NORTHSTAR DAY TREATMENT
6506 SCHROEDER ROAD
MADISON, WI 53711
Phone: (608) 270-1960 / Fax: (608) 270-1965

PATIENT INFORMATION

Name:	Home Phone:
Date of Birth:	Cell Phone:
Address:	Adolescent Cell:
City, State:	Social Security #:
ZIP CODE:	Male_____ Female_____ Other_____
	Who referred you?

BILLING INFORMATION

Name:	Home Phone:
Date of Birth:	Cell Phone:
Address:	Work Phone:
City/ST/ZIP:	Other Phone:
Employer:	Social Security #:
Occupation:	Male_____ Female_____ Other_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER
Company:	Company:
Address:	Address:
City/ST/ZIP:	City/ST/ZIP:
Phone #:	Phone#:
ID or Subscriber #:	ID or Subscriber #:
Group #:	Group #:
Name of Insured:	Name of Insured:

[ ] I do not have insurance benefits for mental health services and agree to pay my bill personally at the time of visit.

Are you currently in treatment with a psychiatrist, psychologist, psychotherapist or social worker? [ ] YES [ ] NO If yes, who? _____ Phone #: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request the payment be made directly to NorthStar Day Treatment. I agree this authorization will cover all medical services rendered until such authorization is revoked by me. I agree a photocopy of this authorization may be used in place of the original.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

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Welcome to NorthStar Day Treatment. We have designed this packet to help you understand our policies and procedures along with your rights as our client. We ask that you read this informational brochure. Please feel free to ask questions. Your signature is required at the end of this packet to indicate your understanding and willingness to participate and abide by these policies. We take pride in our training, knowledge and capabilities, and we want you to know that we are dedicated to giving you quality health care.

OFFICE HOURS:

Our office hours range from approximately 9:00AM to 5:00PM, Monday through Friday. The office staff are generally available from approximately 10:00AM to 4:00PM, Monday through Friday with the exception of holidays. For non-urgent situations, you may leave a message on our confidential voicemail after normal business hours. If there is an emergency before or after business hours, you can call our clinic and be connected to our answering service by pressing #0 or you may directly call our answering service at 1-866-814-4052 to have your doctor or therapist paged. Medication refill requests are not emergencies.

PRESCRIPTION REQUESTS:

Just as we cannot treat illnesses over the telephone, we cannot prescribe new medications over the telephone. Medications will only be handled during regular office hours and only if you are currently under our care. In order to avoid medication errors, prescription refill requests placed after regular office hours, on weekends and holidays will NOT be granted as we cannot check your clinic record after clinic hours. If you are in need of a prescription refill, we advise you to contact our office five days in advance. ***** For controlled substances that need to be mailed, please call one week in advance to avoid lapse in medication as we can neither control nor predict timing of mail delivery. ****** Refill requests made Friday afternoons will not be processed until the following Monday. Our psychiatrist may not be in the office every day of the week and is not always immediately available to fill the prescription. If the doctor is on vacation, another doctor will be on call for emergency requests. The doctor on call will only give you enough medication to get you by until your doctor returns.

When calling the office with your prescription request, please have the following information available. We can only call in your prescription with the following information:

1. Name of the drug
2. How many milligrams in each pill
3. How many you take per day
4. When you will run out of medication
5. Pharmacy telephone number
6. Tell us if you have any side effects or concerns about your medication

NOTE: Requests made due to missed or canceled appointments are not guaranteed and may take additional time to process.

FINANCIAL RESPONSIBILITY & FEE INFORMATION:

I. CLIENT FEES:

A. FINANCIAL POLICY: Clients are responsible for payment of all fees for services priced according to the fee structure outlined in this Service Contract.

B. INSURANCE: Claims will automatically be filed with your insurance company. Clients are responsible for settlement of any disputed charges with their insurance company. You agree for us to release information requested by your insurance company so that your bill will get paid.

C. UNPAID BALANCES: **ALL OUTSTANDING BALANCES ARE DUE UPON RECEIPT. CO-PAYS ARE DUE AT TIME OF VISIT.** If your account is not paid within 6 months, unpaid portions may be turned over to our collection agency. If you have questions or problems with payment, please arrange a payment schedule by calling the billing office at 1-608-270-1960x11.

D. CLIENTS COVERED BY MANAGED CARE/HMOS: It is the client's responsibility to ensure that all necessary referrals/authorizations for services are obtained prior to services provided by NorthStar. Failure to do so will result in the client being held responsible for all charges not covered by such authorizations.

E. PRIVATE PAYMENT/COPAYMENTS/DEDUCTIONS: All such payments are due and payable the time of your appointment.

F. MONTHLY STATEMENTS: Clients who have an outstanding balance will receive monthly statements. If you notice any discrepancies, please contact our billing office at 1-608-270-1960x11.

GENERAL INFORMATION:

I. NOTE TO PARENTS OF MINOR CHILDREN:

It is the clinic's policy to accept the parents or legal guardian's signature on their form as agreement to be responsible for the payment of the minor child's treatment. It is the responsibility of the signing parent to make sure payments are made in a timely manner on this account. It is not the responsibility of NorthStar Day Treatment to determine the financial responsibility of the minor child after a divorce has occurred. Therefore, the parent or guardian who signs the responsibility forms will remain the responsible party until the bill is paid in full.

II. CLIENT STANDARDS:

NorthStar Day Treatment is certified by the WI Department of Health & Social Services. The State of Wisconsin had developed outpatient psychotherapy clinical standards (61.91) to ensure that quality services are provided to clients. As required by these standards, personnel employed by NorthStar are under the supervision of a licensed psychiatrist and/or psychologist. The supervising psychiatrist/psychologist will review client's progress periodically. This review may or may not include the client meeting with the psychiatrist or the psychologist.

III. CONSUMER RIGHTS:

A. At intake, consumers are given to sign the following forms.
    a. Notification of patients' rights
    b. Informed consent for treatment
    c. Client rights acknowledgement form and pamphlet entitled: "your rights" and the grievance "process".
    d. Notice of privacy practices with acknowledgement form.

B. In the event that a clinician leaves NorthStar Day Treatment and is no longer available, you will be offered options for ongoing services.

C. If you do not have the ability to pay for services, your clinician will do their best to arrange a payment schedule or adjust fees.

D. If you are discharged for unacceptable behavior(s) that are the result of your mental health symptoms, the clinician will notify you in writing of the reasons for discharge, the effective date of discharge, sources for further treatment and your rights to have the discharge reviewed prior to the effective date of the discharge by the clients' rights specialist. If you are discharged due to late cancellations or no shows you will be notified of this in writing.

IV. FEE SCHEDULE: A counseling session is normally 45-50 minutes in length with the exception of medication reviews which tend to be 15-30 minutes. This fee schedule may change:

Service	Fee
Day Treatment Initial Evaluation	$190.00
Day Treatment Initial Evaluation with PHD	$210.00
Daily Day Treatment Fee	$110.00 per hour
Initial Evaluation with MD	$320.00
Follow up appointments with MD	
Med Check	$160.00
Med Check with Therapy	$210.00
Staffing with PHD	$210.00

Prices may change without additional notice

**OUR OFFICE REQUIRES A 24-HOUR NOTICE OF APPOINTMENT CANCELLATION OR A NO SHOW/LATE CANCEL FEE WILL BE APPLIED AS LISTED ABOVE.

**Additionally, be advised that late cancellations and no shows may result in treatment termination. Two of these will result in automatic termination.*

V. CONFIDENTIALITY STATEMENT: NorthStar Day Treatment follows the state mandate regarding confidential treatment as outlined in the WI Administrative Code (HSS92). Services provided at NorthStar Day Treatment remain strictly confidential. No information regarding the use of these services will be given without the client's expressed written consent. There are some exceptions to these cases. NorthStar Day Treatment has legal notification to break confidentiality in cases where there is a substantial risk of suicide, homicide, child abuse or if there is a specific court ordering release of clinical records.

I have read the above and I hereby agree to be directly responsible to NorthStar Day Treatment for charges incurred by myself or dependents and agree to terms of the fee schedule and this service contract. I acknowledge that I fully understand the above and will comply with these guidelines. Furthermore, I have received a copy of this packet to take home with me.

_____ _____

Patient or Responsible Party Date

**Updated December 2019*

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Please read, sign and initial below:

NorthStar Day Treatment, in accordance with DHS 94 rights statutes, wants you to be aware of your rights as a patient and asks for your informed consent to receive therapy.

A patient Bill of Rights appears in the waiting room. Please read this.

The following is some general information about the therapy process:

1. The benefits of mental health treatment are to help alleviate the problems and symptoms that you present.
2. We only do treatment and evaluations on a voluntary basis. You have the right not to participate in any treatment.
3. If medication is recommended, side effects will be discussed. Medication recommendations may be refused.
4. The therapist will suggest alternative treatment modalities and make referrals when appropriate or necessary.
5. The possible consequences of not receiving treatment will be discussed.
6. Informed consent is given for period of one year.
7. You have the right to withdraw informed consent at any time in writing.
8. Your therapist will develop a treatment plan which you will have the opportunity to modify, review and approve.

Please ask your psychotherapist if you have any specific questions.

I have received a copy of the "Client Rights and Grievance Procedure for Community Services" brochure and the "Notice of Privacy Practices" handout. _____ (initial here)

Client Signature	Date
Parent/Guardian Signature (for clients under 14)	Date
Witness Signature (if needed)	Date

NORTHSTAR DAY TREATMENT
JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY.

This information is available in Spanish and Hmong. Please ask a staff member if you need a copy in either of these languages. Esta información esta disponible en español. Se usted necesita una copia en español, por favor pregunte a miembro del personl. Cov ntau ntawv no nws muaj cov pes lus hmoob. Yog tias koj xa tau ib daim ntawv uas pes lus hmoob no thov noog cov neeg ua hauj lwm.

When we refer to "you" or "your" in this Notice we refer to the person or persons receiving the services provided by *NorthStar Day Treatment*. When we refer to disclosures of information to "you", we mean disclosures to adults or children, the parent of the children, guardian or other person legally authorized to receive information about the person or persons receiving services from *NorthStar Day Treatment*.

Who follows this Notice:

This Notice applies to all **protected health information** (**PHI**) maintained by *NorthStar Day Treatment* for services provided at any office of *NorthStar Day Treatment* or services provided at non-office locations by any employee of *NorthStar Day Treatment* in the course of their employment. If you have any questions after reading this Notice, please contact the *NorthStar Day Treatment* Privacy Officer.

Each time you receive services from *NorthStar Day Treatment*, a record of the services provided is created. Typically this record could contain information about the type of service you have received, the dates of service and the results of the service provided. At times this will include the reason you have come to *NorthStar Day Treatment* for service and the agreed upon goals of the service provided.

This Notice applies to all of the records containing PHI created as a result of services provided by *NorthStar Day Treatment*.

Our Pledge to Protect Your Health Information: We are required by law to maintain the privacy of your PHI and provide you with a description of our privacy practices. We will abide by the terms of this Notice.

How We May Use and Share Your Health Information With Others

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. For example, a worker or therapist may use PHI about you or your child from a clinic record to determine which treatment option, such as family or individual therapy, best addresses your needs. Your worker or therapist may discuss information found in your record with our consultants, a colleague or their supervisor to assist in treatment planning for you or your child.

For Payment: We may use and disclose PHI to send bills and collect payment from you, your insurance company, or other payors, such as governmental agencies, for the treatment or other related services you receive from *NorthStar Day Treatment*, so *NorthStar Day Treatment* can receive payment for the treatment services provided to you. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing and sending claims to your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

For Health Care Operations: We may disclose PHI about you for business operations of *NorthStar Day Treatment*. These uses and disclosures are necessary for *NorthStar Day Treatment* to provide quality care and cost-effective services. The operations where we may need to disclose PHI includes, but is not limited to, quality assessment activities, employee review activities, and licensing activities. For example, we may share your PHI with third parties that perform various business activities (such as billing or typing services). We will require these third parties to have a contract with us that requires them to safeguard the privacy of your PHI. Quality assessment activities may include evaluating the performance of your therapist or examining the effectiveness of treatment provided to you when compared to patients in similar situations.

Future Communications and Fundraising Activities: We may use your name, address and telephone number to contact you to provide newsletters, information about programs or other services we offer or to raise money for health programs. We may disclose this information to the *[name hospital and its foundation]* so that the Foundation may contact you relating to raising money for *[above named hospital]*, of which *NorthStar Day Treatment* is an affiliate. If you do not want the *[name hospital and its foundation]* to contact you relating to fundraising efforts, you must notify us in writing. Please contact the Privacy Officer to assist you with this request.

Appointments: We may use your PHI for the purpose of sending to you appointment reminders through the mail or by telephone. Messages left for you will not contain specific health information.

Required or Permitted by Law: *NorthStar Day Treatment* is required by law to disclose your PHI in certain circumstances:

- For public health oversight activities
- To facilitate the functions of federal or state governmental agencies
- To report suspected elder or child abuse to law enforcement agencies responsible to investigate or prosecute abuse
- In response to a valid court order
- To the Department of Health and Family Services, a protection or advocacy agency, or law enforcement authorities investigating abuse, neglect, physical injury, death or violent crimes
- To your court-appointed guardian or an agent appointed by you under a health care power of attorney
- Prison officials if you are in custody
- Worker's Compensation officials if your condition is work-related
- If necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When sharing PHI with others outside of *NorthStar Day Treatment*, we share only what is reasonably necessary unless we are sharing PHI to help treat you, in response to your written permission, or as the law requires. In these cases, we share all the PHI that you or the law requires.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your PHI we maintain. To exercise any of the rights discussed in the remainder of this section, please contact the Privacy Officer for *NorthStar Day Treatment* 6506 Schroeder Road Madison WI, 53711.

Right to Request Restrictions: You have the right to request certain restrictions of use and disclosure of your PHI by *NorthStar Day Treatment* for treatment, payment or health care operations. You also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care or the payment for your care. *NorthStar Day Treatment* is not required to agree to restrict the use and disclosure of your PHI. A request for restriction must be made in writing using the form available from the Privacy Officer.

Right to Inspect and Copy: With a few exceptions you have the right to inspect and receive a copy of your PHI. Should you wish to review or copy your PHI you should make a request using the form available from the Privacy Officer. We will arrange for your therapist or another health professional in our clinic to review the PHI with you in our office or to copy the information requested. We may charge you a reasonable fee if you want a copy of your PHI.

Right to Amend or Correct Your Record: If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is maintained by *NorthStar Day Treatment*. Requests for amendment or correction should be made by submitting a form requesting amendment or correction available from the Privacy Officer. We will respond to your request within 60 days after you submit the form. We are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have a right to request an accounting for disclosures. This is a list of those people with whom *NorthStar Day Treatment* may have shared your PHI, with the exception of information shared for purposes of treatment, payment or health care operations or when you have provided us with an authorization to do so. We may charge you a reasonable fee if you request more than one accounting for disclosures in any 12-month period. The request cannot include any disclosures made before April 14, 2003. Requests for an accounting of disclosures should be made by submitting a form requesting an accounting of disclosures to the Privacy Officer. This form is available from the Privacy Officer. We will respond to your request within 60 days after you submit the request.

Right to Request Confidential Communications: You have the right to ask that we communicate your PHI to you in a certain way or a certain location. For example, you can request that we contact you only at work or by mail. We will accommodate reasonable requests.

Right to Revoke Authorization: Uses and disclosures of PHI not covered by this Notice or the laws that apply to *NorthStar Day Treatment* will be made only with your authorization. If you authorize *NorthStar Day Treatment* to use or disclose your PHI, you may revoke that authorization in writing at any time. We are unable to reverse any disclosures we have made previously with your authorization. To revoke an authorization please contact your therapist or the clinic where you receive services.

Right to Complain: If you believe your privacy rights have been violated, you may file a complaint with Northstar Day Treatment or with the Secretary of the Department of Health and Human Services. To file a complaint with *NorthStar Day Treatment*, contact the Privacy Officer. All complaints must be made in writing. The Privacy Officer will assist you in filing your complaint. Filing a complaint will not affect your care.

We reserve the right to revise or change this Notice. Each time you sign a consent for treatment at a site covered by this Notice we will provide a copy of this Notice in effect at that time.

How to Contact Us

NorthStar Day Treatment Privacy Officer:(608) 270-1960 Secretary of Department of Health and Human Service:(877) 696-6775

Effective Date: June 10,2010

- If you and the program manager agree with the CRS's report and recommendations, the recommendations shall be put into effect within an agreed upon time frame.
- You may file as many grievances as you want. However, the CRS will usually only work on one at a time. The CRS may ask you to rank them in order of importance.

Program Manager's Decision

If the grievance is not resolved by the CRS's report, the program manager or designee shall prepare a written decision within 10 days of receipt of the CRS's report. You will be given a copy of the decision.

County Level Review

- If you are receiving services from a county agency, or a private agency and a county agency is paying for your services, you may appeal the program manager's decision to the County Agency Director. You must make this appeal within 14 days of the day you receive the program manager's decision. You may ask the program manager to forward your grievance or you may send it yourself.
- The County Agency Director must issue his or her written decision within 30 days after you request this appeal.

State Grievance Examiner

- If your grievance went through the county level of review and you are dissatisfied with the decision, you may appeal it to the State Grievance Examiner.
- If you are paying for your services from a private agency, you may appeal the program manager's decision directly to the State Grievance Examiner.
- You must appeal to the State Grievance Examiner within 14 days of receiving the decision from the previous appeal level. You may ask the program manager to forward your grievance to the State Grievance Examiner or you may send it yourself. The address is: State Grievance Examiner, Division of Care and Treatment Services (DCTS), PO Box 7851, Madison, WI 53707-7851.

Final State Review

Any party has 14 days of receipt of the written decision of the State Grievance Examiner to request a final state review by the Administrator of the Division of Care and Treatment Services or designee. Send your request to the DCTS Administrator, P.O. Box 7851, Madison, WI 53707-7851.

You may talk with staff or contact your Client Rights Specialist, whose name is shown below, if you would like to file a grievance or learn more about the grievance procedure used by the program from which you are receiving services.

Your Client Rights Specialist is:
Maria Hanson, JD CPS, PRC
Client Rights Specialist Inc.
P.O. Box 14533
Madison WI 53704
(608) 446-8957

NOTE: There are additional rights within sec. 51.61(1) and DHS 94, Wisconsin Administrative Code. They are not mentioned here because they are more applicable to in-patient and residential treatment facilities. A copy of sec. 51.61, Wis. Stats. and/or DHS 94, Wisconsin Administrative Code is available upon request.

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
www.dhs.wisconsin.gov
P-23112 (09/2016)

Client Rights and the Grievance Procedure for Community Services*

for Clients Receiving Services in Wisconsin for Mental Illness, Alcohol or Other Drug Abuse, or Developmental Disabilities

*The term Community Services refers to all services provided in non-inpatient and non-residential settings.

CLIENT RIGHTS

When you receive any type of service for mental illness, alcoholism, drug abuse, or a developmental disability, you have the following rights under Wisconsin Statute sec. 51.61 (1) and DHS 94, Wisconsin Administrative Code:

PERSONAL RIGHTS

- You must be treated with dignity and respect, free from any verbal, physical, emotional, or sexual abuse.
- You have the right to have staff make fair and reasonable decisions about your treatment and care.
- You may not be treated unfairly because of your race, national origin, sex, age, religion, disability, or sexual orientation.
- You may not be made to work except for personal housekeeping chores. If you agree to do other work, you must be paid.
- You may make your own decisions about things like getting married, voting, and writing a will, if you are over the age of 18, and have not been found legally incompetent.
- You may use your own money as you choose.
- You may not be filmed, taped, or photographed unless you agree to it.

TREATMENT AND RELATED RIGHTS

- You must be provided prompt and adequate treatment, rehabilitation, and educational services appropriate for you.
- You must be allowed to participate in the planning of your treatment and care.
- You must be informed of your treatment and care, including alternatives to and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your written, informed consent, **unless** it is needed **in an emergency** to prevent serious physical harm to you or others, or **a court orders it.** [If you have a guardian, however, your guardian may consent to treatment and medications on your behalf.]
- You may not be given unnecessary or excessive medication.
- You may not be subject to electro-convulsive therapy or any drastic treatment measures such as psychosurgery or experimental research without your written informed consent.
- You must be informed in writing of any costs of your care and treatment for which you or your relatives may have to pay.
- You must be treated in the least restrictive manner and setting necessary to achieve the purposes of admission to the program, within the limits of available funding.

RECORD PRIVACY AND ACCESS

Under Wisconsin Statute sec. 51.30 and DHS 92, Wisconsin Administrative Code:

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records may not be released without your consent, unless the law specifically allows for it.
- You may ask to see your records. You must be shown any records about your physical health or medications. Staff may limit how much you may see of the rest of your treatment records while you are receiving services. You must be informed of the reasons for any such limits. You may challenge those reasons through the grievance process.
- After discharge, you may see your entire treatment record if you ask to do so.
- If you believe something in your records is wrong, you may challenge its accuracy. If staff will not change the part of your record you have challenged, you may file a grievance and/or put your own version in your record.
- A copy of sec. 51.30, Wis. Stats., and/or DHS 92, Wisconsin Administrative Code, is available upon request.

GRIEVANCE PROCEDURE AND RIGHT OF ACCESS TO COURTS

- Before treatment is begun, the service provider must inform you of your rights and how to use the grievance process. A copy of the Program's Grievance Procedure is available upon request.
- If you feel your rights have been violated, you may file a grievance.
- You may not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.
- You may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated.

GRIEVANCE RESOLUTION STAGES

Informal Discussion (Optional)

You are encouraged to first talk with staff about any concerns you have. However, you do not have to do this before filing a formal grievance with your service provider.

Grievance Investigation—Formal Inquiry

- If you want to file a grievance, you should do so within 45 days of the time you become aware of the problem. The program manager for good cause may grant an extension beyond the 45-day time limit.
- The program's Client Rights Specialist (CRS) will investigate your grievance and attempt to resolve it.
- Unless the grievance is resolved informally, the CRS will write a report within 30 days from the date you filed the formal grievance. You will get a copy of the report.