

## **Northwest Journey Intake Packet**

This packet of information includes: a program letter that describes the program and services, important releases and consents, and an intake questionnaire. Please thoroughly complete the forms included and return to the Program Coordinator prior to intake. These forms are vital to the intake process and many are required by the state. We have attempted to make these forms as easy to complete as possible, however do not hesitate to contact the program if questions arise. If you have any questions or concerns feel free to call the program. The following forms are included in this packet:

- Program Letter
- Patient Credit Policy
- Financial Intake Form
- Consent for Disclosure-Mental Health/AODA (Release for Medical Assistance)
- Consent for Disclosure-Mental Health/AODA (Release for School, Medical and Previous Providers)
- Notice of Privacy Practices
- Referent Problem Description (optional)
- Intake Questionnaire

Thank you for taking the time to complete these forms.



Northwest Journey  
203 United Way Drive  
Frederic, WI 54837  
715-327-4402(phone) 715-327-4470(fax)

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Dear Potential Client, Care Provider, or Agency,

This letter provides information about the day treatment program and services. If you have any questions or need more information, please do not hesitate to contact us for more information.

#### Criteria for Admissions

- Have a primary mental health disorder (involving behavioral and/or emotional difficulties).
- Have an inability to obtain sufficient benefits from less restrictive treatment services.
- Have a reasonable likelihood to benefit from services based on information available.
- Be experiencing significant dysfunction in basic domains of living, in need of transitional services after placement in an inpatient placement, or acute crisis.
- Have behavior that is principally derived from oppositional and/or conduct disorders
- Needs are not derived from intransigent/severe mental health disorders
- Child's needs are best met by Northwest Journey Level I program and the Northwest Journey program/treatment is a good match for the client.
- Client can be safe in the program

#### Services

Treatment components in the day treatment program include: individual counseling, educational programming, family counseling, group counseling, and group activities. Multiple groups are conducted each day covering a variety of treatment areas. Group areas include anger management, errors in thinking, personal health and safety, living skills, self-awareness, problem solving, communication skills, self-esteem building, conflict resolution, emotional development, school and study skills, cooperation building, social skills building, and others. Depending on the individual needs of the client/student, additional services are often accessible including medication management, psychological consultation, and alcohol & drug abuse services. Additional evaluations, testing, or other services can often be arranged on an as needed basis. Please mention your concerns to the individual counselor or other staff member in order to arrange additional services.

#### Records

Northwest Journey must receive all previous provider records from the past year prior to intake. In order to facilitate this process, please provide signed releases for all providers ASAP.

#### Psychiatric Evaluation and Services

It is expected that your funding source will require your child to have a psychiatric evaluation. For this reason, Northwest Journey expects that every client complete a psychiatric evaluation prior to or within one month of starting treatment. Please note: a psychiatric evaluation is an evaluation completed by a medical doctor, not a psychologist. A psychiatrist is qualified to prescribe medications.

In addition the client must complete regular follow-up visits with a psychiatrist as indicated by the psychiatrist. Continued funding may be dependent upon continued care.

### **Placement & Reintegration**

The average length of placement is 5-7 months, depending on the progress of the individual and the specific circumstances. Placement termination is generally based on the achievement of individualized treatment goals (such as ceased physical aggression, increased cooperation, and increased school productivity, increased appropriate anger/feelings expression). Approximately every 30 days, the treatment progress of the client is reviewed and revisions are made to the treatment focus as needed to enable effective treatment. Multi-disciplinary team meetings, by phone or at the site, are conducted every 30 days, if a physical control hold is implemented or more frequently as requested or needed based on client symptoms. The goal generally is to transition the client back into the public school system or similarly less restrictive placement as soon as possible while maintaining progress achieved. A meeting or phone discussion involving the day treatment staff, family, social service worker if involved, and any school or other treatment professionals involved, will be conducted near the end of placement or as needed to discuss treatment progress, answer questions, and provide information to assist in each case.

### **Payment**

Medical Assistance (MA) and/or private insurance cover most day treatment services. Medical Assistance is often based on financial need of the parents or primary care providers. Schools, social service agencies, or parents can also purchase day treatment services. Generally private insurance and MA are billed prior to other resources. If MA or private insurance funds your student's day treatment services, please notify the Northwest Journey Program Coordinator, immediately if there are any status changes in those benefits during the day treatment placement. In regard to MA, changes in status would include enrollment in an HMO, discontinuation of MA due to changes in financial need or changes in household dependents, or other. In regard to private insurance, please report any changes in employment that alter insurance coverage, changes in insurance company or benefits by employer, or any other changes that might affect benefits. Keeping us informed will help to eliminate any unexpected gaps in coverage, which could otherwise create uncovered costs. **Please contact our business office at (715) 327-4402 with any and all payment/billing questions.**

### **Medication &/or Medical Issues**

If the client will need medication distributed during the day treatment hours please notify us prior to intake. We will need a supply of the medication with specific dosage and time instructions. If there are other medical issues such as allergies or other medical conditions that may affect participation in group activities or treatment, please notify day treatment staff immediately.

Please contact Northwest Journey and speak with the Program Coordinator to arrange an interview, tour, or for additional information about the program. Thank you for your consideration of our day treatment program.

Sincerely,  
Northwest Journey Program Coordinator

## **Northwest Counseling and Guidance Clinic Patient Credit Policy**

We wish to maintain a direct relationship with our clients both in matters of health and finance. Most of our clients enjoy the use of credit when they come into our facility. They are granted this privilege without question. If you have any questions regarding our policy we would be happy to discuss them with you.

**POLICY:** *Your bill is due when you receive your statement.* We realize that medical care can sometimes be unexpected and costly. We are open to developing a payment plan that works for you. If you are having difficulties, we encourage you to call the Northwest Counseling and Guidance Clinic Billing Department at **715-327-4402** to discuss the matter with us. Accepted methods of payment are: cash, cashiers check, personal check, credit card or money order.

After you have exhausted all efforts of assistance to help satisfy your account (including a documented denial from Wisconsin Medicaid), we do have a sliding fee scale for additional assistance to help you resolve your account. You must apply for this program along with a copy of your most recent Income Tax filing and the Medicaid denial of eligibility.

Returned checks will be assessed a \$25.00 service charge.

**INSURANCE:** We will submit claims to your private insurance company if we are provided with complete information and you have signed an "Assignment of Benefits" form authorizing payment directly to Northwest Counseling and Guidance Clinic. If we do not have the appropriate insurance information and signature to obtain payment for our services you will be billed. **Please be advised that although you have insurance, there are times when the insurance does leave a co-insurance as your responsibility. We cannot guarantee payment by your insurance company.** If you have any questions regarding benefits, the processing of your claims and/or any balance left as your responsibility, please contact your insurance carrier. They do have your policy and provisions and can best answer those questions for you. Please be prepared to present your insurance card at each visit.

**If you have a change in insurance coverage,** it is your responsibility to notify NWCGC. Appropriate changes can then be made to your financial files and services submitted to the correct insurance carrier for payment. Failure to do so may result in your being billed for those services.

**HMO's and PPO's:** We participate in several HMO's and PPO's and will submit these claims for you. Some of these insurance plans require that you have a referral from your primary care physician. Questions regarding referral requirements or contracted providers with your insurance carrier can best be answered by your insurance company. Services denied because there was no referral will be billed to you.

**COPAYMENTS:** With the exception of day treatment, co-payments are due at the time of your visit. Since we do not know prior to our claims processing exactly what day treatment clients' responsibility will be, we will bill day treatment clients for whatever balance the insurance

company deems as the client's responsibility. We will be in communication with you about these costs. Please know that we will not deny services based on payment of co-pays. All other clients should be prepared to present payment at the time of their office visit. After payments and adjustments have been made you will be notified of any unpaid balance.

**COUNTY PROGRAM COPAYMENTS:** (excludes MA recipients)

Co-payments for Clients of **Burnett and Polk County Financial Assistance Programs** will be billed by the county.

**MEDICARE:** We are participating providers for Medicare. We will also file your supplemental insurance if you provide us with complete information and sign an "Assignment of Benefits" form authorizing payment directly to NWCGC. Medicare clients will be liable for coinsurance designated by Medicare.

**MEDICAL ASSISTANCE:** We are providers for Wisconsin Medical Assistance and Badger Care. Please present your card at the time of your service. Clients over 18 years of age will be liable for any co-pay or spend down designated by Medical Assistance. Again, we are open to developing payment plans with you.

**NO SHOW FEE:** NWCGC wants to ensure that all clients have an equal opportunity to meet with NWCGC providers. If a client does not show for an appointment or cancels less than 24 hours prior to his/her appointment, NWCGC Outpatient programs will assess a no show fee after the second offense. Insurance companies cannot be billed for no show fees, so they are the responsibility of the client. The no show fee must be paid in full in order to reschedule an appointment.

I have read and understand my responsibility regarding notification to Northwest Counseling and Guidance Clinic of any demographic and/or insurance changes. I also understand that failing to notify Northwest Counseling and Guidance Clinic of said changes, could result in my being billed for services. Also, by my signature I acknowledge that I have read this credit policy and accept these stipulations.

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Signature

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Date

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Client Name (printed)



## Northwest Counseling and Guidance Clinic Release of Information Authorization

Client Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Address (city, state, zip): \_\_\_\_\_

**Authorizes:** \_\_\_\_\_ **To use, exchange, and disclose information with:**  
Medical Assistance/EDS

\_\_\_\_\_  
Name of person/Organization

\_\_\_\_\_  
Name of person/Organization

\_\_\_\_\_  
Address (city, state, zip)

6406 Bridge Road, Madison, WI, 53784

\_\_\_\_\_  
Address (city, state, zip)

Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

**Time Period for which records are requested:** From \_\_\_\_\_ to \_\_\_\_\_  All

Records may be released from the signature date of this authorization forward, until the expiration of this authorization

**Expiration: This authorization will remain in effect:**

From the date this authorization is signed until: \_\_\_\_\_  One year from the date of signature

Until I cancel this authorization in writing  Other, specify: \_\_\_\_\_

**Reason for Release (please check):**  Coordinating Care/Treatment  Transfer of Care  Case Management  Personal

Billing, collection, or payment of claims  Other: \_\_\_\_\_

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

**Redisclosure Notice to Client:** If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

**Disclosure Notice to Recipient of Patient Health Care Records:** Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

**Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**Your Rights with Respect to this Authorization:**

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

*A photocopy of this authorization shall be as effective and valid as the original.*

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature or Parent/Guardian \_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

## Northwest Counseling and Guidance Clinic Release of Information Authorization

Client Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Address (city, state, zip): \_\_\_\_\_

**Authorizes:** \_\_\_\_\_ **To use, exchange, and disclose information with:** \_\_\_\_\_

\_\_\_\_\_  
Name of person/Organization

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**Your Rights with Respect to this Authorization:**

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

*A photocopy of this authorization shall be as effective and valid as the original.*

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature or Parent/Guardian

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

## Northwest Counseling and Guidance Clinic Release of Information Authorization

Client Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Address (city, state, zip): \_\_\_\_\_

**Authorizes:** \_\_\_\_\_ **To use, exchange, and disclose information with:** \_\_\_\_\_

\_\_\_\_\_  
Name of person/Organization

\_\_\_\_\_  
Name of person/Organization

\_\_\_\_\_  
Address (city, state, zip)

\_\_\_\_\_  
Address (city, state, zip)

Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

**Time Period for which records are requested:** From \_\_\_\_\_ to \_\_\_\_\_  All

Records may be released from the signature date of this authorization forward, until the expiration of this authorization

**Expiration: This authorization will remain in effect:**

From the date this authorization is signed until: \_\_\_\_\_  One year from the date of signature

Until I cancel this authorization in writing  Other, specify: \_\_\_\_\_

**Reason for Release (please check):**  Coordinating Care/Treatment  Transfer of Care  Case Management  Personal

Billing, collection, or payment of claims  Other: \_\_\_\_\_

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

**Redisclosure Notice to Client:** If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

**Disclosure Notice to Recipient of Patient Health Care Records:** Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

**Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**Your Rights with Respect to this Authorization:**

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

*A photocopy of this authorization shall be as effective and valid as the original.*

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

\_\_\_\_\_  
Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature or Parent/Guardian

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date



Northwest Journey  
203 United Way Drive  
Frederic, WI 54837  
715-327-4402(phone) 715-327-4470(fax)

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Dear Patients/Parents/Guardians of Northwest Counseling and Guidance Clinic:

Attached you will find a Privacy Notice explaining how medical information about you may be used and disclosed (which is yours to keep). Also enclosed is a privacy notice acknowledgment that will require your signature and must be returned to Northwest Counseling and Guidance Clinic to be retained in your file.

This notice is directly related to the new government regulations involving the protection of your personal information: The Health Insurance Portability and Accountability Act or it is also known as HIPAA. This legislation requires strict privacy regulations in all health care settings as of 4/14/2003. These regulations require all personal information be protected and used only for the necessary functions of the clinic as we deliver your health care. These regulations are designed to guarantee confidentiality of your private information.

Like all government programs, there will be paperwork involved. We will make every effort to make this process as smooth as possible. Your patience, understanding and cooperation will be greatly appreciated as we continue to protect your privacy and improve your care.

Thank you for your help, understanding and cooperation during this time.

Sincerely,

Northwest Counseling and Guidance Clinic

**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.**

Northwest Counseling and Guidance Clinic

Your Health Care Information - Protecting Your Privacy - It is your right as a patient to be informed of the privacy practices of your health care provider as well as to be informed of your privacy rights with respect to your personal health information. This Notice of Privacy Practices is intended to provide you with this information.

Northwest Counseling and Guidance Clinic's Responsibilities-It is your right as a patient to be informed of Northwest Counseling and Guidance Clinic's legal duties with respect to protection of the privacy of your personal health information. Northwest Counseling and Guidance Clinic is required to: maintain the privacy of your health information; provide you with a notice of the legal duties and privacy practices regarding protected health information collected and maintained about you; and abide by the terms of this notice.

Northwest Counseling and Guidance Clinic reserves the right to change the terms of the notice of privacy practices and make the new notice provisions effective for all protected health information that it maintains. Northwest Counseling and Guidance Clinic also reserves the right change the terms of its notice with respect to any applicable more limited uses and disclosures.

Northwest Counseling and Guidance Clinic will promptly revise and distribute its notice whenever Northwest Counseling and Guidance Clinic makes a substantial change to any of its privacy practices. Northwest Counseling and Guidance Clinic will not use or disclose your health information without your authorization, except as described in this notice.

You have the right to: Request a restriction on certain uses and disclosures of your health information. You have the right to request restrictions on certain uses and disclosures of protected health information, even if the restriction affects your treatment or Northwest Counseling and Guidance Clinic's payment or health care operation activities. However, Northwest Counseling and Guidance Clinic is not required to agree to your requested restriction. For example, if you are an employee of the clinic and you receive health care services in the clinic, you may request that your health care record not be maintained in the general record filing area.

Receive Confidential Communications-You have the right to request that Northwest Counseling and Guidance Clinic communicate your health information to you by alternative means or at alternative locations. Northwest Counseling and Guidance Clinic shall accommodate reasonable requests. For example, you may request to be contacted at a phone number that is different from the phone number listed in your health care record.

You have the right to inspect and obtain a copy of your health care record. This request for access to your health care record must be submitted in writing to Northwest Counseling and Guidance Clinic's Privacy Officer. This right may not apply to certain types of psychotherapy notes and Northwest Counseling and Guidance Clinic may charge you a reasonable fee for a copy of your health care record. For example, you may request a copy of your health care record from your family physician.

You have the right to request an amendment to your health care record if you believe your health information is incorrect or incomplete. You may be asked to make this request in writing and state the reason why your health record should be changed. If Northwest Counseling and Guidance Clinic did not create the health information you believe is incorrect or if Northwest Counseling and Guidance Clinic disagrees with you, Northwest Counseling and Guidance Clinic may deny your request. For example, if you believe that information in your medical history is incorrect, such as your birth date, you may request that this information be amended.

You have the right to an accounting of disclosures of your health information that Northwest Counseling and Guidance Clinic has made in compliance with state and federal law. The accounting will describe the dates of each disclosure, a brief description of information disclosed and the reason for disclosure. You will receive one accounting per year at no charge and Northwest Counseling and Guidance Clinic may charge you a reasonable fee for each subsequent request. For example, you may request an accounting of disclosures made from your health record in the last year to the State for disease reporting.

You have the right to obtain a paper copy of the notice upon request. For example, if you received the notice electronically, you may request that Northwest Counseling and Guidance Clinic provide a paper copy of the notice.

Northwest Counseling and Guidance Clinic is permitted by the federal privacy rule to use or disclose your protected health information for treatment, benefit information, payment or health care operations. Northwest Counseling and Guidance Clinic may use or disclose your health information for treatment. Northwest Counseling and Guidance Clinic may use or disclose your health information in the provision, coordination or management of your health care.

Your information may be disclosed from one physician to another if they are consulting each other in relation to your care and treatment.

Northwest Counseling and Guidance Clinic may use your health information to provide you with an appointment reminder.

Northwest Counseling and Guidance Clinic may send you information about treatment alternatives or other health related services that may be of interest to you.

Northwest Counseling and Guidance Clinic may use or disclose your health information for payment. Northwest Counseling and Guidance Clinic may use or disclose your health information to obtain reimbursement for the provision of health care services. The bill may include information that identifies you, your diagnosis and your treatment.

Example: Northwest Counseling and Guidance Clinic may use or disclose your information to your insurer to obtain payment for the provision of health care services.

Northwest Counseling and Guidance Clinic may use or disclose your health information for routine health care operations. Northwest Counseling and Guidance Clinic may use or disclose your health information for evaluation of patient care services, evaluating the performance of health care providers, activities relating to

compliance with the law and business planning and development. Example: Northwest Counseling and Guidance Clinic may review your health record to determine the efficiency of the services provided to you in the emergency room.

Example: Northwest Counseling and Guidance Clinic may contact you as part of a fundraising activity sponsored by your health care provider. Uses or Disclosures of Your Protected Health Information Permitted Without Your Authorization -Without your written authorization, Northwest Counseling and Guidance Clinic may use or disclose your health information for the following purposes:

As Required by Law: Northwest Counseling and Guidance Clinic may use or disclose protected health information to the extent that the use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law. Uses or disclosures required by federal privacy rule and limited by the more protective requirements of state law include the following: 1) disclosures about victims of elderly or child abuse; 2) disclosures for judicial and administrative proceedings; or 3) disclosures for law enforcement purposes.

Public health: As required by law, Northwest Counseling and Guidance Clinic may disclose your protected health information to the State of Wisconsin for the purpose of statutory reporting.

Northwest Counseling and Guidance Clinic may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result to a state or federal public health agency for the purpose of preventing or controlling disease, injury or disability. Northwest Counseling and Guidance Clinic may disclose your protected health information excluding your HIV test result without your authorization to a county agency investigating child abuse. Northwest Counseling and Guidance Clinic may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result without your authorization to the Food and Drug Administration (FDA). Northwest Counseling and Guidance Clinic may disclose your HIV test result without your authorization to a person that may have sustained a contact that carries a potential for transmission of HIV.

Northwest Counseling and Guidance Clinic may disclose your protected health information that is reasonably related to a work related illness or injury if an application for workers' compensation has been filed.

Victims of abuse, neglect or domestic violence: Northwest Counseling and Guidance Clinic may disclose health information except for an HIV test result if Northwest Counseling and Guidance Clinic reasonably believe that an individual is a victim of child or elderly abuse.

Health oversight activities: Northwest Counseling and Guidance Clinic will not disclose HIV test results to health care oversight agencies without an authorization. Northwest Counseling and Guidance Clinic may disclose your mental health, alcohol or drug abuse or developmental disability related health information to the Department of Health and Family Services, to the county for coordination of human services and to a representative of the board on aging and long-term care. The remainder of your protected health information may be disclosed without your authorization to a state or federal agency.

Judicial and Administrative Proceedings: Northwest Counseling and Guidance Clinic may disclose your protected health information in response to a court order. Northwest Counseling and Guidance Clinic may disclose your protected health information in response to a subpoena if Northwest Counseling and Guidance Clinic is a party to a court action, Northwest Counseling and Guidance Clinic has received your authorization to disclose and has not complied within two business days or Northwest Counseling and Guidance Clinic failed to respond to a request for workers' compensation records. Northwest Counseling and Guidance Clinic may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result in response to a subpoena from a state or federal agency.

Law enforcement: Northwest Counseling and Guidance Clinic may disclose your protected health information except for HIV test results to county law enforcement officials for the reporting and investigation of elderly and/or child abuse. Northwest Counseling and Guidance Clinic may disclose your protected health information except for mental health, alcohol or drug abuse or developmental disabled or HIV test results to state and federal law enforcement officials. Northwest Counseling and Guidance Clinic may disclose mental health, alcohol or drug abuse or developmental disabled protected health information for limited law enforcement purposes as required by law. Northwest Counseling and Guidance Clinic may disclose your protected health information to a law enforcement official in response to a court order.

For activities related to death: Coroner or Medical Examiner- Northwest Counseling and Guidance Clinic may use or disclose your protected health information that is not an HIV test result or related to mental health, alcohol or drug abuse and developmental disabilities to a coroner or medical examiner. Funeral Director- Northwest Counseling and Guidance Clinic may use or disclose your HIV test result a funeral director.

For caregiver organ, eye or tissue donation purposes- Northwest Counseling and Guidance Clinic may use or disclose your HIV test result to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or caregiver organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Northwest Counseling and Guidance Clinic may use or disclose your HIV test result and protected health information that is not related to mental health, alcohol or drug abuse and developmental disabilities, to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or caregiver organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research: Northwest Counseling and Guidance Clinic may use or disclose your protected health information for research purposes if the researcher has obtained your permission or fulfilled the stringent privacy requirements of state and federal law.

To avoid a serious threat to health or safety: Northwest Counseling and Guidance Clinic may disclose your protected health information under limited circumstances to law enforcement officials to avert a serious threat to health or safety.

Disclosures for specialized government functions: Northwest Counseling and Guidance Clinic may disclose protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result for national security, for protection of the President and for medical suitability determination or of Armed Forces personnel to a state or federal agency. Northwest Counseling and Guidance Clinic may disclose protected health information to limited staff of a correctional institution or a custodial law enforcement official for the provision of health care and the transport of inmates.

Workers compensation: Northwest Counseling and Guidance Clinic may disclose protected health information reasonably related to a workers' compensation injury.

Northwest Counseling and Guidance Clinic has attempted to explain with this notice the circumstances where state law may be more protective than the federal privacy rule and provides greater privacy protection.

Except for the situations listed above and treatment, payment or health care operation purposes, the use or disclosure of your health information requires Northwest Counseling and Guidance Clinic to obtain your written authorization. You may withdraw your authorization in writing at any time by submitting your written withdrawal to Northwest Counseling and Guidance Clinic's Privacy Officer.

Patient Complaint Process-If you believe your privacy rights have been violated, you may file a complaint with Northwest Counseling and Guidance Clinic or with the Secretary of the Department of Health and Human Services. There will be no retaliation against you for filing a complaint.

To file a complaint with Northwest Counseling and Guidance Clinic please contact the Northwest Counseling and Guidance Clinic's Privacy Officer who will provide you with the necessary assistance.

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact: Ginny Wickman (715-327-4402)

Northwest Counseling and Guidance Clinic  
203 United Way Drive  
Frederic, WI 54837  
Phone number: 715-327-4402  
Fax number: 715-327-4470  
Email address: [ginnyw@nwcgc.com](mailto:ginnyw@nwcgc.com)

Please retain this notice for your records and sign, date and return the next page to Northwest Counseling and Guidance Clinic as an acknowledgment that you did receive this notification. Thank you.....

**Northwest Counseling and Guidance Clinic**

**Written Acknowledgement of Receipt**

I, \_\_\_\_\_ , acknowledge that I have received the written

**Patient Name**

**Notice of Privacy Practices from Northwest Counseling and Guidance Clinic**

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian signature

\_\_\_\_\_  
Date

(required for client under 14 for mental health services, or under 12 for AODA services)

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgment was unable to be obtained. Reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



**Northwest Directions  
Northwest Journey  
Intake Questionnaire**

Thank you for filling out this form. It will help provide important information to aid in the treatment of your child. If you have any questions about this form please contact clinic personnel. All records are confidential. Thanks again!

**Identifying Data**

Parent/Care provider completing form: \_\_\_\_\_ **Date:** \_\_\_\_\_  
Child's Full Name (Client): \_\_\_\_\_  
Child's Date of Birth: \_\_\_\_\_

**Presenting Problem**

Check all those that apply or have applied in the past to your child. List the frequency and severity of the problem (e.g. anger outbursts 3 times each day involving throwing things, hitting and/or swearing). If the problem is no longer present, then indicate when stopped.

- Sleep problems:       Sleeping too little       Sleeping too much
- Trouble falling asleep       Trouble staying asleep
- Frequent nightmares and/or night terrors
  
- Eats too much or too little: \_\_\_\_\_
- Dieting when not needed \_\_\_\_\_
- Child or Parent concerned about child's weight or body image: \_\_\_\_\_
- Low Self-Esteem: \_\_\_\_\_
- Indecisive: \_\_\_\_\_
- Irritable: \_\_\_\_\_
- Unable to care for self: \_\_\_\_\_
- Loss of interest: \_\_\_\_\_
- Lack of energy: \_\_\_\_\_
- Withdrawn: \_\_\_\_\_
- Mood Swings: \_\_\_\_\_
- Self-harmful: \_\_\_\_\_
- Suicide threats, attempts, or thoughts: \_\_\_\_\_
- Significant loss/death of someone: \_\_\_\_\_
- Feeling weepy or crying frequently: \_\_\_\_\_
- Impulsiveness: \_\_\_\_\_
- Hyperactivity/Agitation: \_\_\_\_\_
- Poor or short attention span: \_\_\_\_\_
- Anger/Temper outbursts: \_\_\_\_\_
- Verbal aggression:       threats to harm/kill others       swearing       yelling
- Other verbally aggressive
- behavior: \_\_\_\_\_
- Physical aggression (describe behaviors, to whom, and how often): \_\_\_\_\_
  

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- Oppositional and/or argumentative (refusal to follow directives, arguing): \_\_\_\_\_

Peer Group problems (negative or delinquent friends, easily influenced, fighting, none or few friends)

- Frequent lying: \_\_\_\_\_  
 Stealing or shoplifting: \_\_\_\_\_  
 Running away: \_\_\_\_\_  
 Difficulty forming close relationships: \_\_\_\_\_  
 Anxiety/Fears/Phobias/Worries: \_\_\_\_\_  
 Obsessive-Compulsive Traits: \_\_\_\_\_  
 Perfectionist: \_\_\_\_\_  
 Other: \_\_\_\_\_

### Chemical Health History

#### Substance Abuse of Child

	Yes	No	Last Use	History of Use	Severity/Frequency
Alcohol					
Marijuana					
Over-the-counter drugs					
Cocaine					
Prescription drugs					
Methamphetamine					
Hallucinogens					
Inhalants					
Tobacco					
Other:					

Prior attempts to stop or control usage: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is usage perceived as a problem? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has child ever had an alcohol or drug abuse evaluation? \_\_\_\_\_

If so, please list person who conducted the evaluation, clinic, and date: \_\_\_\_\_  
\_\_\_\_\_

### Medical History

#### Medical History of child

Please check all those that apply:

- Allergic or other reaction to medication  
 Asthma  
 Surgeries (list all): \_\_\_\_\_

- Seizures, convulsions, epilepsy
- Head injury bad enough to knock you out
- Other brain disease (tumor, stroke, etc.)
- Heart problems (rapid or irregular heartbeat, etc.)
- Thyroid problems
- Problems with lungs, liver, or kidney
- Dizzy spells
- Change in vision, hearing, smell, speech, or taste
- Weakness, paralysis, clumsiness, or trouble walking
- Tremor, shakiness, unusual muscle movements or tics
- Numbness, tingling, or unusual body sensations
- Muscle tension, aches, soreness, or pain in joints
- Fever, chills, sweats or hot flashes
- Feeling fatigued, tired, low on energy
- Infectious Diseases (Hepatitis, Tuberculosis, Measles, Mumps, Small Pox)
- Bedwetting or soiling
- Upset stomach
- Shortness of breath
- Increased thirst or dry mouth
- Weight loss or weight gain
- Diabetes
- Bedwetting or soiling:     Day time     Night time
- Hospitalizations: \_\_\_\_\_

Other Medical Conditions: \_\_\_\_\_

**Developmental History**

Your child's early childhood problems:

- Medical problems during pregnancy
- Alcohol or drug exposure during pregnancy
- Medical problems during birth or as a newborn
- Unusual or severe childhood illness: \_\_\_\_\_
- Childhood learning problems needing special help in school

Your child's coordination:

Rate your child on the following skills:			
	Above Average	Average	Below Average
Walking:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throwing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catching:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoelace Tying:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehension and Understanding:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall Level of Intelligence:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Following Directions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Your child's comprehension and understanding:

Do you consider your child to understand directions and situations as well as other children his or her own age? If not, why not?

How would you rate your child's overall level of intelligence compared with other children?

Below average     Average     Above average

### Mental Health History

Your child's past or present problems with thoughts and perceptions:

- Confusion or disorientation
- Trouble concentrating or thinking clearly
- Memory trouble
- Preoccupied mind
- Thinking about death, dying or suicide
- Upsetting or embarrassing thoughts, mental pictures, or memories which keep coming into mind even though you don't want them
- The need to do certain things over and over even though your child doesn't want to
- Excessive fantasies
- Ideas or beliefs other people think are untrue
- Hallucinations (seeing or hearing things other people don't)
- Marked shyness, fears about being with people

Has your child ever been diagnosed with (check all that apply):

- Post Traumatic Stress Disorder (PTSD)
- A Psychotic Disorder
- AODA issues

### Abuse History of child (physical, sexual, emotional)

Has this child been abused?     Yes     No     Maybe

If yes, or maybe, please explain: \_\_\_\_\_

If abuse is or has been present, to your knowledge does your child experience:

- Flashbacks: \_\_\_\_\_
- Recurrent Dreams: \_\_\_\_\_
- Dissociation: \_\_\_\_\_
- Increased arousal: \_\_\_\_\_
- Numbing: \_\_\_\_\_

### Sexual History

Orientation:     Heterosexual  
                     Homosexual

- Bisexual
- Undifferentiated (no identified sexual orientation)

- Activity:
- Engages in sexual activity short of intercourse
  - Engages in intercourse:
    - With protection/contraception
    - Without protection/contraception
  - Masturbation/self stimulation
    - In private
    - In public (i.e., outside of the bedroom/bathroom)
  - Inappropriate sexual commentary: \_\_\_\_\_
- 
- Self exposure/public nudity
  - Utilizes contraception on a regular basis. What form: \_\_\_\_\_

Has your child ever gotten into trouble at school or with the law for inappropriate sexual behavior?  No  
 Yes, details: \_\_\_\_\_

**Family History**

Family Data

	Name	Age	Education Level	Occupation	Residence
Father					
Stepfather					
Foster Father					
Mother					
Stepmother					
Foster Mother					
Guardian					
Sibling					
Sibling					
Sibling					
Sibling					
Other (living in home)					

**Family Relationships**

Describe the relationships between:

Biological-mother and child: \_\_\_\_\_

Biological-father and child: \_\_\_\_\_

Foster parents and child: \_\_\_\_\_

Step-parents and child: \_\_\_\_\_

Siblings and child: \_\_\_\_\_

Significant others of parent and child: \_\_\_\_\_

Couple relationship of primary caregivers: \_\_\_\_\_

**Family Stressors**

In the past year has the child had any of the following present in his/her life:

- Change in schools
- Change in residence
- Loss of family member/friend

Other family issues impacting your child: \_\_\_\_\_

Describe any family history of psychiatric/mental health/drug and alcohol problems: \_\_\_\_\_

Is anyone else in the family having similar problems to this child (or has in the past)? \_\_\_\_\_

Family legal involvement: \_\_\_\_\_

Has anyone in the family ever been abused? \_\_\_\_\_

Does anyone in the family have significant medical problems or illnesses? \_\_\_\_\_

Family Mental Health Treatment History: \_\_\_\_\_

**Family Strengths & Changes**

Describe the strengths of your family: \_\_\_\_\_

Describe what you would like to improve most with your family: \_\_\_\_\_

Describe your parenting style: \_\_\_\_\_

Describe the few most important things you would like to see improved in your child: \_\_\_\_\_

Spiritual/Cultural Considerations: \_\_\_\_\_

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**Vocational and Independent Living Skills**

What skill training has your child had? (skill training may include: woodworking, computer skills, etc.) \_\_\_\_\_

What are your child's hobbies/interests? \_\_\_\_\_

Has your child ever been employed? \_\_\_\_\_

What vocational skills interest your child? \_\_\_\_\_

What are your child's goals for independent living? \_\_\_\_\_

---

**School**

School presently enrolled in: \_\_\_\_\_

Main contact person: \_\_\_\_\_

Current Grade level: \_\_\_\_\_ Last IEP: \_\_\_\_\_

Enrolled in:  EBD  LD  Other: \_\_\_\_\_

Other school services (OT, speech therapy, etc): \_\_\_\_\_

What problems is your child having in school (check all that apply):

Failing classes

Not following directions

Disruptive in class

Problems concentrating or paying attention

Not completing assignments and/or homework

Learning Problems

Receiving detentions, suspension(s) or expulsion

Difficulties with peer relationships

Truancy problems

Other school related problems or areas of concern: \_\_\_\_\_

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**Legal Involvement**

List and briefly describe any contact with the police and any legal charges (include approximate dates of incidents): \_\_\_\_\_

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Are there court appointments or charges pending? \_\_\_\_\_

Is there a court order in place? \_\_\_\_\_

If yes, what are the conditions? \_\_\_\_\_

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**Client Strengths**

What motivates your child? \_\_\_\_\_

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What do you see as the strengths of your child? \_\_\_\_\_

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What do you like most about your child? \_\_\_\_\_

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What interventions have worked for you with your child? \_\_\_\_\_

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