; healthcare operations, the ability to bill your insurance company, a threat to safety of self/others, child abuse/neglect concerns. Wellpoint Care Network's full HIPAA and confidentiality policies can be found in the accompanying HIPAA Notice of Privacy Practices document.

Discharge Policy: Individuals are typically discharged after successfully meeting their treatment goals. However, a discharge may also occur if a) I request to stop care b) I miss 3+ appointments without providing advanced notice c) a referral to another level of care is indicated and provided d) I exhibit behaviors that threaten safety e) I am non-compliant with treatment.

By signing below I attest that:

- I have been provided with a ***Notice of Privacy Practices and Confidentiality Policy***, ***Client Rights and Grievances, Rights of a Minor in Behavioral Health Treatment,*** and the ***Clinic Information Letter***.
- I have read and understood the provided information and give my informed consent to behavioral health evaluation and treatment at Wellpoint Care Network for myself/my child.
- I am the client or their legal guardian with the right to consent to treatment. Individuals 14 and older are required to consent to treatment along with their guardian.

Wisconsin AT4ALL

Signature of Client: _____ **Date:** _____

Required for individuals 14 years of age and older

If not signed by client, individual is: ☐ under 14 yrs of age ☐ Unable to sign due to disability

Signature of Guardian/Legal Authority: _____ **Date:** _____

Required for individuals under 18 years of age

Signer is: ☐ Biological Parent ☐ Legal Guardian ☐ Power of Attorney

Witness Signature:_____ **Date:**_____

Required when proof of legal authority required

Telehealth Informed Consent

Telehealth services (or telemedicine) involves the use of audio and/or video communications between you and your healthcare provider. The information exchanged over telehealth may be used for diagnosis, continuing therapy, intervention follow-up and/or education. Wellpoint Care Network's telehealth and electronic communication systems have network and software security protocols incorporated to protect the confidentiality of Protected Health Information. These measures include encryption and data safeguards that are consistent with the Health Insurance Portability and Accountability Act (HIPAA) and State regulations.

Potential Benefits: Potential benefits include improved access to behavioral health care services and improved behavioral health care outcomes due to increased ability to meet recommended treatment frequency.

Potential Risks: Potential risks include potential interruptions, unauthorized access, or technical issues that may impact the confidentiality or effectiveness of your care. You or your clinician can discontinue the session at any time if interruptions or connectivity issues occur affecting the quality of your care. If a disconnection occurs your clinician will attempt to restart the session, and if they are not able to re-join, they will notify you via phone. You may call our office at any time if you experience issues.

If Choosing to Participate in Telehealth I understand:

- Telehealth services are voluntary, and I can withhold or withdraw consent at any time.
- 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
- The potential benefits and risk and alternatives to telehealth services.
- Telehealth care is not the same as in-person care as I will not be in the same room as my provider.
- How to use and access telehealth technology, including telehealth procedures and how to receive support if needed.
- My clinician will weigh the potential benefits and limitations of telehealth services and if telehealth is not appropriate for my treatment, in-person services will be required to ensure proper care is received.
- The laws that protect privacy and the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the HIPAA and Confidentiality Policy provided.
- I must conduct my telehealth session in a private area to ensure confidentiality.
- If a minor, an adult must be present during the entire session and the guardian must be available to discuss treatment.
- I have documented an emergency contact my clinician may communicate with if the need arises. This information will be verified by my clinician prior to each telehealth session, and I will communicate any changes.

In the event of an emergency during a Telehealth Session my clinician may contact:

Emergency Contact Information: **at least one required*

☐ Information Same as Intake Document

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Milwaukee Mobile Crisis:414-257-7222
Waukesha Mobile Crisis: 262-548-7666
Washington County Crisis Line:262-365-6565
988: National Crisis Line 24/7

By signing this document, I attest to having read and understood the provided information and give my informed consent to telehealth services at Wellpoint Care Network.

Signature of Client: _____ **Date:** _____
Required for individuals 14 years and older.
If not signed by client, individual is: ☐ Under 14 yrs of age ☐Unable to sign due to disability

Signature of Guardian/Legal Authority: _____ **Date:** _____
Required for individuals under 18 years of age
Signer is: ☐ Biological Parent ☐ Legal Guardian ☐ Power of Attorney

Witness Signature:_____ **Date:**_____
Required when proof of legal authority is provided.

Graduate Student Participation

Graduate students must complete supervised placement hours to become a licensed practitioner. Wellpoint Care Network collaborates with local universities to help facilitate the proper training of graduate students and improve access to quality mental health services. Wellpoint Care Network Interns work directly with one of our Clinical Supervisors who reviews/observes all work for quality/competency.

Any information generated where an intern is present is treated as part of the individual's permanent, confidential record. All Wellpoint Care Network HIPAA and confidentiality regulations are followed by the student involved in the case and records remain solely with Wellpoint Care Network. If the graduate student discusses a client situation with their university professor/instructor, all identifying information is removed from this discussion, following confidentiality requirements. Federal regulations prohibit making any further disclosure of this information without specific written consent of the person or their guardian to whom it pertains, or as otherwise permitted by such regulations or as required by law.

Participation is voluntary and you may refuse student involvement in your care. Your refusal will not impact your or your child's care. You may also revoke your consent at anytime by communicating your request to your clinician or any office staff.

☐ I give my permission for graduate student(s) participation in my care

☐ I only give permission for the following to participate in my care:_____

☐ I do not give my permission for graduate student intern(s) participation

I understand the information provided and give my informed consent to have graduate student involvement in my care according to my preferences selected above.

Client Signature:_____ Date:_____

(Required for individuals 14 years and older)

If not signed by client, individual is: ☐ under 14 yrs of age ☐Unable to sign due to disability

Parent/Guardian Signature:_____ Date:_____

(Required for individuals under 18 years of age)

Witness Signature:_____ Date:_____

Required when proof of legal authority is provided. Signer is: ☐ Biological Parent ☐ Legal Guardian ☐ Power of Attorney

Communication Preferences

Please check the methods we are authorized to contact you:

☐ Phone

☐ Voicemail- if call not answered

☐ Text

☐ Email

☐ **All Appointment Reminders**

Please indicate who should receive appointment reminders sent via email & phone

☐ Parent/Guardian ☐Client ☐Placement ☐Other:_____ ☐Do not sent appointment reminders

Financial Responsibility

Please indicate who is responsible for the payment of services and where we may send statements

☐ Client is financially responsible - proceed to signature

Name:_____ DOB: _____ Relationship:_____ ☐ROI signed **Required if not guardian or 18+*

Mailing Address ☐Same as client

Address: _____ City, State, Zip:_____

By signing below I consent to being financially responsible for any incurred costs from behavioral health services at Wellpoint Care Network. I understand I will be contacted contacted regarding treatment, Wellpoint Care Network services, and financial obligations. Wellpoing Care Network

_____ _____

Signature of responsible party Date

Grant Recipient Data Collection and Release

Purpose of Release: Wellpoint Care Network receives grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), allowing for improved access to comprehensive, evidenced-based behavioral health care. Clinicians providing services through this program utilize evidence-based screenings and assessments to improve the treatment you receive. Wellpoint Care Network collects and jointly reviews the data outlined in this document after removing all identifying information, such as name, date of birth and contact information. The review of this data provides key insights into the impact and progress of the program and allows for an overall evaluation of programmatic efforts.

Wellpoint Care Network is committed to protecting your privacy and has several measures in place to carefully protect your data and remove identifiable protected health information prior to release, however we acknowledge by participating, minimal risk to privacy may exist. Wellpoint Care Network and those involved in the data review act in accordance with federal and state regulations outlined in Wellpoint's Notice of Privacy Practices and Confidentiality. You have a right to inspect and upon paying any applicable fees, obtain a copy of the disclosed records, unless circumstances outlined in DHS 51.30, and DHS 92.03-92.06 are present.

Person Receiving Services:
Name:_____ DOB:_____
Address:_____
City, Zip code: _____

Agency Authorized to Release Information:
Wellpoint Care Network-Behavioral Health Clinic
8901 W. Capitol Dr.
Milwaukee, WI 53222 P: 414-465-5770

Agencies Authorized to Receive Information:
Substance Abuse and Mental Health Service (SAMHSA)
5600 Fishers Lane Rockville, MD 20857
P:240-276-0361

DMA Health Strategies
9 Meriam Street, Suite 4 Lexington, MA 02420
781-863-8003

Information to be Released:
All information is de-identified (name, DOB, other identifying information removed) prior to release.

☐PHQ-9/A ☐ GAD-7 ☐CSSRS- Suicide Risk Assessment ☐PRAPARE ☐Health Needs Assessment ☐Referral Data
☐NOMS- National Outcomes Measure Survey ☐SBIRT- Screening, Brief Intervention and Referral to Treatment
☐Demographic Data ☒All ☐Other:_____

Rights Pertaining to this Authorization:

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for: individuals enrolled in financial assistance program as de-identified data must be provided to the funding source for this program.
- The information I authorize to be released may be redisclosed when indicated by federal and state privacy laws. The recipient of this information may be controlled by different laws regarding redisclosure.
- I may revoke this authorization at anytime by submitting my request in writing to a Wellpoint Care Network Clinical Staff. Information released prior to request, will not apply to revocation.
- Unless otherwise specified, authorization will remain in effect until the expiration indicated below.

Dates of Information to be Disclosed: FROM: beginning of treatment TO: end of treatment/expiration

Expiration: This authorization will expire upon the conclusion of this project unless otherwise specified:_____

By signing this authorization, I am confirming that I have had an opportunity to review and understand the content of this authorization form and that it accurately reflects my wishes. I am also confirming that I have read and understand the rights with respect to this authorization.

Signature of Client: _____ **Date:** _____
Required for individuals 14 years and older
If not signed by client, individual is: ☐ under 14 yrs of age ☐Unable to sign due to disability

Signature of Guardian/Legal Authority: _____ **Date:** _____
Required for individuals under 18 years of age
Signer is: ☐ Biological Parent ☐ Legal Guardian ☐ Power of Attorney

Witness Signature:_____ **Date:**_____
Required when proof of legal authority is provided.

MRN:_____
FOR OFFICE USE ONLY

Wellpoint Care Network Behavioral Health Clinic
Authorization for Use and Disclosure of Health or Confidential Information

COMPLETE FOR ANYONE YOU WOULD LIKE INVOLVED IN YOUR CARE OR COORDINATION OF RECORDS

1) Person Receiving Services:
Name: _____ Date of Birth: _____ Phone Number: _____
Address: _____ City, State, Zip: _____

2) Authorizes:
Wellpoint Care Network Behavioral Health Clinic
8901 W. Capitol Dr. Milwaukee, WI 53222
Phone: (414)465-5770 Fax: (414)260-8980

3) To: ☐ DISCLOSE ☐ OBTAIN ☐ EXCHANGE Information

4) With the following Individual/Agency/Organization(s):*separate authorizations are required if difference in use/disclosure details

Name: _____
Address:_____
City, State, Zip:_____
Phone Number: _____
Fax/Email: _____

Name: _____
Address: _____
City, State, Zip:_____
Phone Number: _____
Fax/Email: _____

5) Using Release Format(s): ☐Verbal ☐Paper ☐Fax ☐Email ☐Mail ☐Pick-up: Location_____ Picked up by:_____

6) Type of information authorized to disclose:

☐Intake/Initial Assessment
☐Care Coordination Notes
☐Therapy Progress Reports
☐Financial Information
☐Face sheet
☐Appointment/Attendance
☐Summary Psychosocial History
☐Psychiatric/Psychological Evaluations
☐Diagnostic Report
☐All
☐Treatment Plan/Reviews
☐Discharge Summary
☐Prescriptions/Medications
☐Physical Examination
☐Other(specify)_____

7) In compliance with Wisconsin privacy statutes, we require special permission to release privileged information, please check any records pertaining to the following areas, you allow to be disclosed:

☐Behavioral Health records/notes ☐Alcohol/Drug Abuse Treatment (AODA) ☐Developmental Disabilities
☐Sexually Transmitted Diseases ☐HIV/AIDS

8) Purpose or need for information: ☐ Coordination of Care ☐ Education Planning ☐ Personal ☐ Legal ☐ Benefits
☐ Other:_____

9) Dates of information to be disclosed: FROM:_____ TO:_____☐ Complete Record

10) Expiration: This authorization is good for one year from date of signature unless otherwise specified:_____

11) Rights Pertaining to This Authorization:

Right to Inspect: I understand I have the right to inspect or receive a copy of the confidential information I have authorized to be disclosed except for when not authorized by law. I may arrange to inspect this information or obtain copies by contacting the clinic. **Right to Refuse Signature**: I understand I am not required to sign this authorization and refusing to do so will not affect treatment, payment enrollment or benefits within state regulations, WI Statutes 51.30 and 252.15 requires client authorization to disclose health information for payment purposes, a refusal **Right to Revoke:** I may revoke this authorization at anytime by submitting a request in writing except where information has already been released as a result of this authorization. Unless revoked, this authorization will remain in effect until the expiration date or one year from signature. **Right to Receive a Copy:** I understand if I agree to sign this authorization, I must be provided a copy. 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. **HIV/AIDS Test Results:** I understand my HIV test results may be released without an authorization to persons/organization that have access under state laws and a list of those persons/organizations is available upon request. Re-Disclosure Notice: I understand that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law. The third party may not be required to abide by this Authorization or applicable Federal and State laws governing the use and disclosure of my health or confidential information. This information has been disclosed from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. A copy or facsimile (FAX) of this authorization will be considered valid as the original. If authorizing the use of FAX, I understand and accept the risks association with faxing confidential health information.

By signing this authorization, I am providing my informed consent to release the information outlined in this authorization. I have reviewed the contents of this authorization fully and it accurately represents my wishes.

Signature of Client: _____ Date: _____
Required for individuals 14 years and older.
If not signed by client, client is: ☐ Under 14 yrs of age ☐Unable to sign due to disability

Signature of Guardian/Legal Authority: _____ Date: _____
Required for individuals under 18 years of age
Signer is: ☐ Biological Parent ☐Legal Guardian ☐ Power of Attorney

Witness Signature:_____ Date: _____
Required when proof of legal authority is provided