School Based Mental Health
Referral Form

Additional Information:

1) Return completed paperwork with copy of insurance card or other proof of insurance to school OR you can fax the information to:

Attn: Julie at Fax# (920-320-8662).

2) Once paperwork is returned, the parent should call HFMC to schedule an appointment with Julie at (920-320-8563).

DEMOGRAPHIC INFORMATION

Child's name _____

Child's date of birth _____

Child's SS# (for insurance purposes, if child has Badgercare)_____

Parent's name _____

Home address _____

Ph number _____

Child likes to be called_____

Primary Care provider _____

INSURANCE INFORMATION

Name of insurance _____

Subscriber name _____

Subscriber date of birth _____

Subscriber's employer (if applicable) _____

ID # _____

Group # _____

Do you plan to attend the intake with your child? Yes No (circle one)

Master

MANITOWOC PUBLIC SCHOOL DISTRICT
Manitowoc, Wisconsin

HIPAA-Compliant Confidential Authorization for Exchange of Health and Education Information - Form to Release/Obtain Information

If returning via fax, send to _____ **Attention** _____

Student/Patient Name: Last, First, Middle Initial

Date of Birth: MM/DD/YYYY

I hereby authorize (health care/service provider/other name & title)

Holy Family Memorial Behavioral Health
Rachel Fruin LPC, CSAC- School Based Therapist

Address, telephone and fax number of health care service provider other

339 Reed Ave Manitowoc, WI 54220
Phone: 920-320-8600
Fax: 920-320-8662

and **Manitowoc Public School District Staff**
Central office located at: 2902 Lindbergh Drive, Manitowoc, WI 54220
Office: (920) 686-4777 Fax: (920) 686-4780

Or, if communication can occur with only some individuals, list their information here (name & title of school staff)

Wilson Middle School staff, as appropriate

to exchange health and education information/records for the purpose listed below:

Coordination of services

The specific health information to be disclosed consists of:

- ☐ Medical and/or related health records
- ☐ Appropriate agency reports
- ☐ Psychological evaluations
- ☐ Verbal exchange of information
- ☒ Other: (Specify below)

Necessary verbal and written information

The education information to be disclosed consists of:

- ☐ Official student academic/administrative records (identifying info, grade level completed, grades, class rank, attendance, and test results)
- ☐ Psychological evaluations or other official reports from school staff
- ■ IEP Team evaluations
- ■ Appropriate agency reports
- ☐ Individualized Education Program
- ☐ Verbal exchange of information
- ☐ Response to medication
- ☐ Behavioral rating scales
- ☐ Nursing assessment letter
- ■ Progress Records (Specify below)
- ■ Behavior Records (Specify below)
- ☐ Health Records (Specify below)
- ☐ Other: (Specify below)

Purpose: This information will be used for the following purpose(s):

- ☐ Educational evaluation and program planning.
- ■ Health assessment and planning for health care services and treatment in school.
- ☐ Medical evaluation and treatment.
- ☐ Determine effectiveness of medication prescribed.
- ☐ Other: (Specify below):

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be used or disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department or school.

Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to refuse to sign this Authorization – I understand I am under no obligation to sign this form and that the person(s) and or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Right to withdraw this Authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the health information department or school. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Authorization:

This authorization is valid for one calendar year:

Expiration date: _____
MM/DD/YYYY

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and may become education records protected by the Family Education Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin Law (Section 118.125(2m)(a)(b) and 146.81-146.84, Wis. Stats.). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care

I am (check one) ☐ the person ☐ the authorized representative of the person whose information is authorized to be used or disclosed.

Parent/Legal Guardian Signature (if applicable)

Date Signed MM/DD/YYYY:

Student Signature* (if student is 18 years old or older)

Date Signed MM/DD/YYYY:

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Wisconsin, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for HIV/AIDS, and family planning services.

This form will be uploaded to our student information system. A copy can be supplied to anyone who has a reason to be informed including the parent/guardian.

This CONDITIONS OF ADMISSION and/or TREATMENT AGREEMENT (the "AGREEMENT") applies to all services provided or visits started during this period: __/__/__ (FROM DATE) to __/__/__ (TO DATE). This Agreement expires no earlier than __/__/__ (TO DATE), and only when all treatment/hospital charges have been paid in full and there is a zero balance on the resulting account.

This agreement applies to The Medical College of Wisconsin, Inc. ("MCW") and Froedtert Health affiliates: Froedtert Memorial Lutheran Hospital, Inc.; Community Memorial Hospital of Menomonee Falls, Inc. d/b/a Froedtert Menomonee Falls Hospital; St. Joseph's Community Hospital of West Bend, Inc. d/b/a Froedtert West Bend Hospital; Froedtert & the Medical College of Wisconsin Community Physicians, Inc.; West Bend Surgery Center, LLC; Drexel Surgery Center, LLC; Froedtert Surgery Center, LLC; Froedtert Health Neighborhood Hospital, LLC d/b/a Froedtert Community Hospital; Holy Family Memorial, Inc.; and Froedtert Manitowoc Medical Group, LLC. The term "Affiliate" in this Agreement includes MCW and the Froedtert Health affiliate organizations listed above.

- **Notice of Privacy Practices:** I have received the Joint Notice of Privacy Practices which provides information about how the Affiliate may use and disclose Protected Health Information (PHI) about the patient. Signing this Agreement acknowledges the patient's receipt of the privacy practices. As provided in the notice, the terms of the notice may change. If the Affiliate changes the notice, the patient may obtain a revised copy by stopping at our Admitting Department/ Reception Desk or visiting our website at *froedtert.com*.
- **Medical Consent:** My signature below provides consent for the full duration of this Agreement to medical care and treatment as deemed necessary and proper by the authorized medical providers of the Affiliate for the patient identified below. I understand that the patient is under the direct care of providers while at an Affiliate location and I expect the providers of the Affiliate to carry out their instructions. This Agreement also includes consent for any Affiliate services rendered under the general or special instructions of a provider, including, but not limited to, X-ray examinations, laboratory procedures, medical or surgical treatments and administration of anesthesia. I understand that some of the providers are independent contractors and not employees of the Affiliate.

  I acknowledge that any medical care furnished to the patient in the Emergency Department will be limited solely to emergency treatment. I understand that the patient may be released before all of the patient's medical problems are known or treated, and that it will be necessary for the patient to arrange follow-up care.
- **Consent to Record, Photograph or Film:** I consent to the recording, photographing, closed circuit monitoring or filming of the patient for purposes of treatment (will be in the medical record) or for the organization's internal operations (not in the medical record) such as quality of care and teaching.
- **Student Participation:** I understand that the Affiliate has educational programs and affiliations with academic institutions and I agree to student and resident participation in the patient's care under appropriate supervision.
- **Financial Agreement and Assignment:** I, the undersigned agree, whether signing as agent or as patient, that I am financially responsible for all charges incurred. Assignment of commercial insurance benefits to the Affiliate does not reduce the responsibility for payment. Should the account be referred to any attorney for collection, the undersigned shall also be responsible for reasonable attorney's fees and any additional fees associated with the collection process. Further, by signing below, I authorize payment to be made directly to the Affiliate for the benefits otherwise payable to me by any third party including major medical benefits. I understand that a service fee may be charged for the processing of any uncollectible check presented as payment for goods/services provided by an Affiliate. I agree to pay the Affiliate the patient responsibility, including co-insurance and deductibles, not covered by the patient's insurance, subject to applicable Medicare and Medicaid advance notice requirements.

READ BACK PAGE FOR FURTHER INFORMATION.

_____ Date:____/____/____ Time:_____ ☐ AM ☐ PM
gnature of patient, closest relative, legal guardian, or other authorized person

_____ Date:____/____/____ Time:_____ ☐ AM ☐ PM
gnature of Witness

ITE: If this document is signed by someone other than the patient, complete either A, or B. If a verbal consent is obtained, complete C, whichever applies:

The patient is a minor.

The patient is unable to consent because: _____

Verbal consent received due to: _____

_____ Date:____/____/____ Time:_____ ☐ AM ☐ PM
jnature of Additional Witness

FH Affiliate Agreement - Yearly = 100435

ffiliate Conditions of Admission and/or
eatment Agreement- Yearly - Item # 37988

ORIGINAL - Medical Records
CANARY - Patient

02/22

Froedtert & Medical College of Wisconsin
9200 West Wisconsin Avenue
P.O. Box 26099
Milwaukee, WI 53226-3596

6. **Medical Claims**: I request that payment of authorized Medicare benefits, if applicable, and any Medigap Supplemental Insurance benefits identified by me and provided to or on file with the Affiliate on this date, be made either to me or on my behalf to the Affiliate for any services furnished me by that provider. I authorize any holder of medical information about me to release to Medicare, its agents, and Medigap Supplemental Insurance identified by me, any information needed to determine these benefits or the benefits payable for related services. The authorization contained in this paragraph remains in effect until the date specified for the expiration of this Agreement unless I revoke it sooner or unless I become an inpatient, at which time I will sign a new authorization.

7. **Intent to Donate Unclaimed Patient Refunds:** Occasionally a patient is owed a refund. It is the Affiliate's policy to refund all amounts due to patients. However, if you are owed a refund and the Affiliate is unable to locate you (or your estate) at your last-known address, the Affiliate may ultimately be required to turn over the refund to the Treasurer of the State of Wisconsin pursuant to the laws governing unclaimed property. If the monies remain unclaimed, the State Treasurer will deposit them in the State school fund. Alternatively, a patient may designate that refunds that are not claimed are donated as a gift to the Affiliate. By signing below, I agree that if I am owed a refund and the Affiliate is unable to locate me at my last-known address within one year of the discovery of the refund due, or if the refund amount owed me is less than $20.00, I hereby donate the refund to the Affiliate, at the Affiliate's discretion.

8. **Disclosure of Confidential Information:** To the extent necessary to determine liability for payment and to obtain reimbursement, I hereby authorize the Affiliate to disclose information, including portions or all of my medical record, to any person or public or private funding sources providing health care insurance or reimbursement to or on behalf of the patient (including, but not limited to, Medicare, Medicaid, or other insurance). I understand the specific type of information to be disclosed includes diagnosis, prognosis, and treatment for physical illness, and, where applicable - mental illness, developmental disabilities, HIV test results or AIDS or any AIDS-related diagnosis, alcoholism or drug abuse for the purpose of enabling such evaluation or treatment to be performed.

9. **Personal Valuables**: Currency, watches, rings, necklaces, wallets, credit cards and other personal valuables should be retained outside the Affiliate's facility. Upon admission as an inpatient, if no one can retain such items outside the hospital, the patient may request to store items in the Affiliate's safe. A special waiver form must be signed by the patient before the Affiliate accepts such valuables and before the patient is admitted to the unit. I understand that the patient will be responsible for all articles kept in the patient's room, that the Affiliate assumes no control over personal valuables not deposited in its safe. I understand and agree that the Affiliate assumes no responsibility to reimburse for any loss or damage to money, jewelry, glasses, dentures, personal clothing or other articles brought by or for me to the Affiliate. I understand that the Affiliate maintains a safe for the storage of valuables and other articles during inpatient hospitalization that I may utilize upon request.

10. **No Smoking, Unauthorized Weapons or Firearms Policy:** I understand that no smoking, or unauthorized weapons or firearms are permitted anywhere in the Affiliate buildings and/or the grounds. I understand that a patient who leaves the building to smoke does so at the patient's own risk and is solely responsible for any and all adverse effects that may occur.

11. **Ongoing Care Needs:** At the time of admission/registration, it is important to start considering and planning for any care that might be required after discharge and/or after leaving the clinic. I understand that I have the freedom to choose and the right to select my provider for post-discharge and post clinic care. I am aware that for home health care and hospice services after discharge, the hospital will generally recommend Horizon Home Care and Hospice (an affiliate of the hospital), Froedtert & the Medical College of Wisconsin Home Infusion, or another affiliate of the hospital, unless I select a different provider. I understand that I will receive a list of other available home care agencies when specific discharge plans are discussed, and that I may ask a nurse/case manager for the list at any time.

12. **Notice Regarding Patient Health Care Records:** I acknowledge that upon submitting a valid, written authorization, I may inspect and/or receive a copy of my health care records, including radiology reports, at my own expense. The review shall take place in the Affiliate's Health Information Management (HIM) Department during regular business hours, upon reasonable notice. I am aware that I may authorize other persons to review and receive a copy of my medical records by signing a valid authorization form. An Authorization form that complies with the legal requirements can be obtained from the Affiliate's HIM Department.

13. **Contact Made Via Telephone:** I authorize Froedtert Health and its Affiliates or contractors to contact me for any purpose, including appointment reminder calls or calls for payment of services, at the current or any future numbers that I provide for my landline telephone, cellular telephone or any wireless device, including the use of automated dialing equipment or prerecorded voice or text messages.

Parent Information Questionnaire

Name of Student:_____

Date of Birth:_____

Please complete this form to the best of your ability, as this will help to provide important information to provide the most appropriate treatment. Thank you!

General Background:

1. Was the child born full Term? Yes No (circle one)
2. If not, how far along?
3. Where any added stressors or complications during the pregnancy (parents fighting, illness, moves, adoption)?
   Explain:

4. Did your child meet all developmental milestones on time? (walking, talking, toileting)
   Yes No (circle one)
   Please note any delays:

5. Has your child ever had special education classes or an Individual Education Program? Yes No
   If yes, which years in school:

6. How well did your child detach from you when they began school? (ie, did they hold onto your leg and refuse to let you leave, walk away without so much as a forward glance, etc).

7. Are you aware of any deaths, bullying, or other events in your child's early life which they may have found traumatic? Yes No

8. Is yes, what happened and how old were they?

Family History:

9. Is there any family history of mental illness (Depression, Anxiety, ADHD, Obsessive Compulsive Disorder, Schizophrenia, suicide, Substance Use or Addiction etc). If so, which family members:

Diagnosis	Family Member 1	Family Member 2	Family Member 3
Depression			
Anxiety			
Suicide			
Bipolar Disorder			
Alcoholism			
Drug Addiction			

Obsessive Compulsive Disorder			
Other			

10. Is there any family history of medical conditions? Which family members, and what conditions?

Family member	Diagnosis 1	Diagnosis 2	Diagnosis3	Diagnosis 4
Mother				
Father				
Grandmother (P)				
Grandfather (P)				
Grandmother(M)				
Grandfather (M)				
Aunt/Uncle				

Treatment information:

11. Has your child ever been to counseling before?

Date of treatment	Diagnosis	Therapist or Clinic	Outcome

12. To your knowledge, has your child ever used alcohol or drugs?

13. Is your child currently on any medications? Please list.

14. What are your biggest concerns regarding your child?

15. Is there any other information you would like his/her therapist to know which has not been asked?