

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

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:**

---

Subscriber Name (Last, First, Middle)	Birthdate	Sex
---------------------------------------	-----------	-----

---

Subscriber Address	City	State	Zip Code
--------------------	------	-------	----------

---

Subscriber Home Phone	Subscriber Work Phone	Employer
-----------------------	-----------------------	----------

---

Insurance Company Name	Phone Number
------------------------	--------------

---

Insurance Company Address	City	State	Zip Code
---------------------------	------	-------	----------

---

Subscriber ID Number	Social Security Number	Group Number
----------------------	------------------------	--------------

Relationship to Patient: \_\_\_\_\_

**SECONDARY INSURANCE**

---

Subscriber Name (Last, First, Middle)	Birthdate	Sex
---------------------------------------	-----------	-----

---

Subscriber Address	City	State	Zip Code
--------------------	------	-------	----------

---

Subscriber Home Phone	Subscriber Work Phone	Employer
-----------------------	-----------------------	----------

---

Insurance Company Name	Phone Number
------------------------	--------------

---

Insurance Company Address	City	State	Zip Code
---------------------------	------	-------	----------

---

Subscriber ID Number	Social Security Number	Group Number
----------------------	------------------------	--------------

Relationship to Patient: \_\_\_\_\_

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

**MEDICAL HISTORY**

ATT

35.17-B

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.



**Statement of Understanding**

**Confidential**

**PROGRAM ELIGIBILITY AND COSTS**

United Behavioral Health offers assessment, referral and short-term counseling. Employee assistance services provided by United Behavioral Health are normally delivered at no cost to you.

Referrals to other service providers may be recommended to help you resolve problems. Since not all providers are affiliated with United Behavioral Health, a referral should not be considered an endorsement of the provider. United Behavioral Health is not responsible for unaffiliated providers and does not monitor the quality of care they deliver.

The services to which you are referred may be covered under a medical benefit plan offered by an employer, insurer or HMO. Referral is not a guarantee of benefits. Payment of benefits is subject to any subsequent review of medical information or records as well as confirmation of eligibility on the date the service was provided and any other contractual obligations of the plan. It is your responsibility to determine whether or not services are covered under the plan and to pay any uncovered charges.

**CONFIDENTIALITY**

United Behavioral Health and your counselor will not share information with any person outside the United Behavioral Health system without your written permission, except as allowed by law. If you work in a safety-sensitive position or in an unescorted position, there may be additional events that could warrant sharing of information without your permission. Your counselor can discuss these with you. Audits of United Behavioral Health may be conducted; however, personally identifying information will not be disclosed to the auditors unless required by law.

Federal and state laws and regulations may also protect the confidentiality of your participation in this program. Violations are a crime and may be reported.

United Behavioral Health staff may follow up with you by phone or questionnaire to evaluate its effectiveness and your satisfaction.

I have read this statement and acknowledge its conditions.

\_\_\_\_\_  
Signature of client or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client

\_\_\_\_\_  
Case number