

Acct #: \_\_\_\_\_ Referred by: \_\_\_\_\_  
Appt Date \_\_\_\_\_ First Session Fee: \_\_\_\_\_ Subsequent Sessions: \_\_\_\_\_  
Therapist: \_\_\_\_\_ Consultant: \_\_\_\_\_

**NORTHSHORE CLINIC OF SHEBOYGAN**  
**615 SOUTH 8<sup>TH</sup> STREET SHEBOYGAN, WI 53081**  
**920-457-8866**

**MINOR INTAKE FORM/INSURANCE INFORMATION**

Name of Client: \_\_\_\_\_  
(Last, First, Middle Initial) Birthdate Sex Age

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
May we call home and leave messages? Yes \_\_\_ No \_\_\_ Initials \_\_\_

**Father's Name and Employer:** \_\_\_\_\_  
**Father's Social Security Number:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_  
May we call you at work and leave messages? Yes No Initials \_\_\_ Work Number: \_\_\_\_\_  
May we call your cell phone and leave messages? Yes No Initials \_\_\_ Cell Number: \_\_\_\_\_

**Mother's Name and Employer:** \_\_\_\_\_  
**Mother's Social Security Number:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_  
May we call you at work and leave messages? Yes No Initials \_\_\_ Work Number: \_\_\_\_\_  
May we call your cell phone and leave messages? Yes No Initials \_\_\_ Cell Number: \_\_\_\_\_

Minor *primarily* resides with: \_\_\_ Mother\* \_\_\_ Father\* \_\_\_ Both \_\_\_ Other

\*If applicable, do you have *Joint Legal Custody*? \_\_\_ Yes \_\_\_ No

\*If applicable, the *Legal Custodian* is:

\_\_\_\_\_  
Name Address City State Zip Code Phone Number

**CONSENT FOR TREATMENT OF MINOR CHILD**

As the Legal Custodian/Guardian for \_\_\_\_\_, I give permission to Northshore Clinic of  
(Name of Minor Child)  
Sheboygan, Inc. and \_\_\_\_\_ to treat my child. This treatment may include  
(Therapist's Name)  
individual counseling, family counseling, or group psychotherapy, as well as psychological testing or AODA  
assessment. This treatment may include consultations with associates of this clinic. Treatment may also  
include referrals to appropriate State and County, or professional agencies for further counseling.

\_\_\_\_\_  
Signature of Legal Custodian/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**PRIMARY INSURANCE**

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Subscriber Name (Last, First, Middle)	Birthdate	Sex
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Subscriber Address	City	State	Zip Code
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Home Phone	Work Phone	Employer
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Insurance Company Name	Phone Number
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Address	City	State	Zip Code
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Identification Number	Social Security Number	Group Number
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Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE**

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Subscriber Name (Last, First, Middle)	Birthdate	Sex
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Subscriber Address	City	State	Zip Code
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Home Phone	Work Phone	Employer
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Insurance Company Name	Phone Number
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Address	City	State	Zip Code
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Identification Number	Social Security Number	Group Number
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Relationship to Patient: \_\_\_\_\_

NORTHSHORE CLINIC OF SHEBOYGAN, INC.  
615 S 8<sup>th</sup> Street • Sheboygan WI 53081 • 920-457-8866

NOTIFICATION OF TREATMENT

TO: \_\_\_\_\_ (Doctor Name)  
\_\_\_\_\_  
\_\_\_\_\_  
(Doctor Location/Address)

RE: \_\_\_\_\_ (Client Name)

DOB: \_\_\_\_\_

CLIENT ADDRESS: \_\_\_\_\_

Your patient(s) was seen at our clinic on \_\_\_\_\_ and requested psychotherapy and consultation. After an assessment of the presenting problem(s), symptoms and other information, an initial diagnosis of \_\_\_\_\_ will be used for beginning treatment.

This recommendation will remain in effect for one year.

The type(s) of service that will be needed include(s) individual family conjoint group.

We welcome your participation in helping us work with your patient. If you have any questions or concerns regarding therapy with your patient or the work we do at Northshore, please contact us.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

CLIENT AUTHORIZATION:

**I DO/DO NOT (circle one)** authorize Northshore Clinic of Sheboygan, Inc. to send a copy of this notification to the physician named above regarding my treatment for the physician's record. Any additional contact with my physician would be discussed with me and requires a separate authorization.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature (Parent or guardian if minor)

NORTHSHORE CLINIC OF SHEBOYGAN, INC.  
615 South 8<sup>th</sup> Street  
Sheboygan WI 53081  
(920) 457-8866

**CONSENT TO USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION**

**Client Name** \_\_\_\_\_

**Account Number** \_\_\_\_\_

**Date of Admission** \_\_\_\_\_

By signing this form, you are agreeing to let us use your personal health information (PHI) here and to send it to others. You are acknowledging that you have read Northshore Clinic's Notice of Privacy Practices (summarized or full version) and understand how your health information can be used or disclosed (shared). You are agreeing that you have been offered a copy of our Notice of Privacy Practices (NPP) and have been encouraged to discuss any concerns you may have. You have also been given a copy of your rights as a patient of Northshore Clinic of Sheboygan, including your right to restrict, review or stop this consent.

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.** In addition, if you choose to revoke this consent at any time, treatment will terminate.

If in the future, we change our Notice of Privacy Practices, we will post and date any changes made and provide copies of our new NPP for your review.

\_\_\_\_\_  
**Signature of client or legal representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Description of legal representative's authority

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize and assign payment directly to Northshore Clinic of Sheboygan, Inc., located at 615 South 8<sup>th</sup> Street, Sheboygan, Wisconsin of insurance and other benefits and payments otherwise payable to me. I also permit a photocopy or other facsimile of this authorization to be used in place of the original assignment.

**I understand that I am financially responsible** to Northshore Clinic and promise to pay all charges which are not paid by my insurance, PPO, HMO or other coverage in addition to co-payments and deductible charges. I am aware that the unpaid balance will be referred to Small Claims Court or a collection agency, as well as the necessary information to process such actions. I will discuss any concerns about payment or insurance billing with the billing department or my therapist.

\_\_\_\_\_  
**Signature of Client or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Witness Signature

TREATMENT AGREEMENT

**PLEASE READ THIS AND DISCUSS IT WITH YOUR THERAPIST**

Informed Consent

Each patient, or person acting on the patient's behalf (parent, legal guardian, advocate), will be provided with specific, complete and accurate information and time to study the information or to seek additional information concerning the proposed treatment or services made necessary by and directly related to the person's mental illness, developmental disability, alcoholism or drug dependency including:

- A. The recommendations and benefits of the proposed treatment and services;
- B. The way the treatment is to be administered and the services to be provided;
- C. Possible side effects or risks of the recommended treatment;
- D. Alternative treatment modes and services;
- E. The probable consequences of not receiving proper treatment and services;
- F. The right and responsibilities in developing and implementing an individual treatment plan.

Psychiatric/Psychological Evaluation/Consultations

Evaluations/consultations are available by our staff. The client or the therapist may request an evaluation/consultation. The client may ask the therapist or clinic director about this procedure. Your therapist may also want to refer you to a consultant outside our agency. Our staff does meet on a regular basis for case consultation. At intake and at least every 90 days your therapy will be reviewed with the staff psychiatrist or psychologist.

Patients Rights and Grievance Procedure

I have received information, orally and in writing, about my rights as a patient and my right to file a Grievance on an informal or formal basis should I or my representative believe my rights have been violated.

Involuntary Discharge

A client may be terminated from receiving services from Northshore Clinic of Sheboygan, Inc non-voluntarily: (a) when the client exhibits physical violence, verbal abuse, carries weapons or engages in illegal acts at the clinic; (b) when the client refuses to comply with stipulated program rules and treatment recommendations; (c) when the client does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter and may appeal the decision.

Confidentiality

I further understand that my treatment and records are confidential and no information about me or my treatment will be given to anyone without my written permission. I have received information regarding the format of written permission to release confidential information and the exceptions to the confidentiality rule.

I have had an opportunity to review the points listed in the above document, have had time to consider those points and to ask questions for clarifications. I agree to receive treatment at Northshore Clinic and understand that this consent for treatment is in effect for a period of 15 months and that I have the right to withdraw the informed consent in writing at any time.

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Signature of patient, parent or legal guardian

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Date

**TREATMENT BILLING POLICY**

ATT 35.18-B

**Fee Schedules:** A therapy session normally consists of 50-minutes of face-to-face contact. The fee for sessions lasting less/more than 50 minutes will be pro-rated accordingly. Your service provider’s fees are indicated below:

<u>Psychologist</u>	<u>Masters/Psychotherapist</u>	<u>AODA Counselor</u>
Initial Assessment \$205.00	Initial Assessment \$175.00	Initial Assessment \$155.00
Psychotherapy \$155.00	Psychotherapy \$140.00	Psychotherapy \$125.00
Testing \$165.00/hour	No Show/Late Cancellation-Full Fee	Group Therapy \$ 70.00/hour
No Show/Late Cancellation-Full Fee		No Show/Late Cancellation-Full Fee
 <u>Late Payment Fees</u>	 <u>M.D.</u>	
Assessed after the 15 <sup>th</sup> of each month	Psych. Evaluation \$255.00	
Partial/full payments 0-30 days-\$0.00	Med. Management \$90.00/15 min; \$105/20 min; \$135/30 min	
31+ days-\$10.00 per occurrence	No Show/Late Cancellation fee at the discretion of the doctor	

**Estimated Cost for Service:** The average length of service time is 8-10 sessions. Your approximate costs of treatment: Initial Assessment Cost + # of sessions x Service Provider Rate (above). You will subtract any insurance payments and discounts your insurance company receives. You will then add any deductible amounts, co-pay, coinsurance and costs of sessions if the maximum benefits of your insurance coverage are reached.

**Insurance Responsibility**

It is your responsibility to know what coverage your insurance provides. Our clerical staff will assist you in reviewing your policy booklet and/or calling for benefits. However, information our office is given over the phone is not guaranteed by the insurance company and may not be correct. We advise comparing telephone information with your policy statement of benefits. All charges are the sole responsibility of the client, regardless of insurance payment.

**Self-Pay Clients**

Our Clinic expects that you and your therapist will make arrangements for the professional fee. Clients are expected to keep the balance current and pay at each session. Negotiated fee: \_\_\_\_\_/hour.

**Cancellation or Failed Appointments**

**Cancellations must be made 24 hours in advance** or you will be billed for the professional fee; clients will also be billed for not appearing for a scheduled appointment. Insurance companies will not reimburse for failed or improperly cancelled appointments and therefore you will be billed personally.

**Collection Policy**

Past Due accounts will be turned over to Small Claims Court/Collection Agency. An additional fee of \$50.00 will be added to the account for all balances transferred to Small Claims Court/Collections Agency. All fees incurred by this action will be the responsibility of the client. \_\_\_\_\_ **(client’s initials)**

**Hours of Service**

The clinic office is open: Mon-Thurs from 8:30 AM to 8:00 PM, Fridays from 8:30 AM to 3:00 PM. Clinical hours vary with each therapist. Your therapist is available by calling the main number (920-457-8866).

**Telephone/Emergency**

The clinic has a 24-hour answering service so you can contact your therapist in the event of an emergency. If your call is urgent, please tell the answering service so that your therapist or the therapist on call can be contacted.

I UNDERSTAND AND AGREE TO THE ABOVE ADMINISTRATION/BILLING POLICIES IN THIS AGREEMENT.

\_\_\_\_\_  
**(Client Signature/Responsible Party)**

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**(Witness)**

**MEDICAL HISTORY**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_

Have you ever had or been treated for the following conditions:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Blood Disease    | <input type="checkbox"/> Blood Pressure    | <input type="checkbox"/> Back Trouble     |
| <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Chronic Pain     |
| <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Low Blood Sugar  | <input type="checkbox"/> Bladder Problems  | <input type="checkbox"/> Headaches        |
| <input type="checkbox"/> Skin Problems    | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Prostate Disease  | <input type="checkbox"/> Injury/Fracture  |
| <input type="checkbox"/> Constipation     | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Epilepsy/Seizure |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Abortion/Miscarry | <input type="checkbox"/> Eating Disorder  |
| <input type="checkbox"/> Irritable Bowel  | <input type="checkbox"/> Vision Problems  | <input type="checkbox"/> Sexual Problems   | <input type="checkbox"/> Drinking Problem |
| <input type="checkbox"/> Weight Problems  | <input type="checkbox"/> Dental Problems  | <input type="checkbox"/> Sleep Problems    | <input type="checkbox"/> Drug Abuse       |

Please list any hospitalizations (dates and reasons): \_\_\_\_\_

Please list all prior mental health services received:

With Whom: \_\_\_\_\_ Year: \_\_\_\_\_ How Long: \_\_\_\_\_ For What: \_\_\_\_\_

Are there any physical problems in the family that concern you?

Are there any emotional problems in the family that concern you?

Have you ever been: physically abused  or sexually molested  ?

Are you currently under the care of a doctor for any physical or emotional condition?

If so, please list doctor's name, reason for treatment, date last seen: \_\_\_\_\_

Current medications you are taking: \_\_\_\_\_

Current Health Concerns: Please check any area where you think you may have a problem:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Hearing/Vision        | <input type="checkbox"/> Anxiety/Nervousness   | <input type="checkbox"/> Interpersonal Relationships |
| <input type="checkbox"/> Speech                | <input type="checkbox"/> Depression            | <input type="checkbox"/> School Problems             |
| <input type="checkbox"/> Dental Health         | <input type="checkbox"/> Anger or Temper       | <input type="checkbox"/> Work/Job/Career Problems    |
| <input type="checkbox"/> Breathing             | <input type="checkbox"/> Frequent Mood Changes | <input type="checkbox"/> Marital Problems            |
| <input type="checkbox"/> Circulation           | <input type="checkbox"/> Guilt                 | <input type="checkbox"/> Parenting Skills            |
| <input type="checkbox"/> Digestion             | <input type="checkbox"/> Self-Concept          | <input type="checkbox"/> Sexuality                   |
| <input type="checkbox"/> Bowel Function        | <input type="checkbox"/> Tiredness/Fatigue     | <input type="checkbox"/> Problems with Relatives     |
| <input type="checkbox"/> Urinary Function      | <input type="checkbox"/> Sleep Disturbances    | <input type="checkbox"/> Legal                       |
| <input type="checkbox"/> Joint/Muscle Function | <input type="checkbox"/> Suicide Ideas         | <input type="checkbox"/> Exercise, Hobbies           |
| <input type="checkbox"/> Skin Condition        | <input type="checkbox"/> Indecision            | <input type="checkbox"/> Drinking Problems           |
| <input type="checkbox"/> Pain                  | <input type="checkbox"/> Memory/Concentration  | <input type="checkbox"/> Drug Problems               |
| <input type="checkbox"/> Menstrual Cycle       | <input type="checkbox"/> Eating/Appetite       | <input type="checkbox"/> Behavior Problems           |
| <input type="checkbox"/> Menopause             | <input type="checkbox"/> Weight Loss/Gain      | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Smoking               | <input type="checkbox"/> Phobias               |  |

Name of your physician: \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## **Northshore Clinic of Sheboygan, Inc.**

615 South 8<sup>th</sup> Street • Sheboygan, WI 53081  
(PH) 920-457-8866

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.

### **NOTICE OF PRIVACY PRACTICES – SUMMARIZED VERSION**

We are required by law to follow the practices described in this handout. This is a summary of our Privacy Practices, but does not replace the full version, which you can request to review at any time. This notice applies to personal medical/health information that we have about you, and which is kept in or by Northshore Clinic of Sheboygan, Inc.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities which are called, in the law, health care **operations**. After you have read this notice, we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an **Authorization** to allow this. We are required to follow the terms of this notice currently or any revision to it that is in effect.

We realize these laws are complicated, but we must provide you with the following important information. Neither this Summary nor the full Notice of Privacy Practices covers every possible use or disclosure. If you have any questions, please contact the Privacy Officer for Northshore Clinic. The name and phone number of our Privacy Office is listed at the end of this Notice.

#### **Who has access to your personal information?**

We may use your health information and disclose it to appropriate persons, authorities and agencies as allowed by federal and state law. We may do this without your written permission for the following purposes:

- 1). Plan your treatment and services. This includes releasing information to qualified professionals who work at our facility and/or are involved in your care or treatment. We may also use or disclose your information to health care providers outside Northshore. An example would be giving information at the onset and termination of treatment to an Employee Assistance Program about your referral. Another example is to give your information to a pharmacist in order to assure your prescription will be filled.
- 2). Submit bills to your insurance, Medicare, or third party payer
- 3). Obtain approval in advance from your insurance company. (Ex. Pre-authorizations for certain managed-care plans)

- 4). Measure our quality of services.
- 5). Decide if we should offer more or fewer services to our community.
- 6). Exchange information with other State agencies as required by law.
- 7). Review and evaluate the skills, qualifications and performance of the therapist providing service to you. For example, a case review is performed every 90 days. A second example is review of case files when our license is renewed/granted by the state.

We may use your personal health information without your permission under these circumstances:

- 1). When used or disclosure is required by state, federal or local law. This includes investigations, audits, inspections and licensure.
- 2). When public health authorities and oversight agencies are authorized by law to collect information on a serious public health or safety threat to you or others.
- 3). To report abuse, neglect or domestic violence when required and authorized by law or when you agree to the disclosure.
- 4). When ordered to do so by court or administrative order.
- 5). To law enforcement as permitted or required by State Law.
- 6). When there is a serious threat to health and safety to you or another person. If you are the victim of a crime, involved in a crime at our facility, or if you have threatened to commit a crime, information will be released if we believe in good faith that this disclosure will help prevent or lessen a serious threat. We do this as allowed by law and standards of ethical conduct.
- 7). For appointment reminders by phone or mail.
- 8). To inform you about treatment options. An example might be sharing financial information to verify a non-profit clinic could provide fees on a sliding scale.
- 9). For certain types of research. For example, a possible investigation into the effects of a medication used could be made.
- 10). To coroners and medical examiners for purposes of determining the cause of death, as authorized by law.
- 11). As required by appropriate authorities: if you are a member of U.S. or foreign military forces (including veterans) or to federal officials for intelligence and national security.
- 12). For Worker's Compensation and similar programs.

#### **Authorization to Use or Disclose Health Information**

Other than is stated previously, Northshore Clinic will not disclose your health information unless we have your **written authorization**. If you or your representative authorizes Northshore to use or disclose your health information, you may revoke that authorization in writing at any time.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer:

**Patricia A. Brinkman, MSW, LCSW**  
**Northshore Clinic of Sheboygan, Inc.**  
**615 South 8<sup>th</sup> Street**  
**Sheboygan, WI 53081**  
**(920) 457-8866**

This notice is effective as of April 14, 2003.

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# YOUR CONSUMER RIGHTS

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When you receive any type of service for mental health, alcoholism, drug abuse or a developmental disability you have the following rights under Wisconsin Statute sec. 51.61(1) and HSS 94 Wis. Administrative Code. You also have rights under federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) explaining how we handle and use information about you. This brochure outlines the rights that are most applicable to individuals being treated in an outpatient setting. The full listing of your rights under Wisconsin Law and Federal Law are posted in our reception area.

## **I. Personal Rights**

You must be treated with dignity and respect, free of any verbal or physical abuse.

You have the right to have staff make fair and reasonable decisions about your treatment and care.

You cannot be treated differently because of your race, national origin, sex, age, religion, disability or sexual orientation.

## **II. Treatment and Related Rights**

You must be provided prompt and adequate treatment, rehabilitation and educational services appropriate to you.

You must be allowed to participate in the planning of your treatment and care.

You must be informed of your treatment and care, including alternatives and possible side effects of medications.

No treatment or medication may be given to you without your consent.

You must be informed of any costs of your care and treatment that you or your relatives may have to pay.

## **III. Communication and Privacy**

You have the right to request confidential communication. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.

You have the right to request restrictions on the uses and disclosures of your health information for treatment, payment or operations. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when against the law, in emergencies, or when the information is necessary to treat you.

You may not be filmed or taped unless you agree to it.

## **IV. Record Privacy and Access Law**

You have been asked to read our Notice of Privacy Practices and to sign a consent form so that we can use/disclose your health information for treatment, payment and healthcare operations.

You have a right to a paper copy of our Notice of Privacy Practices.

You have the right to see and copy your health information. This includes your medical record and billing record but **does not include psychotherapy notes**. We may ask a reasonable charge for copying.

You have the right to amend or change your health information if you believe it is incorrect or incomplete. You must make this request in writing and you will need to explain your reasons for requesting the change.

You have the right to ask for a list of the disclosures we have made of your health information. You can ask for a listing of what information we sent, when we sent it and to whom it was sent. You will be asked to fill out a form so that we can provide this list to you.

## **VI. Authorizations**

Other than is stated previously, Northshore Clinic will not disclose your health information unless you have signed an **authorization for disclosure**. You have the right to revoke this authorization at any time but disclosures made before your revocation cannot be recovered or undone. In some cases, the law requires some disclosures and these cannot be revoked.

## **VII. Complaints**

You have the right to file a complaint if you believe your privacy rights have been violated in any way. You cannot be threatened or penalized for filing a complaint. Any member of our staff can explain your rights and the complaint process. We also have an anonymous "How are we doing" box in our reception area. Please feel free to give us suggestions or comments at any time.

Our Privacy Officer is: **Patricia A. Brinkman, MSW, LCSW**

You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing.



### **Northshore Clinic of Sheboygan, Inc.**

615 South 8<sup>th</sup> Street  
Sheboygan, WI 53081

Phone (920) 457-8866  
Fax (920) 457-8867