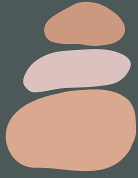

North Shore Center, LLC

CLIENT INTAKE FORMS

Patient Information

Patient name (last, first, middle initial) *SSN*

Address (street, city, state, ZIP)

Gender identity Age Birth date Relationship status **Single** **Partnered** **Married** **Divorced**

Home phone *Work/cell phone*

In case of emergency, who should be notified? *Emergency contact phone*

Primary Insurance Information (please provide copy of card)

Policy holder's name (last, first, middle initial) *DOB*

Relationship to patient **Self** **Parent** **Spouse**

Policy holder's SSN

Insurance company *Phone*

Subscriber ID# *Group #*

Is prior authorization needed? **Yes** **No**

Authorization #

Parent or authorized person's signature, I authorize the release of any medical or other information necessary to process your claims. I permit a copy of this signature to be used in place of the original. I authorize payment of medical benefits to North Shore Center. I also understand that I am responsible for my bill.

Patient signature (14 years or older) *Date*

Parent/guardian signature *Date*

Medical Profile

Patient name

Please list all medications that you are currently taking.

List any medications that you are allergic to.

Current medical conditions (check all that apply)

- Allergies
- Asthma
- Arthritis
- Back trouble
- High blood pressure
- Cancer
- Other
- Chronic pain
- Diabetes
- Frequent constipation
- Frequent headaches
- Hay fever
- Heart problems
- Hearing problems
- Irritable bowel
- Stomach problems
- Skin problems
- Vision problems
- Smoker

Medical doctor

Are you currently under a physician's care? **No** **Yes**

Name *Date last seen*

Significant past medical history if not included earlier.

Past surgery

Past accident

How would you rate your current physical health? **Excellent** **Good** **Fair** **Poor**

Number of cups of coffee and/or cola daily?

Parent/guardian signature *Date*

CONSENT TO TREATMENT

Any person believing their rights, as specified herein to have been violated, may contact the appropriate member.

Informed Consent

1. I hereby request and consent to outpatient treatment by North Shore Center, L.L.C. (NSC).
2. Benefits of proposed treatment; during my involvement in outpatient treatment at NSC, I will receive an evaluation in which my presenting problems will be addressed and I will learn ways to help alleviate them. I understand that the therapist will outline services that will be offered under my treatment plan, treatment recommendations, potential side effects, benefits of my treatment and will approximate the duration and desired outcome of my treatment which he or she concludes are medically necessary and/or potentially beneficial to my mental health. I also understand I have the right to collaborate with my therapist in the development and implementation of my treatment plan.
3. In the event of the administration to me of any psychotropic medications as part of my outpatient treatment, I will be informed of any possible side effects or risks and an additional informed consent will be given.
4. NSC is part of a treatment system for outpatient mental health, which includes referral for inpatient care as necessary. I understand that other treatment facilities of similar nature are available in the greater Milwaukee area offering both inpatient and outpatient treatment and that I can be referred or can seek a second opinion either within NSC or from an outside referral source if necessary.
5. I hereby acknowledge I have been informed of the fee charged for professional services (Hourly rates range between $200.00-$220.00).
6. I have been informed that emergency mental health services are available during periods outside the normal operating hours by calling NSC's answering service.
7. I am aware that I may be involuntarily discharged due to concerns my behavior poses to other clients/staff or inability to pay.
8. Your provider may communicate with you via email or standard SMS text messaging regarding various aspects of your clinical care, which may include, but shall not be limited to, scheduling, phone coaching, treatment planning, or prescriptions. I understand that email and standard text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard text messaging regarding my clinical care might be intercepted and read by a third party.
9. I hereby acknowledge that I am voluntarily seeking outpatient mental health treatment and I understand that certain mental illnesses left untreated may be harmful to one's physical, social, vocational, legal and psychological health.
10. This informed consent will be valid until such time that my treatment provider or I terminate treatment and, in any event, will be valid for a maximum of one year. I have the right to withdraw this informed consent at any time during treatment if the request is made in writing. If I am a minor 14 years of age or older, I understand that I have the right to refuse to sign the informed consent.
11. I have been given adequate time to study and ask questions prior to signing the informed consent.

Grievance Policy & Procedure

If at anytime, during treatment through NSC, you believe your rights have been violated, you have the right to a grievance procedure. You may file a complaint with the clients rights specialist in writing within 45 days of the incident or issue. If you are not satisfied with the way your appeal is handled, you may file a complaint with the clinic director. If in the unlikely event you may need further resolution of your complaint, you have the right to notify the following resources: 1) State of Wisconsin Department of Health and Social Services, 1 West Wilson Street, Madison, WI 54701; 2) Office of the Commissioner of Insurance, 121 East Wilson, Madison, WI 53703.

Statement of Patient Care & Rights

1. The Right to individual dignity.
2. The Right to equal treatment.
3. The Right to individual treatment.
4. The Right to protection of privacy and confidentiality.
5. The Right to informed patient consent.
6. The Right to informed patient consent regarding medications.
7. The Right to refuse participation.
8. The Right to request the opinion of a consultant.
9. The Right to information regarding patient billing.
10. The Right to a grievance procedure.
11. The Right to be fully informed of all patient rights

I have read and understand all of the above information provided to me.

Patient signature (adult or adolescent 14 years or older))

Parent/guardian signature *Date*

INFORMATION FOR CLIENTS

This sheet contains important information about our policies and procedures. Please read it carefully. Ask your provider to answer any questions you may have.

Eligibility

Eligibility for North Shore Center counseling, therapy and academic programs is based on the existence of a presenting problem. You may be referred to another community resource if you (1) do not meet the eligibility criteria; (2) there is not enough staff time available to help you; or (3) there is a more appropriate service provider elsewhere in the community or your insriranCe company has another counseling resource for you.

After you begin working with North Shore Center, services may continue: (1) so long as there are identified treatment goals which have not yet been met; and (2) there is evidence that you are interested in pursuing these goals.

The agency may discontinue services if: (1) all treatment goals have been rnet; (2) you fail to demonstrate an interest in actively pursuing treatment goals, for example, by showing a pattern ofregularly missing appointments; (3) you fail to pay for services as agreed upon in your Fee Agreement; or (4) upon the professional recommendation of your therapist.

Appointments

Initial

Appointments are scheduled with individual providers. A therapy or psychotherapy hour consists of a one 45-60 minute session with your provider. If you need to cancel an appointment, please do so at least 24 hours in advance; should you fail to do so, you will be charged the full hourly rate of your provider. You, not your insurance, will be billed for missed appointments. Report Reviews, Phone Consults, School Visits, and any balance above the "usual and customary" or charges not covered by insurance will be your responsibility.

Fee Policy

Initial

A fee is charged for professional services provided by the professionals at North Shore Center (Hourly rates range between $200-$220). If you have private insurance we will bill for services at the established rate. If you do not have insurance, or if your insurance does not pay in full, you wlll be responsible for paying the rate established on your Fee Schedule. You are also responsible for continued payment at the agreed upon rate once your maximum insurance benefits have been used.

If you are receiving services under managed care, health insurance, or an EAP, the agency will need to obtain information about covered services, co-payments and deductibles, etc. The agency will either obtain the specific information required or ask you to obtain the information. Your signature on this form authorizes North Shore Center to release any information necessary to process insurance claims.

Hours

The agency office is open Monday through Friday 8:00 a.m. to 5:00 p.m. and on Saturday's 8:00 a.m. to 12:00 p.m. Evening hours are available by appointment.

Confidentiality

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

Alternative Settings (School Based Mental Health)

Alternative settings may be utilized when therapeutically indicated for example, School based mental health, school observations, exposure work, etc. Any alternative setting outside of the clinic presents its own confidentiality risks, staff will make reasonable attempts to protect your confidentiality whenever possible.

Emergencies

If you have a life-threatening emergency, please dial 911. For non-life threatening emergency you may call the office during regular business hours at (262) 241-5955 to speak to your/a therapist. During non-working hours you may contact our answering service at (262) 255-9852. Your provider or provider on call will be paged and your call will be returned promptly.

Informed Consent

It is the policy of North Shore Center that each patient, or individual acting on behalf of the patient, will receive specific, complete and accurate information regarding the psychotherapy or other treatment they receive through the agency. You will be asked to read and sign the Consent to Treat form prior to beginning'work with your provider. Those patients receiving medication from an agency consultant will be asked to sign an Ioformed Consent specific to the medication being used.

Grievance Procedure

North Shore Center shall, as part of the intake process, share information with clients concerning informal methods for resolving client concerns and formal procedures by which clients may seek resolution of a grievance.

No sanctions will be threatened or imposed against any client who files a grievance, or any person including an employee of the agency, the department, or a county department or a service provider, who assists a client in filiing a grievance or participates in or testifies in a grievance procedure or in any action for any remedy authorized by law.

If you have a concern about the services you ate receiving, you ate encouraged to discuss it with your provider. If this does not resolve the issue, you may present a written complaint to the client rights specialisi. If. y01i are still not satisfied, please request a written copy of the Grievance Procedure.

Client Access to Records

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

My signature below indicates that I have been given a copy of this information sheet and North Shore Centers Notice of Privacy Practices.

Patient signature (14 years or older) *Date*

Parent/guardian signature *Date*

CHARGES FOR PROFESSIONAL SERVICES NOT COVERED BY INSURANCE COMPANIES

ATTENTION: Your co-pay and deductible amounts are due at time of service – thank you.

All cancellations must be made within 24 hours of appointment time; failure to do so may result in you being charged the full hourly rate.

The charges for missed appointments are not covered by Insurance.

It is the policy of North Shore Center, LLC to charge for the time your Therapist spends on professional services related to your treatment.

Professional services include, but are not limited to, activities such as:

1. Telephone consultations with the patient, family members, other professionals, etc.
2. Preparation of written correspondence to/for MD's, schools, employers, etc.
3. Meetings with school personnel, attorneys, employers, etc.
4. Telephone consultations requested by Managed Care or Insurance Company case reviewers.
5. Preparation of treatment plans requested by managed care companies or Insurance Companies.
6. Travel time
7. Time blocked out for scheduled court dates, meetings and appointments on behalf of the patient.
8. Review of medical, school, legal reports.
9. Patients are responsible if charges are incurred for correspondence via emails/internet.

The charges for these services will be based on your Therapist's hourly rate of $200.00 and will be billed in 15-minute increments of time dedicated to professional service activities.

Insurance companies do not reimburse for these services. The costs of these services will be the responsibility of the patient.

Balances over 90 days from the date of service will become the patient's responsibility unless special payment arrangements have been made. Any balances over 90 days, without a payment plan, will incur a monthly late payment fee of $35.00.

I understand that my treatment may require my Therapist to provide professional services in conjunction to psychotherapy, and that it is my responsibility to pay for those services. Failure to comply with your treatment plan or financial obligation may result in a referral to another provider/facility.

Patient signature (14 years or older) *Date*

Parent/guardian signature *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (patient name),
have received a copy of this office's Notice of Privacy Practices.

Patient signature (14 years or older) *Date*

Parent/guardian signature *Date*

FOR OFFICE USE ONLY:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency prevented us from obtaining acknowledgement

Other (please specify)

You may refuse to sign this acknowledgement

SUBSCRIBE TO EMAIL LIST

We at North Shore Center would like to invite you to visit our website at www.northshorecenterllc.com.

In the near future, we will be adding informational articles and various links to interesting and educational mental health topics.

If you would like us to notify you when we have new articles of interest, please share your e-mail address with us (below). Please keep in mind that while we cannot guarantee absolute security due to the public nature of the internet and e-mail, we make every effort to guard our client's privacy.

By signing this form, you are giving us permission to send you information from North Shore Center and understand and accept the possible risk of disclosure of your relationship to North Shore Center, LLC.

Email address

Printed name *Patient name (if different)*

Patient signature *Date*

FINANCIAL POLICY

North Shore Center, LLC has been serving the community since 1994, aside from our dedication to providing comprehensive ahd compassionate therapeutic options for you or your family, we also remain sensitive to the fiscal realities that many are working through. As a result, our rates were determined with this in mind and remain competitive with other clinics across southeastern Wisconsin. **Our rates vary depending on provider and service type.** We are available to answer any questions you may have regarding the rates forourhost of services. Please feel free to give us a call at 262-241-5955 and we'll do our part to give you the answer you need.

Health Insurance

Services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by asking the following questions:

- Do I have mental health insurance benefits?
- What is my deductible and has it been met?
- Is my provider in or out of network?

The client's health insurance is a contract between the client and insurance company, and is a vehicle to help pay for medical care, As a service to you, we will call your insurance company prior tq your first visit in an attempt to determine your benefits. **Please keep in mind that insurance companies DO NOT guarantee payment for services over the phone, and you are ultimately responsible for any expenses incurred if your insuranqe does not pay. It is in your best interest to be aware of your outpatient mental health benefits before you attend your first appointment.** We will submit yo·ur claims to your insurance company, if you provide us with current insurance information. Depending on your insurance company, our fees may or may not be considered usual and customary.

Clinic policy requires that all anticipated co-pays and visit fees be collected at time of service. These payments may be applied against any unmet deductibles. If your insurance company pays more than anticipated, your account will be credited. We accept cash (exact amount appreciated), personal checks, and credit cards (Visa, Mastercard & Discover). Please be prepared to make payment at the time of your visit. If you have questions regarding clinic fees, please contact our office staff.

I attest I do not have Medicaid insurance and will update NSC if I do have Medicaid at any time.

Non-Sufficient Funds / Returned Checks

The clinic charges a $35 fee to you for any check returned by your bank, which is payable before or at time of your next scheduled visit.

Failure to Pay

Our staff of mental health clinicians and office support professionals provide confidential, compassionate and effective care to our clients. We adhere to the highest standards of ethical practice and serve your needs in good faith. In order to continue our services to you and other members of our community, we expect payment for services rendered in a prompt manner. If extenuating circumstances arise, please consult with our office staff regarding an acceptable payment arrangement. Failure to do so may result in the.need to curtail further sessions until the financial situation is resolved.

If it becomes apparent that a client does not intend to satisfy his/her financial responsibility, a collection agency or attorney may be contacted to pursue collection of the account.

Contact

If you have questions call (262) 241-5955 ext 202 for further information.

Signature (adult/guardian if under age 18) *Date*

CREDIT CARD ON FILE BILLING AUTHORIZATION FORM

Please complete this form if you would like North Shore Center, LLC to keep your credit/debit card on file for future appointments/monthly payments. You may elect to provide us payment information with each visit if you do not wish us to keep your information on file. You may also cancel this automatic billing authorization at any time.

Patient Name

Cardholder Name *Visa/Mastercard/Discover*

Card Number *Expiration Date*

Authorized Signature *Security Code*

We do not share information provided to us with any third party. We take special care to ensure that all account and personal information is held in the strictest confidence.

LIST OF PROVIDERS & RATES

Craig L. Abrams, Ph.D.
Judy Blumenfeld, Ph.D.
Elliot Broch, Ph.D.
Terry Carr, LCSW
Julie Housiaux Caldwell, Psy.D.
Chelsea Gilbertson, LCSW
Elizabeth Laurila, LCSW-IT
Michael A. Mazius, Ph.D.
Brigid Miller MFT-IT
Angela Miller, LPC
Melissa Nelson, Ph.D, LPC
Jenny O'Brien, LPC
Laurie B. Pasch, LCSW, LMFT, DCSW
Terri Peckerman-Stein, LCSW, MSW
Sammi Schams, LPC, SAC, NCC
Caroline Schmidt, Ph.D.
Amy Schwabe, LPC
Nathanael Schwarz, Pd.D.
Anne Spahr, Ph.D.
Jenny Strom, LPC
Patti Suhr, LCSW

Psychotherapy Evaluation – $220/hour
Aoda Initial Evaluation – $350/hour
Individual Psychotherapy 30 Minutes – $100
Individual Psychotherapy 45-60 Minutes – $200

Donna M. Laughrin, Ph.D.
Robert Newby. Ph.D.
Kimberly Rennie, Ph.D.
Consultation, Records Review & Rating Scales – $340
Neuropsychological Testing – $240/hour

Cheryl Ward, MSM, CALP
Maria Morales, MSM, CALP
Reading Assessment – $100/Hr
Consultation/Lessons – $95-$120/hour

Nina Sebastian Bredehorn, MSN, APNP, CPNP, PMHS
Diagnostic Evaluation – $450
1 Hr Follow-up Appointments – $350
45 Min Medication Check – $265
30 Min Medication Check – $175

Dr. Caroline Palmer, M.D.
Diagnostic Evaluation – $500
45 Min Follow-up Session – $265

Nettie Palay, MSN, APNP, PMHNP-BC, CPNP-PC, PMHS, LMT
Diagnostic Evaluation – $450
1 Hr Follow-up Appointments – $350
45 Min Medication Check – $265
30 Min Medication Check – $175

Dina Gruber, LMT, AMTA
45 min - $65
60 min - $85
90 min - $115
60 min Hot Stone - $100
90 min Hot Stone - $125
60 min Cranial Sacral - $75

PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

North Shore Center, LLC respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state laws allow us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

For Treatment

Information obtained by a therapist or physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.

We may also provide information to others providing your care. This will help them stay informed about your care.

For Healthcare Operations

We use your medical records to assess quality and improve services. We may use and disclose medical records to train our staff. We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services. We may use and disclose your information to conduct or arrange for services including:

- Medical quality review by your health plan.
- Accounting, legal, risk management, and insurance services
- Audit functions, including fraud and abuse detection and compliance program.

Your Health Information Rights

The health and billing records we create and store are the property of North Shore Center, LLC. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this notice.
- If you want to restrict certain uses and disclosure you may do so in writing.
- You may see a copy of your medical record at any time. Please discuss this with your therapist or M.D.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to:

- Keep your protected health information private.
- Give you this notice.
- Follow the terms of the notice.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your

protected health information you may contact: Client Rights Specialist, the Office Manager at North Shore Center.

If you believe your privacy rights have been violated, you may discuss your concerns or deliver a written complaint to the client rights specialist or the Director, Dr. Michael Mazius.

Other Disclosures and Uses of Protected Health Information:

Notification of Family and Others

We will not disclose information about you to others without your consent except for the following:

- Funeral Directors/Coroners consistent with applicable law to allow them to carry out their duties.
- Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
- Worker's Compensation Laws – if you make a worker's compensation claim.

Public Health & Safety Purposes as Allowed or Required by Law:

- to prevent or reduce a serious, immediate threat to the health or safety of a person.
- or the public.
- to public health or legal authorities
- to protect public health and safety.
- to prevent or control disease, injury, or disability.
- to report vital statistics such as births or deaths.

To Report Suspected Abuse or Neglect to public authorities.

To Correctional Institutions. If you are in jail or prison, as necessary for your health and health and safety of others.

For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.

For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

For Work Related Conditions that Could Affect Employee Health. For example, an employer may require us to assess health risks on a job site.

To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.

In the course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.

For Specialized Government Functions. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information.

Uses and disclosures not in the Notice will be made only as allowed or required by law or with your written authorization.

For help with these rights during normal business hours or if you believe your right have been violated, please contact: Client Rights Specialist at 262-241-5955 or Dr. Michael Mazius, you may also deliver a written letter.