Beloit Health System
COUNSELING CARE CENTER
CONSENT FOR TREATMENT OF A MINOR

I, _____, hereby authorize the staff of Beloit Health System, Operated by Beloit Memorial Hospital, Counseling Care Center to provide mental health services to _____. I understand that I will be responsible for payment of all charges incurred in the course of such services.

I further understand that no guarantee of the effectiveness of such services is made or implied, and that I agree to respect the confidentiality of communication between my child (or ward) and his/her therapist.

_____

Parent/Guardian/Power of Attorney (PLEASE PRINT)

_____

Signature Parent/Guardian/Power of Attorney Date

_____

In the Presence of Date

Beloit Health System
COUNSELING CARE CENTER
SERVICE AGREEMENT AND INFORMED CONSENT

The Counseling Care Center of Beloit Memorial Hospital is a certified clinic by Wisconsin statue (623.89), which enables the clinic to receive mandated benefits from Wisconsin-based insurance companies. Our staff consists of licensed psychiatrists, psychologists, social workers and counselors. Staff psychiatrists and psychologists provide clinical supervision for each client. The initial assessment sessions in the clinic last 50 to 120 minutes. Most psychotherapy sessions consist of 25 to 50 minute visits. Other individual and group sessions typically last from 15 minutes to 2 hours, as scheduled. A fee schedule has been provided and discussed with you and is available on request.

SCHEDULED APPOINTMENTS: See separate agreement.

PAYMENT FOR SERVICES: The billing department of Beloit Memorial Hospital will cooperate with you in filing for reimbursement with your third party payer. By signing below, you give consent for release of information, including photocopies of your record as requested, which may be necessary to obtain reimbursement. However, the hospital does not accept responsibility for collection of your claim or of negotiating a settlement on a disputed claim**. I understand that it is my responsibility to contact my insurance company regarding coverage limits at the Counselor Care Center and its providers. I further understand that any fee not covered by insurance will be made my responsibility unless prior financial arrangements have been made with the hospital's billing department.**

CONFIDENTIALITY AND PATIENT RIGHTS: You have received and have had explained to you the Counseling Care Center's description of its confidentiality policy and have received a description of patients' right for patients treated in the Counseling Care Center.

I agree to participate in services for the Counseling Care Center, in accord with my service agreement. Customary fees have been discussed with me, and I know I may request a copy of the fee schedule. I have also received a copy of the Counseling Care Center's confidentiality statement. I understand the terms of the above and assign insurance benefits by my signature. I may receive a copy of this document. This consent shall remain in effect for 12 months from the date signed unless otherwise revoked in writing.

Patient Signature Date In the Presence of Date

Parent/Guardian/Power of Attorney Date

Beloit Health System
COUNSELING CARE CENTER
DESCRIPTION OF PATIENT RIGHTS

The following is a brief summary of your rights as a patient treated in the Counseling Care Center. Please feel free to ask questions about your rights at any time during meetings with your treatment providers or other Counseling Care Center staff.

1. You have the right to be informed of your treatment plan including:
   a. Possible outcomes and side effects of treatment recommended in the treatment plan.
   b. Treatment recommendations and benefits of the treatment recommendations.
   c. Approximate duration and desired outcome of recommendations in the treatment plan.
   d. The rights of the patient receiving outpatient mental health services, including the patient's rights and responsibilities in the development and implementation of an individual treatment plan.
   e. The outpatient mental health services that will be offered under the treatment plan.
   f. The nature of care, procedures and treatment that you will receive;
   g. Potential treatment risks, including potential adverse affects of medication;
   h. Treatment alternatives.
   i. The time period for which you will provide informed consent for treatment, which is one year unless otherwise specified;
   j. The right to withdraw your informed consent at any time, in writing.
   k. Under what circumstances you may be involuntarily discharged from care, and resulting referral needs.

2. You have the right to treatment in the least restrictive setting available, consistent with your and others' safety and your health and well-being.
3. You have the right to receive prompt and adequate treatment.
4. You have the right to refuse medication, unless ordered by a court.
5. You have the right to request a second opinion of a consultant, at your expense (or as covered by your public or private insurance) if you do not agree with any or all of your treatment plan.
6. You have the right to review your treatment records with your treatment provider(s).
7. You have the right to confidential treatment except as otherwise provided by law.
8. You or your guardian may inspect or receive a copy of your treatment records and challenge any inaccuracies. Records will be copied without a due delay only upon your written request.
9. You have a right to know the fees you will be expected to pay for services.
10. You have a right to be informed of means to obtain emergency mental health services during periods outside the normal operating hours of the clinic.
11. You have the right to file a grievance concerning any aspect of your treatment, and to have your grievance investigated.
12. You have the right to be provided assistance in exercising your rights if you request it.

I understand these rights and have received a copy of this document. I understand that I may contact Greg Ammon, clinic Director at 364-5686 or Julie Riese, Beloit Memorial Hospital patient representative at 363-5745, for patient grievance or advocacy needs.

Patient signature Date

Signature of Parent/Guardian Date

Beloit Health System
COUNSELING CARE CENTER
AGREEMENT FOR ATTENDING, RESCHEDULING AND CANCELING APPOINTMENTS

In order to provide prompt mental health services to you and to our other clients, we need your cooperation in being on time and attending all scheduled appointments. Our staff will also make every effort to be on time, but because of emergencies, there may be short delays. If a significant delay is anticipated, you will be informed.

If you know that you will need to change or cancel a scheduled appointment, you must do so at least ***one business day prior to the day of your scheduled appointment, during normal business hours.*** "Business days" are Monday through Friday, excluding holidays.

We understand that you may have a personal emergency that will make it impossible for you to attend a scheduled appointment and to provide advance notice of cancellation. If such a situation arises, we still ask that you call our clinic to inform us that you cannot attend your appointment. You will not need to provide any explanation in such a circumstance. However, if there are more than two instances in any six month period in which:

A. You miss or fail to appear for any scheduled appointments and/or

B. You do not give advance notice for cancellations (as defined above)

then all of your treatment in the Counseling Care Center will be terminated.

I have read and understand the importance of the above agreement. I understand that my failure to comply will result in termination of all of my services in the Counseling Care Center.

_____ _____

Patient Signature Date In the Presence of Date

_____

Parent/Guardian/Power of Attorney Date

Beloit Health System 1969 West Hart Road – Beloit, Wisconsin 53511 (608) 364-5686 PHONE (608) 364-5756 **COUNSELING CARE CENTER**	MR # Name: Date of Birth: Age: Today's Date: Social Security #

Client Self-Reported History – Page 1 of 4

Below are a number of questions about you and your health history. This information will be helpful to our staff in assessing and planning treatment for you. Please check a response for each question/item. Feel free to discuss these with our staff.
All information you provide here is confidential. Thank you.

DEMOGRAPHIC *(check one answer or fill in the blank)*

1. Gender? ☐Male ☐Female
2. Date of Birth _____/_____/_____
3. What is your Status? ☐Married ☐Widowed ☐Separated ☐Divorced ☐Never Married ☐Long Term Partnership
4. How far did you go in school? ☐8th grade or less ☐some high school (HS) ☐HS graduate or equivalent (GED)
   ☐ some college or associate degree ☐ college graduate
5. How many children do you have? _____
6. How many children live in your home? _____
7. Military? ☐No ☐Yes If so, what branch? _____ Active? _____
8. Religious affiliation? _____ Actively Involved? ☐Yes ☐No

MEDICATIONS

9. Please list the names of all medications that you are now taking, including prescribed, over-the-counter, herbals/vitamins, and as-needed medications:
   Prescribed: _____
   _____
   _____
   Other: _____
   _____
10. Have you ever had an allergic or other bad reaction to any medications or foods? (*Check one)* ☐ No ☐ Yes
    If yes, please explain _____

The following questions will help us assess your health history. Please mark an X in the Yes or No box to the right for each question below, answering to your best knowledge.

Please list your physician(s) names: _____

Rate any pain you experience from 1 to 10, with 10 being completely unbearable _____ Where is the pain? _____

HABITS

1. Have you ever smoked cigarettes, cigars or a pipe? …… Yes ☐ No ☐
2. How many days in the past month have you smoked cigarettes, cigars or a pipe? …… _____ days
3. What is the average total number of cups or cans of coffee, tea or caffeinated sodas (cola, Mountain Dew, Dr. Pepper) that you drink in a typical day? …… ____cups & cans
4. Approximately how many days have you had beer, wine, or liquor to drink in the past 30 days? …… _____ days
5. On days when you did drink, what is the average total number of drinks you had? *(one drink = one 12 oz. Beer, or one shot of spirits, or one 4 oz. Glass of wine)* …… _____ drinks
6. In the past month, did you ever have 5 or more drinks in a single day? ……Yes ☐ No ☐
7. Approximately how many days have you used amphetamines, cocaine, crack, marijuana, sleeping pills, Valium or other sedatives in the past 30 days? …… _____ days

HABITS - Continued

8. Have you ever felt you should cut down your drinking of alcohol? ..... Yes ☐ No ☐
9. Have you ever been annoyed by complaints about your drinking? ..... Yes ☐ No ☐
10. Have you ever felt guilty or upset about your drinking? ..... Yes ☐ No ☐
11. Have you ever had a drink in order to feel better in the morning? ..... Yes ☐ No ☐
12. Have you ever had professional counseling about your drinking or drug use? ..... Yes ☐ No ☐

EMOTIONAL PROBLEMS

1. Have you ever had a panic attack, when you suddenly feel frightened, anxious or extremely uncomfortable? ..... Yes ☐ No ☐
2. Do you often feel very uncomfortable being watched or noticed by other people (such as when you speak to someone in public, write in a public place, or eat in public) because you feel you will do something embarrassing or humiliating? ..... Yes ☐ No ☐
3. Are there things that you have been especially afraid of like flying, heights, seeing blood, closed places, bridges or certain kinds of animals or insects? ..... Yes ☐ No ☐
4. Are you often bothered by thoughts that make you anxious, seem senseless and that you cannot get rid of, even when you try to resist having them? ..... Yes ☐ No ☐
5. Have you ever had things that you had to do over and over again and couldn't resist doing (like washing your hands again and again, or checking something several times to make sure you'd done it right) more than most other people you know? ..... Yes ☐ No ☐

In the **past six months**, have you had a lot of difficulty with:

6. Controlling your "nerves" or feeling anxious and on the edge? ..... Yes ☐ No ☐
7. Worrying excessively about many different things on most days? ..... Yes ☐ No ☐

In the **past three months**, have you had:

8. Several eating binges in which you ate very large amounts of food in a short amount of time? ..... Yes ☐ No ☐
9. A feeling your eating was out of control? ..... Yes ☐ No ☐

In **your lifetime**, have you ever had a period that lasted **at least two weeks** when, most of the day, every day, you felt:

10. Little interest or pleasure in doing things? ..... Yes ☐ No ☐
11. Down, sad, depressed or hopeless? ..... Yes ☐ No ☐

In the **past two weeks**, have you been bothered most of the day, every day, by:

12. Feeling little interest or pleasure in doing things? ..... Yes ☐ No ☐
13. Feeling down, sad, depressed, or hopeless? ..... Yes ☐ No ☐
14. Have you **ever in your life** had a period lasting **a week or more** when you were feeling so good or hyper that other people that that you were not your normal self, or you were so irritable that you would shout at people or start fights or arguments? ..... Yes ☐ No ☐
15. Has a counselor or doctor ever told you that you had bipolar disorder or a manic episode? ..... Yes ☐ No ☐
16. Have you ever felt that people were talking about you behind your back or taking special notice of you? ..... Yes ☐ No ☐
17. Have you ever felt that anyone was going out of the way to give you a hard time, attack, cheat or try to hurt you? Yes ☐ No ☐
18. Have you ever felt that you were especially important in some way, or that you had powers to do things that normal people couldn't do? ..... Yes ☐ No ☐
19. Have you ever felt that someone or something outside yourself was controlling your thoughts or actions against your will? ..... Yes ☐ No ☐
20. Have you ever felt that your thoughts were being broadcast out loud so that other people could actually hear what you were thinking? ..... Yes ☐ No ☐
21. Have you ever heard things that other people could not hear, such as noises or the voices of people talking or whispering? ..... Yes ☐ No ☐
22. Have you ever had visions or seen things that others couldn't see? ..... Yes ☐ No ☐
23. Have you ever intentionally overdosed, physically injured yourself or attempted suicide? ..... Yes ☐ No ☐

EMOTIONAL PROBLEMS - Continued

24. Have you ever injured another person accidentally or intentionally? ..... Yes ☐ No ☐
25. Have you ever been arrested, charged with a crime or do you have any legal concerns? ..... Yes ☐ No ☐
26. Are you experiencing suicidal/homicidal feelings/thoughts? ..... Yes ☐ No ☐
27. What do you do for leisure? _____
28. Has your interest in this changed? ..... Yes ☐ No ☐

MENTAL HEALTH TREATMENT

Have you ever seen a counselor, psychologist, psychiatrist or other mental health specialist for help with a problem before today?

No ☐ Yes ☐ If yes, please tell us when, where and why you sought treatment:

Year/Date Place Reason/Diagnosis

_____

_____

_____

PSYCHIATRIC HOSPITALIZATIONS

Have you ever been hospitalized for psychiatric treatment?

No ☐ Yes ☐ If yes, please tell us when, where and why you were hospitalized:

Year/Date Place Reason/Diagnosis

_____

_____

_____

MEDICAL HOSPITALIZATIONS

Have you ever had an overnight hospital stay or ambulatory surgery for treatment of a problem other than mental health problems?

☐ No ☐ Yes If yes, please indicate when, where and why:

Year/Date Place Reason/Diagnosis

_____

_____

_____

NEUROLOGICAL

1. Have you ever had a seizure? (convulsion, epilepsy)..... Yes ☐ No ☐
2. Do you have frequent headaches? ..... Yes ☐ No ☐
3. Have you had problems with coordination or weakness? ..... Yes ☐ No ☐
4. Problems with tingling or numbness of your hands or feet? ..... Yes ☐ No ☐
5. Have you ever had a serious head injury or been comatose? ..... Yes ☐ No ☐

CIRCULATORY - Have you ever had significant amounts of:

1. Swelling of your hands or feet? ..... Yes ☐ No ☐
2. Bad circulation, leg pain when walking or varicose veins? ..... Yes ☐ No ☐
3. Fainting Spells ..... Yes ☐ No ☐
4. Dizziness, lightheadedness, or fainting spells? ..... Yes ☐ No ☐

CIRCULATORY – Have you ever had significant amounts of:

5. High blood pressure? ..... Yes ☐ No ☐
6. Chest pain? ..... Yes ☐ No ☐
7. Palpitations or heart pounding? ..... Yes ☐ No ☐
8. Have you ever had a heart attack? ..... Yes ☐ No ☐

CIRCULATORY – Continued… Have you ever had significant amounts of:

9. Have you ever had an abnormal heart rhythm? ……Yes ☐ No ☐
10. Have you ever had a heart murmur? …… Yes ☐ No ☐
11. Have you ever had rheumatic fever? ……Yes ☐ No ☐

RESPIRATORY – Have you ever had:

1. Shortness of breath after minor exercise, asthma, or emphysema? ……Yes ☐ No ☐
2. Tuberculosis or a positive TB skin test? ……Yes ☐ No ☐
3. Pneumonia, chronic bronchitis, or frequent sinusitis? ……Yes ☐ No ☐

URINARY

1. Have you ever been told that you have kidney disease? …… Yes ☐ No ☐
2. Have you ever had kidney stones? …… Yes ☐ No ☐
3. Have you ever had a urinary tract (bladder) infection? …… Yes ☐ No ☐
4. Do you ever notice blood in your urine? ……Yes ☐ No ☐

GASTROINTESTINAL

1. Have you lost or gained more than 5 lbs. in the past 6 months? ……Yes ☐ No ☐
2. Do you have any pain or difficulty when swallowing? ……Yes ☐ No ☐
3. Have you ever had significant heartburn? ……Yes ☐ No ☐
4. Have you ever had an ulcer? ……Yes ☐ No ☐
5. Have you ever had black or bloody bowel movements? …… Yes ☐ No ☐
6. Have you ever had hepatitis or other liver disease? ……Yes ☐ No ☐
7. Have you ever been told that you had pancreatitis? ……Yes ☐ No ☐
8. In the **past month**, have you had significant amounts of:

   Nausea …… Yes ☐ No ☐ Diarrhea ……Yes ☐ No ☐

   Vomiting …… Yes ☐ No ☐ Constipation ……Yes ☐ No ☐

ENDOCRINE

1. Have you ever been told you have diabetes? ……Yes ☐ No ☐
2. Have you ever been told you have thyroid disease? ……Yes ☐ No ☐

REPRODUCTIVE - FEMALE

1. Have you had a tubal ligation or hysterectomy? ……Yes ☐ No ☐
2. Have you ever had abnormal PAP tests or uterine/cervical cancer? …… Yes ☐ No ☐
3. Have you gone through menopause? ……Yes ☐ No ☐

REPRODUCTIVE – MALE

1. Have you ever had problems with impotence? …… Yes ☐ No ☐

OTHER

1. Have you ever had anemia? …… Yes ☐ No ☐
2. Have you ever had cancer? …… Yes ☐ No ☐
3. Have you ever had psoriasis or other serious skin disease? …… Yes ☐ No ☐
4. Have you ever had arthritis, gout, or other joint disease? …… Yes ☐ No ☐

Patient Signature _____ Date _____

Patient Printed Name _____ Revised 07/15/2009