3120 Memorial Drive Two Rivers, WI 54241
Phone (920) 657-1780 Fax (920) 657-1784 www.phoenixbhc.com

Welcome, please carefully read the following policies so you will feel fully informed about how our clinic staff can best serve your needs during your time with us. Included is the paperwork that needs to be completed and brought to your first appointment. **Please bring this paperwork, your insurance card and a photo ID to your appointment**. If you have any questions, please feel free to call or we can discuss any questions during your appointment.

Clinic Policies

Cancellations

We ask you to notify our office 24 hours in advance for any cancellation. **Failure to call may result in cancellation of future appointments and placed on same day scheduling, or a charge of $65.00 for the missed session.** Please cancel if you are ill, for your safety and the safety of others in the clinic. In an emergency situation, the therapist may suspend this fee. If you are late for an appointment, the time missed will be part of your therapy time. If the therapist is late, he/she will only charge for the time actually spent with you.

Office Hours

The business office is open from 9:00 am to 5:00 pm, Monday through Thursday and 9am to 4pm on Friday to receive calls and schedule appointments. Appointments outside these hours may be available upon request.

Telephone Calls / Emergencies

Our Intake Specialist answers our telephone during regular business hours. After hours, our crisis line number is 920-629-0956. If you need to talk to an on-call therapist, he/she will return your call as soon as possible.

Grievance Resolution Process

A copy of our program's Grievance Procedure is available upon request. If you feel your rights have been violated, you may file a grievance. You cannot be threatened or penalized in any way for presenting your concerns. Instead of filing a grievance, at the end of the grievance process, or at any time during the process, you may choose to pursue legal channels. Contact Laura Townsend, the Client Rights Specialist at Phoenix Behavioral Health Services, LLC, to file a grievance or to learn more about the specific grievance process.

Payment Policy
Responsibility for the payment of all professional charges remains with the patient or responsible party regardless of insurance coverage. If you have insurance, we ask you to make your co-payment at each visit. If you do not have insurance, the entire amount must be paid at the time of service unless prior payment arrangements have been made. Returned checks will receive a $35.00 charge.

Insurance Coverage
Phoenix Behavioral Health Services, LLC is a certified outpatient mental health facility in the State of Wisconsin. We are authorized to receive mandated benefits under Wisconsin State Statute 632.89. When you schedule your appointment with us, we will contact your insurance company to verify eligibility and coverage. <u>It is your responsibility</u> to call your insurance to verify that Phoenix, as well as your therapist, are in-network providers, and that therapy and psychological testing are covered under your insurance plan.

Bill of Client's Rights
You have the right to:
- Be informed, both verbally and in writing of your rights prior to entering treatment.
- Expect an explanation of your treatment plan or any procedure, test, or treatment technique in a manner in which you can understand.
- Be informed of the side effects or risks of side effects (if any) from treatment/medications.
- Refuse treatment to the extent permitted by law and to be informed of any consequences of refusal.
- Every consideration of privacy and confidentiality concerning your care and records. You further have the right to examine, challenge such records, and request a copy of all treatment records upon discharge. You may be charged a reasonable fee for reproduction.
- Expect prompt and adequate treatment in a safe and therapeutic manner. You further have the right to have your physical, emotional, social, and spiritual needs respected.
- Obtain information concerning any relations of this agency to other health services insofar as your care is concerned and to the existence of any professional relationships among individuals who are treating you.
- Reasonable continuity of care including discharge planning.
- Examine and receive an explanation of any charges of fees for services.
- Refuse to be filmed or taped.
- Have a grievance procedure available to you and to have an advocate represent you during the grievance process.
- Bring court action for damages against persons violating your rights.

Locations:
Two Rivers – 3120 Memorial Drive Two Rivers, WI 54241
Green Bay – 1600 Shawano Ave Suite 100 Green Bay, WI 54303
Stevens Point – 2607 Post Rd Stevens Point, WI 54881

Thank you for choosing Phoenix Behavioral Health Services, LLC.

PHOENIX BEHAVIORAL HEALTH SERVICES, LLC

LAST NAME FIRST MI	PHONE	BIRTH DATE	AGE
ADDRESS	SS#	MALE ___ FEMALE ____	
CITY STATE ZIP	MARTIAL STATUS - SINGLE MARRIED . WIDOWED DIVORCED		
EMAIL ADDRESS- required	Client Employer		
DESCRIPTION OF PROBLEM	WHO REFERRED YOU		

FOR MINOR CLIENTS - IS THERE A CUSTODY AGREEMENT - YES (Please provide a copy) NO

HOW DID YOU HEAR ABOUT US? (check)	INTERNET _____	DR. REFERRAL _____	PERSONAL REFERRAL _______
	COURT ORDERED ______	INSURANCE PPO LIST _____	OTHER (please list)

EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE
SPOUSE OR PARENT(S) NAMES	SPOUSE'S OR PARENTS EMPLOYER	PHONE
GUARDIAN NAME	GUARDIAN ADDRESS	GUARDIAN PHONE

BILLING AND/OR INSURANCE INFORMATION (PLEASE LIST IN ORDER TO BE SUBMITTED).

COMMERCIAL INSURANCE _____	PRIMARY INS. CO	SECONDARY INS. CO
MEDICARE ______	NAME OF POLICY HOLDER - required	NAME OF POLICY HOLDER - requried
MEDICAID ______	BIRTH DATE OF POLICY HOLDER - required	BIRTH DATE OF POLICY HOLDER-required
MEDICAID HMO PLAN _______	ID#	ID#
PRIVATE PAY _____	GROUP # OR NAME	GROUP # OR NAME
ADDRESS OF POLICY HOLDER (If different than above)		

All professional services are charged to the client. Phoenix will bill your insurance as a courtesy. However, the client is responsible for all fees regardless of insurance coverage. We ask that insurance clients make their co-pays at the time of each session. Private pay clients must pay the entire amount at time of visit, unless other payment agreements have been made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of any information necessary to determine benefits associated with visits to Phoenix Behavioral Health Services, LLC and request payment directly to them for services provided. I recognize and accept responsibility for any balance remaining after payment of benefits associated with my health insurance policy

Revalidation of HIPAA & Consent to Treat and Contact

I acknowledge receipt of the HIPAA Notice of Privacy Practices, grant permission to Phoenix Behavioral Health Services, LLC. to contact me and grant consent to treat and acknowledge program policies & procedures of Phoenix Behavioral Health Services, LLC.

CLIENT or LEGAL REPRESENTIVE SIGNATURE **DATE**

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Behavioral Health Services LLC
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PAYMENT AND CREDIT POLICY

I understand that PBHS charges the following fees for professional services.

$230.00 Diagnostic Interview (1st Visit) **$200.00** Psychotherapy/Family Therapy

$50.00 Group Therapy (1 hour) per Individual

PHD RATES **$250.00** Diagnostic Interview **$220.00** Psychotherapy/Family Therapy

$230.00 Psychological testing per unit

The responsibility for the payment of all professional charges remains with the patient or responsible party regardless of insurance coverage. If you choose to use your insurance, we do file claims with your insurance companies (primary and secondary), verify your insurance benefits, but we **cannot guarantee payment for services by your insurance provider.** Therefore, **you are responsible for services provided.** If payment from your insurance is not received in 30 days, the account is due and payable in full. ANY CHECKS RETURNED FOR N.S.F WILL BE CHARGED A $35.00 FEE.

Insurance clients are required to make their co-payment (the portion your insurance does not cover) at each visit. This will be collected by the receptionist before the start of you session. **Private pay clients** must pay the entire fee at the time of service unless prior arrangements have been made.

You are responsible to notify us of any change in your insurance coverage, your benefits, and your name, address, and telephone number.

If you need to cancel your appointment, please call us 24 hours in advance. **Failure to call may result in cancellation of future appointments and placed on same day scheduling or a charge of $65.00 for the missed session.** If we are not available to take your call, you may leave a message with our 24-hour answering service.

PAYMENTS MUST BE CURRENT IN ORDER TO RECEIVE SERVICES.

CLIENT FINANCIAL AGREEMENT

I make this agreement with the knowledge and understanding that I accept full responsibility and liability for any and all charges incurred by me and guarantee timely payment of same.

Client Name ___________________________ Date ________________

Client or Legal Representative Signature ______________________________

Date _______________

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Client Informed Consent & Acknowledgement of Clinic Policies and Procedures

This is to acknowledge that I have been provided with and understand the following information.

1. The general nature and purpose for outpatient treatment services & the services available through the clinic, including benefits, administration, and side effects of treatment.
2. Client responsibilities relating to treatment.
3. Alternatives to treatment modes.
4. Consequences of not receiving proposed treatment.
5. "Bill of Client Rights"
6. Clinic hours & treatment costs.
7. How to access emergency services.
8. Client rights and grievance procedure.
9. Criteria for discharge from treatment.
10. 24 hours advance notice for cancellation of an appointment.
11. My rights to request consultation with consulting psychiatrist or psychologist.
12. Confidentiality of client information.

I consent to the treatment plan as described by my Therapist until such time as I terminate treatment with Phoenix Behavioral Health Services, LLC. or 15 months from the date signed. I understand that I may withdraw informed consent for treatment at any time by submitting such a request in writing to my Treatment Therapist_____ initial

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge receipt of the HIPAA Notice of Privacy Practices for Phoenix Behavioral Health Services, LLC. Questions or Concerns about privacy rights, Phoenix Behavioral Health Service's privacy-related policies or the information contained in this notice, contact Chief Privacy Officer of Phoenix Behavioral Health Services at 3120 Memorial Drive, Two Rivers, WI 54241, 920-657-1780 or at info@phoenixbhc.com

I have declined a paper copy of HIPAA Practices ______ initial or
I have received a paper copy of HIPAA Practices ______ initial

CONSENT TO CONTACT:

I give my express permission to Phoenix Behavioral Health Services, LLC and its Affiliates or contractors to contact me for any purpose at the current or any future numbers that are provided for landline telephone, cellular telephone or any wireless device including the use of automated dialing equipment, prerecorded voice or text messages.
I have agreed to be contacted by employees of Phoenix BHS _______ initial

Client Name (printed)____

Client or Legal Representative Signature____ Date______________

Clients may request a copy of this consent form if they wish to have one for their records.

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INFORMED CONSENT CHECKLIST FOR TELEMEDICINE SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for Telemedicine services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the counselor will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- For our Autism In-Home program, when staff uses their own, possibly non-secure device, they may need the family's Wi-Fi and password.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the counselor in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in Telemedicine sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- Your counselor or BCBA may determine that due to certain circumstances, Telemedicine is no longer appropriate and that sessions should resume in-person.

I consent to use of Telemedicine as described above.

____

Client Name Printed

____ ______________________

Client or Legal Representative Signature Date

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information in regard to 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 at your request. If there is a resurgence of the pandemic, if other health concerns arise, or either of us feel it is feasible and clinically appropriate, we may require that we meet via telehealth.

Risks of Opting for In-Person Services

You understand that there is a risk of exposure with face-to-face sessions. This risk may increase if you use public transportation, cab or rideshare services. You understand that there is no way to entirely eliminate the possibility of the transmission of COVID in our facility. By coming to our facility, you acknowledge that we cannot eliminate the risk of transmission of COVID and accept that one of the risks of visiting our facility is the potential for contracting COVID.

Your Responsibility to Minimize Your Exposure

To obtain services in person, and reduce the risk of exposure, you agree to take certain precautions which will help keep you, me, our families, staff, and other clients healthy. If you do not adhere to these safeguards, it may result in telehealth sessions only.

1. You will keep appointment only if you are symptom free.
2. You will take your temperature before coming to each appointment. If temperature is higher than 100 degrees Fahrenheit, you have symptoms of COVID or tested positive, you will call and cancel this session. You will not be charged a cancellation fee.
3. You will be required to wash your hands or use hand sanitizer before session.
4. You will adhere to safe distancing precautions & no physical contact.
5. You may choose to wear a mask even if not required by the CDC.
6. You will keep hands away from your face. If you touch your face, you will be required to use hand sanitizer.
7. If you are bringing a child for a session, the above rules apply to you and the child.

We are committed to minimizing exposure by taking extra cleaning precautions and following CDC guidelines. If any staff member that you have had direct contact with tests positive for COVID, you will be notified. If we are required to report COVID data, we will only provide minimal information to assist with contact tracing. Your signature below indicated that you are in agreement with these terms and conditions.

Client or Legal Representative Signature ____

Date _________________

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MEDICATION HISTORY

Client Name ______________________________ Date ____________________

Name of Medication	Date Began	Date Ended	How is medication taken?	Dosage	Prescribing Physician/ Psychiatrist
			__ Topical __ Oral __ Injection	__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed	
			__ Topical __ Oral __ Injection	__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed	
			__ Topical __ Oral __ Injection	__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed	
			__ Topical __ Oral __ Injection	__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed	
			__ Topical __ Oral __ Injection	__ 1x daily __ 2x daily __ 3x daily __ 4x daily __ as needed	

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Intake and Assessment

Please complete the following to the best of your ability.

Name ___________________________________ **Age** ____________ **Birth date** __________________________

Presenting Problem

State in your own words the nature of the problem you are seeking help for: _________________________________

____

____

When did the problem begin? (Approximate dates and circumstances): ____________________________________

____

____

What do you hope to accomplish through the counseling process?

____

____

Lifestyle Behaviors – Briefly describe:

Eating habits (i.e. frequently overeat, erratic, on a diet…) ____

____

Sleep/Rest Patterns (how much, restful, toss & turn) ____

____

Physical Exercise (how much, what kind) ____

Use of Alcohol (frequency, how much, what kind) ____

____

Use of Other Drugs (frequency, how much, what kind) ____

____

Caffeine Intake (how much, in what) ____

____

Smoking (how much) ____

Current Concerns. Please circle any area where you think you may have a PROBLEM:

Anger/Temper	Anxiety/Nervousness	Stress/Burnout	Parenting Skills	Gambling Problem
Fears/Phobias	Behavior Problems	Work/Job/Career	Self-Concept	Recurring Nightmares
Indecision	Relationships	Depression	School Problems	Hopelessness
Irritability	Marital Problems	Suicidal Thoughts	Weight Loss/Gain	Finances/Money
Mood Swings	Sexual Problems	Menopause	Menstrual Problems	Self-Injury
Memory	Concentration	Hyperactivity	Alcohol/Drugs	Guilt

Other: ____

Personal History

Name ___________________________________ **Age** ____________ **Birth date** __________________________

Ethnicity ______________________ **Do you have any Spiritual variables that may impact treatment**? Yes No

If Yes, Please explain ____

Marital Status
Single _____ Engaged _____ *How long?* _____ Married _____ *How long?* _____
Widowed _____ *Date* _______________ Divorced _____ *How long?* _____

Children (List names and ages)

____

____

Parents

Mother ____________________________________ Age ___________ Occupation _________________________

Deceased _______ Age of death ____________ Cause of death __________________________

Father ____________________________________ Age ___________ Occupation _________________________

Deceased _______ Age of death ____________ Cause of death __________________________

Brothers and Sisters (List name(s) from oldest to youngest)

____

____

Who lives in your home? ____

Work

What is your present occupation or job title? ____

How long have you been employed with your present employer? _________________________________

Do you like your job? ____

Recreation & Leisure

What are your personal hobbies and/ or interest? ____

____

How often do you involve yourself in your hobbies and other interests? ___________________________

How often do you vacation? ____

Education

Highest grade completed _______________________ Degree(s) completed _________________________

Did you have academic, behavioral, or social difficulties in school? _________________ Explain: _______________

____

____

____

Strengths in school: ____

____

PHYSICAL HEALTH AND SYMPTOMS

Do you have any concerns about your physical health? Please Explain:

____

____

Do you have or been recently exposed to an infectious and or contagious disease? YES NO

If yes, please explain ____

Are you currently under the care of a physician for treatment of a physical or emotional condition? _______________

If yes, please list physician's name, reason for treatment, and date last seen _________________________________

____

Current Physician ____

Last Examination and Results: ____

Please check any of the following that apply to you or a family member (currently or in the past):

	You	**Others**		**You**	**Others**
Thyroid Disease	_____	_____	Infectious Disease	_____	_____
Kidney Disease	_____	_____	Diabetes	_____	_____
Asthma	_____	_____	Hypoglycemia	_____	_____
Allergies	_____	_____	Cancer	_____	_____
High Blood Pressure	_____	_____	Pulmonary Disease	_____	_____
Neurological Disease	_____	_____	Glaucoma	_____	_____
Prostate Problems	_____	_____	Gastrointestinal	_____	_____
Heart Disease	_____	_____	Epilepsy	_____	_____
Premenstrual Syndrome (PMS)	_____	_____	Sleep Disorder	_____	_____
Abortion/Miscarriage	_____	_____	Alcohol/Drug Problem	_____	_____

Other: ____

Please check any of the following that apply to you:

	Never	**Occasionally**	**Often**	**Very Often**
Marijuana	_____	_____	_____	_____
Cigarettes	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Sleeping Pills	_____	_____	_____	_____
Narcotics	_____	_____	_____	_____
Painkillers (Aspirin, Tylenol, ect)	_____	_____	_____	_____
Cocaine	_____	_____	_____	_____
Speed	_____	_____	_____	_____
Gambling	_____	_____	_____	_____
Overeating	_____	_____	_____	_____
Tension	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Vomiting	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Hyperventilation	_____	_____	_____	_____
Restless Sleep	_____	_____	_____	_____

MENTAL HEALTH

Have you ever been in counseling or received any form of professional help for your problems: ________________

With Whom? When? ____

____

Was previous counseling or treatment helpful? (Explain) ____

____

Any history of psychiatric hospitalizations (dates & reasons) ____

____

Any history of traumatic experiences of any nature? ____

____

Please check any of the following that often apply to you:

Anger	_____	Tired	_____	Peaceful	_____	Annoyed	_____	Guilty	_____	Bored	_____
Sad	_____	Happy	_____	Restless	_____	Depressed	_____	Hopeless	_____	Tense	_____
Anxious	_____	Hopeful	_____	Lonely	_____	Energetic	_____	Regretful	_____	Content	_____
Fearful	_____	Helpless	_____	Excited	_____	Envious	_____	Relaxed	_____	Joyful	_____
Optimistic	_____	Frustrated	_____	Pessimistic	_____						

List three things you worry about the most:

____

____

____

When do you feel the most calmed and relaxed? ____

____

How would you like to feel? ____

What do you imagine your life looking like when the problem that brought you here is taken care of?

____

____

Marriage/Intimate Relationships

How long have you been married? _______ (or) in a present relationship? ______ Partner's age? ________________

Describe your partner's health: ____

Describe your partner's hobbies: ____

What do you like most about your partner? ____

What do you like least about your partner? ____

Describe any problems you see currently affecting your relationship: ______________________________________

____

____

To what extent can you depend on your partner for support (emotional and/or financial)? ______________________

____

____

List previous relationships/marriages and the reason for their ending: _____________________________________

____

____

Signature:____ **Date**: _______________

Beck's Depression Inventory

Name: ______________________________ Date: _________________

Please circle the number (0, 1, 2, or 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1.	0	I do not feel sad
	1	I feel sad
	2	I am sad all the time and I can't snap out of it
	3	I am so sad and unhappy that I can't stand it
2.	0	I am not particularly discouraged about the future
	1	I feel discouraged about the future
	2	I feel I have nothing to look forward to
	3	I feel the future is hopeless and that things cannot improve
3.	0	I do not feel like a failure
	1	I feel I have failed more than the average person
	2	As I look back on my life, all I can see is a lot of failures
	3	I feel I am a complete failure as a person
4.	0	I get as much satisfaction out of things as I used to
	1	I don't enjoy things the way I used to
	2	I don't get real satisfaction out of anything anymore
	3	I am dissatisfied or bored with everything
5.	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time
6.	0	I don't feel I am being punished
	1	I feel I may be punished
	2	I expect to be punished
	3	I feel I am being punished
7.	0	I don't feel disappointed in myself
	1	I am disappointed in myself
	2	I am disgusted with myself
	3	I hate myself

8.	0	I don't feel I am any worse than anybody else
	1	I am critical of myself for my weaknesses or mistakes
	2	I blame myself all the time for my faults
	3	I blame myself for everything bad that happens
9.	0	I don't have any thoughts of killing myself
	1	I have thoughts of killing myself, but I would not carry them out
	2	I would like to kill myself
	3	I would kill myself if I had the chance
10.	0	I don't cry any more than usual
	1	I cry more now than I used to
	2	I cry all the time now
	3	I used to be able to cry, but now I can't cry even though I want to
11.	0	I am no more irritated by things than I ever was
	1	I am slightly more irritated now than usual
	2	I am quite annoyed or irritated a good deal of the time
	3	I feel irritated all the time
12.	0	I have not lost interest in other people
	1	I am less interested in other people than I used to be
	2	I have lost most of my interest in other people
	3	I have lost all of my interest in other people
13.	0	I make decisions about as well as I ever could
	1	I put off making decisions more than I used to
	2	I have greater difficulty in making decisions more than I used to
	3	I can't make decisions at all anymore
14.	0	I don't feel that I look any worse than I used to
	1	I am worried that I am looking old or unattractive
	2	I feel there are permanent changes in my appearance that make me look unattractive
	3	I believe that I look ugly
15.	0	I can work about as well as before
	1	It takes an extra effort to get started at doing something
	2	I have to push myself very hard to do anything
	3	I can't do any work at all
16.	0	I can sleep as well as usual
	1	I don't sleep as well as I used to
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
	3	I wake up several hours earlier than I used to and cannot get back to sleep.

17.	0	I don't get more tired than usual
	1	I get tired more easily than I used to
	2	I get tired from doing almost anything
	3	I am too tired to do anything
18.	0	My appetite is no worse than usual
	1	My appetite is not as good as it used to be
	2	My appetite is much worse now
	3	I have no appetite at all anymore
19.	0	I haven't lost much weight, if any, lately
	1	I have lost more than five pounds
	2	I have lost more than ten pounds
	3	I have lost more than fifteen pounds
20.	0	I am no more worried about my health than usual
	1	I am worried about physical problems like aches, pains, upset stomach, or constipation
	2	I am very worried about physical problems and it's hard to think of much else
	3	I am so worried about my physical problems that I cannot think of anything else
21.	0	I have not noticed any recent change in my interest in sex
	1	I am less interested in sex than I used to be
	2	I have almost no interest in sex
	3	I have lost interest in sex completely

Signature: ____ Date: __________________