ALAY HEALTH TEAM AUTHORIZATION
FOR CONSENT OF TREATMENT
**ALL SECTIONS MUST BE COMPLETED (1* through 16)**

*PLEASE WRITE CLEAR AND LEGIBLY, **READ**, AND **THEN SIGN**

**Todays Date:** _____

**Section 1*:** If someone other than patient is signing this form for consent, please check who you are:

☐Natural or Adoptive Parent for child under 18 ☐Legal Guardian ☐Durable Power of Attorney

**Section 2:**
**Patients Legal Name** (Last, First, Middle):_____ **DATE OF BIRTH**: _____

*Please specify name/pronouns for health care providers to use if different from Legal Name: _____

**Sex**: ☐Male ☐Female

**Gender**: ☐Male ☐Female ☐Transgender male/Trans Man/ Female-to-male

☐ Transgender female/Trans Woman/ Male-to-Female ☐Genderqueer/Non Binary

**Please Note the Sex and Name must match with patients insurance company.*

**Section 3: Mailing Address**
**ADDRESS**: _____ **CITY**: _____ **STATE**: ___ **ZIP CODE**: _____

**Section 4: Contact Information:**
**PHONE NUMBER**: _____ **EMAIL**: _____
*If other than patient, whose number is this*: _____
***Please note that if your number or email changes it is your responsibility to contact office to give correction***

**Section 5: *COPY OF INSURANCE CARD IS NECESSARY AND MUST BE PROVIDED**
If you are Self Pay, please provide debit/credit card information (and insurance card), for each appointment this card will be charged the day of the appointment, you will receive a receipt in the email you provided when you are charged. If you are self-pay and you owe a balance, you will not be seen until that balance is paid in full.

**Insurance Carrier**: _____
**Subscriber ID**: _____ **Group #:** _____
**Name of Subscriber**: _____ **Subscriber DOB**: _____
*Any section marked with a "*" is dependent on patient circumstances.

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# Information For Patients

This sheet contains important information about the patients care with us. Please read it carefully. Talk to your provider or anyone on our team about any questions you may have. A provider at Alay is a Psychiatric Mental Health Nurse Practitioner – Board Certified.

**Who we Serve**
We care for children, adolescents, adults, and elderly ages 0-99 and their families in a telepsychiatry outpatient clinic. If there is any reason why we are not the best place to care for you, we will explain why and direct you where to find care elsewhere.

**Hours**
Clinic hours are Monday – Thursday 9:00am – 5:00pm CST and Friday 9:00am – 1:00pm CST, Evening and weekend hours may be available. Ask your provider for more information, the front office staff cannot assist with evening or weekend hours, only your provider.

**Telehealth**
In order to receive care at Alay Psychiatry/Alay Health Team you must be able to use a computer/device to use zoom. Please see the Telehealth page for more information. (Page 5)

**Attendance and Cancellations**
It is important to come to all of your scheduled visits. Not attending appointments delays your care and your prescriptions. If you are not able to make an appointment, call 262-260-9000 as soon as you can.

A **no call no show** is when you:
- Do not show for a schedule appointment

A **Late Cancel** is when you
- Cancel a visit less than 24 hours before your appointment (including after the scheduled appointment time)
- Arrive when more than ½ of your appointment time has passed.

If you have **3** no call no shows and/or late cancels within a 1-year time from your first visit with your provider, you may be discharged from the clinic.

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# CONSENT FOR TREATMENT

I understand this consent for an initial assessment and treatment, or substance abuse assessment and treatment in which I am agreeing to participate in this initial mental health intake screening at Alay Health Team.

I understand that this consent is voluntary and that I can withdraw my consent for treatment at any time. The purpose of this assessment is to evaluate my current mental health or substance abuse needs and to develop specific assessment recommendations related to my concerns which has brought me to Alay health Team.

I understand the initial assessment will be conducted by Alay Health Team, who are qualified Mental Health Substance Abuse professionals. The assessment will consist of interviews between the provider and myself. Psychological testing may be recommended to evaluate my needs more thoroughly. Some mental disorders can have medical or biological origins and may require a consultation with a physician. In addition, urine screenings may be needed, oral drug swab tests will be done, providers can see medications in these tests, whether prescribed or not.

Medication decision making is comprised of collateral information obtained via reported history, objective findings and decision making by the provider. Patients have the right to have their opinion known, considered, and documented by the treatment team, but patient opinion will not dictate medication prescribing.

I understand the practitioner may need to discuss my case in a confidential manner with a professional treatment and/or supervisor for the purpose of providing quality service. I am aware additional professional staff may be asked to participate in the evaluation and treatment. I understand these discussions will be kept confidential unless I authorize that information be released or unless allowed or required by law. These exceptions to confidentiality are referenced in the Notice of Information Practices handout what I have been given a copy of.

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I understand that some treatment recommendations may be addressed during the initial interviews(s). Once the assessment is complete and an initial treatment plan has been formulated, I will be given the opportunity to review and discuss with the practitioner the results of the assessment, the nature of condition, and any treatment recommendations, including alternatives to these recommendations

Alay Psychiatry/Alay Health Team is an outpatient mental health clinic. Alay is not equipped to handle crisis situations regarding a patient's mental health without an appointment. It is Alay's policy that the patient goes to the ER or call the suicide hotline when Alay is not available to provide outpatient mental health services or the patient's provider is unavailable to assist with a crisis. We cannot assist with patients' medications if they are new to Alay, they must have an appointment before ANY medications can be prescribed.

A patient may be involuntarily discharged from treatment because of the patients' inability to pay for services or for behavior that is a reasonable result of mental health symptoms only as provided in par (DHS 35.24(3)(a)). A warning letter of discharge will be mailed to you, when appropriate, regarding any reason you may be discharged, as a patient can also receive a discharge letter without the warning when appropriate.

Prescribers at Alay recognize that the separation and divorce of parents takes a heavy toll on their children. This often requires the support of psychiatrists and therapists in addition to meaningful communication between separated parents. We never want your child's care compromised, so if your child is suffering because of a divorce or separation, please help us out by having both parents in agreement with our medical care team, and do not put the child in the middle of a parental feud that entwines our medical practice. We find it is usually best that both parents attend doctor visits for these children when legally and safely possible. We ask that there is no "instructing" of the doctor on what to "write down". When our prescribers are placed in the middle angry, accusing parents, it irreparably compromises the doctor-patient relationship. **Explanations of your child's care plan will be provided <u>once</u> during the visit to the person present**. Please do not expect the provider to call the other parent to discuss the care plan a second time. If custody paperwork, CPS or restraining orders are in play, it is your duty as a parent to provide that information to our team so we can properly and safely provide care to your child.

**By Signing Below, you acknowledge and agree to our policy and procedures and agree to consent of care**

**Section 6: Printed Name (Of Patient/Legal Guardian):** _____

**Section 7: Signature(Of Patient/Legal Guardian):** _____**TODAYS DATE**: _____

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## Telepsychiatry

**Section 8:** I _____ (name of patient) herby consent to engaging in telepsychiatry with Alay Health Team and participating providers for management of medication and psychotherapy. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consolation, treatment, transfer of medical date, and education using interactive audio, video, or data communications. I understand that telepsychiatry also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in Wisconsin, Arizona, Oregon, or outside of these states.

I understand that I have the following rights with respect to telemedicine:

(1) I accept that I need access to PC, laptop, or mobile device and a good internet connection in order to have an efficient telepsychiatry appointment.
(2) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
(3) I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.
(4) I Understand that there are risks and consequences from telemedicine, including but not limited to, the possibility, despite reasonable effects on the part of my qualified Psychiatric Mental Health Nurse Practitioner, that: the transmission of my medication information could be disrupted or distorted by technical failures, the transmission of my medication information could be interrupted by unauthorized persons, and/or the electronic storage of my medical information could be accessed by unauthorized persons.
In addition, I understand that telepsychiatry -based services and care may not be as complete as face-to-face services, I also understand that if my qualified Psychiatric Mental Health Nurse Practitioner believes I would be better served by another form of mental health services (e.g., face-to-face services) I will be deferred elsewhere. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry and that despite my efforts, the efforts of my qualified Psychiatric Mental Health Nurse Practitioner, my condition may not improve and in some cases may even get worse.
(5) I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.
(6) I understand that all existing laws regarding access to medical information and copies of medical records apply to telepsychiatry appointments.
(7) Telecommunications with patients will not be records and stored. Patients' medical information obtained by the diagnosis and analysis can be used anonymously for further improvements in scientific studies.

**By signing below, I acknowledge, understand, and agree to the information provided above.**

**Section 9: Printed Name (Of Patient/Legal Guardian):** _____

**Section 10: Signature(Of Patient/Legal Guardian):** _____**TODAYS DATE**: _____

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# Alay Health Team Consent to Treatment- Confidentiality

## Limits of confidentiality

Contents of all sessions are considered to be confidential. Both verbal information and written record about a client cannot be shared with another party without the written consent of the client of the client's legal guardian. Note exceptions are as follows:

**Duty to warn and Protect**

When a client discloses intention of a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify legal authorities and make reasonable attempts to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Parental Exposure to Controlled Substances**

Mental health care professionals are required to report admitted parental exposure to controlled substances that are potentially harmful.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to request the client's records unless it is determined that access would have a detrimental effect on the medical relationship, or on the client's physical safety or psychological well-being.

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**Judicial or Administrative Proceedings**

Health care professionals are required to release records of clients when a court order has been placed. In the event of a court order, only the minimally acceptable amount of information will be revealed. Additionally, if a client files a complaint or a lawsuit against anyone affiliated with or working with Alay Health team; relevant client files a complaint or a lawsuit against anyone affiliated with or working with Alay Health Team; relevant information regarding the client may be disclosed for the purpose of formulating an appropriate defense.

**Insurance Providers (when applicable)**

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: Types of services, dates/times of services, diagnosis, treatment plan and description or impairment, progress of patient, case notes, and summaries.

# Overview of Privacy Policies

Alay Health Team policy and federal regulations protect the privacy of our patients; health information The Health Insurance Portability and Accountability Ace (HIPAA) is a set of federal rules that defines what certain rights regarding their information. Alay Health team has its own policies that reflect these regulations as well as best ethical standards. These rules protect information that is collected or maintained, (verbally, in paper, or electronic format) that can be linked back to an individual patient is related to his or her health, the provision of health care services or the payment for health care services. This includes, but is not limited to, clinical information, billing, and financial information and demographic/scheduling information. Even the fact that an individual has received care at Alay Health Team is protected by Alay Health Team policy and federal regulations.

Alay Health Teams Psychiatric Mental Health Nurse Practitioners' have Residents - health professionals in training, they will be with selected prescribing providers. The Residents are all licensed medical professionals who are trained in Alay Health Teams Policies. Because our providers help with training these residents, you will

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possibly be having an appointment with a resident instead of your usual provider. Your provider will always be at the appointment with the Resident and patient, your provider will be assisting with the management of the medications at those appointments when they occur, a licensed PMHNP-BC will always need to prescribe the patients' medications. If you, the patient, have questions/concerns or if you do not give consent to our policies, please notify the office staff of this, and do not sign, by signing below you agree you have acknowledged Alay Health Teams policies and give consent to have appointments with Residents and your prescriber.

By Signing below, you have read, understand, and agree to the above limits of confidentiality and understand the meanings and ramifications.

**Section 11: Printed Name (Of Patient/Legal Guardian):** _____

**Section 12: Signature(Of Patient/Legal Guardian):** _____**TODAYS DATE**: _____

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# Financial Agreement

I hereby give my permission for Alay Psychiatrics to give me medical treatment. I allow the practice to file for insurance benefits to pay for the care I receive. I understand that the Practice will have to send my medical record information to my insurance company, I must pay my share of the costs. I must pay or the cost of these services if my insurance does not pay or I do not have insurance. I Understand that I have the right to refuse any procedure or treatment and I have the right to discuss all my medical treatments with my provider. Although health insurance may aid in payment, you are responsible for paying for services and appointments with Alay Health Team. If you have a co-payment or you are self-paying (no insurance or insurance not accepted by Alay Health Team), you will be expected to pay that amount at the time the services are provided, you will not be seen if you are Self Pay and have not paid the day before/of the appointment. If a copay is not made, a bill will be sent to the client for all copays not paid. If you have a balance on your account, that will need to be paid in FULL before you can be seen and before any medications will be refilled. Alay will work with you in getting payments processed as well as Alay's billing department.

If you did not receive a bill and you have a balance, please contact Alay so they can assist.

Telephone consultations, reports, and letters to other professionals may be provided as a courtesy at no fee if they are rare and require less than 10 minutes. Most services requiring more time, such as lengthy phone consultations, reports letters, or conferences will have an hourly fee corresponding with your hourly appointment rate and are not services billable to insurance.

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It is your responsibility to find out if Alay Health Team is participating provider with your insurance plan. If your insurance company requires you to obtain authorization from them prior to treatment, and you do not do so, you are responsible for payment in full at the time services are provided.

If you fall to cancel a scheduled appointment with less than a 24 hour-notice, we cannot use this time for another client, and you will be billed $100. This will not be billed to your insurance company but directly to you. 3 or more missed appointments reduce therapeutic alliance, this may result in you being discharged from Alay Health Team as a client. Exceptions will be made ONLY on case-by-case basis and at the discretion of Alay Health Team.

Alay Health Team reserves the right to collect any unpaid balances. If a client is not making agreed upon regular monthly payments on the account balance, or no action to pay your bill is taken, we will use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections actions will become part of your credit record. Clients will be notified in writing before an account is referred for collections. Any outstanding balances will likely result in a discharge.

By signing below, you acknowledge, understand, and agree to Alay Health Teams Financial Agreement.

**Section 13: Printed Name (Of Patient/Legal Guardian):** _____

**Section 14: Signature(Of Patient/Legal Guardian):** _____**TODAYS DATE**: _____

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# Alay Health Team Psychiatric Prescribing Providers
## Medication Refill Policy

Our providers participate in the Wisconsin Prescription monitoring program.

Alay Health Team Psychiatric Prescribing Providers participates with electronic prescribing directly to your mail order and local pharmacies. Our goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

1. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
2. Medication refills will only be addressed during regular office hours (Monday – Thursday 9:00am – 5:00pm, Friday 9:00am to 1:00pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday, or Holidays.
3. Prescription refills require close monitoring by your provider to ensure its safety and effectiveness. Your provider will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, not out of medication, refills, its labeled on your medication bottle, it is time to schedule a follow up appointment. We prefer you request any refills of your medications at the beginning of your office visit. And call your pharmacy for any CONTROLLED medications, no refills are given on those, but you may have a prescription at the pharmacy for you.
4. Patients requesting new prescriptions or controlled prescriptions must be seen for an appointment. They are not prescribed without an appointment with a provider.
5. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.
6. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
7. It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills as well as a possible discharge.
8. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately to make an appointment with your provider.
9. We reserve the right to charge an administrative fee for if there are multiple requests for prescriptions requested outside of a visit.

By Signing Below, you acknowledge, understand, and agree to our policy, without signing no medications will be prescribed

**Section 15: Printed Name (Of Patient/Legal Guardian):** _____

**Section 16: Signature(Of Patient/Legal Guardian):** _____**TODAYS DATE**: _____