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
COUNSELING CARE CENTER
CHILD/ADOLESCENT INITIAL INTAKE ASSESSMENT

Name________________________________ Medical Record Number ____________________

Therapist ____________________________ Today's Date (Intake) ____________________

Date of Birth ______________________ Age ______________________________

Address ____

City ________________________________ State ___________ Zip _________________

Home Phone __________________________ Cell Phone ___________________________

Gender ☐ Male ☐ Female

How would you describe you/your child's cultural identity?

☐ African American ☐ Caucasian/White ☐ Asian American ☐ Native American

☐ Hispanic ☐ Biracial ______________________ ☐ Other ___________________

Are you/your child a US citizen? ☐ Yes ☐ No

Referred by: ☐ Self ☐ Dr. ____________________ ☐ Other ___________________

Which of the following concerns do you have for your child?

Suicidal Thoughts &/or Attempts ☐
Homicidal Thoughts &/or Behaviors ☐
Anger outbursts/ Aggressive behaviors ☐
Learning difficulties ☐
Attention and concentration difficulties ☐
Hyperactivity ☐
Anxiety/ Nervousness ☐
Victim of Abuse/Neglect ☐
Fatigue/Low Energy ☐
Depression/sadness ☐
Feeling Hopeless/Worthless ☐
Obsessive thinking/behaviors ☐
Motor Coordination ☐
Relationship problems ☐
Seizures ☐
Grief/Loss Issues ☐
Nightmares/ Night Terrors ☐
Problems Falling Asleep ☐
Other ________________________ ☐

Self Injury Behaviors ☐
Troubling Thoughts/Urges/Habits ☐
Poor Academic Performance ☐
Parenting Issues ☐
Physical Health/Pain ☐
Traumatic Experience/s ☐
Fears ☐
Low Self-Esteem ☐
Mood Swings ☐
Social Isolation ☐
Unstable/Excited moods ☐
Hallucinations/Delusions ☐
Repetitive Behaviors/ Movements ☐
Alcohol/drug Use ☐
Eating habits/nutrition/problems ☐
Medication Problems ☐
Problems with Hearing/Vision ☐
Problems Staying asleep ☐
Defiant/Oppositional Attitude ☐

Please rate how intense the issues are, that bring you/your child to the Counseling Care Center today.

0 1 2 3 4 5 6 7 8 9 10

Not At All Overwhelming

What do you hope to accomplish in your sessions at the Counseling Care Center? What is your main goal?

____

____

FAMILY INFORMATION

Mother

Name ______________________ Lives with child? ☐ Yes ☐ No

Address (if different from child's) ______________________

Home Phone ______________________ Parent's Work Phone ______________________

Parent's Cell Phone ______________________

Marital Status ☐ Married ☐ Divorced ☐ Never Been Married ☐ Separated

Father

Name ______________________ Lives with child? ☐ Yes ☐ No

Address (if different from child's) ______________________

Home Phone ______________________ Parent's Work Phone ______________________

Parent's Cell Phone ______________________

Marital Status ☐ Married ☐ Divorced ☐ Never Been Married ☐ Separated

Who has legal custody of this child? ☐ Mother ☐ Father ☐ Joint ☐ Other ______________

When did this legal arrangement begin? ______________________

Please list all members in your/your child's *PRESENT* household:

Name	Relationship	Age	Employment/School Status

Please list any significant family members *NOT LIVING* in your/your child's home (i.e., siblings, stepparents, ect)

Name	Relationship	Age	Employment/School Status

Please describe the child's family life:

Areas of Strength:

____

____

Areas of Conflict:

____

____

Methods of Discipline:

____

____

Other unique family issues for consideration:

____

____

DEVELOPMENTAL INFORMATION

Did your child have any of the following problems growing up?

☐ Physical developmental problem – please describe ____________________

☐ Learning difficulty/disability – please describe ____________________

☐ Emotional/Behavioral problems/disability – please describe ____________________

☐ Problems during pregnancy and/or delivery – please describe ____________________

Please describe any other significant childhood/adolescent issues that are still affecting your child today:

____

____

Please describe any other significant childhood/ adolescent issues that are still affecting your child today:

____

____

Please describe any statements or comments your child has said regarding hurting him/herself, suicidal feelings, or hurting others:

____

____

School Experience

Current School/Daycare: ______________________________ Grade____________

Other schools the child has attended:

____

Please describe your child's academic performance:

____

____

Please check any of the following that the child has experienced at school:

Has/had an IEP	☐	Repeated a grade	☐
Has been expelled	☐	Special help for learning disabilities	☐
Has been suspended	☐	Special help for behavior disorder	☐
Dropped out of school	☐	Self Contained Classroom	☐

Please describe the child's relationships with teachers:

____

____

PLEASE DESCRIBE THE CHILD'S RELATIONSHIPS WITH OTHER STUDENTS/FRIENDS:

____

____

SUBSTANCE USE/ABUSE HISTORY

Has anyone expressed concern about your/your child's use of alcohol or drug use? ☐ Yes ☐ No

During the past year, how often does your child use nicotine products?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Daily-Amount per day: ________

During the past year, how often does your child use caffeine products?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Daily-Amount per day: ________

Please describe any family history of alcohol/drug/addiction issues:

____

____

SOCIO-ECONOMIC INFORMATION

Please check all those that apply to you/your child:

☐ Housing concerns ☐ Limited social supports ☐ Financial concerns

☐ Legal concerns

☐ Other ____

Please describe any cultural or religious/spiritual practices that you/your child participates in:

____

____

Please list any of your child's current interests, hobbies, community or recreational activities:

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____

____

What are your child's strengths that will assist him/her in being successful in accomplishing their goals?

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PSYCHIATRIC INFORMATION

Please list previous *outpatient* mental health/counseling or alcohol/drug/addiction services:

Dates of Mental Health/Addiction Treatment	Hospital/Clinic	Diagnosis	Age	Type of Treatment (Mental health or addiction)

Please list previous *inpatient* mental health services or alcohol/drug/addiction inpatient treatment:

Dates of Mental Health/Addiction Treatment	Hospital/Clinic	Diagnosis	Age	Type of Treatment (Mental health or addiction)

Please describe any family members who have experienced mental health concerns:

____

____

____

MEDICAL INFORMATION

Who is your/your child's current physician(s)? ______________________________

When was your most recent physical exam? ______________________________

***Please list any allergies including food, pollens and medications:

____

____

Is there a history of any of the following in you or your family?

☐ Tuberculosis ☐ Birth Defects ☐ Emotional Problems ☐ Behavior Problems
☐ Thyroid Problems ☐ Cognitive Disabilities ☐ Heart Disease ☐ Cancer Type:____________
☐ High Blood Pressure ☐ Alzheimer's disease/dementia ☐ Obesity ☐ Stroke ☐ Diabetes
☐ Auto-Immune Disease- Lupus ☐ Fibromyalgia ☐ Ulcers/Colitis ☐ Asthma
☐ Cirrhosis ☐ Multiple Sclerosis ☐ Huntington's Disease ☐ Parkinson's Disease
☐ Other: Please Describe: ______________________________

Please describe any current/past medical concerns or issues you/ your child has and the current medical status:

____

____

____

Past medical history:

Date of Hospitalization Surgery Treatment	Hospital/Clinic	Type of Procedure	Child's Age at time of treatment	Current Status

What is your child's current pain level?

0 1 2 3 4 5 6 7 8 9 10

None Unbearable

Where is the pain located in his/her body?

____

____

Would you like referral information on medical providers in our area? ☐ Yes ☐ No

Please list any current medications/ over counter medications/ vitamins/ natural remedies:

Brand name of medication/ Generic name of medication	Physician Prescribing	Dosage	Times per Day	Date first prescribed?	For what medical/ psychiatric condition	Is it Helpful?

Is there anything else you would like to let us know that may be significant to your child's treatment here?

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