DEDUCT/COPAY

MAX VISITS PER YR

ENCOMPASS
Effective Mental Health Services, Inc.

INTAKE INFORMATION

Name: _____Gender: _____ Age: _____ DOB: _____

Name of Parent/Guardian, or Spouse: _____

Address: _____City: _____ ZIP: _____

Phone: Hm( )_____Cell( ) _____ Wk( )_____

Other Address:_____ City: _____ ZIP: _____

Phone: Hm( )_____Cell( ) _____ Wk( )_____

(Emergency contact name/number):_____

Relationship Status: Never Married ____ Married ____ Divorced ____ Widowed ___ Other ___

Children/Siblings: Names and Ages _____

Client's, Parent's or Guardian's Employer _____

INSURANCE INFORMATION

Insurance Co:_____ Ph:_____

Insured Person _____ Insured's Policy/ID#_____

Group Number/Employer_____ Insured's SS#_____

Other Insurance _____

FOR OFFICE USE ONLY

	Therapist	Psychiatrist
Auth/name & #(s)	___ #_____	____ # _____
[# of sessions/auth dates]( )	_____	( ) _____
_____( )	_____	( ) _____
_____( )	_____	( ) _____
_____( )	_____	( ) _____
_____( )	_____	( ) _____
_____( )	_____	( ) _____
_____( )	_____	( ) _____

50/50 M_____ F_____

Pharmacy address/ph# _____

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MEDICAL INFORMATION

Name: _____

Family Medical History: (Please state which of your relatives have/had the following.)

_____ Alcohol/Drug Use	_____ Heart Disease	_____ Thyroid Disorder
_____ Cancer/Tumors	_____ Mental Illness	_____ Other
_____ Neurological Disorders	_____ Mental Retardation	

Personal Medical History: (Check all that have occurred to you at any time.)

		___ Irritable Bowels
___ Alcohol/Drug Use	___ Depression	___ Neurological Disorder
___ Allergies	___ Diabetes	___ Seizure
___ Anemia	___ Eating Disorder	___ Skin Problems
___ Anxiety	___ Fatigue	___ Sleep Difficulties
___ Arthritis	___ Frequent Constipation	___ Smoking Tobacco
___ Asthma	___ Frequent Headaches	___ Stomach Problems
___ Back Trouble	___ Heart Problems	___ Thyroid Disorder
___ Cancer	___ High Blood Pressure	___ Vision Problems
___ Chronic Pain	___ Infectious Disease	___ Weight Loss/Gain

Significant past or present medical problems not listed above:_____
_____
_____

Are you now under the care of a primary care doctor other health practitioner? **If, yes:**
Name _____Name_____
Problem _____Problem _____
Problem _____ Problem _____
Date of last visit _____ Date of last visit _____

Date of last physical exam: _____ Results: _____

Have you been hospitalized or been in the emergency room in the past 3 years? Yes ____ No ____
Why? _____

Are you currently taking any prescription or non-prescription medications? Yes _____ No _____ **If yes**, name & dosage: _____

Have you ever participated in counseling or been seen by a psychiatrist? Yes ___ No ___ **If yes**, please give name and dates: _____
_____

_____
Client Signature Parent/Guardian Signature Date

ENCOMPASS
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CONSENT TO RECEIVE TREATMENT

The providers at Encompass - Effective Mental Health Services, Inc. want you to be aware of your rights as a client and request your consent to receive treatment. Therapy is conducted in family, individual, couples or group sessions with a therapist for the purposes of determining and resolving problems or concerns. Specific treatment goals will be developed between you and your therapist.

The benefits of therapy may include, but are not limited to, a greater ability to cope with stressful situations, improved skills in communication and fulfilling your emotional needs, more satisfying and intimate relationships, and a better understanding of your personal values, needs, and goals.

Therapy may include the risk of remembering unpleasant events and can arouse intense emotions of sadness, fear, and anger. Anxiety, depression, frustration, loneliness, or helplessness may also be experienced. The success of therapy depends upon many variables, among them your willingness and ability to take part in the therapeutic process. Your therapist may suggest alternate treatment modalities and will make referrals when appropriate or necessary.

The use of medication may or may not be a part of your treatment. If medication is necessary, and you wish to be seen by the nurse practitioner for an evaluation, an appointment can be made. Any questions you have pertaining to the use of medication or its side effects will be discussed with you at that time.

It is your right to refuse therapy or medication at any time. If you forego therapy, it is possible that your problems will not be resolved or may become worse than they were at the time you discontinue therapy. A therapist will discuss with you at any time the possible outcome of withdrawal from therapy.

This informed consent will be in effect until you are discharged from treatment, either by mutual agreement with your therapist, through your own decision, or for a period no longer than fifteen months. This consent can be withdrawn at any time with written or verbal notice. You have a right to receive a copy of this consent upon request.

Client's Name (please print)	Signature	Date
Parent or Guardian Signature	Relationship to Client	Date
Witness Signature		Date

ENCOMPASS
Effective Mental Health Services, Inc.

RELEASE OF INFORMATION TO INSURANCE COMPANY

I authorize the release of information from Encompass, Inc. to my health insurance company as necessary for the purpose of processing my insurance claim. I also authorize payment of medical benefits to Encompass, Inc. Should my insurance refuse to pay for services due to lack of coverage, authorization, or medical necessity, **I am financially responsible for all fees related to professional services provided to me and/or my dependents.**

_____
Client / Authorized Signature Date

_____
Parent Signature Date

STORING PAYMENT INFORMATION

I authorize Encompass, Inc. to securely store my credit card information for the purpose of payment of fees. The data can be repealed upon request and will be deleted upon discharge.

Client / Authorized Signature _____ Date _____

INFORMATION CHECK OFF FORM

I have reviewed the following forms and have had them sufficiently explained to me.

_____ Consent to receive treatment

_____ Client's rights/Grievance procedure

_____ Policy on the denial of client's rights

_____ Treatment policy and fee statement

_____ Release of information to insurance company

_____ Privacy pledge

_____
Client Signature Date

_____
Parent Signature Date

_____
Witness Signature Date

For Client

ENCOMPASS
Effective Mental Health Services, Inc.

TREATMENT POLICY AND FEE STATEMENT

Providing Services
It is the policy of Encompass - Effective Mental Health Services, Inc. to provide psychotherapy and psychiatric services to any client requiring treatment or to refer the client to another resource that could provide an appropriate service. All clients will be assessed for appropriateness of treatment and continuation of treatment is contingent upon client cooperation. Lack of motivation including but not limited to, two or more missed sessions without appropriate notice, may result in termination. Treatment is contracted with a specific therapist, nurse, or doctor.

Minors
It is the policy of this facility to release all information pertaining to minors to their parents or legal guardians upon their request unless it would seriously affect the therapeutic process. The parent or guardian is responsible for **financial obligations incurred by their minors and paid at the time of session**. A release of information may be obtained so that communication may be shared with the primary care physician, pediatric doctors, teachers, or other health related professionals related to the care of the minor.

Charges
The standard and customary fee for your therapist is $150.00 for initial evaluation, $125.00 per hour for an individual session, and $150.00 for family sessions. Psychiatric charges are billed at $225.00 for the initial evaluation and $130.00 for medication management sessions thereafter. When sessions run over, charges will be made accordingly. If a client is late, the same hourly fee will be applied to the time remaining in the session.

Client's Responsibility
The client is responsible for all charges including but no limited to co pays, deductibles, and any costs that the insurance company does not cover. All clients are responsible for checking with their employer and/or insurance company for exact coverage of services, including any changes that may occur with respect to their coverage for services provided by Encompass - Effective Mental Health Services, Inc. All fees will be paid at the time of session Encompass accepts cash, checks, and credit cards.

Cancellation - Encompass, Inc. has a strict cancellation policy, **a notice of at least 24 hours must be given before cancellation of any appointment.** If cancellation is not made in compliance with this policy, or an appointment is missed, the client will be billed a fee up to the amount charged for the session which must be paid prior to rescheduling or may be discharged from services.
Emergencies - Encompass has a 24-hour emergency crisis pager system available to all clients. There is no charge for this service for the first 5 calls of each year. After this, calls are billed at the individual session rate. **The pager number for emergencies only is 414-477-8380.**

For Client

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CLIENT'S RIGHTS

1. Clients have the right to treatment free of discrimination by race, sex, color, origin, age, religion, handicap, or sexual preference.
2. Clients have the right to be treated with dignity and respect.
3. Clients have the right to receive prompt and adequate treatment appropriate for his or her needs.
4. Clients have the right to be involved in his or her planning of treatment.
5. Clients have the right to confidentiality of treatment and records, and have the right of access to those records.
6. Clients have the right to refuse treatment or medication.
7. Clients have the right to be informed of the cost of treatment.
8. Clients have the right to be informed of the clinic's grievance procedure.
9. Clients have the right to file a grievance if they believe their rights have been violated.

GRIEVANCE PROCEDURE

The Clinic grievance procedure is as follows:

1. A complaint may be filed, verbally or in writing, with any staff member or with the Clinic Director. A guardian, relative, or concerned person may file a complaint on behalf of the client. If you are uncertain or unable how to file a grievance, assistance will be provided.
2. Within three days of receiving notification of a grievance, the Clinic Director will hold an informal hearing and attempt to resolve the situation.
3. The Clinic Director will write a report based on her findings. A copy of the report will go to the client (and/or guardian) and a copy will be filed at the clinic with the client's right specialist.
4. If the client is not satisfied with the informal resolution, he or she may pursue the matter by contacting the client's rights specialist.
5. No sanction will be threatened or imposed upon any person filing a grievance or assisting a client to file a grievance.

POLICY ON THE DENIAL OF CLIENT'S RIGHTS

1. Client's rights may be denied if it becomes known that there is a danger to the life or health of the client, or potential harm to others.
2. The right to confidentiality may be waived if there are indications of child physical or sexual abuse or neglect (S. 48.891).
3. Non-compliance of court ordered treatment must be reported to the court.
4. Upon denial of these rights, a written notice, with clearly stated reason for denial, shall be provided to the client and/or guardian, if applicable, and a copy retained in the client's record.

5. The denial shall only apply to a specific situation and rights will be reinstated when the issue is resolved.
6. If the client is a county department patient a written notice, with specifics, shall be sent to the local county Department of Human Services client's rights specialist within two days of the denial of rights.
7. At the client's request (or the request of a parent/guardian), an informal hearing will be held regarding the denial of these rights. This hearing will be held within three days after receiving the request.
8. The Clinic Director will conduct the hearing and shall render the final decision.
9. If you disagree with the decision of the Clinic Director you have the right to a hearing with the Client's Rights Specialist.
10. The client may temporarily waive his or her right to confidentiality with verbal consent in cases of emergency. Written consent of disclosure must be obtained within ten days.

RELEASE OF INFORMATION AUTHORIZATION

Our staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders and information about treatment or insurance information. If this contact is made by phone and you are not at home, a message will be left on your answering machine. Your signature on the consent for treatment gives us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization.

In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. Your signature releases information in order to process claims. You also authorize Encompass, Inc. to receive payment of medical benefits on your behalf. **Please be aware that you are financially responsible for all fees related to professional services provided to you or your dependents.**

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

For Client

There are several circumstances in which we may have to use or disclose your health care information.

- We may need to disclose your health information to other health care providers or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.