CLIENT REGISTRATION FORM

O:\Outpatient Forms\Client File Forms 06-26-20\Registration Packet.docx 06/26/2020

RAWHIDE YOUTH SERVICES

Date: _____ **Counselor:** _____ **Referred by:** _____

CLIENT INFORMATION

Last Name	First Name	M.I.	Date of Birth	Age	☐ Male ☐ Female ☐ Other
Street:	City:	State:	ZIP:	County:	
SS#:	*Email:				
Phone (with area code): Home:	Work:	Cell:			
Religion:	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Ethnicity: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other		☐ Military Dependent			
Employed: ☐ Full time ☐ Part time ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Student	Employer:				

*Email address for in-house use only. We will never share with any third party.

SPOUSE or LEGAL GUARDIAN(S)

Last Name	First Name	M.I.	SS#:	Date of Birth	Age
Street:	City:	State:	ZIP:	County:	
Phone (with area code): Home:	Work:	Cell:			
☐ Emergency Contact ☐ Primary Custody ☐ Military Dependent ☐ Spouse ☐ Mother ☐ Father ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Ethnicity: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other	☐ Military Dependent				
Employed: ☐ Full time ☐ Part time ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Student	Employer:				

Last Name	First Name	M.I.	SS#:	Date of Birth	Age
Street:	City:	State:	ZIP:	County:	
Phone (with area code): Home:	Work:	Cell:			
Emergency Contact ☐ Primary Custody ☐ Military Dependent Spouse ☐ Mother ☐ Father ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Ethnicity: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other	☐ Military Dependent				
Employed: Full time ☐ Part time ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Student	Employer:				

Continued on Page 2.

Please list 3 things you (or your child) would like to change during treatment:
1.
2.
3.

Adult clients (as applicable): I authorize Rawhide Youth Services to discuss (check all that apply):

☐ Scheduling/canceling sessions ☐ Account balance and/or payments with _____

Relationship to client: ☐ Spouse/Significant Other ☐ Parent ☐ Child ☐ Other _____

INFORMED CONSENT FOR RELEASE OF INFORMATION

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RAWHIDE YOUTH SERVICES

I AUTHORIZE AND REQUEST RAWHIDE, INC. (d/b/a "RAWHIDE YOUTH SERVICES") TO:

☐ Release to ☐ Obtain from (check one or both)

Agency/Individual Name: _____

Address: _____

Phone: _____ Fax# or Email Address: _____

THE FOLLOWING SPECIFIC INFORMATION FROM THE RECORDS OF:

Client Name: _____ Client Name: _____

Address: _____

Specific information requested by Rawhide Youth Services:

Release Format: ☐ Verbal ☐ Written ☐ Electronic

☐ Client Identification ☐ Treatment Plan ☐ Initial Assessment
☐ Progress Reports ☐ Diagnosis ☐ Discharge Summary
☐ IEP ☐ 504 Plan ☐ Other _____

Specific information to be released by Rawhide Youth Services:

Release Format: ☐ Verbal ☐ Written ☐ Electronic

☐ Progress Reports ☐ Treatment Plan ☐ Discharge Summary
☐ Initial Assessment ☐ Diagnosis ☐ Other _____

This information relates to services received from or on behalf of Rawhide Youth Services and/or its clients.

Purpose or need for information: ☐ Continuity of Care ☐ Collaboration

☐ Other _____

This authorization expires as of: _____

I make this consent understanding that certain parts of my or, as the case may be, my child's or ward's records may be protected from disclosure under federal and state statutes and regulations, including 42 CFR, Part 2; The Health Insurance Portability and Accountability Act of 1996 (commonly known as "HIPAA") and implementing regulations; Secs. 48.78 and 51.30 Wis. Stats; and regulations adopted by the Wisconsin Department of Health Services, including DHS Secs. 92.03 and 94.17, and may not be disclosed without written consent unless otherwise provided by applicable law. I also understand that I may revoke this consent at any time and that, in any event, it will expire automatically on the date set forth above; that I have the right to inspect and receive a copy of the disclosed material and a copy of this consent form; and that information released prior to revocation cannot be retrieved nor can Rawhide, Inc. be held responsible for such disclosure. I hereby release Rawhide, Inc. from all legal responsibilities or liability that may arise from such disclosure. I have given this consent voluntarily and I confirm that I am able to understand all of the information on this form.

Client Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

Continued on Page 2.

INFORMED CONSENT FOR RELEASE OF INFORMATION

RAWHIDE YOUTH SERVICES

DCF 154.08 Confidentiality of records. Screening questionnaires, testing results, and treatment records relating to this chapter may not be disclosed unless for purposes connected with the administration of the program unless disclosure is otherwise authorized by law or by written consent from the person who is the subject of the record. The department may establish administrative, physical, and technical safeguard procedures administering agencies may be required to follow to assure compliance with state and federal laws relating to public assistance program records, drug testing and treatment records, and medical records.

History: EmR1612: emerg. cr. eff. 3-17-16; CR 16-022: cr. Register July 2016 No. 727, eff. 8-1-16.

DCF 105.08 Confidentiality of records. Screening questionnaires, testing results, and treatment records relating to this chapter may not be disclosed unless for purposes connected with the administration of a work experience program unless disclosure is otherwise authorized by law or by written consent from the individual who is the subject of the record. The department may establish administrative, physical, and technical safeguard procedures administering agencies may be required to follow to assure compliance with state and federal laws relating to public assistance program records, drug testing and treatment records, and medical records.

History: EmR1523: emerg. cr., eff. 11-9-15; CR 15-091: cr. Register June 2016 No. 726, eff. 7-1-16.

I acknowledge that certain parts of my child's records may be protected from disclosure under federal and state statutes and regulations including 42 CFR, Part 2; the Health Insurance Portability and Accountability Act of 1996 (commonly known as "HIPAA") and implementing regulations; and Secs. 48.78 and 51.30 Wis. Stats.), and may not be disclosed without written consent (such as this Informed Consent and Authorization/Media Advertising form), unless otherwise provided by applicable law;

51.30 Drug and Alcohol Programs Informed Consent. An informed consent for disclosure of information from court or treatment records to an individual, agency, or organization must be in writing and must contain the following: the name of the individual, agency, or organization to which the disclosure is to be made; the name of the subject individual whose treatment record is being disclosed; the purpose or need for the disclosure; the specific type of information to be disclosed; the time period during which the consent is effective; the date on which the consent is signed; and the signature of the individual or person legally authorized to give consent for the individual.

DHS 92.03

(3) INFORMED CONSENT. Informed consent shall be in writing and shall comply with requirements specified in s. 51.30(2), Stats., and this subjection.

(a) Informed consent shall be valid only if voluntarily given by a patient who is substantially able to understand all information specified on the consent form. A guardian may give consent on behalf of the guardian's ward. If the patient is not competent to understand and there is no guardian, a temporary guardian shall be sought in accordance with s. 54.50, Stats.

(b) Informed consent is effective only for the period of time specified by the patient in the informed consent document.

(c) A copy of each informed consent document shall be offered to the patient or guardian and a copy shall be maintained in the treatment record.

(d) Each informed consent document shall include a statement that the patient has a right to inspect and receive a copy of the material to be disclosed as required under ss. DHS 92.05 and 92.06.

(e) Any patient or patient representative authorized under s. 51.30(5), Stats., may refuse authorization or withdraw authorization for disclosure of any information at any time. If this occurs, an agency not included under s. 51.30(4)(b), Stats., that requests release of information requiring informed consent shall be told only that s. 51.30, Stats., prohibit release of the information requested.

DHS 94.17 Confidentiality of records. All treatment records are confidential. A patient or guardian may inspect, copy and challenge the patient's records as authorized under s. 51.30, Stats., and ch. DHS 92.

CONSENT TO TREAT & HIPAA RELEASE

Client Rights & Consent to Treat Signature Form Hard Copy 08/24/2021

RAWHIDE YOUTH SERVICES

ACKNOWLEDGMENT OF CLIENT RIGHTS, INFORMED CONSENT FOR TREATMENT AND DISCHARGE POLICIES

The types of services I am requesting from Rawhide Youth Services have been explained to me. I voluntarily consent to become actively involved in the process of treatment. I have been offered a copy of the Grievance procedures.

It has been explained to me that normal business hours for Rawhide Youth Services are 8:00 a.m. to 4:30 p.m., Monday through Friday.

If I have a mental health emergency during non-business hours, I understand I should call the on-call counselor at 920-389-1164 and leave a message with detailed information about the crisis and the on-call counselor will return my call as soon as possible. If I feel I have an immediate need, I should dial 911 and/or go to my local emergency room. I may also contact my local county Crisis Center using the numbers given to me by my counselor.

I acknowledge that I have been offered a copy of and understand the Client Rights, Informed Consent for Treatment and the policies regarding Voluntary and Involuntary Discharge.

If applicable, I give permission for my child to receive evaluation and treatment by a counselor of Rawhide Youth Services.

Client Name (please print)

Client Signature (age 14 and older) **Date**

Parent or Guardian Signature (all minor clients) **Date**

HIPAA RELEASE (Health Insurance Portability and Accountability Act)

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Federal regulations (HIPAA) allow us to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations"). Nevertheless, we ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be available from this office. You may ask for a printed copy of our Notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use and disclosure of my Protected Health Information as specified above.

Client Name (please print)

Client Signature (age 14 and older) **Date**

Parent or Guardian Signature (all minor clients) **Date**

A copy of this informed consent will be given to the client upon request.

CLIENT PSYCHOSOCIAL HISTORY QUESTIONNAIRE

/Users/ryanwienandt/Downloads/School-Based Mental Health Program Referral Packet (2).doc 12/31/2019

RAWHIDE YOUTH SERVICES

Client Name: _____ Date: _____

DEVELOPMENTAL HISTORY

Pregnancy/Delivery: (Briefly describe your or your child's prenatal environment/development)

Smoking during pregnancy: ☐ No ☐ Yes Amount: _____

Alcohol during pregnancy: ☐ No ☐ Yes Amount/type: _____

Drugs during pregnancy: ☐ No ☐ Yes Amount/type: _____

Medications during pregnancy: ☐ No ☐ Yes Details: _____

Premature: ☐ No ☐ Yes Weight: _____

Milestones:

Motor Skills: ☐ Delayed ☐ On Target ☐ Advanced

Language Development: ☐ Delayed ☐ On Target ☐ Advanced

Social Skills: ☐ Delayed ☐ On Target ☐ Advanced

MEDICAL HISTORY

Past or Current Illnesses/Disorders: (Check all that apply.)

☐ Allergies ☐ Anemia ☐ Bed Wetting ☐ Concussion/TBI ☐ Diabetes

☐ Ear Infections ☐ Epilepsy ☐ Lyme Disease ☐ Mononucleosis ☐ Seizures

☐ Strep ☐ Thyroid Problems ☐ Vision Problems ☐ Other _____

Have you had any surgeries? ☐ No ☐ Yes Age: _____ Complications: _____

Have you (our your child) received any of the following? (Check all that apply. Use the back side if additional space is needed.)

☐ Mental Health Counseling ☐ School Counseling ☐ Hospitalization ☐ Psychological Testing ☐ Psychiatric Services

Dates: _____ Provider Name: _____ Issue Treated: _____

Dates: _____ Provider Name: _____ Issue Treated: _____

Dates: _____ Provider Name: _____ Issue Treated: _____

Drugs or Alcohol Rehabilitation? ☐ No ☐ Yes Dates: _____ Where: _____

Issue(s) Treated: _____

Please list all medications you (or your child) are taking including prescriptions, over-the-counter, herbals, vitamins or suspected illegal drugs:
(Please use the back side if additional space is needed.)

Name of Medication:	Dosage:	Dosage Frequency:	Prescribing Doctor:	Date Medication Started:

Continued on Page 2.

CLIENT PSYCHOSOCIAL HISTORY QUESTIONNAIRE

/Users/ryanwienandt/Downloads/School-Based Mental Health Program Referral Packet (2).doc 12/31/2019

RAWHIDE YOUTH SERVICES

Mothers Name: _____ _____ _____ _____
(Last) (First) (MI) (Age)

Education Level: _____ Occupation: _____

Fathers Name: _____ _____ _____ _____
(Last) (First) (MI) (Age)

Education Level: _____ Occupation: _____

Parents: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Deceased

FAMILY/SOCIAL

Family History: (If client is under 18 years old:)

Who has parental rights of the child?

☐ Mother ☐ Father ☐ Guardian (Relationship): _____

Has either biological mom or dad had parental rights terminated or suspended?

☐ No ☐ Yes If yes, when? _____

Is the child adopted?

☐ No ☐ Yes If yes, at what age was the child adopted? _____

Child's current living arrangements: _____

CHILDREN or SIBLINGS (First and Last Names):	Age:	Male/Female/Other:	Live with mom, dad, other:

Family History: (If client is under 18 years old:)

Substance Abuse: ☐ No ☐ Yes Details: _____
Mental Illness: ☐ No ☐ Yes Details: _____
Suicide: ☐ No ☐ Yes Details: _____
Domestic Violence: ☐ No ☐ Yes Details: _____

EDUCATIONAL

Highest Educational Level - Adults:

☐ High School ☐ Associates Degree ☐ Some College ☐ College Degree ☐ Graduate School

Highest Educational Level - Minor:

Current Grade: _____ School: _____

Continued on Page 3.

CLIENT PSYCHOSOCIAL HISTORY QUESTIONNAIRE

/Users/ryanwienandt/Downloads/School-Based Mental Health Program Referral Packet (2).doc 12/31/2019

RAWHIDE YOUTH SERVICES

Type of Placement: (Check one or more)

☐ Special Education ☐ Regular Classes ☐ Honor Classes (G & T) ☐ Advanced Classes ☐ Home Study

Attitude towards School: (Check one or more)

☐ Truancy	☐ Augmentative	☐ Fighting with Peers	☐ Poor Effort
☐ Disruptive	☐ Attentive	☐ Repeated Grades	☐ Expulsions
☐ Suspensions	☐ Drugs/ETOH	☐ Difficulty with Peers	☐ Performance Problems

Describe any behavior problems, suspensions or expulsions:

Schools Attended:

Dates Attended:

Notes:

BILLING & FEE AGREEMENT & WAIVER

O:\Outpatient Forms\Client File Forms 06-26-20\Billing & Fee Agreement.docx 06/26/2020

RAWHIDE YOUTH SERVICES

Rawhide, Inc. (doing business as "Rawhide Youth Services," herein "Rawhide") is a licensed mental health provider. As a courtesy, Rawhide will submit claims to your insurance company, subject to the Terms and Acceptance set forth below. Please consult your insurance policy or contact your insurance company directly to be fully informed of your benefits and any limitations.

If you have a Co-pay or Deductible, it must be paid at the time of service. Please make checks payable to "Rawhide, Inc."

Our fees are usual and customary for master's degree-level professionals providing EAP, evaluation and psychotherapy services. These are our standard rates, but other rates may apply based on type and/or length of session::

Initial Evaluation Fee:	$214.50
Group Fees:	$154 (per 60-minute session)
Session Fees:	$95.70 (per 30-minute session) $143 (per 45-minute session) $190.30 (per 60-minute session)

We require a minimum of 24-hour notification for appointment cancellations. If you need to cancel an appointment, please contact us at 877-300-9101 as soon as possible. **If you miss an appointment without notifying us 24 hours in advance of your scheduled time, you will be charged $75 for the missed appointment.**

TERMS AND ACCEPTANCE

I understand that, as a courtesy, Rawhide will submit claims to my insurance company for counseling services provided to my child, dependent, ward or me. I agree to provide all information reasonably required by Rawhide or my insurance company to permit processing of claims, and I hereby authorize payment of medical benefits to Rawhide. I also authorize Rawhide to furnish to insurance companies or their representatives necessary EAP evaluation and/or treatment information concerning my child, dependent, ward or me, as may be needed to complete claims processing for benefits.

I understand that not all services may be covered or authorized for payment by my insurance company, and I therefore agree that I will be personally liable for any portion of fees not paid by insurance. I will reimburse Rawhide for reasonable professional fees and related expenses if my account should be referred to a lawyer or agency for collection. I have been advised that Rawhide may discontinue services if my insurance company or I do not pay for services promptly.

By my signature below, I am giving voluntary consent for release of treatment information for billing purposes as related to my insurance benefits only. I am aware that this information may be sent by electronic means on a secured line and/or by paper claim form. I further understand that Rawhide shall endeavor to maintain, but cannot guarantee, the confidentiality of information disclosed via email and/or telephone.

_____

Client Name (please print)

_____ _____

Responsible Party (please print) **Relationship**

_____ _____

Responsible Party (signature) **Date**

INSURANCE INFORMATION

O:\Outpatient Forms\Registration Forms\Insurance Information Form.docx 01/02/2019

RAWHIDE YOUTH SERVICES

CLIENT NAME:

Last Name _____ First Name _____ M.I. _____

PRIMARY INSURANCE COVERAGE				
Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female
SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____			
Street:	City:	State:	ZIP:	
Phone (with area code): Home:	Work:	Cell:		
Employer:				
Ins. Co. Name:	Ins. Co. Name:			
Claims Address:				
Member/ID#:	Group#:			

SECONDARY INSURANCE COVERAGE (if applicable)				
Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female
SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____			
Street:	City:	State:	ZIP:	
Phone (with area code): Home:	Work:	Cell:		
Employer:				
Ins. Co. Name:	Ins. Co. Name:			
Claims Address:				
Member/ID#:	Group#:			

In the event you have an account balance, please provide your invoice address:

CLIENT RIGHTS & CONSENT TO TREAT DISCLOSURE

RAWHIDE YOUTH SERVICES

OUR NORMAL BUSINESS HOURS ARE 8:00 A.M. TO 4:30 P.M., MONDAY THROUGH FRIDAY.

If you have a mental health emergency during non-business hours, dial 911 for immediate help or go to your nearest emergency room. You may also contact your local county Crisis Center or refer to the procedures your counselor discussed with you.

The State of Wisconsin provides that each individual in treatment has rights. These rights are pertinent to outpatient mental health clinics (DHS 94.04)

TREATMENT RIGHTS

1. To receive prompt and adequate treatment.
2. As a voluntary patient, to refuse treatment or medication at any time.
3. To be free from unnecessary or excessive medication or drastic treatment.

COMMUNICATION/PRIVACY RIGHTS*

1. To refuse to be filmed or taped without your consent.
2. To have your treatment records and conversations about your treatment kept confidential.
3. To have access to your treatment record after discharge (or during treatment, if the facility director approves it).

***Note: In certain circumstances, communication with clients may take place via texting or email. Rawhide Youth Services makes every effort to maintain client confidentiality. However, the security of systems used for text and/or email communication cannot be guaranteed.**

CIVIL RIGHTS

1. No client is to be refused services on the basis of race, creed, color, religion, age, sex, or national origin (DHS 61.10-61.13).

RIGHT TO COMPLAIN

1. If you feel your rights have been violated, you have a right to use a grievance procedure. Please refer to the enclosed copy of "Client Rights and the Grievance Procedure for Community Services."

INFORMED CONSENT FOR TREATMENT

THE PROCESS OF TREATMENT

1. **Benefits of Treatment:** The benefits of therapy are to help the client meet his/her goals for treatment. These goals will be developed together with the counselor.

2. **Administration of Treatment:** The client and the counselor together determine how best to meet the goals of treatment. If the client does not think that his/her goals are being met, this should be discussed with the counselor for evaluation, re-contracting, or referral to a provider who may better meet the needs and goals of the client. If the counselor does not feel the clinic is able to meet the needs of the client, the client may be involuntarily discharged and given referral options to other providers better suited to the client's needs.

3. **Side Effects of Treatment:** Therapy helps the client work on his/her goals. In some cases this means that unhappy feelings may increase before things start to get better.

4. **Probable Benefits of Receiving Proper Treatment:** People who choose counseling to overcome their problems in living have a better advantage at making more appropriate life choices and decisions.

5. **Effective Time Period of Consent for Treatment:** The client's consent for treatment will last until the client either withdraws the consent and terminates treatment or the goals of treatment have been satisfactorily reached and the case is closed.

6. **Clinic's Grievance Policy:** There is a copy of the Grievance Procedure given to the client with the registration packet for the counselor to go over with the client.

7. **After Hours Emergency Procedure:** Client will be instructed by their counselor on how to obtain emergency services after normal business hours.

Continued on Page 2.

DISCHARGE FROM TREATMENT

A client may be discharged from treatment for any of the following reasons:
(DHS 35.18 (1)(k))

1. Completion of treatment goals
2. Referral to another therapist or more intensive treatment
3. Noncompliance with the course of treatment or violation of clinic rules
4. Repeated cancellations or missed appointments
5. No contact with therapist for at least 30 consecutive days
6. Inability to pay for services
7. Other reasons as determined by the counselor

A **Notification of Discharge** is sent to all clients who have been discharged from care. In most cases, a client may return to receive additional treatment as needed, provided the reasons for seeking treatment are within the scope of our licensing or clinic set up, and the counselor has available openings.

INVOLUNTARY DISCHARGE FROM TREATMENT

A client may be involuntarily discharged from treatment for either of the following reasons:
(DHS 35.24 (3)(a)(b))

1. Inability to pay for services
2. Behavior that is reasonably a result of mental health symptoms

Prior to the effective date of the involuntary discharge, a **Notification of Involuntary Discharge** will be sent to the client, which includes the following information:

1. Reasons for the discharge
2. Effective date of the discharge
3. Sources for further treatment
4. Consumer's right to have the discharge reviewed prior to the effective date of discharge