DELTA CENTER

IN PARTNERSHIP WITH SHERMAN COUNSELING

www.deltactr.com

CHILD/ADOLESCENT REGISTRATION Please fill in this form to register as a new patient.

*Part of new patient registration is completing the **Biographical Checklist.***

Patient's Last Name:	
Patient's First Name:	
Patient's Middle Initial:	
Patient's Nickname:	
Date of Birth (e.g. 7/4/1976)**:**	
Patient's Gender:	
Home Address:	
City/State/Zip Code:	
Email address:	
Cell Phone Number (999-999-9999):	
Phone Number – Other:	
School/Grade:	
Party Responsible for billing (name/address/phone)	
Parent Name/Step/Foster (name/address/phone)	
Parent Name/Step/Foster (name/address/phone)	
Parents Marital Status:	○ Single ○ Married ○ Divorced ○ Widowed ○ Other
Emergency Contact : (name, relationship, phone contact)	
Permission to speak to Emergency Contact?	○ Yes ○ No

Name/Relationship of Family Members we have permission to speak with about appointments:

Over

Briefly, explain the areas of concern you would like to address with your therapist.

Have you experienced any of the following? (Please Check)

○ Conflict with friends ○ Conflict with parents ○ Truancy ○ Low self-esteem ○ Lack of energy

○ Early awakening ○ Trouble falling asleep ○ Nightmares ○ Difficulty concentrating ○ Weight loss

○ Weight gain ○ Nausea ○ Diarrhea ○ Other

Increase use of:

○ Alcohol ○ Drugs ○ Prescription ○ OTC ○ Street

Is there a family history of:

○ Drug Abuse ○ Alcohol Abuse

Do you find yourself feeling:

○ Afraid ○ Angry ○ Hurt ○ Guilty ○ Anxious ○ Depressed

Other feelings: _____

Do you find yourself having thoughts of suicide?

○ YES ○ NO

Medical History:

○ Allergies ○ Diabetes ○ Thyroid ○ Epilepsy ○ High Blood Pressure

Major Surgeries: _____

Physical Disabilities: _____

Appointment Reminders:	____text ____ call
○ Yes (choose one) ○ No	

*Appointment information is considered to be **Protected Health Information** under HIPAA.
By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted.

I acknowledge that I received the notice of Privacy Practices (HIPAA) from Delta Center/Sherman Counseling.

I hereby authorize Delta Center/Sherman Counseling to bill my insurance carrier (if applicable), release any medical or other information to process the claim, and authorize payment of medical benefits to Delta Center/Sherman Counseling for the services that I and/or my family members receive.

X_____ _____
Signature Date

Update _____ _____ Update _____ _____
Signature Date Signature Date

Delta Center
Counseling Services

INFORMED CONSENT (DHS 94.03/35.18)

The Process of Treatment:

1. **Consent to Evaluate/Treat:** I voluntarily consent that I/My child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or alternative treatments by staff from Delta Center. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a psychiatrist, licensed certified social worker, a licensed professional counselor, or a marriage and family therapist. Treatment will be conducted within the boundaries of Wisconsin Law for Psychiatric, 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, and intake assessment. During the first two sessions the therapist will discuss expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation may include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
3. **Technology Use:** All records are stored in a secure cloud based server and only your therapist has access to the information. Confidentiality of unencrypted communication such as email cannot be guaranteed. Please use the online secure email to communicate with your therapist, set up a secure password, and use a secure network to log in. Use of public WiFi is not a secure network.
4. **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. I will be responsible for a ***$150.00*** late cancellation fee if an appointment is cancelled without ***24*** hour notice.
5. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record on HIPAA compliant web account and in a file at Delta Center, and I consent to disclosure for use by Delta Center staff for the purpose of continuity of my care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records. Confidentiality also applies to the waiting room. Should you see someone you know, please keep that information confidential.
6. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.
7. **Expiration of Consent:** This consent to treat will expire 15 months from the date of signature, unless otherwise specified.
8. **Discharge Policy:** There are circumstances under which I may be involuntarily discharged which include unpaid balance or inability to pay for services. I understand the discharge policy of the clinic. If Delta Center, is not able to provide appropriate services, Delta Center will refer me to alternative resources within the community and other agencies that can provide services.
9. **Grievance Policy:** If you feel that your rights have been violated or not respected please speak with Dr. Casey Hanson. If you feel that your rights have not been respected or heard you have the right to contact: State Grievance Examiner, DHS, P.O. Box 7851, Madison, WI 53707-7851.

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. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time. *If applicable:* I give permission for my child to receive evaluation and treatment by a therapist at Delta Center. The types of services I am requesting from Delta Center, have been explained to me. I voluntarily consent to become actively involved in the treatment process. I have read and understand the rights of a patient and informed consent.

Client Signature (Parent/Guardian Signature) Date

Clinic Staff Signature Date

Delta Center
Counseling Services

FINANCIAL AGREEMENT - Delta Center.
OUTPATIENT COUNSELING SERVICES

I UNDERSTAND AND AGREE TO THE FOLLOWING

- Delta Center will bill my insurance as a courtesy to me and I understand that I am ultimately responsible to pay all charges incurred. We invite you to contact your insurance provider with any questions, concerns or clarifications needed.
- Check in before each session to pay my co-pay, co-insurance and/or deductible.
- If my account reaches a balance of $100.00, my services can be suspended until the balance has been paid.
- In the event I am sent an insurance check, I will sign it over and deliver it to Delta Center immediately.
- To notify Delta Center within **24 hours prior to a scheduled appointment** if I am unable to attend, or I will pay the no show charge ($150.00) for the missed appointment. **Please note:** Appointment reminders are a *courtesy* not a *certainty*. If an appointment is missed due to a failed reminder, the No Show fee will still apply.
- I will be billed at the current hourly rate for services that require a therapist's appearance, correspondence or phone calls related to legal, medical, educational or psychological assessment.
- Telephone conferences or collaboration with client in excess of 15 minutes will be billed at an hourly rate and payments for these services will be billed to client's account, which **may not be** covered by insurance, unless otherwise noted. $100 - $300/hr
- Delta Center will be reimbursed by me for fees that are not covered by my insurance i.e., unexcused/missed appointments, deductibles, insurance co-payments, and psychological assessments.
- I will be charged a NSF fee/processing fee of $30.00 and/or be sent to collections for any unpaid bills.

INSURANCE

- The initial visit will is **billed** at the cost of **$480/hr.** The initial visit is the diagnostic interview where the clinician will develop my treatment plan and then collaborate with peer therapists to form a diagnosis.
- Additional session is **billed** at the cost of $**250 - $435/hr**, Masters Level, Psychotherapy
- My insurance information and is only an estimate of benefits not a guarantee and I will contact my insurance with questions or any further need of verification or clarification.

I hereby authorize Delta Center/Sherman Counseling to bill my insurance carrier for the services that I and/or my family members receive. I have been informed of Delta Center/Sherman Counseling's fee schedule and policy regarding insurance reimbursement. I further agree to pay my co-payment on the day I receive service. Co-payments include the percentage of charges not paid by my insurance company, deductibles and unexcused/missed appointments.
Delta Center/Sherman Couseling reserves the right to unsolicited discharge from treatment.

Signed _____ _____
Client or Responsible Party Date

S**igned** _____ _____
Delta Center Staff Date

Delta Center
Counseling Services

CLIENT RIGHTS OUTPATIENT DIVISION

Under Wisconsin Statute (x.51.67) you have certain rights as an outpatient.

Your rights are:

- To a humane psychological and physical environment within the facility.
- To refuse to take excessive or unnecessary medication and to refuse medication if your religion forbids it.
- To refuse to take part in experimental research.
- To receive prompt and adequate treatment.
- To meet with the supervising psychiatrist upon request.
- To have your conversation with staff and all medical and health care records kept confidential in accordance with Wisconsin Law (s.51.30).
- To refuse to be filmed or taped.
- To bring action for damages (ss.51.61(7)) against persons violating your rights or confidentiality.
- To see your health care record after termination of treatment according to Center policy.
- To see parts of your health care record during treatment if your physician or case manager agrees.
- To receive a list of medications and somatic treatments upon request and at the time of your termination of treatment.
- To have a grievance procedure available to you and to have an advocate represent you during the grievance process.
- Some of the above rights may be restricted because of your treatment or security needs.

I acknowledge receipt of the above rights both orally and in writing.

_____ _____

Client Signature Parent/Guardian/Next of Kin

_____ _____

Delta Center Staff Date

Other rights listed under Wisconsin Statute (s.51.67) pertain to inpatient status. If you are interested in a copy of the complete text of the law or a copy of the grievance procedure, feel free to contact the receptionist.

Dr. Casey Hanson is the client rights officers and can be reached by calling Delta Center's phone number: 920-921-3343.

Delta Center
Counseling Services

CLIENT
MEDICATION LIST

Family Physician:_____ **CLIENT NAME:**_____

Pharmacy:_____ Therapist:_____

Pharmacy phone #:_____ Adverse reaction to:_____

Past medications: _____

Date of Rx	Current Medication(s)	Dosage	Time of day	Purpose	Doctor	Comments

NO MEDICATIONS AT THE CURRENT TIME ☐ Date _____

Update: _____ Date:_____

Update:_____ Date:_____

Delta Center
Counseling Services

Child Biographical Information

We ask that you complete this form, which will provide information useful in treatment. It will take around 30 minutes to complete. Please bring this with you to your first appointment.

*If you are filling this form out for your child please have them participate in answering as many questions as possible.

Symptoms:

Check each concern experienced recently

	☐ abuse/ physical	☐ anger/mad	☐ anxiety/ nervous	☐ appetite	☐ avoidant	☐ blended families
☐ boundaries	☐ bullying	☐ compulsions	☐ concentration problems	☐ conduct	☐ conflict with friends	☐ crying spells
☐ depression/ sadness	☐ disappointment	☐ disorganized	☐ distractible	☐ emptiness	☐ family conflict	☐ fear/scared
☐ feeling misunderstood	☐ grades	☐ grief	☐ guilt	☐ hopelessness	☐ hyperactivity	☐ impulsivity
☐ inactivity	☐ inattention	☐ inhibition	☐ irritability	☐ isolation	☐ jealousy	☐ meaning-lessness
☐ medical	☐ memory loss	☐ mood swings	☐ nausea	☐ obsessions	☐ oppositional/ defiant	☐ pain
☐ panic	☐ parents' divorce/ separation	☐ perfectionism	☐ poor motivation	☐ rage/upset	☐ rejection	☐ relationship difficulties
☐ resistance	☐ restlessness	☐ ruminative/ racing thoughts	☐ school difficulties	☐ self-esteem	☐ sexual abuse	☐ shame
☐ shyness	☐ sibling conflict	☐ sleep	☐ social skills	☐ social withdrawal	☐ stress	☐ thoughts of suicide
☐ trauma	☐ treated unfairly	☐ trust	☐ unusual thoughts	☐ unusually sensitive	☐ weight change	☐ worry

More on next page

Presenting Problem

What is happening or has happened that motivated you/your parents to seek counseling for yourself?_____

_____

_____

_____

_____

_____

_____

Describe the progression of the problem or behavior (When did it begin, How long has it lasted?)

_____

_____

_____

_____

Under what conditions/things do the problems usually get worse?

_____

_____

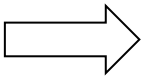
_____

Under what conditions/things are the problems usually improved?

_____

_____

_____

More on next page 

Family History

With whom do you live with at this time?

_____

_____

_____

Were your parents ever married? _____Yes _____No

Are parents divorced or separated? _____

If so how old were you when that happened? _____

Who has primary placement/custody? _____

What is the visitation schedule? _____

Parents

(Please include step-parents and significant others)

Name	Relationship	Quality of Relationship

Siblings

(Please include half and step siblings. If you need more space, continue below)

Name	Age	Relationship	Quality of Relationship

More on next page

Is there any mental health history in the family? (depression, anxiety, addiction, bipolar, etc.)

_____

_____

Education and Occupations:

The school I attend is: _____

I am currently in _____ grade.

My teachers name is: _____

My favorite subject in school is: _____

My least favorite subject in school is: _____

After school activities that I'm involved in (sports, clubs, etc.):

_____

_____

_____

How do you spend your free time? (List hobbies, sports, clubs, groups, family activities, etc.)

_____

_____

_____

Health:

List any health problems you may have:_____

_____

_____

How many hours do you sleep in an average night? | |

Do you exercise? How often? | |

How much caffeine do you drink in an average week? | |

More on next page

Who is your primary physician? _____

When was your last physical? _____

Have you seen a therapist in the past (therapist name, year, issues/concerns, how long)?

_____

_____

_____

Additional Information:

What do you feel you are good at? (I.e. strengths)

_____

_____

_____

List any additional information that it might be important for me to know:

_____

_____

_____

_____

_____

_____

SHERMAN COUNSELING

Informed Consent to Treatment through Telehealth Services

Delta Center Counseling Services

I consent to receive mental health treatment through telehealth services provided by Sherman Counseling. I hereby attest that the staff of Sherman have explained to me the policies, procedures, and alternative methods to this treatment. In addition, I agree to follow the policy and procedures of teletherapy/telemedicine services. I have been given documentation of these policies as well.

I understand and agree to the following:

- If I have questions, I may request specific information in writing at any time during the course of treatment.
- I have had time to study this information and/or seek additional treatment options.
- This consent is effective throughout my treatment at Sherman.
- I have the right to withdraw consent at any time, in writing.
- I understand what the benefits and risks of the proposed treatment will be or have been explained to me by my treatment provider.
- I understand that the staff at Sherman are trained in telehealth and are retrained annually.
- I understand that Sherman primarily uses a HIPPA protected telehealth program called Doxy.me. Other approved HIPPA compliant programs may be used if there are technical limitations, such as latency issues or inability to connect through Doxy.me.
- I understand that because I will not be on site for appointments that I will either prepay or keep a credit card on file to pay for services rendered/co-payments/deductibles.
- I understand that in the event there are technical difficulties such as, internet services outage, telehealth services provision latency, power outage, etc., the session will need to end (at no charge to me) and rescheduled for the next soonest available session.
- I understand that sessions over the phone or email do not qualify as telehealth services and cannot be a substitute.
- I understand and agree to having the appropriate equipment available for a telehealth therapy session such as a working computer with working camera and microphone, working internet etc.
- I understand and agree to having a confidential and private space for the telehealth sessions.
- I understand and agree to signing releases of information for my other care providers to coordinate care with the Sherman team. I will keep these releases current and active for the duration of time that I am using telehealth services.
- I understand that if I am not compliant with the policies and procedures for treatment through telehealth, telehealth services may be revoked and discontinued.

*** **Disclaimer** *** This consent document is in place during the COVID-19 disease prevention, effective March 20.2020 until further notice. Additional clauses or revisions may be needed for future services and operations. You may be asked to sign a new consent to treat as revisions are developed.

Once you have reviewed the policy and procedure document, please sign below to indicate that you have obtained all information that you deem necessary and that you accept the policy and procedures outlined above. A copy of this form is supplied to you at your initial appointment; however, you can always request additional copies.

_____ _____ _____ _____

Client Signature Date Parent/Guardian Date

(Required if the client is under 18 years of age)

_____ _____

Agency Witness Date

PLEASE CHECK ONE: I prefer to have services provided via

___ Video ___ Phone

What you should know: Giving Informed Consent to Treatment through Telehealth Services:

Sherman Counseling is proud of our ability to offer high quality, evidence-based treatments to the clients we serve. For those who have difficulty accessing care in person, we offer telehealth services. Because telehealth services offer treatment through technology over an internet connection, there are some risks to this service. We have created policies for Sherman staff and clients to follow. This is to ensure that clients are afforded quality treatment, confidentiality, and respect at all times.

WHAT IS TELEHEALTH:

Telehealth is the use of telecommunication and information technology to provide clinical health care from a distance. It has been used to overcome distance barriers and to improve access to medical services that would often not be consistently available in distant rural communities.

TELEHEALTH PORTAL:

We primarily use Doxy.me portal services for telehealth sessions. Doxy.me is a HIPPA compliant portal service that has been approved for telehealth sessions.

Your provider will send you a secure link via email to register for Doxy.me services. It is an easy to use service, but in the event there is difficulty with using this service our staff are all trained on how to use Doxy.me and will be able to assist you. Other approved HIPPA compliant programs may be used if there are technical limitations, such as latency issues or inability to connect through Doxy.me

WHO CAN USE TELEHEALTH SERVICES:

Telehealth services are online forms of treatment, often used during inclement weather or when there are barriers to access to care. We, by law, can only provide telehealth services in the state in which we are licensed. For example, if you are traveling to California we could not meet with you on-line as we are not licensed in the State you are in. Sherman is only licensed to provide services received within the State of Wisconsin. Some providers may hold licenses in other States.

EQUIPMENT REQUIRED:

In order to use Doxy.me, clients will need a working computer with working microphone and camera. Internet access is also necessary. Use of a phone with internet access does not always work and is not recommended for this. Provider equipment will be maintained through password

CANCELLATION AND NO-SHOW POLICY:

A $150.00 charge is billed for all appointments cancelled with less than 24 hours' notice. Insurance does not pay for missed sessions. This policy is in effect unless we determine that you were not able to make your appointment or give sufficient notice due to circumstances beyond your control.

No shows will be charged and billed to you at $150.00. Because treatment sessions are in high demand and waiting lists for appointments are long, if there happens to be 3 consecutive missed appointments or late cancelations in a row your treatment will be terminated, and a list of referral sources will be provided for you. See interpreter section of this document for information about cancelling sessions that require the use of an interpreter—this cancelation policy is different as we need to adhere to our contractual obligations with the interpreter services we use.

FEES:

There is no cost to the client for the Doxy.me service.

Clients, however, are expected and responsible to pay for all services rendered. Some, but not all insurances cover telehealth services. We will inform you prior to starting telehealth if your insurance carrier will cover these services. If insurance does cover these services you are still responsible for any insurance deductibles and/or co-payments. If your insurance carrier does not cover telehealth services you are able to pay out of pocket for such services. The pricing for telehealth services is the same for a face to face session. Because telehealth is a remote service, we require any payment to be made ahead of time or for you to keep a credit card on file for us to charge fees at the time of service.

CONTACTING US:

We make every effort to be available by telephone during normal business hours. Our customer service representatives are able to answer calls Monday-Thursday 8am-4pm. You can also connect with us through our monitored inbox at support@deltactr.com.

Our treatment providers make every effort to return calls and email within 24 hours during normal business days. If you are unable to connect with your treatment provider, please call our main number 920-921-3343, including afterhours. Alternatively, if you are having a medical emergency, contact your primary care physician, 9-1-1, or the nearest emergency room.

HOURS OF OPERATION:
General office hours are Monday–Thursday 8am-4pm. Other times may be available, as hours for individual counselors will vary as not all of our providers have the same schedule. Please speak with your provider about their schedule. We are closed on major holidays.

BENEFITS, RISKS AND ALTERNATIVES TO TELEHEALTH SERVICES:

Benefits: improved access to care, eliminates travel barriers and travel time, no need to cancel appointments due to inclement weather or illness

Risks: loss of interpersonal connection between yourself and your therapist, possible technological difficulties or delays in care provision, possible slowed treatment progress, possible lack of coverage by insurance.

Alternatives: face-to-face sessions, medication management, treatment at a higher level of care facility, and postponing or ending treatment.

TREATMENT PROVIDER CREDENTIALS:

All clinical providers at Sherman Counseling are licensed by the State of Wisconsin and hold an advanced degree in the specialty area of Social work, Counseling, Psychology, and Psychiatry. Continuing education is an obligation of all providers, and clinicians are encouraged to pursue professional development opportunities beyond their minimum license requirements. All staff using telehealth have been trained in these services as well as have been trained in how to use the Doxy.me portal.

.**TERMINATION/DISCHARGE CRITERIA:**

There are circumstances under which clients may be involuntarily discharged from telehealth services, such as but not limited to failure to respect session times, failure to pay for treatment, failure to respect the boundaries and privacy of our staff, and not following treatment recommendations that can be life threatening.

For telehealth to be used successfully it is important to understand how important it is for clients to have local providers in their home town who can assist Sherman staff with providing the care and treatment clients need. Therefore, releases of information must be kept up to date and current as well as emergency contact information. If these documents are not current or you decline to complete these documents or decline to have a care team in your home town then teletherapy/telemedicine services cannot be used.

Before Sherman can involuntarily discharge a client, the clinic shall notify the client in writing of the reasons for the discharge, the effective date of the discharge, sources for further treatment, and of the client's right to have the discharge reviewed prior to the effective date of the discharge.