DELTA CENTER

A DIVISION OF 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 ○ Academic difficulties ○ 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: _____

How would you like to receive statements?	___ E-mail ____ Traditional Mail
Appointment Reminders: ○ Yes (choose one) ○ No	____text ____call

*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

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Revised 8/24/2022

INFORMED CONSENT

Consent to Evaluate/Treat: We realize that you have many options in choosing your healthcare providers and we appreciate you choosing Sherman Counseling in partnership with PACER Clinic, Delta Center, New Directions, and Baeten Counseling. I and/or members of my family will be receiving therapy, assessment and/or psychiatric services at Sherman Counseling Clinics beginning on this date. All policies, procedures and possible alternative methods of treatment have been explained to me by my therapist or provider. I have been informed of my client rights and authorize Sherman Counseling Clinics to provide mental health and/or services identified as appropriate I have been informed of the benefits of proposed treatment, the way treatment is to be administered, approximate length of treatment and any side effects which are a reasonable possibility, including risk of side effects from medication. I have also received information regarding alternative treatment methods and probable consequences of failure to receive treatment, as well as after-hours crisis coverage. This consent remains in effect throughout the duration of treatment (12 months maximum) and may be withdrawn by written request at any time. I am aware that my case will be periodically reviewed by Sherman Counseling Clinics, consulting psychologists, psychiatrists, and affiliated staff members.

Please check that you have been offered the following documents:

- ❑ Client Rights and the Grievance Procedure for Community Services, Grounds for Involuntary Termination, Notice of Privacy Practices and Telehealth Practices.

Technology Use: All records are stored on 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, if available for your location, to communicate with your therapist, set up a secure password, and use a secure network to log in. Use of public Wi-Fi is not a secure network. Sherman Counseling staff can use email or text to communicate with you about administrative details, such as appointment times and cancellations, but we cannot do therapy. Email is not secure or confidential.

Confidentiality, Harm, and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record on HIPAA (Health Insurance Portability and Accountability) compliant web account and in a file at a Sherman Counseling Clinic, and I consent to disclosure for use by Sherman Counseling Clinics 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.

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.

Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

Discharge Policy: There are three 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 Sherman Counseling Clinics are not able to provide appropriate services, Sherman Counseling Clinics will refer me to alternative resources within the community and other agencies that can provide services. If I cancel without 24 hours' notice or no show my appointment more than 2 times my therapist has the right to discharge me and discontinue services.

Grievance Policy: If you feel that your rights have been violated or not respected, please speak to Dr Casey Hanson, Psychology@sherman-counseling.com. If you feel that your rights have not been respected or heard you have the right to contact the State Grievance Examiner, DHS (Department of Health Services), P.O. Box 7851, Madison WI 53707-7851.

Consent to Treatment through Telehealth Services: I consent to receive mental health treatment through telehealth services provided by Sherman Counseling Clinics. I hereby attest that the staff of Sherman Counseling Clinics 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 polices as well. I understand and agree with the following:

- I understand that I must be in the state of Wisconsin due to licensing restrictions.
- I understand there are potential risks to this technology including interruptions, unauthorized access, and technical difficulties. I understand that the provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation.
- Confidentiality applies for telehealth services, and the session will not be recorded without written permission from both myself and the provider.
- I agree to use the videoconferencing platform selected for the telehealth sessions and the provider will explain how to use it.
- I understand that I will need to use a webcam or smartphone during the session and use a secure internet connection.
- If I need to cancel or change my in-person or tele-appointment, I will notify the administrative staff in advance by phone. If I miss a scheduled appointment without notice, a no-show fee up to $150 will apply.
- If a session ends due to technology failure in less than 20 minutes, and a reconnection is not successful, there will be no charge for the session.
- A safety plan will include at least one emergency contact and the closest emergency services to my location, in the event of a crisis situation.
- Permission of a parent/ legal guardian and contact information is required for minor clients in order to participate in telehealth sessions.
- I understand that I need to confirm that the telehealth sessions will be reimbursed by my insurance carrier; if they are not reimbursed, I am responsible for full payment.

I agree to work with my therapist on choosing the modality of the appointment whether that be in person, telehealth, or phone sessions.

_____	_____	_____/_____/_____
Client Name (PLEASE PRINT)	Client Signature (14 years & older)	Today's Date
_____	_____	_____/_____/_____
Parent Name (PLEASE PRINT)	Parent Signature	Today's Date
	_____	_____/_____/_____
	Clinician Signature	Today's Date

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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 office receptionist.

Dr. Casey Hanson is the client rights officer 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:_____** Therapist:_____

Pharmacy:_____ 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:_____

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?

_____

_____

_____

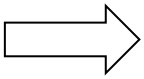
Under what conditions/things are the problems usually improved?

_____

_____

_____

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:

_____

_____

_____

_____

_____

_____

FINANCIAL POLICY

We strive to exceed expectations and eliminate financial surprises for all our patients. We want to partner with you in keeping your account accurate and up to date. Your patient financial rights and responsibilities are listed below. Please review and sign this document. The original document will be placed in your patient record and a copy given to you for your records by request.

Sherman Counseling in partnership with PACER Clinic, Delta Center, New Directions and Baeten Counseling are state certified outpatient clinics which utilize the following fee schedule:

Initial Assessment	$480/hr.	Missed Appointment/Late Cancellation	$150/hr.
Therapy	$250-$435/hr.	Deposition	$500/hr.
Psychiatric Services	$227-$435/hr.	Telephone Consultation (15 minutes or more)	$100-$300/hr.
Psychological Testing	$200-$480/hr.	Letters / Report Writing	$250-$300/hr.
PACER Clinic Services	$47-$480	Men's Group (Private)	$60 / $360

- I understand that you are responsible for determining whether services are covered under my health insurance plan.
- I will be responsible for the full amount charged if you do not provide Sherman Counseling Clinics with my insurance information. You understand you are responsible for any collection fee(s) associated with your account. You further understand Sherman Counseling Clinics will honor all discounts, fee schedules, and network participation pricing as per signed contract. Other financial arrangements without a signed agreement with Sherman Counseling Clinics will be handled on a case-by-case basis.
- **All payments are due at the time of service**. You understand that if your health insurance does not include coverage for behavioral health benefits, you will be required to pay at the time of service. You understand that you have an option to set up a payment plan with Sherman Counseling Clinics for all patients' financial responsibility associated with each account. If you are unable to pay your balance in full, please contact Sherman Counseling Clinics to make arrangements for a payment plan.
- **No Show Fee/Late Cancellation Fee: I**f it is necessary to cancel an appointment, a **24 business-hour notice** is required. There will be a charge **up to $150** for late cancellations and "no shows" applied to my account, except in the case of emergency. For appointments that exceed an hour in duration, a no-show fee will be assessed for each hour scheduled. This charge is not covered by insurance and will be my responsibility. Sherman Counseling Clinics reserves the right to charge a higher fee for consistently missed appointments and also reserves the right to not schedule future appointments.

Financial Agreement

There are two possible methods of payment for services that have been explained to me. My selection is initialed below:

_____ I have insurance and authorize Sherman Counseling Clinics to submit billing to my insurance company or third-party carrier. I give permission for Sherman Counseling Clinics to submit any additional information necessary to process my insurance claim if requested by my insurance carrier.

_____ I do not have insurance or do not wish to utilize my insurance coverage and agree to pay the self-pay rate of $180 for the initial appointment and $150 for follow-up sessions.

Financial Obligations

Please be aware that most insurance benefits include a deductible, co-insurance and/or co-payment. Please contact your insurance carrier for this information. Deductible and co-payment are due at the time of service. I am solely responsible for payment for any services provided, including by not limited to deductibles, co-insurance and/or copayments, denied claims and all charges not covered by insurance. We will assume your deductible has not been met until your insurance company informs Sherman Counseling Clinics otherwise.

- ☐ I have a copay
- ☐ I have a deductible and understand that a payment of $100 or my deductible/coinsurance amount (whichever is lesser) is due at the time of my appointment.
- ☐ I understand that if my balance reaches $500, my services can be suspended until my balance has been paid.

It is my responsibility to provide Sherman Counseling Clinics with all necessary insurance information and to notify the office if there is a change in my insurance status, I understand that Sherman Counseling Clinics will send a monthly statement to my home, and I agree to make a personal payment on the outstanding balance. Any payments more than my insurance payments will be refunded to me by Refresh Mental Health.

_____ _____ _____/_____/_____

Client Name (PLEASE PRINT) Client Signature Today's Date

_____ _____ _____/_____/_____

Parent Name (PLEASE PRINT) Parent Signature Today's Date

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Client's Name: _____ DOB: ___/___/_____

Credit Card Authorization

Sherman Counseling encourages keeping your credit or debit card on file as a convenient method of payment for the portion of services that you are liable for. This includes copays, co-insurance, deductible, No Show/Late cancel fee, etc. Your financial information is kept confidential and secure. **Effective 10/24/22 a credit card is required to be on file when doing telehealth sessions and must authorize payment to be made at the time of service.**

Please initial all statements that apply below:

_____ I authorize Copay/ co-insurance/ Self pay/ late cancel/ no show fees or $100.00 towards deductible to be processed at the time of service and no later than the next business day. **This option is required for Telehealth.**

_____ I authorize a minimum payment of $200 to be charged to my card the first week of each month unless otherwise indicated Exception – Day of each month to be billed: _____ (Example: 15th of each month)

_____ I authorize the entire balance to be charged to my card the first week of each month unless otherwise indicated Exception – Day of each month to be billed: _____ (Example: 15th of each month)

_____ I authorize my card to be stored on file only. This card will not be charged without verbal authorization by me, the card holder.

Credit card information		
❑ Amex ❑ Visa ❑ Mastercard ❑ Discover	Credit Card #	
	Expiration: ____/___	CCV:
	Cardholder's Name:	

Card Holder Address: _____

City_____ State _____ Zip_____

Phone Number: (___) _____ - _____

Cardholder Signature: _____ Date: _____

I understand that this authorization will remain in effect until I cancel it in writing, the credit card expires or once I have paid my balance in full. I agree to notify Sherman Counseling in writing of any changes to my account information or termination of this authorization by the 1st of the next billing month. I certify that I am an authorized user of this credit card/ bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions are indicated in this authorization form.

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Telehealth Practices

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 HIPAA 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 HIPAA 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.

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-Friday 8am-5pm. You can also connect with us through our monitored inbox at info@shermanconsulting.net.

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 920-733-2065, 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–Friday 8am-5pm. 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 hometown 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 hometown, 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.