NorthLakes
COMMUNITY CLINIC

(888) 834.4551

www.nlccwi.org

OUTPATIENT MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES
WELCOME LETTER

Welcome to our clinic! We understand that the amount of paperwork presented for review and signatures during the first visit can be overwhelming. We urge you to let us know if you need a break or if you have any questions as the required paperwork is completed. Thank you for your patience.

Forms

Attached you will find several items for your review. You may keep the following documents for your records:

- HIPAA Notice of Privacy Practices
- Brochure – "Client Rights and the Grievance Procedure" or "Rights of Children and Adolescents"
  -This includes information about filing a grievance

Upon completion of your paperwork, you may ask for a copy of your signed:

- Informed Consent
- Clients Rights Policy

Contact numbers

You may call the clinic at: 888-834-4551 to make an appointment. **NorthLakes Community Clinic does not provide emergency behavioral health care. Always, in the case of an emergency, dial 911. If you are having a crisis after hours call the Mental Health Crisis line at 1-866-317-9362 or the National Suicide Prevention Lifeline at 1-800-273-8255 or go to your local emergency room.**

General clinic hours of services are Monday through Friday from 8:00 a.m. to 5 p.m.

Discharge

As determined by you and your therapist, you will be discharged upon completion of your treatment program.

There are circumstances under which you may be involuntarily discharged. The following are possible reasons for an involuntary discharge:

- referral to another treatment resource is deemed necessary by your provider
- excessive missed appointments

I have read and understand the above, have had an opportunity to ask questions about this information. I understand that I have the right to ask questions of my treatment provider about the above information at any time.

_____ _____

Signature of client ages 18 years or older or legal representative **Date**

_____ _____

Witness **Date**

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Child and Adolescent Mental Health Intake Form

This intake form is for individuals' ages 3-17 years
It may be completed by the child, the parent and/or both

Legal Name: **Preferred Name:**

Gender Assigned at Birth: **Pronouns: she/hers he/his they/them ze/zer ask me**

Parent/Legal Guardian Name:

Legal shared parenting agreement? □Yes □ No **Custody concerns? □Yes □No**

For what issues are you seeking help?

When did these issues start?

What do you hope to gain from counseling? How will you know things are better?

How long do you expect to be in counseling?
□1-3 sessions □4-10 sessions □ A long time □No idea

Education

School/Day Care Name: _____
Current Grade: _____ **Have an IEP or 504 Plan? □Yes □No**

Any behavioral or academic concerns? □Yes □No

Developmental History

Complications prior to birth? □Yes □No **Complications at birth? □Yes □No**

All developmental milestones met? □Yes □No

Any significant changes in life such as:

□Frequent moves **□Changes in Caregivers** **□Death of a friend/relative**

□Witness to violence **□History of Abuse/Neglect** **□Other:**

Work a part time job? □Yes □No

Involved in extra-curricular activities (sports, youth groups, or clubs)? □Yes □No

What do you like to do for fun?

Is spirituality a part of your life? □Yes □No □It's complicated

Family &Relationships

Who lives in your home with you?

Do you have visits with another parent? □ Yes □ No If yes, how often do you visit?

Do you have siblings who live in another home? □ Yes □ No

Describe your relationship with family:

Are you dating? □ Yes □ No **Are you currently in a relationship? □ Yes □ No**

Describe your relationship with friends:

Do you feel supported by your friends and family? □Yes □No □Sometimes

Medical & Mental Health Treatment History

Physician Name: **Dentist Name:**

Chronic medical problems □Yes □No **Head Traumas/Concussions: □Yes □No**

Past Counseling Experience? □Yes □No When?_____ Where?_____

Please list any current medications:

Mental Health History					
	Self	Mother	Father	Sibling	Grandparent
Depression	□	□	□	□	□
Anxiety	□	□	□	□	□
Bipolar Disorder	□	□	□	□	□
Schizophrenia	□	□	□	□	□
Post-Traumatic Stress	□	□	□	□	□
Drug/Alcohol Addiction	□	□	□	□	□
Eating Disorder	□	□	□	□	□
Violence	□	□	□	□	□
Suicide	□	□	□	□	□
Problems with Focus or Attention	□	□	□	□	□
Other	□	□	□	□	□

Strengths & Difficulties			
	Not True	**Somewhat True**	**True**
Considerate of other peoples' feelings	□	□	□
Restless, overactive, cannot stay still for long	□	□	□
Often complains of headaches, stomach-aches or sickness	□	□	□
Shares readily with other youth	□	□	□
Often loses temper	□	□	□
Would rather be alone than with other youth	□	□	□
Generally well behaved, usually complies with adult requests	□	□	□
Many worries or often seems worried	□	□	□
Helpful if someone is hurt, upset or feeling ill	□	□	□
Constantly fidgeting or squirming	□	□	□
Has at least one good friend	□	□	□
Often fights with other youth or bullies them	□	□	□
Often unhappy, depressed or tearful	□	□	□
Generally liked by other youth	□	□	□
Easily distracted, concentration wanders	□	□	□
Nervous in new situations, easily loses confidence	□	□	□
Kind to younger children	□	□	□
Often lies or cheats	□	□	□
Picked on or bullied by other youth	□	□	□
Often offers to help others (parents, teachers, children)	□	□	□
Thinks things through before acting	□	□	□
Steals from home, school or elsewhere	□	□	□
Gets along better with adults than with other youth	□	□	□
Many fears, easily scared	□	□	□
Good attention span, completes chores and/or homework	□	□	□

CURRENT SYMPTOMS CHECKLIST

Please check the appropriate box for symptoms you/your child have experienced in the past 2 weeks.	**Daily** √	**Some** √	**None** √
Sadness/Depressed Mood/Crying Spells			
Temper Outbursts			
Withdrawn or Isolated			
Daydreaming			
Fearful			
Clumsy			
Over-reactive			
Short Attention Span/Difficulty Concentrating			
Fatigue/Low Energy			
Hard to make decisions			
Appetite increase or decrease/Feeding or eating problems			
Weight increase or decrease			
Distractible			
Suicidal thoughts			
Attempts to self -harm			
Peer Conflict/Mean to others			
Mood swings			
Increased energy			
Racing thoughts			
Bedwetting			
Decreased need for sleep			
Excessive worry			
Feeling "on edge"			
Panic Attacks			
Destructive			
Restlessness			
Irritability or Anger			
Stealing, lying, disregard for others			
Defiance toward authority			
Impulsivity			
Nightmares			
Hearing or seeing things - others don't see/hear			

Who completed this form: □Parent/Guardian □Client/Child □ Both Parent and Client

_____ _____

Parent/Guardian Signature Date **Client/Child Signature Date**

Client Name:_____

The CRAFFT Questionnaire (version 2.1)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2.	Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

		No	Yes
4.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
5.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
6.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
7.	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
8.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
9.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

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CLIENT RIGHTS POLICY- BH

Patient Name: _____ DOB: _____

Clients have the following rights under Wisconsin state law:

- The right to be informed of your rights as a patient/client.
- Nondiscrimination on the basis of race, religion, age, sex, or sexual orientation, ethnic origin, physical or mental impairment, financial or social status.
- The right to the least restrictive treatment conditions necessary.
- The right to receive prompt and adequate treatment.
- The right to be informed of your treatment and care, treatment options and to participate in the planning of your treatment and care.
- The right to be free from any unnecessary or excessive medications at any time.
- The right to refuse all medication and treatment unless court-ordered or unless medication and/or treatment is necessary to prevent serious physical harm to yourself or to others.
- The right to a humane psychological and physical environment.
- The right not to be subjected to experimental research without your informed, written consent.
- The right not to be subjected to psychosurgery or other drastic treatment procedures without your written, informed consent.
- The right to petition the court for review of your commitment order.
- The right to confidentiality of all treatment records, to review and copy certain records, and to challenge the accuracy, completeness, timeliness or relevance of information in your records in accordance with the provisions of section.
- The right not to be filmed or taped without your permission.
- Be informed about the costs of treatment and medications.
- The right to file a grievance about violation of these rights without fear of retribution.
- The right to go to court if you believe that your rights were violated.
- Have the right to be treated with respect and recognition of the patient's dignity and individuality by all employees of the treatment facility or community mental health program and by licensed, certified, registered or permitted providers of health care with whom the patient comes in contact.

By my signature below, I acknowledge that I received or was offered a copy of the Clients Rights.

X_____ _____

Signature of Patient/Legal Guardian Date

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INFORMED CONSENT- BH

Patient Name:_____ DOB:_____

I understand that I am seeking services regarding a health problem or suspected health problem at NorthLakes Community Clinic (NorthLakes) to be provided by authorized employees of the Clinic, etc. I consent to routine services, which may include but are not limited to: assessment, evaluation, diagnosis, treatment planning, therapy, group therapy, education, discharge planning, referral, and follow up care. These program elements have been explained to me and I understand what the services are. I understand I can withdraw this consent at any time, and that **it is effective for one year from this date**.

In addition to the above be informed that:

- Benefits that will come from this treatment could include a solution to your presenting problem, better coping skills or a better adjustment to your life situation.
- You and your provider will establish a treatment plan that will include how often you will meet with the provider and who may be included in your treatment.
- The clinician providing treatment may not be credentialed by OptumHealth/UBH and the visits will be billed under their supervising provider.
- Treatment does not always result in positive changes. Occasionally the problems remain despite your and your provider's best efforts. In some cases, new problems may arise, or unwanted changes occur. For example, talking about your depression may make you feel worse initially, or as you get better, other problems arise and become important.
- Besides the proposed ways of addressing your problems, there are other resources such as self-help groups, spiritual teachers, cultural activities, church or other support groups or providers with different approaches.
- If you elect not to seek treatment a number of things could happen. Your problems may solve themselves, your problems may remain as they are, your problems may worsen, or new problems may appear.
- Information shared in visits is confidential and will not be released without specific written authorization from you or your representative. For the purpose of continuity of care, information can be shared with other providers within the NorthLakes Clinic who are also involved in your treatment. This confidentiality remains after termination and we maintain records for seven years.

Information that cannot be kept confidential that your provider and NorthLakes Community Clinic is required by law to release includes:

- Suspected or actual physical and/or sexual abuse or neglect of a child or vulnerable adult
- Information requested in a court order.
- Situation in which you are judged to be in imminent or immediate danger of harming self or others.

NorthLakes Clinic does not provide emergency behavioral health care. In case of an emergency, please contact your local emergency room or call the Suicide and Crisis Lifeline at 988.
Our general hours of service are 9:00AM-5:00PM.

By my signature below, I give consent for the administration of the above described treatment. I have been given complete and accurate knowledge, and I understand that no promises have been made to me as to the results of the treatment.

X_____ _____

Signature of Patient/Legal Guardian Date

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CONSENT TO TREATMENT

Patient Name: _____ **Birth date:** _____

I give consent for my child or dependent adult of whom I am the parent/guardian to receive counseling as deemed necessary by the providers at NorthLakes Community Clinic. **This consent shall be considered in effect until rescinded or amended.**

_____ _____
(Print your name) (Relationship) (Date)

_____
(Your signature)

_____ _____
(Witness) (Date)

This section needs to be completed for children under the age of 18 and dependent adults by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named patient. If I am unable to accompany the patient, I give permission for the individuals named below to escort the patient and authorize treatment. The responsible adult bringing the patient must remain at the office for the duration of the appointment.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

*If child / dependent adult is 16-18 years old, please check one:

❒ Since my child / dependent adult is over the age of 16, I also give permission for him/her to present for treatment unaccompanied.

❒ Although my child / dependent adult is over 16, I wish to be present for all treatments performed.

Consent provided by: ❒ In Person ❒ Telephone

Name: _____ **Relationship:** _____

_____ _____
(Signature of parent or legal guardian) (Date)

This consent shall be considered in effect until rescinded or amended.

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ATTENDANCE POLICY

Date: _____

Client Name: _____ DOB: _____

Therapy will not be effective unless it is consistent and regular. Therefore, regular attendance at all appointments is important.

CANCELLATIONS – NON EMERGENCY:

Except for emergency situations, all appointments are to be cancelled at least 24 hours in advance by calling or cancelling in person. We consider the following to be examples of NON EMERGENCY reasons to cancel an appointment: vacations, prescheduled doctor appointments, family events, parties, recreational events, after school activities, lack of baby sitter, holiday weekend, school holiday, day before or after a holiday, schedule conflict, and sibling illness. **Initial** _____

CANCELLATIONS – EMERGENCY:

In case of emergency (sudden illness, death in family, hospitalization, emergency doctor visit), appointment must be cancelled as early as possible prior to appointment time. **Initial** _____

CLOSINGS DUE TO WEATHER:

If NorthLakes Community Clinic decides to close the office due to poor weather, we will contact you. We do not necessarily close because school is closed. If we are open, and you decide to cancel due to weather conditions, we ask that you do so at least 2 hours before your scheduled appointment. **Initial** _____

ATTENDANCE:

If two appointments are missed and/or cancelled with less than 24 hours due to a non-emergency you and I will have to discuss whether or not to continue working together. A third such event within a two month period may lead to termination of your behavioral health treatment at NorthLakes Community Clinic. **Initial** _____

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THE ABOVE POLICY AND UNDERSTAND AND ACCEPT THE TERMS AND CONDITIONS.

X_____ _____

Client Signature Date

X_____ _____

Parent/Guardian Signature Date

X_____ _____

Therapist Signature Date

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SERVICE FEES

Fees associated with our counseling services

This table shows session fees for Behavioral Health Services with a Behavioral Health Counselor.
These fees exclude any Pyschiatriac Nurse Practioner Testing
Insurance benefits vary, please call your insurance for coverage questions.

BEHAVIORAL HEALTH COUNSELING FEES

Initial and Updated Evaluations	$205.00
Individual- 30 minute Session	$140.00
Individual- 45 minutes Session	$160.00
Individual- 60 minutes Session	$215.00
Family without Client Session	$115.00
Family with Client Session	$156.00
Group Session	$125.00
Couples Therapy Please check with your insurance about Couple's Therapy coverage	$156.00

QUALIFYING- BEHAVIORAL HEALTH SLIDING FEE SCALE FEES

Slide A	$ 0.00
Slide B	$10.00
Slide C	$15.00
Slide D	$20.00
Slide E	$25.00

TESTING FEES

OWI Assessment- Ashland County Resident	$275.00
OWI Assessment- Bayfield County Resident	$275.00
Psychological/Neuropsychological Testing	$297.00 first 60 minutes and $226.00 for each additional 60 minutes
Psychological/Neuropsychological Battery of Tests	$120.00 first 30 minutes and $111.00 for each additional 30 minutes

I verify that I have been shown the fees for Behavioral Health Services.

Client Signature:_____ Date:_____

Parent/Guardian:_____ Date: _____

Witness Signature:_____ Date: _____

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DELEGATION OF CONSENT FOR CARE FOR MINORS & DEPENDENT ADULTS

Name of Patient: _____
Patient Date of Birth:_____

I state that I have legal medical authority of the patient named above. I hereby delegate the full power of consent for care and treatment provided by all NorthLakes Community Clinics to the appointee(s) named below.

Appointee Name: _____
Relationship to Patient:_____
Appointee Phone Number: _____

Appointee Name: _____
Relationship to Patient:_____
Appointee Phone Number: _____

Appointee Name: _____
Relationship to Patient:_____
Appointee Phone Number: _____

This delegation of consent for care and treatment will expire one year from the date of signature.
This delegation may be revoked in writing at any time by parent or legal guardian.

_____

Signature of Parent or Legal Guardian Date