RAWHIDE
YOUTH SERVICES

APPLETON · FOND DU LAC · GREEN BAY · GREATER MILWAUKEE
SHIOCTON · NEW LONDON
E7475 RAWHIDE RD., NEW LONDON, WI 54961-9052
PHONE 1-877-300-9101 FAX (920)982-5040 RAWHIDE.ORG

You are scheduled with: _____ on _____ at _____ AM/PM

☐ 446 Westhill Blvd., Ste. A
Appleton, WI 54914

☐ N5682 County Road K
Fond du Lac, WI 54937

☐ E7475 Rawhide Road
New London, WI 54961

Payment is due at the time of service for co-pays or session fees.

Please read, complete, and sign the following paperwork as indicated prior to initial evaluation.

Minors must have paperwork signed by a parent or legal guardian.

☐ **CLIENT REGISTRATION FORM** - Fill out completely.

☐ **CLIENT RIGHTS/HIPPA FORM** – Sign and date.

☐ **Occupational Therapy Billing and Fees Agreement** – Sign and date.

☐ **INSURANCE INFORMATION FORM** – If applicable, complete the form, then sign and date at the bottom. *Bring your insurance card to your first session for us to copy or return a copy of the **front and back** of the card with your paperwork.*

☐ **RELEASE OF INFORMATION FORMS** – Fill out completely. Please complete one for all individuals you would like information shared with and/or released to (i.e. referring physician, school, case manager, step-parent, guardian(s), etc.)

☐ **Occupational Therapy Questionnaire** – Fill out completely.

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CLIENT REGISTRATION FORM

Date: _____ Therapist:_____ 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: Home ( ) Work ( ) Cell ( )

Religion: Primary Language Spoken: ☐English ☐Spanish ☐Other Marital Status: ☐Minor ☐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.

LEGAL GUARDIAN(S)

(1) Last Name	First Name	M.I.	SS#	DOB	Age

Street City State Zip

Contact Info: *E-mail: Cell ( ) Cell Phone Carrier:

Preferred Method of Communication:

☐ Emergency Contact ☐ Primary Custody ☐ Military Dependent
☐ Spouse ☐ Mother ☐ Father ☐ Other_____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employed: ☐Full time ☐Part time ☐Unemployed ☐Homemaker ☐Retired ☐Student Employer:

(2) Last Name	First Name	M.I.	SS#	DOB	Age

Street City State Zip

Contact Info: *E-mail: Cell ( ) Cell Phone Carrier:

Preferred Method of Communication:

☐ Emergency Contact ☐ Primary Custody ☐ Military Dependent
☐ Mother ☐ Father ☐ Other _____

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

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.

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 _____

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ACKNOWLEDGEMENT 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 920-982-6100, then press 1, then 1 again 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.

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**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.**

CLIENT RIGHTS

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.

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

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Notice of Privacy Practices

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.

Use and Disclosure of Protected Health Information (PHI)
Rawhide Youth Services (hereafter referred to as Rawhide) may use your Protected Health Information for the purpose of providing treatment, obtaining payment for care and other related health care operation.

Circumstances Involving Use and Disclosure of Protected Health Information

To Provide Treatment
Rawhide may use your Protected Health Information to consult with Rawhide employees or designated treatment providers to provide the best quality of care. For example, a coordinating physician may need to know additional information about your symptoms to prescribe appropriate medications.

Payment
Rawhide may disclose your Protected Health Information to other parties involved in paying for your treatment or care.

Operations
Rawhide may use the minimum required Health Information for quality assessment activities, licensing, or statistical and accreditation purposes. For example, Rawhide's Outpatient Clinic Administrator is required to review charts for formatting and signatures in order to remain licensed through the State of Wisconsin.

Note-Psychotherapy notes are never released to anyone internally or externally for treatment, payment or operation.

When Required by Law
Rawhide will disclose your Protected Health Information when it is required to do so by Federal, State or Local law. This includes responding to a subpoena.

To Report Abuse or Neglect
Rawhide and its' employees are mandated by law to report suspected child abuse, either physical or sexual, and child neglect.

To Report a Serious Threat to Health or Safety
If an employee of Rawhide has good reason to believe that your safety is in jeopardy (for example, because of a suicide threat) or that another's safety is in jeopardy (for example, because of a threat to harm another), we are mandated by law to disclose Protected Health Information for the purpose of preventing harm to yourself or to someone else.

Use and disclosure for any purpose described above is limited to the minimum necessary information needed by a third party to carry out services that are in the best interest of the customer. The customer will be notified by Rawhide when a disclosure must be made in the above instances.

Authorization and Rights Regarding Your Health Information
Other than stated above, Rawhide will not disclose your Protected Health Information other than with your written authorization. If you authorize the agency to use your Protected Health Information, you may revoke the authorization in writing at any time.

You have the following rights regarding your health information:

1. Right to request restrictions on disclosure of your health information. We will respectfully consider your request, but there may be times when we are not required to agree to your request. (If disclosing information would jeopardize the customer or if the law requires disclosure.)
2. Right to inspect and copy your health information. You must request your health information in writing, signing your request, and allow the agency 72 hours to process your request.
3. Right to amend Protected Health Information. If you believe that your health care information is incorrect or incomplete, you may request to amend your record. Your request must be made in writing and be signed. We will respectfully consider your request, but there may be times when we are not required to abide by your request.
4. Right to an accounting of disclosures. You have the right to request an accounting of the disclosures that Rawhide makes of your health information.

Complaints

If you believe Rawhide has violated your privacy rights, you have the right to file a complaint in writing with your Client Rights Specialist. Send your complaint to Micki Fecteau, Outpatient Office Supervisor, Rawhide Youth Services, E7475 Rawhide Road, New London, WI 54961. Or contact the State Grievance Examiner, Division of Mental Health and Substance Abuse Services (DMHSAS), PO Box 7851, Madison, WI 53707-7851.

Effective Date

This notice is effective December 31, 2019, and replaces any previous notice of privacy practices issued by Rawhide.

Questions

If you have any questions regarding this notice, please contact the Outpatient Office Supervisor.

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BILLING & FEE AGREEMENT & WAIVER

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: $230

Session Fees:
$170 (per 45-minute session)
$200 (per 60-minute session)
$100 (per 30-minute session)
$50 (per 15-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:_____

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INSURANCE INFORMATION

Client:	Last Name	First Name	M.I.

PRIMARY INSURANCE COVERAGE

Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female ☐ Other

SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Street	City	State	Zip

Phone: Home ( )	Work ( )	Cell ( )

Employer:	
Ins. Co. Name:	Ins. Co. Phone#:
Claims Address:	
Member/ID#:	Group#:

SECONDARY INSURANCE COVERAGE (if applicable)

Policy Holder: Last Name	First Name	M.I.	Date of Birth	☐ Male ☐ Female ☐ Other

SS#:	Relationship to Client: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Street	City	State	Zip

Phone: Home ( )	Work ( )	Cell ( )

Employer:	
Ins. Co. Name:	Ins. Co. Phone#:
Claims Address:	
Member/ID#:	Group#:

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

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INFORMED CONSENT FOR RELEASE OF INFORMATION

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: _____ Date of Birth: _____

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: _____

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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: _____ Date of Birth: _____

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: _____

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INFORMED CONSENT FOR RELEASE OF INFORMATION

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: _____ Date of Birth: _____

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: _____

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.

RAWHIDE YOUTH SERVICES

APPLETON · FOND DU LAC · GREEN BAY · GREATER MILWAUKEE
SHIOCTON · NEW LONDON
E7475 RAWHIDE RD., NEW LONDON, WI 54961-9052
PHONE 1-877-300-9101 FAX (920)982-5040 RAWHIDE.ORG

Occupational Therapy Questionnaire

Client Name: _____ Date of Birth: _____

Developmental History

Pregnancy/Delivery: [briefly describe 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 amount/type _____

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 ☐ Diabetes ☐ Mononucleosis ☐ Vision problems
☐ Anemia ☐ Ear Infections ☐ Seizures ☐ Other_____
☐ Bed Wetting ☐ Epilepsy ☐ Strep
☐ Concussion/TBI ☐ Lyme Disease ☐ Thyroid problems

Have you had any surgeries? ☐ no ☐ yes If yes, please explain: _____
Age: _____ Complications: _____

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

☐ Early Intervention Services ☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Other

Dates: _____ Provider Name:_____ _____

Dates: _____ Provider Name:_____ _____

Dates: _____ Provider Name:_____ _____

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 back side if additional space is needed) :

Name of Medication	Dosage	Dosage Frequency	Prescribing Doctor	Date Medication Started

Family/Social

Family History:

Biological Mother: _____ Age: _____
(Last) (First) (M.I.)
Educational Level: _____ Occupation: _____

Biological Father: _____ Age: _____
(Last) (First) (M.I.)
Educational Level: _____ Occupation: _____

Biological Parents: □ Married □ Never Married □ Separated □ Divorced □ Deceased

Adoptive/Foster Mother's Name: _____ Age: _____
(Last) (First) (M.I.)
Educational Level: _____ Occupation: _____

Adoptive/Foster Father: _____ Age: _____
(Last) (First) (M.I.)
Educational Level: _____ Occupation: _____

Adoptive/Foster Parents: □ Married □ Never Married □ Separated □ Divorced □ Deceased

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 & Last Name)	Age	Male/Female/ Other	Live with mom, dad, both, other

Educational

Highest Educational Level - Adults:

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

Highest Education Level - Minor:

Current Grade _____ School _____

Type of Placement: [check one or more]

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

Accommodations:

☐ Individualized Education Plan (IEP) ☐ 504 Plan ☐ Other ☐ N/A

Explain: _____

_____

Attitudes toward school: [check one or more]

☐ Truancy	☐ Argumentative	☐ 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**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please List any Additional Questions/Concerns: _____

_____

_____

_____

_____

_____

Scheduling Preference(s): _____

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Supplementary Questions

What is your child really great at?

_____
_____
_____

What objects/topics does your child love?

_____
_____
_____

What activities does your child enjoy?

_____
_____
_____

What activities does your family really enjoy?

_____
_____
_____

What do you think is your child's best characteristic?

_____
_____
_____

We want to focus our effort on your family's interests and priorities. Think about what would make life easier or more enjoyable with your child; what are the most important tasks or activities that you would like your child to be able to do?

_____
_____
_____

Think about the activities you just listed. Describe how your child does these activities right now. This will give us a way to see changes in the future. For example, if you wanted your child to play with others, you might say "plays alone" or "picks only a few toys to play with." What does it look like when your child does the task or activity today?

_____
_____
_____

Can you describe any barriers that prevent your child participating in the tasks / activities you listed on the previous question?

_____

_____

_____

Now tell us what you want your child to do. What will your child look like when you feel satisfied with his or her behaviors?

_____

_____

_____

Tell us where your child needs to do the activities you have listed?

_____

_____

_____