Red Oak Counseling, Ltd. - Psychiatry

Client Master Record

Client Legal Name: _____Preferred Name: _____

Date of Birth: _____ Age: _____Assessment Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: _____ Pronouns: _____

Relationship Status: □ Married □ Separated □ Partnered

□ Divorced □Widowed □Single/Never Married

Race: □ African American □ Caucasian □ Hispanic

□ Native American □ Asian □ Other

Contact Information:

Cell: _____ Work: _____

Home #: _____ Email Address: _____

Is it okay to leave a message at these numbers? (*Circle One*) Yes or No

SS Number: _____

Referred By: _____ Phone Number: _____

Emergency Contact Information

Emergency Contact: _____ Relationship to Client: _____

Home Phone: _____Work Phone: _____

Email Address: _____

In case of an emergency, I give permission for the staff at Red Oak Counseling to call the person listed above and/or (911) for medical assistance and to release any information that will allow for proper medical care.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____Date: _____

Payment Agreement

The following agreement states your financial obligations for psychiatry/medication management provided by Red Oak Counseling, I understand that:

1) I am responsible for all the fees incurred. Self-pay rates are as follow:
   - ❖ Intake Appointment/Assessment (typically 60 minutes): $325.00
   - ❖ Follow up appointments (typically 30 minutes): $150.00
   - ❖ Charge for No Show/Late Cancellation of Intake Appointment: $150.00
   - ❖ Charge for No Show/Late Cancellation of Follow-Up Appointment: $75.00
2) All fees are due at the time of service and a valid credit card on file may be required to receive services. Red Oak Counseling reserves the right to attempt to collect any unpaid bills by reasonable means. If your account balance is not paid in full your account may be turned over to a collection agency & a collection fee up to 50% may be assessed to any unpaid balance. Non-payment of fees can be cause for termination from treatment.
3) We offer complimentary benefit checks for both in and out of network levels of care. The information you receive from us regarding your insurance benefits is what we are quoted from your insurance company & we cannot guarantee the accuracy of the information until we begin receiving the explanation of benefits. If we are informed by your insurance company that you have an unmet deductible, a co-payment and/ or coinsurance as part of your plan, that amount will be due at the time of service.
4) Our stipulated rates with the insurance companies that we contract with are subject to change at any time and may result in an increase to your out-of-pocket responsibility. We may not be aware of this change until the explanation of benefits is received.
5) No show appointments or appointments canceled without 24-hour notice will result in the fee amounts listed above for psychiatry/medication management services. Insurance plans will not reimburse you for late cancellations or for not showing up for appointments and it is your responsibility for payment on or before your next appointment. We understand that there may be times you need to miss an appointment due to emergencies or obligations related to work or family; however, when we do not receive timely notification of a cancelation or reschedule, this may prevent another patient from receiving treatment. A total of 2 late cancellations and/or missed appointments may result in termination of services. If you arrive late for any appointment, please be aware your appointment will be shortened. Arriving 10 minutes late to a 30-minute appointment or 15 minutes late to a 60-minute appointment may result in cancellation of the appointment. We understand emergencies and illnesses do occur and we will review any situation that arises on an individual basis.
6) I am authorizing Red Oak Counseling, Ltd. to bill my insurance company or other source of reimbursement for services incurred. In doing so, I also understand that my insurance company, managed care organization, or other source of reimbursement may require direct clinical management in the treatment process. This involvement will directly impact the confidentiality of my records.

Fee Statement

Name of insurance Company or Reimbursement Source: _____

Please check options that apply:

□ I am self-paying and agree to pay the amounts listed above.

□ I am utilizing my insurance coverage.

I have carefully reviewed all the above statements and accept all the above conditions as indicated. If there are any changes in my insurance benefits, I will immediately inform Red Oak Counseling. If I fail to report changes, I agree to all charges.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Treatment History

Are you currently receiving psychiatric services or psychotherapy elsewhere? ( ) Yes ( ) No
If yes, with: _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) Yes ( ) No
If yes. please list:_____

Prescribed by: _____

Health and Social Information

Do you currently have a primary physician? ( ) Yes ( ) No

If yes, who is it? _____ When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Are you currently on medication to manage a physical health concern? ( ) Yes ( ) No

Are you having any problems with your sleep habits? ( ) Yes ( ) No

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep ( ) Disturbing dreams ( ) Other _____

How many times per week do you exercise and for how long? _____

Are you having any difficulty with appetite or eating habits? ( ) Yes ( ) No

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Binging ( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) Yes ( ) No

How many alcoholic drinks do you consume in one week? _____

Do you use recreational drugs? If so, please list _____

Do you smoke cigarettes or use other tobacco products? ( ) Yes ( ) No

Have you had suicidal thoughts recently? ( ) Frequently ( ) Sometimes ( ) Rarely ( ) Never

Have you had them in the past? ( ) Frequently ( ) Sometimes ( ) Rarely ( ) Never

Are you currently in a relationship? ( ) Yes ( ) No

If yes, how long have you been in this relationship? _____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No	
Dramatic mood swings	Yes / No	
Rapid speech	Yes / No	
Extreme anxiety	Yes / No	
Panic attacks	Yes / No	
Phobias	Yes / No	
Sleep disturbances	Yes / No	
Hallucinations	Yes / No	
Unexplained losses of time	Yes / No	
Unexplained memory lapses	Yes / No	
Alcohol/substance abuse	Yes / No	
Frequent body complaints	Yes / No	
Eating disorder	Yes / No	
Body image problems	Yes / No	
Repetitive thoughts (e.g., obsessions)	Yes / No	
Repetitive behaviors (e.g., frequent checking, hand washing)	Yes / No	
Homicidal thoughts	Yes / No	
Suicidal attempts	Yes / No	If yes, when? _____

Occupational Information

Are you currently employed? ( ) Yes ( ) No

If yes, who is your current employer/position?_____

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, unc1e, etc.)

Difficulty	Yes / No	Family Member: _____
Depression	Yes / No	Family Member: _____
Bipolar disorder	Yes / No	Family Member: _____
Anxiety disorder	Yes / No	Family Member: _____
Panic attacks	Yes / No	Family Member: _____
Schizophrenia	Yes / No	Family Member: _____
Alcohol/substance abuse	Yes / No	Family Member: _____
Eating disorders	Yes / No	Family Member: _____
Leaming disabilities	Yes / No	Family Member: _____
Trauma history	Yes / No	Family Member: _____
Suicide attempts	Yes / No	Family Member: _____
Chronic illness	Yes / No	Family Member: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____Date: _____

Consent for Treatment

The mission of Red Oak Counseling is to enhance the well-being of individuals and families in a way that blends traditional and innovative approaches, creating an atmosphere of dignity and respect while fostering hope and encouragement for our clients.

For the best results and for your own welfare, it is very important that you take the time to read and understand what it means to be receiving psychiatric/medication management services from Red Oak Counseling. Please read the brief description below. If you understand it and you choose to receive services from Red Oak Counseling as described here, sign and date this form and return it to your provider. If you have any questions of concerns, you are urged to talk about them with your clinician.

Client Information & Informed Consent for Psychiatric Medication Management

Psychiatric medications may be used in conjunction with therapy to provide an integrated approach towards treatment for many conditions. The goals of psychiatric medication management are to provide relief towards symptoms of mental illness that impact the ability to work, maintain interpersonal relationships, or the ability to appropriately care for your basic needs. In some instances, when talk therapy, exercise and supplementation is not enough, medications are indicated to aid in the treatment and management of a client's symptoms and treatment. In these cases, the provider will discuss with the client the risks, benefits, and side effects of these medications that they feel are indicated and will only prescribe if both they and the client agree. Red Oak Counseling has a strict policy against prescribing opiates, as these are not indicated in psychiatric and mental health concerns, as well as strict guidelines in the prescription of other controlled medications, including benzodiazepines and stimulants. In the instance that these medications are indicated, contractual agreements will be made with the client.

I understand that if I choose to participate in psychiatric services, my provider will discuss with me in understandable language the nature of my illness as assessed and all options for treatment, medication or otherwise, that are available to appropriately treat my current condition. In the case I'm already receiving psychotherapy, I understand Red Oak Counseling strongly recommends that I separately consent to the coordination of care between my therapist and psychiatric provider to provide effective care. I understand that medication management may not be appropriate for all clients.

If a medication is indicated, my provider will ensure I understand the type(s) of medication being recommended; the purpose for the medication and potential benefits; dosage and frequency of administration including a discussion of the initial dose, the maintenance dose and the dose range; probable side effects known to commonly occur and any side effects likely to occur in particular cases, as determined by your medical and psychiatric history or known medical conditions; any risks or government warnings associated with this medication; and any possible long term effects which may occur after taking the medication for long periods or terminating the medication, including tardive dyskinesia or withdrawal. I understand that results are not guaranteed, and I agree to hold my provider harmless for claims or damages in connection with our work together. This is a contract between myself, and the provider and I understand that it is also a release for potential liability.

I understand that prescription of certain medications may require a urinalysis screen for baseline readings. I agree that I will comply with routine, ongoing urinalysis screenings if I am prescribed a controlled substance to ensure compliance. I understand that other lab work, including but not limited to blood labs, may be required as a part of my treatment to monitor for potentially adverse effects of medication. I understand that all screenings, including urinalysis and blood labs, taken as a part of my treatment at Red Oak Counseling are sent to an outside lab. I understand that this facility is separate from Red Oak Counseling, and as such insurance coverage may differ.

Prescription Policy

Our medical staff provides refills and renews prescriptions only during office appointments - except for urgent circumstances or medical necessity. Our providers do not approve refill requests from patients or pharmacies outside of an appointment. This practice reduces prescription errors, improves patient safety and encourages appropriate follow-

up. It also improves compliance with new state laws governing controlled substances. Patients will receive enough medication or refills to last until their next recommended follow-up. Patients are asked to track their supply, and to ensure they have an appointment scheduled before they run out of medication or run out of existing refills.

Some patients find that they become aware of running low on medications only at the last minute. Please be proactive in your care, and track how much medication you have and how many refills remain on the prescription, and ensure you have an appointment to see your provider before you're out of medication.

Nutrition and Supplements

In the integrative approach a client's daily habits are very important aspects of the healing process. Exercise as well as nutrition are imperative components to living an optimal life. Clients should expect to have a thorough medical history with possible laboratory testing to determine if electrolytes, nutrients, or vitamins are deficient. If the client is interested in more intensive nutrient and supplemental inquiry and treatment the provider will make referrals to specialists that can engage the patient in homeopathic remedies as well as naturopathic processes.

Audio or Video Recording of Any Session is Forbidden

I agree that neither I nor any other participant in my session(s) will record any audio or video portion of my session without written mutual consent from myself and my provider (and any other participant as applicable). If I or any participant in my session do record any audio or video information during my treatment session(s) without written mutual consent, the session will immediately be terminated (with my obligation to pay the full fee for the session), all future treatment sessions of any kind will be canceled/terminated, and I may be permanently discharged from my provider and all providers in the Red Oak Counseling company.

Client Information and Informed Consent for Telehealth Treatment

Telehealth services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable counselors to provide services to individuals who may otherwise not have adequate access to care. Telehealth may be used for services such as individual, couples, or family therapy. Telehealth is a relatively recent approach to delivering care and there are some limitations compared with seeing a counselor in person. These limitations can be addressed and may be minor depending on the needs of the client and the care with the technology (cell phone, computer, etc.) which is being utilized. It is important that both the client and the counselor be in a place where there is the most privacy, as possible, during their sessions, and that the security of their technology be as up to date as possible with appropriate security protection.

Additional Points for Client Understanding:

• I understand that telehealth services are completely voluntary, and I can choose not to do it or not to answer questions at any time.
• I understand that none of the telehealth sessions will be recorded or photographed without my written permission.
• I understand the laws that protect privacy and the confidentiality of client information also apply to telehealth.
• I understand that telehealth may be performed over a communication that is not encrypted. My therapist and I will work together to choose the telehealth communication system/program that will work best for my needs. I do accept the risk that this could affect confidentiality.
• Red Oak Counseling has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telehealth sessions will not be the same as an in-person session since I will not be in the same room as my therapist.
• I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the videoconferencing, text, or telephone connections are not adequate for the situation.
• I understand that I may experience benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

• I understand if there is an emergency during a telehealth session, as with an in-person session, my therapist will call emergency services and my emergency contacts if needed clinically necessary.
• I understand that in advance of the telehealth session, a plan will be in place about how to re-connect if the connection drops while I am in a session.
• I understand that my therapist and I will create and have in place a safety plan in case of an emergency (see below).
• I understand I have the right to withhold or withdraw this consent at any time.
• I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment document.
• I understand that patient cost-sharing, such as a co-pay or co-insurance, may apply to my visit.

Consent:

I consent to engaging in telehealth as part of my treatment at Red Oak Counseling. I understand telehealth includes the practice of health care delivery, diagnosis, transfer of personal health information via conversation, and psychoeducation using interactive audio, video, or data communications.

I understand the information provided above regarding telehealth. I have discussed the consent with my therapist and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

A Mental Health and AODA Clinic
Confidentiality of Alcohol and Drug Abuse Client Records

Federal law and regulations protect the confidentiality of alcohol and drug abuse client records maintained by the Red Oak Counseling. Generally, Red Oak Counseling may not say to a person outside of the clinic that a client attends the clinic, or disclose any information identifying a client as an alcohol or drug abuse client unless:

1. The client consents in writing
2. The disclosure is allowed by court order.
3. The disclosure is made to medical personnel in a medical emergency.

Violation of the Federal law and regulations by Red Oak Counseling is a crime. Suspected violations may be reported to the appropriate authorities in accordance with Federal regulations, the U.S. Attorney where the clinic is located:
Eastern District of Wisconsin, 517 E. Wisconsin Ave., Suite 530, Milwaukee, WI 53202 Phone 414-297-1700
Federal Law and regulations do not protect any information about a crime committed by a client either at Red Oak Counseling or against any person who works for Red Oak Counseling or about any threat to commit such crime.
Federal law and regulations do not protect reports of suspected child abuse or neglect made under state law to appropriate state or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for federal regulations).

Confidentiality of Mental Health Client Records

All information concerning your identity and all treatment information in your files at Red Oak Counseling shall remain confidential. Your records shall be released without your written informed consent **ONLY** as provided under sections 46.21, 46.215, 51.30, and 146.81, et seq., of Wisconsin State Statues, 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3. of the federal state statutes, 42 C.F.R. Part 2 of the federal regulations, or as otherwise allowed or required by state or federal law. They may also be released to other people with your written informed consent, or the written informed consent of a person authorized by you. Feel free to request additional information or have your Therapist/Counselor explain the circumstances under which your records may be released if you wish further clarification.

You are not required to give Red Oak Counseling any specific information. However, all information that you give will help us gain funds for the services you may receive.

All information that you give will also help your prescriber provide you (and your family) with the best care possible. Feel free to have your provider explain further if you wish clarification.

You have the right to review your file with staff present and to contest the accuracy of any statement in your file with which you disagree.

Grievance Procedures Outline

Red Oak Counseling is devoted to providing competent mental health and AODA Treatment to our clientele. The agency would also like every client to know that he/she does have a voice in the kind of care received. Grievances involve complaints about service, breach of confidentiality or abuse. The following instructions are steps to be taken should a client feel the need for resolution of a situation. If level one does not provide satisfactory results, the client should proceed to the next level, and so on.

Level One

One of the most important tools in psychiatry/medication management is the relationship between the prescriber and the client. If a client has a discrepancy with the prescriber, those issues should be discussed directly with the provider. The two parties will discuss the matter and come to an agreeable resolution. If the provider is a student intern, the student should bring the issue to the attention of the clinical director.

Level Two

Clients of **Red Oak Counseling** have the right to speak directly to the Clinical Director if speaking with the therapist has not helped. The Clinical Director will attempt to mediate the difficulties between provider and client.

Level Three

At this level, clients should place all grievances and steps that have been taken to remedy the situation in writing using the "Grievance and Complaint Summary Form" within one month of the meeting with the Clinical Director. This form may be obtained from the Client Rights Specialist/ Director. The Director will review the situation and meet with the parties involved to discuss a resolution. A letter outlining the agency's position will be mailed to the parties involved within two weeks of the meeting.

Acknowledgement of Receiving "Client Bill of Rights and Grievance Procedure for Community Services" and "Notice of Privacy Practices"

I acknowledge that I have received the written "Client Bill of Rights and Grievance Procedure for Community Services" under Wisconsin Statute sec. 51.61 (1) and HFS 94 and the Notice of Privacy Practices as explained by staff of Red Oak Counseling/Refresh Mental Health. I understand the "Client Bill of Rights and the Grievance Procedure for Community Services" and the Notice of Privacy Practices and confirm my understanding of both by signing this acknowledgement.

I have read and understand the above confidentiality policy of client records. I understand that my records may be released to other people without my informed consent only as provided by State and Federal law, or to persons with my informed consent or the informed consent of a person authorized by me.

I have read the policy regarding the prohibition of audio and video recording. I agree to abide by this policy.

Your signature indicates that you have understood the above description of psychiatry/medication management and are consenting to psychiatry/medication management & telehealth if applicable with the understanding that you retain the right to review and revise the decision at later points in time.

_____

Client Name Printed Date

_____

Client Signature Date

_____

Parent or Guardian Signature Date

_____

Staff Signature Date

Controlled Substances Agreement – Benzodiazepines and Stimulants

Benzodiazepine treatment is sometimes used for acute panic and/or other anxiety related issues. Along with this treatment, other medical care may be prescribed to help improve your ability to do daily activities. Stimulant (narcotic) treatment for ADHD is used to decrease your ADHD symptoms and to improve what you're able to do each day. Along with this treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic medication, psychological counseling or other therapies or treatment.

1. I will take medications as prescribed & not increase or decrease dose without discussion.
2. I will not obtain medications from several physicians, but my physician/APRN only.
3. I will not share or sell the medication to anyone including family members.
4. I will not get replacement for any lost or stolen medication regardless of the circumstance.
5. I will not get early refills.
6. I will notify if I abuse alcohol or use other illicit drugs along with ADHD medication.
7. I agree to periodic random drug screening tests.
8. I will not request prescription refills when the clinic is closed after hours or on weekends.
9. If I am pregnant or intend to get pregnant, I am required to notify Red Oak Counseling, Ltd. immediately to discuss medication options. I will not hold the clinic responsible for any harm that may occur to me and/or my unborn.

I understand that this physician/APRN may stop prescribing the medication or change the treatment plan if I failed to follow the above recommendations. I have read this document, understand, and have had all my questions answered satisfactorily. I consent to the use of benzodiazepine and/or stimulants if recommended and I understand that my treatment with these medications will be carried out as described above.

_____

Client Signature Date

_____

Parent or Guardian Signature Date

_____

Staff Signature Date

CONSENT TO BE CONTACTED FOR POST-VISIT SATISFACTION SURVEY FORM

Client First Name: _____ **Client Last Name:** _____

Client Date of Birth: _____

Red Oak Counseling, Ltd. ("Center") is committed to ensuring clients' satisfaction of services received. Center has contracted with a third party – Burke, Inc. – to conduct satisfaction surveys on our behalf. The survey will be provided online and will take no more than 10 minutes to complete. If you agree to be contacted to participate in a survey about our services, please indicate your consent by checking one of the boxes below:

☐ I agree to be contacted by Burke, Inc. via email (at the email listed below) for purpose of the survey and understand that the invitation will mention Center. I acknowledge and agree that these messages, which may contain Protected Health Information, will be sent via unencrypted means and there is some risk of disclosure or interception of the messages.

Email Address: _____

I understand that this consent may be withdrawn by me at any time via the email I receive from Burke, Inc., via telephone by calling **262-780-1020** or via email message at **help@redoakcounseling.com**. I understand that my withdrawal of consent to be contacted for a post-visit satisfaction survey shall not withdraw my consent to otherwise by contacted by Center.

☐ I do not wish to be contacted for the purposes of this survey.

Signature:

I confirm that I have read and fully understand the above information prior to my signing and all my questions regarding this form have been answered to my satisfaction. I agree that I am signing this Consent to be Contacted for Post-Visit Satisfaction Survey Form freely and voluntarily. I understand that my consent given with my signature below will remain in effect unless and until I cancel this consent in writing pursuant to the terms set forth above.

Signature of Client or Responsible Party: _____Date: _____

Printed Name of Client (or Responsible Party): _____

Responsible Party's Relationship to Client: _____

Credit Card Authorization Form

Clinic Name: **Red Oak Counseling**

Card Holder Name: _____ Date: _____

Client Name (if different):_____

Card Number: _____Exp. Date: _____

CVV/CVC Code: _____Zip Code:_____

Card Type (Circle One):

● Master Card ● Visa ● Discover Card ● American Express

□ I authorize Red Oak Counseling to use this card for all future sessions, balances and/or missed appointments.

□ I authorize Red Oak Counseling to use this card for telehealth sessions only.

□ I authorize Red Oak Counseling to use this card for a one-time payment only.

Amount: _____

Signature: _____ Date: _____