



REFERRAL PACKET: (Please check each area upon completion.)

- Checklist
- Referral Information Document (pg 2)
- History of Prior Placements & Services (pg 4-5)
- Notice of Privacy Practices (pg 7-13)
- Family and Intake Policies (pg 14-16)
- Clothing List (pg 17)
- Financial Intake Form (pg 18-20)
- Authorization for Release Form (Medical Assistance/EDS) (pg 21)
- Authorization for Release Form (Commercial Insurance) (pg 22)
- Consent for Disclosure of Confidential Information Form (NWCGC; NWP; NWP) (pg 23)
- Consent for Disclosure of Confidential Information Form (SCRMC) (pg 24)
- Medical Services Consent Form (pg 25-26)
- Authorization for Release of Patient-Identifiable Health Information - MEDICAL (1 Form) (pg 28)
- Authorization for Release of Patient-Identifiable Health Information - MENTAL HEALTH (4 Forms) (pg 29-32)
- Informed Consent (pg 33-34)
- Evaluation Plan (pg 35)
- Your Rights and the Grievance Procedure (pg 36-39)
- Influenza Precautions (pg 40)

Please call the center if any of the forms are not included.

FORMS FOR PARENTS/LEGAL GUARDIAN:

- Notice of Privacy Practices (pg 7-13)
- Family and Intake Policies (pg 14-16)
- Clothing List (pg 17)
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**NORTHWEST PASSAGE CHILD & ADOLESCENT CENTER
REFERRAL INFORMATION**

Intake planning for this program is handled through the **Program Director, Mark Elliott, Assistant Program Director, Ellen Race, and Case Manager, Nina Affeldt.**

Characteristics that may prevent admission:

- Significant psychotic disorder (requiring 24 hour psychiatric care)
- Significant mental or physical disability
- Sexual predators
- Habitually assaultive behavior
- Complex medical issues (i.e. heart conditions, diabetes)

Intake can be arranged immediately depending on availability. We ask that you send any written information. Materials that would be most helpful include:

- discharge reports from any prior placement
- copies of any prior evaluations
- social history
- medical summaries
- school information (behavioral records, IEP, transcripts)

In the accompanying forms for parents or legal guardians are releases of information. We ask that parents or legal guardians provide releases so that we may gather information from all previous out of home placements (foster care, hospitalizations, group homes, or previous RCC's) and service providers including therapists or in-home family service providers, medical/family doctors or psychiatrists, county social service providers, and schools.

***Please indicate all prior placements and services on attached form.**

Prior to admission it is necessary for us to know:

1. Medical information; any special needs, disabilities, and medications (their purpose and prescribing physician).

***We prefer that a child receiving any prescription medication present with amounts sufficient for 30 days.**

2. Medical assistance / insurance information.

It is important that we have a client's MA number prior to placement and actual MA card at placement (all incoming clients should be on MA due to placement in RCC). If the child has health insurance, we require all relevant insurance information. Copies (front and back) of all insurance and drug prescription cards must be provided.

***Note - Clinical services are separate from residential (RCC) costs.**

Our standard assessment includes educational, behavioral, chemical health, medical, neuropsychological, psychiatric, family, and child psychosocial evaluations, as well as an assessment summary. We provide other evaluations (i.e. sex offender) depending on objectives established by previous evaluations or by our assessment team. We request to be informed of all pertinent issues in order to prepare our assessment staff. With the obvious time constraints, we ask that the amount of individuals participating in the family assessment be limited - otherwise the assessment period may need to be extended. If you have any questions, please consult with the director or case manager.

SOCIAL WORKER: COMPLETE
THE FOLLOWING FORMS

**NORTHWEST PASSAGE CHILD & ADOLESCENT CENTER
HISTORY OF PRIOR PLACEMENTS AND SERVICES**

Referent: To facilitate your client's assessment, we need a complete record of previous interventions related to your client and his/her family. It is very important that all significant records related to these interventions be secured prior to intake or very early in the assessment period. Please provide the following information as completely as possible, considering all out-of-home placements (residential treatment, hospitalization, foster care, group home, shelter care, correctional) as well as outpatient programs and services (evaluations, medical services, counseling, day treatment programs, parent training programs, in-home services.)

Client's Name: _____ **D.O.B.** _____

Prior out-of-home placements

Placement: _____ Dates of Placement: _____
Reason for Placement: _____
Response to placement (discharged successfully?): _____

Placement: _____ Dates of Placement: _____
Reason for Placement: _____
Response to placement (discharged successfully?): _____

Placement: _____ Dates of Placement: _____
Reason for Placement: _____
Response to placement (discharged successfully?): _____

Placement: _____ Dates of Placement: _____
Reason for Placement: _____
Response to placement (discharged successfully?): _____

Placement: _____ Dates of Placement: _____
Reason for Placement: _____
Response to placement (discharged successfully?): _____

(Please continue on extra page if necessary)

Prior Medical or Dental Services

Type of Service: Dental Examination Dental Clinic Name: _____
Name of Dentist: _____ Date of Last Exam: _____

Type of Service: Health Check Physical Medical Clinic Name: _____
Name of Physician: _____ Date of most recent Health Check Physical: _____

Type of Service Psychiatric Medical Clinic Name: _____
Name of Physician: _____ Date of most recent visit: _____

Other Treatment or Evaluation Services

Type of Service: _____ Facility or program name: _____
Dates of Service: _____ Reason for commencing: _____
Reason for ending: _____

Type of Service: _____ Facility or program name: _____
Dates of Service: _____ Reason for commencing: _____
Reason for ending: _____

Type of Service: _____ Facility or program name: _____
Dates of Service: _____ Reason for commencing: _____
Reason for ending: _____

Type of Service: _____ Facility or program name: _____
Dates of Service: _____ Reason for commencing: _____
Reason for ending: _____

PARENT/LEGAL GUARDIAN:
COMPLETE THE FOLLOWING
FORMS



Dear Patients/Parents/Guardians of Northwest Passage, Ltd.:

Attached you will find a Privacy Notice explaining how medical information about you may be used and disclosed (which is yours to keep). Also enclosed is a privacy notice acknowledgment that will require your signature and must be returned to Northwest Passage, Ltd. to be retained in your file.

Due to our affiliation with both Northwest Counseling and Guidance Clinic and Northwest Pediatric Specialties, we must also inform you that both of those agencies have adopted exactly the same privacy notice. In the interest of conserving paper, we are providing only one copy of the notice, although it is important that you know that the policy of all three agencies is exactly the same and will be applied in the same way.

Similarly, because of the federal regulations that state that all clients must acknowledge receipt of the privacy notice(s), we must ask that you sign separate privacy notice acknowledgement forms for each entity. Those forms accompany this letter and we ask that all three signature pages be signed and returned to us immediately.

If you have any questions about the treatment of your health records or your child's health records with regard to any of the agencies, you may contact the Northwest Passage, Ltd. designated Privacy Officer, Carey Lillehaug, who will either assist you or connect you with the appropriate person to aid in addressing your question or concern.

Thank you for your help, understanding and cooperation during this time.

Sincerely,

Carey Lillehaug,
Northwest Passage, Ltd.
Privacy Office

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.

Northwest Passage, Ltd.

Your Health Care Information - Protecting Your Privacy -It is your right as a patient to be informed of the privacy practices of your health care provider as well as to be informed of your privacy rights with respect to your personal health information. This Notice of Privacy Practices is intended to provide you with this information.

Northwest Passage, Ltd.'s Responsibilities-It is your right as a patient to be informed of Northwest Passage, Ltd.'s legal duties with respect to protection of the privacy of your personal health information. Northwest Passage, Ltd. is required to: maintain the privacy of your health information; provide you with a notice of the legal duties and privacy practices regarding protected health information collected and maintained about you; and abide by the terms of this notice.

Northwest Passage, Ltd. reserves the right to change the terms of the notice of privacy practices and make the new notice provisions effective for all protected health information that it maintains. Northwest Passage, Ltd. also reserves the right change the terms of its notice with respect to any applicable more limited uses and disclosures.

Northwest Passage, Ltd. will promptly revise and distribute its notice whenever Northwest Passage, Ltd. makes a substantial change to any of its privacy practices. Northwest Passage, Ltd. will not use or disclose your health information without your authorization, except as described in this notice.

You have the right to: Request a restriction on certain uses and disclosures of your health information. You have the right to request restrictions on certain uses and disclosures of protected health information, even if the restriction affects your treatment or Northwest Passage, Ltd.'s payment or health care operation activities. However, Northwest Passage, Ltd. is not required to agree to your requested restriction. For example, if you are an employee of the clinic and you receive health care services in the clinic, you may request that your health care record not be maintained in the general record filing area.

Receive Confidential Communications-You have the right to request that Northwest Passage, Ltd. communicate your health information to you by alternative means or at alternative locations. Northwest Passage, Ltd. shall accommodate reasonable requests. For example, you may request to be contacted at a phone number that is different from the phone number listed in your health care record.

You have the right to inspect and obtain a copy of your health care record. This request for access to your health care record must be submitted in writing to Northwest Passage, Ltd.'s Privacy Officer. This right may not apply to certain types of psychotherapy notes and Northwest Passage, Ltd. may charge you a reasonable fee for a copy of your health care record. For example, you may request a copy of your health care record from your family physician.

You have the right to request an amendment to your health care record if you believe your health information is incorrect or incomplete. You may be asked to make this request in writing and state the reason why your health record should be changed. If Northwest Passage, Ltd. did not create the health information you believe is incorrect or if Northwest Passage, Ltd. disagrees with you, Northwest Passage, Ltd. may deny your request. For example, if you believe that information in your medical history is incorrect, such as your birth date, you may request that this information be amended.

You have the right to an accounting of disclosures of your health information that Northwest Passage, Ltd. has made in compliance with state and federal law. The accounting will describe the dates of each disclosure, a brief description of information disclosed and the reason for disclosure. You will receive one accounting per year at no charge and Northwest Passage, Ltd. may charge you a reasonable fee for each subsequent request. For example, you may request an accounting of disclosures made from your health record in the last year to the State for disease reporting.

You have the right to obtain a paper copy of the notice upon request. For example, if you received the notice electronically, you may request that Northwest Passage, Ltd. provide a paper copy of the notice.

Northwest Passage, Ltd. is permitted by the federal privacy rule to use or disclose your protected health information for treatment, benefit information, payment or health care operations. Northwest Passage, Ltd. may use or disclose your health information for treatment. Northwest Passage, Ltd. may use or disclose your health information in the provision, coordination or management of your health care.

Your information may be disclosed from one physician to another if they are consulting each other in relation to your care and treatment.

Northwest Passage, Ltd. may use your health information to provide you with an appointment reminder.

Northwest Passage, Ltd. may send you information about treatment alternatives or other health related services that may be of interest to you.

Northwest Passage, Ltd. may use or disclose your health information for payment. Northwest Passage, Ltd. may use or disclose your health information to obtain reimbursement for the provision of health care services. The bill may include information that identifies you, your diagnosis and your treatment.

Example: Northwest Passage, Ltd. may use or disclose your information to your insurer to obtain payment for the provision of health care services.

Northwest Passage, Ltd. may use or disclose your health information for routine health care operations. Northwest Passage, Ltd. may use or disclose your health information for evaluation of patient care services, evaluating the performance of health care providers, activities relating to compliance with the law and business planning and development. Example: Northwest Passage, Ltd. may review your health record to determine the efficiency of the services provided to you in the emergency room.

Example: Northwest Passage, Ltd. may contact you as part of a fundraising activity sponsored by your health care provider. Uses or Disclosures of Your Protected Health Information Permitted Without Your Authorization -Without your written authorization, Northwest Passage, Ltd. may use or disclose your health information for the following purposes:

As Required by Law: Northwest Passage, Ltd. may use or disclose protected health information to the extent that the use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of the law. Uses or disclosures required by federal privacy rule and limited by the more protective requirements of state law include the following: 1) disclosures about victims of elderly or child abuse; 2) disclosures for judicial and administrative proceedings; or 3) disclosures for law enforcement purposes.

Public health: As required by law, Northwest Passage, Ltd. may disclose your protected health information to the State of Wisconsin for the purpose of statutory reporting.

Northwest Passage, Ltd. may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result to a state or federal public health agency for the purpose of preventing or controlling disease, injury or disability. Northwest Passage, Ltd. may disclose your protected health information excluding your HIV test result without your authorization to a county agency investigating child abuse. Northwest Passage, Ltd. may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result without your authorization to the Food and Drug Administration (FDA). Northwest Passage, Ltd. may disclose your HIV test result without your authorization to a person that may have sustained a contact that carries a potential for transmission of HIV.

Northwest Passage, Ltd. may disclose your protected health information that is reasonably related to a work related illness or injury if an application for workers' compensation has been filed.

Victims of abuse, neglect or domestic violence: Northwest Passage, Ltd. may disclose health information except for an HIV test result if Northwest Passage, Ltd. reasonably believe that an individual is a victim of child or elderly abuse.

Health oversight activities: Northwest Passage, Ltd. will not disclose HIV test results to health care oversight agencies without an authorization. Northwest Passage, Ltd. may disclose your mental health, alcohol or drug abuse or developmental disability related health information to the Department of Health and Family Services, to the county for coordination of human services and to a representative of the board on aging and long-term care. The remainder of your protected health information may be disclosed without your authorization to a state or federal agency.

Judicial and Administrative Proceedings: Northwest Passage, Ltd. may disclose your protected health information in response to a court order. Northwest Passage, Ltd. may disclose your protected health information in response to a subpoena if Northwest Passage, Ltd. is a party to a court action, Northwest Passage, Ltd. has received your authorization to disclose and has not complied within two business days or Northwest Passage, Ltd. failed to respond to a request for workers' compensation records. Northwest Passage, Ltd. may disclose your protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result in response to a subpoena from a state or federal agency.

Law enforcement: Northwest Passage, Ltd. may disclose your protected health information except for HIV test results to county law enforcement officials for the reporting and investigation of elderly and/or child abuse. Northwest Passage, Ltd. may disclose your protected health information except for mental health, alcohol or drug abuse or developmental disabled or HIV test results to

state and federal law enforcement officials. Northwest Passage, Ltd. may disclose mental health, alcohol or drug abuse or developmental disabled protected health information for limited law enforcement purposes as required by law. Northwest Passage, Ltd. may disclose your protected health information to a law enforcement official in response to a court order.

For activities related to death: Coroner or Medical Examiner- Northwest Passage, Ltd. may use or disclose your protected health information that is not an HIV test result or related to mental health, alcohol or drug abuse and developmental disabilities to a coroner or medical examiner. Funeral Director- Northwest Passage, Ltd. may use or disclose your HIV test result a funeral director.

For caregiver organ, eye or tissue donation purposes- Northwest Passage, Ltd. may use or disclose your HIV test result to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or caregiver organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Northwest Passage, Ltd. may use or disclose your HIV test result and protected health information that is not related to mental health, alcohol or drug abuse and developmental disabilities, to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation or caregiver organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research: Northwest Passage, Ltd. may use or disclose your protected health information for research purposes if the researcher has obtained your permission or fulfilled the stringent privacy requirements of state and federal law.

To avoid a serious threat to health or safety: Northwest Passage, Ltd. may disclose your protected health information under limited circumstances to law enforcement officials to avert a serious threat to health or safety.

Disclosures for specialized government functions: Northwest Passage, Ltd. may disclose protected health information excluding mental health, alcohol or drug abuse or developmental disabled or HIV test result for national security, for protection of the President and for medical suitability determination or of Armed Forces personnel to a state or federal agency.

Northwest Passage, Ltd. may disclose protected health information to limited staff of a correctional institution or a custodial law enforcement official for the provision of health care and the transport of inmates.

Workers compensation: Northwest Passage, Ltd. may disclose protected health information reasonably related to a workers' compensation injury.

Northwest Passage, Ltd. has attempted to explain with this notice the circumstances where state law may be more protective than the federal privacy rule and provides greater privacy protection.

Except for the situations listed above and treatment, payment or health care operation purposes, the use or disclosure of your health information requires Northwest Passage, Ltd. to obtain your written authorization. You may withdraw your authorization in writing at any time by submitting your written withdrawal to Northwest Passage, Ltd.'s Privacy Officer.

Patient Complaint Process-If you believe your privacy rights have been violated, you may file a complaint with Northwest Passage, Ltd. or with the Secretary of the Department of Health and Human Services. There will be no retaliation against you for filing a complaint.

To file a complaint with Northwest Passage, Ltd. please contact the Northwest Passage, Ltd.'s Privacy Officer who will provide you with the necessary assistance.

If you have any questions or concerns regarding your privacy rights or the information in this notice, please contact:

Carey Lillehaug
Northwest Passage, Ltd.
203 United Way Drive
Frederic, WI 54837
Phone number: 715-327-4402
Fax number: 715-327-4470
Email address: Carey@nwpass.com

Effective Date: This Notice of Privacy Practice is effective as of April 14, 2003.

Please retain this notice for your records and sign, date and return the next page to Northwest Passage, Ltd. as an acknowledgment that you did receive this notification. Thank you.

Northwest Passage, LTD

Written Acknowledgement of Receipt

I, _____, acknowledge that I have received the written
(*Patient Name*)
Notice of Privacy Practices from Northwest Passage, Ltd.

Patient or Personal Representative Signature

Date

If Personal Representative, describe relationship

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgment was unable to be obtained. Reason: _____

Employee Signature

Date

Northwest Counseling and Guidance Clinic

Written Acknowledgement of Receipt

I, _____, acknowledge that I have received the written
(Patient Name)
Notice of Privacy Practices from Northwest Counseling and Guidance Clinic.

Patient or Personal Representative Signature

Date

If Personal Representative, describe relationship

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgment was unable to be obtained. Reason: _____

Employee Signature

Date

Northwest Pediatric Specialties, Inc.

Written Acknowledgement of Receipt

I, _____, acknowledge that I have received the written
(*Patient Name*)
Notice of Privacy Practices from Northwest Pediatric Specialties, Inc.

Patient or Personal Representative Signature

Date

If Personal Representative, describe relationship

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgment was unable to be obtained. Reason: _____

Employee Signature

Date

NORTHWEST PASSAGE CHILD AND ADOLESCENT CENTER FAMILY AND INTAKE POLICIES

The following policies have been developed with considerable thought and consideration for the family and individuals who enter our program. Providing a safe and secure environment is a primary reason for these policies --your cooperation is greatly appreciated.

*These policies are not all inclusive - extenuating circumstances may require adjustments in policy.

PHONE CALLS:

Your son/daughter may receive phone calls from immediate family, attorney, and social workers throughout the 30-day evaluation period. We encourage immediate family to place their calls between 8:30 p.m. & 9:30 p.m. on weekdays due to the daytime structure. Your understanding and cooperation during these times will be appreciated. Evening staff will attempt to accommodate as much as possible. Because of the amount of incoming calls, a schedule may need to be set when several family members call. Residents are allowed to place three phone calls home to their family per week, Mondays, Thursdays, and once during the weekend (time may vary depending on the schedule). Exceptions to this rule are made depending on circumstances. The resident's attorney and/or social worker may call at anytime. In addition, the resident may contact their attorney and/or social worker at any reasonable time upon request without restriction.

WRITTEN COMMUNICATION:

Letters to your son/daughter from family and friends are permitted and encouraged.

VISITATION:

In recognition of the importance of family support for the residents, the program seeks to facilitate visits by providing families the following guidelines:

Prior to intake, the social worker will provide the case manager background information regarding resident and family. The social worker will help determine the level of visitation including frequency, duration, and location throughout the assessment process.

Due to confidentiality and other safety concerns we do not have open visitation. **Any unauthorized visitors will not be allowed. For this reason, visitors to the Center must have the approval of the social worker and case manager for any visit prior to entering the grounds.** Typically, due to the intense needs of the assessment period, we recommend two visits during the 30-day assessment. Exceptions to this rule are made depending on circumstances. **Again, visitors to the Center must have authorization from the social worker and case manager in order to visit. This authorization can be secured Monday through Thursday between the hours of 8:30 am and 4:30 pm. Visitations must be authorized by Thursday for the upcoming weekend due to the needs of weekend activity planning.**

For safety and confidentiality purposes we have designated visiting areas. All visitors are expected to follow the following rules of conduct:

1. conduct themselves in a positive and mature manner
2. not use profanity or act irresponsible
3. no one under the influence of drugs or alcohol may remain on the grounds or have contact with residents
4. anyone attempting to traffic drugs or prohibited possessions into the program will be reported to the local sheriff and barred from entering the program in the future.

PLACEMENT INTAKE:

If parents and social workers would like, they may participate in the placement intake, which will last approximately 1-2 hours. Please note: participation in this intake is neither required nor always necessary. Families will be asked to make themselves available to the assessment team approximately one week to ten days into the assessment for the Family Assessment. Participation in that Family Assessment should be given priority over attendance at the time of intake if attendance at both will not be possible due to scheduling time off from work or limitations in travel expenses. A tour of our facility will be given, information shared regarding rules and regulations, and expectations of the child, parents, and workers.

MEDICATION:

We ask that if your son/daughter is on prescribed medication they be supplied with an amount sufficient for the 30 days.

MISCELLANEOUS:

- Smoking is prohibited
- Portable CD players, MP3 players and radios are allowed. Hand held games are also allowed. Inappropriate language or content will not be allowed.
- We ask that you do not send money, food, or candy as residents' needs will be met per this agency.



I have read and understand the family and intake policies provided to me by the Northwest Passage Child and Adolescent Center program.

Parent/Legal Guardian Signature Date

I, undersigned, hereby give permission to Northwest Passage Child and Adolescent Center to administer medication to my son/daughter while enrolled in the program. Please note: If any new prescription medications or change in medications are needed we will call you prior to these changes.

Parent/Legal Guardian Signature Date

I, _____, give permission for Northwest Passage to use photographs taken
(Parent/Guardian)
of _____, for potential application in brochures, newsletters, or recognition
(Resident/Client)
in newspaper articles for participation in community service projects. These photographs may also be shared with other clients and their families to reflect on the positive experiences of the program. The intent is to display the positive activities that your daughter may be involved in or, as mentioned, in recognition of accomplishments.

Northwest Passage operates within the confidentiality guidelines of HFS 92.03(c). As such, we will not use photographs of residents for out of program use without permission of parent or guardian. Northwest Passage also does not identify the names of the residents in these photographs.

Parent/Legal Guardian Signature Date

**NORTHWEST PASSAGE CHILD & ADOLESCENT CENTER
CLOTHING LIST**

We request that your son/daughter have enough clothing for 30 days. He/she will be involved in recreation every day and will need appropriate attire (i.e. gym shoes, shorts, swimsuits, etc.). Each resident does his or her own laundry once a week.

MINIMUM REQUIREMENTS:

Boys		Girls
<input type="checkbox"/> 10 pair underwear		<input type="checkbox"/> 10 pair underwear
<input type="checkbox"/> 10 pair socks		<input type="checkbox"/> 4 bras
<input type="checkbox"/> 3 long pants		<input type="checkbox"/> 10 pair socks
<input type="checkbox"/> 2 pair sweat pants		<input type="checkbox"/> 3 long pants
<input type="checkbox"/> 3 gym shorts		<input type="checkbox"/> 2 pair sweat pants
<input type="checkbox"/> 7 t-shirts		<input type="checkbox"/> 3 gym shorts
<input type="checkbox"/> 2 sweatshirts		<input type="checkbox"/> 7 t-shirts
<input type="checkbox"/> 2 long sleeve shirts		<input type="checkbox"/> 2 sweatshirts
<input type="checkbox"/> 1 fall jacket		<input type="checkbox"/> 2 long sleeve shirts
<input type="checkbox"/> 2 pair shoes (1 sneakers)		<input type="checkbox"/> 1 fall jacket
<input type="checkbox"/> Pajamas		<input type="checkbox"/> 2 pair shoes (1 sneakers)
WINTER		<input type="checkbox"/> Pajamas
<input type="checkbox"/> 1 winter coat		WINTER
<input type="checkbox"/> 1 pair boots		<input type="checkbox"/> 1 winter coat
<input type="checkbox"/> 1 pair gloves/mittens		<input type="checkbox"/> 1 pair boots
<input type="checkbox"/> 1 wool type hat		<input type="checkbox"/> 1 pair gloves/mittens
<input type="checkbox"/> 1 pair long-john bottoms		<input type="checkbox"/> 1 wool type hat
<input type="checkbox"/> 1 long-john top		<input type="checkbox"/> 1 pair long-john bottoms
SUMMER		<input type="checkbox"/> 1 long-john top
<input type="checkbox"/> 1 swim suit		SUMMER
		<input type="checkbox"/> 1 swim suit

Northwest Passage Child & Adolescent Center will provide any clothing deficiencies from this list. All necessary bathroom and personal hygiene supplies will be collected and replaced by Northwest Passage Child & Adolescent Center. Northwest Passage Child & Adolescent Center will provide clothing until arrangements can be made to secure residents personal clothing. ***Please no ripped, torn, or holey clothes.***

Financial Intake Form

Admission Date: _____ Site Name: _____
Type of Service: Outpatient Day Treatment Both

Client Information

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Fax: _____
Date of Birth: _____ Sex: Male Female Social Security #: _____
Family Physician: _____ Physician Phone: _____
Emergency Contact: _____ Relationship to Client: _____
Home Phone: _____ Work Phone: _____

Financial Information

Responsible Party

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Fax: _____
Date of Birth: _____ Sex: Male Female Social Security #: _____

Primary Insurance Company

Policy Holder

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Fax: _____
Date of Birth: _____ Sex: Male Female Social Security #: _____
Status: Active Duty Deceased Retired Other
Relationship to Insured: _____ Employer: _____
Employer's Health Plan: _____ Under Employer Health Plan: Yes No
Insurance Company: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
ID Number: _____ Policy Number: _____ Group Number: _____
Type of Insurance: Medicare Champus FECA Medicaid Group
 ChampVA Employee Assistance Program Other

Secondary Insurance Company

Policy Holder

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Fax: _____
Date of Birth: _____ Sex: Male Female Social Security #: _____
Status: Active Duty Deceased Retired Other
Relationship to Insured: _____ Employer: _____
Employer's Health Plan: _____ Under Employer Health Plan: Yes No
Insurance Company: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
ID Number: _____ Policy Number: _____ Group Number: _____
Type of Insurance: Medicare Champus FECA Medicaid Group
 ChampVA Employee Assistance Program Other

We are legally required to obtain the 3 signatures listed below. Failure to sign any one of the authorizations may result in delay of services.

Records Release: I hereby authorize the release of **all** information that is obtained by **Northwest Counseling and Guidance Clinic**, to my referring doctor, insurance company, or other funding source on behalf of myself.

Date: ___/___/_____ Authorized Signature: _____

Assignment of Benefits: I hereby authorize payment of Medical Benefits (including Medicare) to Northwest Counseling and Guidance Clinic for services rendered to myself and/or dependents.

Date: ___/___/_____ Authorized Signature: _____

Financial Responsibility: I acknowledge responsibility for full payment of this account and all charges and costs incurred by this client.

Date: ___/___/_____ Authorized Signature: _____

OPTION: It is my decision not to supply the required signatures necessary to adjudicate my services for payment. I understand that if I do not supply the above signatures I will pay for my services in full at the time of each visit.

Date: ___/___/_____ Authorized Signature: _____

Insurance Benefits Statement

Northwest Counseling and Guidance Clinic will not guarantee your insurance benefit (in or out of network), or payment by insurance. We encourage you (client) to contact your insurance company directly to verify your level of benefits. If you have any questions, please feel free to contact our business office.

We are legally required to obtain the 3 signatures listed below. Failure to sign any one of the authorizations may result in delay of services.

Records Release: I hereby authorize the release of **all** information that is obtained by **Northwest Pediatric Specialties**, to my referring doctor, insurance company, or other funding source on behalf of myself.

Date: ___/___/_____ Authorized Signature: _____

Assignment of Benefits: I hereby authorize payment of Medical Benefits (including Medicare) to Northwest Pediatric Specialties for services rendered to myself and/or dependents.

Date: ___/___/_____ Authorized Signature: _____

Financial Responsibility: I acknowledge responsibility for full payment of this account and all charges and costs incurred by this client.

Date: ___/___/_____ Authorized Signature: _____

OPTION: It is my decision not to supply the required signatures necessary to adjudicate my services for payment. I understand that if I do not supply the above signatures I will pay for my services in full at the time of each visit.

Date: ___/___/_____ Authorized Signature: _____

Insurance Benefits Statement

Northwest Pediatric Specialties will not guarantee your insurance benefit (in or out of network), or payment by insurance. We encourage you (client) to contact your insurance company directly to verify your level of benefits. If you have any questions, please feel free to contact our business office.

Northwest Passage Ltd.
Release of Information Authorization-Mental Health and AODA

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

Authorizes:

Northwest Counseling and Guidance Clinic 203 United Way Drive Frederic, WI 54837	Northwest Passage, LTD 203 United Way Drive Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Drive Frederic, WI 54837
--	--	---

To use, exchange, and disclose information with: **Medical Assistance/EDS, 6406 Bridge Road, Madison, WI 53784**

Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

- From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

Disclosure Notice to Recipient of Patient Health Care Records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your Rights with Respect to this Authorization:

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) _____
Date

Signature or Parent/Guardian _____
Date

Relationship to Client

**Northwest Passage Ltd.
Release of Information Authorization-Mental Health and AODA**

Client Name: _____ D.O.B.: _____
Address (city, state, zip): _____

Authorizes:

Northwest Counseling and Guidance Clinic 203 United Way Drive Frederic, WI 54837	Northwest Passage, LTD 203 United Way Drive Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Drive Frederic, WI 54837
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To use, exchange, and disclose information with: _____
Commercial Insurance Name, Address, City, State, Zip

Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

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- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) Date

Signature or Parent/Guardian Relationship to Client Date

Northwest Passage Ltd.
Release of Information Authorization-Mental Health and AODA

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

I hereby consent to the disclosure of records and information between the agencies specified below:

Northwest Counseling and Guidance Clinic 203 United Way Drive Frederic, WI 54837	Northwest Passage, LTD 203 United Way Drive Frederic, WI 54837	Northwest Pediatric Specialties 203 United Way Drive Frederic, WI 54837
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Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records <input type="checkbox"/> Intake/Initial Assessment <input type="checkbox"/> Progress Notes <input type="checkbox"/> Treatment Plan <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Educational Records <input type="checkbox"/> Standardized Test Scores <input type="checkbox"/> Teacher/Counselor/Social Worker Records <input type="checkbox"/> Medical Evaluation/Health Records <input type="checkbox"/> Psychiatric Evaluations <input type="checkbox"/> Psychological Evaluations/Test Results	<input type="checkbox"/> Human Service Records <input type="checkbox"/> Acknowledgement of Admission <input type="checkbox"/> Verbal/Written Communication <input type="checkbox"/> Appointment Information <input type="checkbox"/> Other:
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Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

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Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
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- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

 Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) _____
Date

 Signature or Parent/Guardian _____
Date

 Relationship to Client

Northwest Passage, Ltd.
Release of Information Authorization-Medical

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

Authorizes:
Northwest Passage LTD
 Name of person/Organization
 203 United Way Drive, Frederic, WI 54837
 Address (city, state, zip)

To use, exchange, and disclose information with:
St. Croix Regional Medical Center
 Name of person/Organization
 208 South Adams Street, St. Croix Falls, WI 54024
 Address (city, state, zip)

Records to be Disclosed (please check):

<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Immunizations
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Medications
<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/> Consultations	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> EKG/EEG	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> X-ray	<input type="checkbox"/> Labs	<input type="checkbox"/> Other:
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Operative Reports	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

Disclosure Notice to Recipient of Patient Health Care Records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your Rights with Respect to this Authorization:

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

 Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) _____
Date

 Signature or Parent/Guardian _____
Date

 Relationship to Client

MEDICAL SERVICES CONSENT – CHILD WELFARE FACILITIES

Use of form: Use of this form is voluntary. However, completion will help ensure compliance with HFS 52 and 57 of the Wisconsin Administrative Code. Personally identifiable information gathered on this form will be used for identification purposes only. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: The authorization is to be completed by the parent or guardian of the child in care and shall be valid for the duration of that child’s placement. If additional space is required, attach separate sheet(s).

A. Facility Information

Name – Facility Northwest Passage, LTD	Telephone Number – Facility 715-327-4402
---	---

Address – Facility (Street, City, State, Zip Code) 203 United Way Drive, Frederic, WI 54837
--

B. Child Information

Name – Child (Last, First, MI)	Birthdate (mm/dd/yyyy)
--------------------------------	------------------------

Home Address – Child (Street, City, State, Zip Code)
--

C. Parent/Guardian/Legal Custodian Information

1. Name – Parent/Guardian/Legal Custodian

Address – Home (Street, City, State, Zip Code)	Telephone Number – Home
--	-------------------------

Address – Work (Street, City, State, Zip Code)	Telephone Number – Work
--	-------------------------

Address – Other (Street, City, State, Zip Code)	Telephone Number – Other
---	--------------------------

2. Name – Parent/Guardian/Legal Custodian

Address – Home (Street, City, State, Zip Code)	Telephone Number – Home
--	-------------------------

Address – Work (Street, City, State, Zip Code)	Telephone Number – Work
--	-------------------------

Address – Other (Street, City, State, Zip Code)	Telephone Number – Other
---	--------------------------

D. Routine Medical Services Consent and Exclusions

For purposes of routine medical services for the above-named child, I hereby give my consent for the above-named facility to approve the provision of routine medical services including medical and dental examinations and non-emergency prescribed treatments (e.g., tooth repair, immunizations, medications, reproductive health needs assessment). Note: Any medical examination or service provided shall be provided only by an individual licensed to perform the examination or service. Add any exceptions you may have to this provision in the space provided below.

E. Emergency Medical Services Consent and Exclusions

In case of a medical emergency involving the above-named child, I understand that the following procedures will be used. I hereby give my consent for the facility to arrange for emergency medical services using the following procedures:

1. A reasonable effort will be made to contact me and secure my consent for needed medical services, including surgical procedures.
2. Verbal consent may be obtained in an emergency situation where time or distance precludes obtaining written consent. It shall be documented in the child's record by indicating who obtained the consent, who gave the consent and that person's relationship to the child, and what specific services are authorized by the consent. Verbal consent is valid for 10 calendar days, during which time there shall be a good faith effort to obtain written consent.
3. If I cannot be located within a reasonable time, the facility has the authority to consent to emergency medical services including surgery.
4. The juvenile court has the authority to consent to other medical services.

Note: Any medical examination or service provided shall be provided only by an individual licensed to perform the examination or service.

F. Signatures

<hr/> <p>Parent/Guardian/Legal Custodian (Required for all residents under 18 years of age and any residents 18 years of age or older who have been deemed incompetent by a court)</p>	<hr/> <p>Date Signed</p>
<hr/> <p>Resident (Between 14 and 18 years of age – whenever feasible)</p>	<hr/> <p>Date Signed</p>
<hr/> <p>Resident (18 years of age or older – Required unless resident has been deemed incompetent by court)</p>	<hr/> <p>Date Signed</p>

The following 5 pages are releases of information we will use to gain previous records from people who have previously provided services to your child or your family

The first page is for Medical Information – this form should be completed for medical providers. (i.e. pediatrician, endocrinologist, cardiologist, etc.) Please make a copy if more than 1 is needed.

The following 4 pages are the same and are for Mental Health or Alcohol and Drug Information.

**You should fill out at least 4 releases:
1 for your child's school
1 for your child's therapist
1 for your child's psychiatrist
1 for each previous out of home placement**

Please use one of the blank copies to make more copies, if more than 4 are needed.

Northwest Passage, Ltd.
Release of Information Authorization-Medical

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

Authorizes: Northwest Passage LTD To use, exchange, and disclose information with: _____
 Name of person/Organization _____
 203 United Way Drive, Frederic, WI 54837 Name of person/Organization _____
 Address (city, state, zip) _____ Address (city, state, zip) _____

Records to be Disclosed (please check):

<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Immunizations
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Medications
<input type="checkbox"/> Emergency Room Records	<input type="checkbox"/> Consultations	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> EKG/EEG	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> X-ray	<input type="checkbox"/> Labs	<input type="checkbox"/> Other:
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Operative Reports	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

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- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
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- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

 Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) _____ Date _____

 Signature or Parent/Guardian _____ Relationship to Client _____ Date _____

Northwest Passage Ltd.
Release of Information Authorization-Mental Health and AODA

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

Authorizes: Northwest Passage LTD Name of person/Organization 203 United Way Drive, Frederic, WI 54837 Address (city, state, zip)	To use, exchange, and disclose information with: Name of person/Organization Address (city, state, zip)
--	---

Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

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 Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) _____
Date

 Signature or Parent/Guardian _____
Date

 Relationship to Client

Northwest Passage Ltd.
Release of Information Authorization-Mental Health and AODA

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

Authorizes: Northwest Passage LTD Name of person/Organization 203 United Way Drive, Frederic, WI 54837 Address (city, state, zip)	To use, exchange, and disclose information with: Name of person/Organization Address (city, state, zip)
--	---

Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
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<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:
 From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

Disclosure Notice to Recipient of Patient Health Care Records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your Rights with Respect to this Authorization:

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health)	Date
Signature or Parent/Guardian	Relationship to Client
	Date

Northwest Passage Ltd.
Release of Information Authorization-Mental Health and AODA

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

Authorizes: _____ Northwest Passage LTD Name of person/Organization 203 United Way Drive, Frederic, WI 54837 Address (city, state, zip)	To use, exchange, and disclose information with: _____ Name of person/Organization _____ Address (city, state, zip)
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Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

Disclosure Notice to Recipient of Patient Health Care Records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your Rights with Respect to this Authorization:

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

 Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) _____
 Date

 Signature or Parent/Guardian _____
 Relationship to Client Date

Northwest Passage Ltd.
Release of Information Authorization-Mental Health and AODA

Client Name: _____ D.O.B.: _____
 Address (city, state, zip): _____

Authorizes: Northwest Passage LTD Name of person/Organization 203 United Way Drive, Frederic, WI 54837 Address (city, state, zip)	To use, exchange, and disclose information with: Name of person/Organization Address (city, state, zip)
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Records to be Disclosed (please check):

<input type="checkbox"/> Mental Health Treatment Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Human Service Records
<input type="checkbox"/> Intake/Initial Assessment	<input type="checkbox"/> Standardized Test Scores	<input type="checkbox"/> Acknowledgement of Admission
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Teacher/Counselor/Social Worker Records	<input type="checkbox"/> Verbal/Written Communication
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Medical Evaluation/Health Records	<input type="checkbox"/> Appointment Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Psychiatric Evaluations	<input type="checkbox"/> Other:
<input type="checkbox"/> Alcohol/Drug Treatment Records	<input type="checkbox"/> Psychological Evaluations/Test Results	

Time Period for which records are requested: From _____ to _____ All

Expiration: This authorization will remain in effect:

From the date this authorization is signed until: _____ One year from the date of signature
 Until I cancel this authorization in writing Other, specify: _____

Reason for Release (please check): Coordinating Care/Treatment Transfer of Care Case Management Personal
 Billing, collection, or payment of claims Other: _____

I understand that information will be exchanged verbally, by mail, by facsimile or by email.

Redisclosure Notice to Client: If the recipient of the information is not a health care provider or health care clearinghouse, the health information disclosed as a result of your authorization may no longer be protected by the Federal privacy standards if such person(s) and/or organization (s) redisclose your health information.

Disclosure Notice to Recipient of Patient Health Care Records: Unless otherwise authorized by Section 146.82 of the Wisconsin Statutes, you are prohibited from making any further disclosure of patient health care records without the specific written authorization of the person who is the subject of such records.

Disclosure Notice to Recipient of Mental Health, Alcohol and/or Drug Treatment Records: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person who is the subject of such information or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Your Rights with Respect to this Authorization:

- You have the right to receive a copy of this authorization
- You have the right to refuse to sign this authorization. The person(s) and/or organization(s) listed above may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on your decision to sign this authorization except regarding: research-related treatment, health plan enrollment or eligibility, the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party.
- You understand that if you want to cancel this authorization, you must do so in writing. You understand that your cancellation will not be effective as to uses and/or disclosures of your health information that the person(s) and/or organization(s) above have made prior to the receipt of your cancellation form. You understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under policy or the policy itself.
- You have the right to inspect or copy (may be provided at a reasonable fee) the health information you have authorized to be used or disclosed by this authorization form.
- Your HIV test results may be released without your authorization to persons/organizations that have access under Wisconsin law and a list of those persons/organizations is available upon request.
- You have the right to inspect and receive a copy of your mental health treatment records to the extent required by HFS 92.05 and 92.06 of the Wisconsin Administrative Code.

A photocopy of this authorization shall be as effective and valid as the original.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

 Signature of Client (required for age 12 & over for AODA, 14 & over for Mental Health) Date

 Signature or Parent/Guardian Relationship to Client Date

**Northwest Counseling and Guidance Clinic
Northwest Passage**

INFORMED CONSENT (HFS94.03)

As a client of Northwest Passage and Northwest Counseling and Guidance Clinic, you or the person acting on your behalf will be provided with complete and accurate information and time to study the information, or seek additional information from the outpatient clinic and/or day treatment program, concerning the proposed treatment or services made necessary by, and directly related to, your mental health disorder, developmental disability, alcoholism, or drug dependency. This information includes:

- The benefits of proposed treatment
- The way treatment is to be administered and services to be provided
- Expected treatment side effects or risks of side effects which are a reasonable possibility including side effects or risks of side effects from medication
- Alternative treatment modes and services
- Probable consequences of not receiving the proposed treatment and services
- A time period for which the informed consent is effective which shall be no longer than 15 months from the time the consent was given
- The right to withdraw informed consent at any time, in writing
- I understand that information shared in any session will be confidential. Confidentiality means that your records or information regarding your treatment will not be given to others unless you agree in writing to release confidential information. Confidentiality will remain in effect even after you stop services.
- Confidentiality is necessary to establish a trusting treatment relationship. In specific instances therapists are required by law to release information without the client's informed consent. These include (1) suspected or actual physical and/or sexual abuse or neglect of a child or vulnerable adult; (2) if a court serves a subpoena for specific information; or (3) if a client is in imminent and/or immediate danger of harming self or others.
- I understand that information shared in any session will be subject to disclosure among all family members who attend treatment, at the discretion of the Mental Health Provider. I am aware that within the terms and condition of receiving therapeutic services with this program, it may be necessary to share significant treatment issues and information during family sessions and/or staffings. I understand that releases will be obtained prior to information being shared with other professionals involved in my case.
- I understand that Northwest Counseling and Guidance Clinic is part of a larger system of care. For this reason, confidential mental health records may be shared with other mental health providers within the system on a need to know basis. Need to know means that the program and its providers have, are, or will be providing mental health services to the identified client. For example, if the identified client is transferring to another Day Treatment Program, the originating day treatment program may provide copies of treatment records pertinent to ongoing care to the receiving day treatment program.
- I understand that Northwest Passage is part of a larger system of care. For this reason, confidential mental health records may be shared with other mental health providers within the system on a need to know basis. Need to know means that the program and its providers have, are, or will be providing mental health services to the identified client. For example, if the identified client is transferring to another Northwest Passage Program, the originating Northwest Passage program may provide copies of treatment records pertinent to ongoing care to the receiving Northwest Passage program.
- Northwest Passage and Northwest Counseling and Guidance Clinic Programs have a variety of services and locations. The hours of operation vary from site to site. In general, hours of operation

are between 8:00 a.m. and 4:30 p.m. Monday through Friday. Appointments must be scheduled in advance. Please feel free to contact the specific location for more details.

- I hereby request admission and give voluntary consent to the usual and customary diagnosis, evaluation, care, and treatment provided by Northwest Passage and Northwest Counseling and Guidance Clinic.
- I understand that there are times when it is necessary to terminate treatment. Those situations may include, but are not limited to: abusive or threatening behavior or attitude, non-compliance with the treatment plan, use of drugs during treatment, and failure to inform the billing department of a change in funding source.
- I understand that if I request a copy of my record, there may be a fee associated with that request.
- Our office will be glad to contact your insurance carrier to verify benefits as well as submit charges. We encourage you to contact them as well. **You will be responsible for co-payments and yearly deductible charges. All unpaid charges are the responsibility of the client.** Please address all questions regarding insurance to the billing department.
- Northwest Passage and Northwest Counseling and Guidance Clinic will not guarantee your insurance benefit (in or out of network), or payment by insurance. We encourage you (client) to contact your insurance company directly to verify your level of benefits. If you have any questions, please feel free to contact the billing department.
- In emergency situations or where time and distance preclude obtaining written consent before beginning treatment and a determination is made that harm will come to the client if treatment is not initiated before written consent is obtained, informed consent for treatment may be temporarily obtained by telephone from the parent or guardian of a minor client. Verbal consent will be valid for a period of ten (10) days during which time informed consent shall be obtained in writing.
- I understand that this consent will remain in effect for one year from the date signed below.

Client Signature (age 14 and over)

Date

Legal Guardian Signature

Date

I agree to participate in a Consumer Satisfaction Survey. I will be sent a Consumer Satisfaction Survey to fill out and return to this agency at the time of the client's discharge from services. I understand this is a voluntary program and I may withdraw participation at any time.

Parent/Legal Guardian Signature

Date

Client Signature

Date

**Northwest Counseling and Guidance Clinic
Evaluation Plan**

Client Name: _____ **D.O.B.:** _____
Intake Date: _____ **Start Date:** _____

Mental Health Counselor: _____
Neuropsychologist: _____
AODA Counselor: _____

Presenting Problem:

Please see final evaluation report.

Evaluation Plan:

Patient will comply with clinical interviews and testing as needed for this evaluation.

Parent/Legal Guardian Signature (required for client under 18) Date

Client Signature (required for 12 and over) Date

Mental Health Counselor Signature Date

Neuropsychologist Signature Date

AODA Counselor Signature Date

Clinical Supervisor Signature (only applicable for AODA) Date

Physician Signature Date

Northwest Counseling and Guidance Clinic
203 United Way Drive, Frederic, WI 54837, 715-327-4402

Client Bill of Rights and the Grievance Procedure

Below is the Bill of Rights given to the client at the time of intake. The Bill of Rights is in accordance to Wisconsin Statute sec. 51.61 (1) and HFS 94 Wisconsin Administrative Code.

BILL OF RIGHTS

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

Each service provider must post this bill of rights where anyone can easily see it. Your rights must be explained to you. You may request a pamphlet also.

Rights designated in *italics* generally apply to inpatient and residential settings, not necessarily day treatment.

Personal Rights

- You must be treated with dignity and respect, free of 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 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.
- *You have the right to participate in religious services and social, recreational and community activities away from the living unit to the extent possible.*
- *Your surroundings must be kept safe and clean.*
- *You must be given the chance to exercise and go outside for fresh air regularly and frequently, except for health and security concerns.*
- *You have the right to receive treatment in a psychologically and physically humane environment.*

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 and possible side effects of treatment, including medications.
- No treatment or medication may be given to you without your 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 a 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 safely and appropriately meet your needs.
- *You may not be restrained or placed in a locked room (seclusion) unless in an emergency when it is necessary to prevent physical harm to you or to others or when it is part of a treatment program to which you or your guardian have consented.*

COMMUNICATION AND PRIVACY RIGHTS

- *You may call or write to public officials or your lawyer.*
- *Except in some situations, you may not be filmed, taped or photographed unless you agree to it.*
- *You may use your own money as you choose, within some limits.*
- *You may send and receive private mail. [Staff may not read your mail unless you or your guardian asks them to do so.] Staff may check your mail for contraband. They can only do so if you are watching.*
- *You may use a telephone daily.**
- *You may see visitors daily.**
- *You must have privacy when you are in the bathroom and while receiving care for personal needs.**
- *You may wear your own clothing.**
- *You must be given the opportunity to wash your clothes.**
- *You may use and wear your own personal articles.**
- *You must be have access to a reasonable amount of secure storage space.**

*Some of your rights may be limited or denied for treatment, safety or other reasons. [See the rights with an * after them.] Your wishes and the wishes of your guardian should be considered. If any of your rights are limited or denied, you must be informed of the reasons for doing so. You may ask to talk with staff about it. You may also file a grievance about any limits of your rights.

RECORD PRIVACY AND ACCESS LAWS

Under Wisconsin Statute sec. 51.30. and HFS 92, Wisconsin Administrative Code.

- Your treatment information must be kept private (confidential), unless the law permits disclosure.
- Your records cannot be released without your consent, unless the law specifically allows for it.
- You can 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 in the grievance process.
- After discharge, you may see your entire 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 HFS 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.
- *If you have been placed against your will, you may ask a court to review your commitment or placement order.*

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 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.

- 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, DSL, P.O. 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 Supportive Living or designee. Send your request to the DSL Administrator, P.O. Box 7851, Madison, WI 53707-7851.

CONTACT YOUR CLIENT RIGHTS SPECIALIST, WHOSE NAME IS SHOWN BELOW, TO FILE A GRIEVANCE OR TO LEARN MORE ABOUT THE GRIEVANCE PROCEDURE USED BY THE PROGRAM FROM WHICH YOU ARE RECEIVING SERVICES.

Your Client Rights Specialist for Northwest Passage is:

Ellen Race

Address: 203 United Way Drive, Frederic, WI 54837

Phone: (715) 327-4402

NOTE: There are additional rights within sec. 51.61(1) and HFS 94, Wisconsin Administrative Code. A copy of sec. 51.61, Wis. Stats. and/or HFS 94, Wisconsin Administrative Code is available upon request.

RIGHTS and GRIEVANCE PROCEDURE

When you receive services for a mental illness, developmental disability, or alcohol or drug abuse you have certain rights under Wisconsin law (s.51.61). You have these rights whether your program is residential or outpatient.

Under the rights of access and legal status you have the right: to be considered legally competent, unless otherwise determined by a court so that you can make your own decisions about things like getting married, voting and making a valid will, if you have a guardian, to have your guardian fully informed and allowed to participate in your treatment plan, and to sue for damages if someone violates your rights (s.51.61 (7)).

Whatever your particular needs are, you have the right to: treatment which is offered promptly and which is adequate to help with your particular problems, to refuse to take part in experimental research, and to be free from unnecessary or excessive medications.

While in therapy you have the right to refuse to: be filmed or taped without your consent, to have your treatment records and conversations among staff about your treatment kept confidential (s.51.30, Statutes. And HSS 92), and to have access to your treatment records at all times.

If you feel your rights were violated you may file a grievance with this agency. It is recommended that you, at first, make every effort to reconcile or correct the disagreement with your therapist. Notify your therapist/case manager of the grievance and seek resolution. That failing, a written statement describing the nature of your grievance needs to be presented to this agency. If you need assistance in preparing a written complaint, please contact the Client Rights Specialist (CRS) to help facilitate the process or notify the day treatment program to contact the CRS on your behalf. The CRS will be notified of the grievance and will review the grievance with you personally, and attempt to resolve the problem. If you disagree with the outcome you may appeal to the state grievance examiner.

If you believe a grievance is necessary: you are protected from any retribution, all information relative to a grievance is confidential, you have a right to have your grievance resolved within an appropriate amount of time. In most cases, a grievance will be resolved within 30 days, and you may have any person act as your advocate.

I acknowledge that I have received a copy of the Client Bill of Rights and the Grievance Procedure. I have read and understand the rights and grievance process. This acknowledgement is effective for one year from the date signed below.

Client Signature (Required for 14 & over)

Date

Parent/Legal Guardian Signature (Required for under 14)

Date

Northwest Passage Residential Treatment Programs

Influenza Precautions Alert

Due to the epidemic of H1N1 influenza (“Swine flu”), NWP is required to take measures to help prevent the spread of influenza. H1N1 influenza is most often recognized by causing cough or sore throat, and a fever (temperature > 100 degrees).

For parents or guardians of residents: Please notify Northwest Passage staff if your child has either:

- Been exposed to someone known to have, or suspected of having influenza
- Had a cough or sore throat, and a fever (temperature > 100 degrees)

This applies to new residents coming into our facility and to residents who have been outside the program for an overnight visit.

For visitors to Northwest Passage facilities: Prior to visiting (when possible) or immediately at the time of entering our facility, please notify staff if you have either:

- Been exposed to someone known to have, or suspected of having influenza
- Had a cough or sore throat, and a fever (temperature > 100 degrees)

You may be asked to make arrangements for a later visit, or to use a mask to help protect others from exposure.

For all visitors, please make use of tissues when sneezing or coughing, and dispose of them in the trash. We also encourage frequent hand washing. We will attempt to make tissues and hand cleanser easily available to all visitors.