Mequon Clinical Associates Patient Benefit Check

MCA cannot make any guarantees that your provider is in network due to the many plans and networks available. Please call your insurance to confirm your provider is in your specific network.

When you call your insurance, please make note of the agent's name, date, time, and request a reference number. Record this information here and return a copy at your next session. **If your claims are incorrectly denied or you are given bad information, MCA will appeal on your behalf *if this form is completed and returned before your second session.***

Provider Name: _____

Please note benefits must be quoted for Mequon Clinical Associates

Per your call to insurance, is the provider in network? ❑ Yes ❑ No

Agent's Name: _____

Date and Time: _____

Reference Number: _____

I understand that I am responsible to verify my benefits. If my provider is out of network, I understand that my in-network benefits will not apply and I will be responsible for any outstanding balance.

_____ _____

Name (Printed) DOB

_____ _____

Signature Date

Completed form returned to office on _____ and received by _____.

Date Front Desk Signature

9/25/2012

Mequon Clinical Associates, SC

CHILD / ADOLESCENT HISTORY

INSTRUCTIONS: Therapist would like parents / guardian answers to these questions to help better understand your child's situation.
Child's Name: _____ D.O.B. _____/_____/_____

Counselor's Name: _____

In case of emergency, please give name and phone number of child's parent or legal guardian:

Name: _____ Phone: _____

Child's School: _____ Phone: _____

School Contact (counselor/teacher, etc.): _____ Phone: _____

PSYCHOLOGICAL HISTORY

What problem(s) caused you to come to therapy?

_____
_____
_____
_____
_____

Have there been any recent illnesses or deaths among your family or close friends? ____ Yes ____ No
Have there been any recent crises or major changes for your family? ____ Yes ____ No
Any history of emotional, physical, or sexual abuse in the family? ____ Yes ____ No
Has your child ever intentionally hurt himself/herself or made a suicide attempt? ____ Yes ____ No
Has your child ever intentionally hurt others? ____ Yes ____ No
Has your child ever run away? ____ Yes ____ No
Is your child or any family member taking any medication for anxiety, depression, sleep, or other behavioral health issues? ____ Yes ____ No
Is there a family history of emotional problems? ____ Yes ____ No
Have you or your child ever been in counseling or psychotherapy before? ____ Yes ____ No
If yes, for what issues? _____
Who did you see and when? _____
Any hospitalizations in the family for emotional problems? ____ Yes ____ No
Please name any people or organizations that provide help and support to your family:

_____
_____

MEDICAL HISTORY

List your child's current medical conditions: _____

_____
Are any medications taken for these conditions? ____ Yes ____ No
If yes, what medications and dosages? _____

List other major medical conditions your child had in the past (including surgeries):_____

_____

Name of child's physician(s), telephone number(s) and address(es):

_____
_____

When was child's last medical exam? _____

Describe other significant medical conditions in your family, including inherited disease or disabilities:

_____
_____

Check any of these symptoms your child experienced in the past year:

____ School problems	____ Headaches	____ Crying spells
____ Learning disability	____ Anemia	____ Eating changes/problems
____ Developmental delays	____ Diabetes	____ Sleep changes/problems
____ Speech problems	____ Stomach problems	____ Refuses to obey
____ Hyperactivity	____ Low energy/fatigue	____ Nervousness
____ Short attention span	____ Bedwetting or soiling	____ Nightmares
____ Asthma	____ Other _____	

DRUG AND ALCOHOL USE

Please describe the drug and alcohol use of your family. Use the number which best states how often each person uses each drug. For siblings, please write in the name of sibling at the top of the column.

0 = Never; 1 = less than once a month; 2= 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now

SUBSTANCE	CHILD	MOTHER	FATHER	SIBLING
Nicotine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
LSD	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Other	_____	_____	_____	_____

LEGAL PROBLEMS

Has your child ever had problems with law enforcement? ____ Yes ____ No

Has your child ever been involved with Protective Services? ____ Yes ____ No

SCHOOL HISTORY

Where does your child currently enrolled in school? _____

Does your child have a problem with school attendance? ____ Yes ____ No

Does your child have a problem with school behavior? ____ Yes ____ No

Does your child have a problem with learning or academic performance? ____ Yes ____ No

Child's highest grade completed: _____

10/1/2011

Mequon Clinical Associates, SC
1045 West Glen Oaks Lane, Suite 1
Mequon, WI 53092
262-241-7778

Privacy Officer: Dr. Jeffrey Taxman Effective Date: 10/1/2011

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. We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official Notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information (PHI). This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to PHI . If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization.

FOR TREATMENT. We may use medical information about you to provide you with medical treatment or services.

FOR PAYMENT. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party.

FOR HEALTH CARE OPERATIONS. We may use and disclose medical information about you for health care operations to assure that you receive quality care.

OTHER USES OR DISCLOSURES THAT CAN BE MADE WITHOUT YOUR CONSENT OR AUTHORIZATION

· As required during an investigation by law enforcement agencies
· To avert a serious threat to public health or safety
· As required by military command authorities for their medical records
· To workers' compensation or similar programs for processing of claims
· In response to a legal proceeding
· To a coroner or medical examiner for identification of a body
· If an inmate, to the correctional institution or law enforcement official
· As required by the US Food and Drug Administration (FDA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

RIGHT TO REQUEST RESTRICTIONS. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer of this practice. In your request, you must tell us what information you want to limit and where in your record this information is contained.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request in writing to the Privacy Officer of this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests, but reserve the right to charge you a cost-based fee for any non-customary expenses involved. Your request must specify how or where you wish to be contacted.

RIGHT TO INSPECT AND COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer of this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be submitted in writing to the Privacy Officer of this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information keep at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

RIGHT TO AN ACCOUNTING OF NON-STANDARD DISCLOSURES. You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing to the Privacy Officer of this practice. Your request must state the time period for which you want to receive a list of disclosures, which is no longer that six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of our current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request it in writing from the Privacy Officer of this practice.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current Notice, with the effective date in the upper right corner.

Mequon Clinical Associates, SC

Name:_____ DOB:_____
Please print

Other Adult:_____ Relation to patient:_____

Address:_____ Phone:_____

_____ Email:_____

_____ Referred by:_____

FINANCIAL POLICY

Payment is expected at the time of service. You are ultimately financially responsible for all services you or members of your household receive from Mequon Clinical Associates.

Consent to Treatment/Privacy Policy

I hereby consent to treatment as agreed upon by my therapist and myself, and I understand my rights as a patient. I have received and understand the written Notice of Privacy Practices provided by Mequon Clinical Associates.

_____initials

Private Pay

If you will be paying for visits privately (i.e., not through an insurance company), clinic policy requires payment at time of service. Please be prepared to make payment upon arrival for your session.

_____initials

Health Insurance

I authorize insurance payment of medical benefits to Mequon Clinical Associates for services described on the itemized claim form. I also authorize the release of information necessary to process this claim. Payment of benefits should be paid directly to: Mequon Clinical Associates. **I recognize and accept personal responsibility for all services rendered and will make payment in full of any self-pay charges, co-payments or deductibles, and for any balance outstanding after payment or denial of such insurance benefits.**

Client / Financially Responsible Party Signature: _____

Outstanding Patient Balances

After insurance is billed any portion not covered will be billed to the patient. Any balance that is billed to the patient must be paid in full no later than 60 days from the billing date. The clinic charges a $30 fee to you for any returned checks, which is payable before or at the time of your next scheduled visit.

_____initials

Cancelled Appointments

I understand that any appointments cancelled or missed without 24 hours notice may be charged a minimum fee of $75 and **my insurance does not cover this fee.**

_____initials

Failure and/or Inability to Pay

In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.

_____initials

I have read and understand the above financial policy.

Client / Financially Responsible Party Signature: _____

Date: _____ **Please Print Name:** _____